"The art of nursing, a new profession," boasted Florence Nightingale in the 1890. Our wildest dreams could never have imagined the advances and changes in nursing and health care over the last century. The lighted glow of the Florence Nightingale lamp has shown the way, but will we be able to keep it lit as we meet the challenges that lie ahead?

Nursing has been present throughout the century responding to advances in health care technology, hospital reorganizations, health care reimbursement developments, and diverse environments in need of care. It has transitioned with the discovery of blood typing, antibiotic creation, vaccine development, transplantation of organs, and new innovative therapies for cancer treatment. We have survived hospital expansions, downsizing, specialization, and multiple mergers. Nursing has weathered the storm of health care reimbursement challenges. The development of Medicare, the impact of Medicaid, HMOs, PPOs, ICD coding initiatives, and reimbursement regulations have all influenced our practice.

Nursing has moved into diverse environments. We have taken care out of the hospitals back into the home. We have moved care into our prisons, schools, workplaces, and local outpatient facilities. Nurses have followed our military endeavors around the world in times of peace and war. Nursing has grown with new technologies and met the challenges of integrating them into patient care information. Radiology advancements have enhanced the nursing role. We have grown with the computer industry, incorporating informatics into care delivery systems.

In an effort to continually promote the nursing profession and meet the needs of our patients, nursing educational opportunities have broadened. Throughout this nursing transformation, we as nurses have continued to demonstrate over and over again our commitment to the patients in our care. Even with all of the above changes, we continue to be patient advocates, sharing moments of joy and sadness, and touching the hearts of those in need. We care!

What lies ahead of us in the next century? No doubt there will be more change. New advances in medicine will continue to broaden our knowledge base and force us to develop new standards of practice. A commitment to advancing educational opportunities will answer the need for a strong nursing work force and well-developed professional leaders. Nurses will have to be flexible to face the challenge of meeting patient needs within the ever-changing health care reimbursement guidelines. The nursing scope of practice will be redefined and broadened to include new technology that will ultimately replace some of our technical skills and create new opportunities. Strong international colleague relationships will be necessary to foster support, maintain our focus, and share innovative ideas in our diverse profession. As the world continues to explore space, nurses will be involved and are already making an impact. Why must we focus on the future? Because we care!

continued on page 18
**President’s Message**

**Nurturing the Nurturer**

Many of us entered this wonderful world of nursing because we are truly nurturers at heart. Nursing is the most caring and nurturing profession in the world. It has been documented on several occasions that people trust nurses. We receive our rewards when we have touched another human being’s life with kindness and care. We give so much of ourselves on a daily basis. How do we re-energize, refuel, and refocus ourselves? Where does the nurse go to be nurtured? Who cares for the care giver?

We all have heard the saying “physician, heal thyself.” I believe that nurses are not very good about taking care of themselves; we tend to put everyone else first. At times, we feel guilty about putting ourselves first or saying no, even when we are pushed to our limit. However, it is nearly impossible to take care of others unless you are physically and emotionally fit. Your life must have some balance to be an effective care giver.

**The Balanced Life**

The demands of life can have you focusing in many different directions. Managing multiple tasks in both your professional and personal life may make you feel like you are about to explode, so it is very important to have balance in your life. Living a balanced life means that you are able to give some of yourself to your profession and personal life. You should focus on doing a few things really well. “Put yourself wholeheartedly into something, and energy grows. If, on the other hand, you are divided and conflicted about what you are doing, you create anxiety. And the amount of physical and emotional energy consumed by anxiety is exorbitant” (Helen DE Rosi, MD).

In order to have balance, you should give up on the idea that you must be perfect at everything and instead concentrate on your strengths. Many nurses are over achievers and feel bad when they can’t accomplish it all. Nurses do not like to say the word no. Learning how to balance career and family is a must if you are going to live a balanced life. Although you may work hard at your job, you still need to spend time with your family, friends, and even yourself to achieve a well-rounded life.

**Nurturing Yourself**

When you leave work for the day, leave work. Don’t bring work home with you unless it’s absolutely imperative depending on your role. If you must bring work home, set a time when you put it away and finish for the day. Take time out to take care for yourself. You can do this by penciling time in for yourself. Write it down on your calendar, or log it into your Day Timer or PDA. Do something good for yourself everyday. Take the time to smell the roses, read a good book, take a walk, or try yoga. Lock yourself in the bathroom, light some candles, put on your favorite music, and take a bubble bath. Become organized, don’t overextend yourself, and learn how to say no gracefully without feeling guilty. Let your answering machine take the calls during your scheduled “me time” and get back to people at your own pace – just as long as you remember to get back to them. Nurses, nurture yourselves! Only then can you truly care and nurture others.

Doris Greggs-McQuilkin, MA, BSN, RN

AMSN President

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**Clinical Practice Committee**

The AMSN Clinical Practice Committee is a dynamic and essential part of AMSN. The committee functions in selection of recipients of the Clinical Leadership and Clinical Practice Awards, which are presented during the AMSN Annual Convention. The committee is also responsible for reviewing the AMSN Scope and Standards, as well as developing, approving, and distributing position statements.

Position statements play an important role in directing adult medical-surgical nursing care and nursing practice. Clinical Practice Committee members are responsible for writing and critiquing position statements. It is important that potential members recognize that this is a working committee. Therefore, each member’s commitment and contribution is vital to the success of the committee. Existing position statements may be reviewed on the AMSN Web site (www.medsurgnurse.org). A template has been developed to aid in creating a position statement.

Please contact Nancy Ciarrocca, Chairperson, by phone, e-mail, or U.S. mail if you are interested in serving on this committee or require additional information.

Nancy Ciarrocca, Chair
651 Elliott Dr.
Lewisberry, PA 17339
Phone: 717-938-4423
E-mail: nciarrocca@comcast.net
nciarrocca@pinnaclehealth.org

We look forward to hearing from interested individuals who are willing to assist AMSN in serving the medical-surgical patient and professional nurse.

Nancy Ciarrocca, RN
Chair, AMSN Clinical Practice Committee
The Academy of Medical-Surgical Nurses’ (AMSN) growth and the evolving expectations of AMSN’s members have inspired the Board of Directors to consider a new model of governance. Although the region-based model has worked well since AMSN’s inception, the Board of Directors hopes to implement a knowledge-based strategic governance model that strengthens the Board’s focus on the core competencies and strategic direction of AMSN. To effectively implement this knowledge-based strategic governance model, the board structure needs to change. This change requires a bylaws amendment that must be approved by the membership. The following discussion outlines the rationale for the move to strategic governance and supports the bylaws changes that will be proposed to the membership.

Knowledge-Based Strategic Governance

The climate in health care and in our members’ work setting is one of constant change, evolving new treatments, workforce shortages, and increased consumer savvy, to name a few. Medical-surgical nursing is increasingly being recognized as a specialty of its own. These realities place AMSN in a position of needing to act quickly and strategically take advantage of opportunities to enhance the visibility of the specialty, provide cutting edge information and education to nurses providing health care to the adult population, and increase membership. A strong, knowledgeable, strategic, and nimble infrastructure is needed for AMSN to be proactive in leading medical-surgical nursing into the future. The Board of Director’s role in designing the future is critical.

A strategic governance model has as its center the needs of the organization’s membership. In this type of model, the AMSN Board of Directors can direct their energies on understanding the health care environment and the needs of medical-surgical nurses practicing within that environment, identifying strategies to promote excellence in practice, and fostering recognition of medical-surgical nursing as a specialty. Although this has been the mission of the Board of Directors since AMSN’s inception, the operational tasks of managing the organization have consumed much of the time and energies of the Board of Directors. Using the structure of a strategic governance model, the Board of Directors will focus on the broader issues impacting the organization and the medical-surgical nursing specialty. Therefore, they will more effectively delegate the operational aspects to AMSN committees and management staff.

Several organizations have adopted the knowledge-based strategic governance model and have cited the following advantages of the model:

- The Board of Directors has a better understanding of the needs of its diverse membership.
- The Board of Directors focuses on larger, strategic issues of the organization rather than the day-to-day operational decisions.

Restructuring the Board of Directors

An organization’s governance structure is directly connected to the mission and focus of an organization. The main goal of a governance restructure is to impact AMSN’s strategic focus and effectiveness, and enable all parts of the organization to work together better, thereby enhancing services to the membership. Competence and expertise rather than geography are the primary considerations in selecting individuals for leadership positions on the Board of Directors. The essence of the bylaws changes will focus on the composition of the Board of Directors (currently, President, President-elect or Past President, Secretary, Treasurer, and Regional Directors from the Western, Southern, North Central and Northeast regions). The offices of President, President-elect or Past President, Secretary, and Treasurer will remain the same. The proposed revisions to the bylaws include the selection, terms, and election of regional directors and regional directors-elect from each of the four regions. These revisions propose that four Board members be elected from and serve the entire membership.

The selection and election of the Regional Directors and Regional Directors-elect by geographical location limits members’ access to qualified candidates. Some qualified members cannot get on the ballot because they represent a region that does not have an open position. This process is detrimental to the organization and consequently to the membership because qualified members may be ineligible for positions because of geographic location. In addition, the present election process only allows members within a region to vote for a particular regional director; thus, four members of the Board of Directors (half of the Board) are elected by a small portion of the membership. This leads to fragmentation and the perception that the regional directors can only represent their region. The Board of Directors believes that the membership can be better served by selecting from a talent pool that is nationwide and elected by the entire membership.

Bearing in mind that it is the role of the Board of Directors to lead and govern the organization, and the role of the membership to govern the practice of medical-surgical nursing, the following proposals are presented:

1. Select and elect all Board positions nationally. This allows all members of the organization the opportunity to run for any Board position. It also allows all members to vote for all individuals who sit on the Board and represent the membership.

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Celebrate!
The Magnificent Specialty of Medical-Surgical Nursing

Chicago, IL, September 8-12, 2004, is the place to be to join in an exhilarating AMSN convention focused on the magnificence of our specialty of medical-surgical nursing. The 13th Annual AMSN Convention promises to provide opportunities for you to strengthen your knowledge, reaffirm your expertise, and network with your colleagues across the nation.

The AMSN Convention Program Committee invites you to this exciting convention, featuring 4 pre-convention workshops, 4 inspiring general sessions, and numerous concurrent sessions. The program diversity will allow each attendee to tailor the convention to meet his or her specific needs.

Pre-convention Workshops

Dr. Linda Yoder, noted nurse researcher, will conduct a dynamic pre-conference workshop entitled, Clinical Research Skills to Enhance Your Practice and Career. Dr. Yoder will discuss research methods to create outcomes management, performance improvement, and program evaluation projects that are meaningful to nursing and health care organizations. Hands-on activities will allow participants an opportunity to construct a framework for a research project. Finally, the key components for submitting a clinical or research abstract for presentation or publication will be presented.

Get out of your chair and learn is the idea of our clinical pre-conference workshop entitled, Taking the Mystery Out of Wound Care, presented by Marsha Kline, BSN, RN, CWCN, and sponsored by 3M. A national expert in the field of leadership, Connie Curran, EdD, RN, FAAN, will present our leadership pre-conference workshop focused on developing nurses in leadership roles. On Wednesday and Thursday, September 8th and 9th, AMSN Board member Karen McPherson, MS, RN, CMSRN, BC, CRNP, APRN-BC, and AMSN Education Director Sally Russell, MN, CMSRN, will present a 2-day Medical Surgical Certification Review Course. This is a perfect opportunity to review all body systems and important nursing interventions, especially if you are planning to take the Certified Medical-Surgical Registered Nurse exam offered by MSNCB.

General Sessions

Don’t miss one minute of the Saturday morning general session featuring Eyewitness News Anchor and Emmy Award Winner Anne Ryder. Anne has earned numerous national, regional, and state honors for her reporting, including the prestigious Gabriel and Wilbur awards, the Edward R. Murrow award, and more than a half-dozen Emmys. She created and produces Hope to Tell, an ongoing series of reports about hope, faith, and the resilience of the human spirit. Her reporting has taken her all over the world, from Bosnia and Kosovo during the wars, to Northern Ireland during the historic Good Friday peace accord, to Calcutta, India. Anne was the only American reporter in more than a decade to be granted a sit-down interview with Mother Teresa. It was the last interview the nun gave before her death. Anne’s documentary, In the Arms of Mother Teresa, sold more than 7,000 copies, with proceeds benefitting the Missionaries of Charity.

Connie Curran, EdD, RN, FAAN, will inspire all of us on Opening Night with a keynote address on the Magnificence of Medical Surgical Nursing. Our very own Kathleen Reeves, MSN, RN,C, and Cece Grindel, PhD, RN, CMSRN, plan to reinforce our commitment to Nurses Nurturing Nurses and provide an interesting real-life look at the outstanding results of our N3 project. Back by popular demand is Faith Roberts, BSN, RN, CRRN, to once again promote patient advocacy in a light and caring spirit.

Concurrent Sessions

Our 25-plus concurrent sessions should keep you busy and provide ample opportunity to learn new things. The hardest part is going to be choosing which session to attend. Just to give you an idea of what is planned, here are a few topics: Integrated Medicine, Critical Thinking Skills, Post-op Care, IV Therapy, Magnet Status, Diabetes, Irritable Bowel Syndrome, Pain Management at the End of Life, Delegation, Adult Asthma, Renal Failure, and Suicide Assessment in the Med-Surg Patient. In addition, Paula Frenza, BS, Ed, MA, from Mather Institute in Aging, will present a session on Dementia and Linda Hollinger-Smith, PhD, RN, from Rush University will be present on Transcultural Aging. Camilla Rogers, MSN, RN, PNP, Vice President of Quality Improvement at Mercy Medical Center in Baltimore, MD, will address the new Patient Safety Standards, and Billie Ann Wilson, PhD, RN, will return to talk about Pharmacology – Why Drugs
Don’t Work. We plan to continue our tradition of a session exploring our unique Oral Posters. Keep your eyes open for the complete convention brochure with the details on these sessions and more.

Book Review

Enjoy historical memoirs of one of Chicago’s most famous hospitals, Cook County, through the eyes of a nurse. Carol Kurels, RN, author of the book, Cooked: An Inner City Memoir, is a 1974 graduate of Cook County School of Nursing. Her book takes place in the early 70s inside the huge wards of Cook County Hospital on Chicago’s dangerous gang-ridden and drug-infested west side. There, nursing was learned by immersion in a charity hospital, where nurses provided patient care in often desperate circumstances.

First-Timers Welcome

If you are a new member or this is your first AMSN convention, don’t worry! We want you to get involved, and we will nurture you along the way. The AMSN Program Planning Committee has designed several opportunities for you to learn more about AMSN. The committee will be hosting an Orientation session on Thursday before the opening of the convention to assist you in successfully navigating the AMSN convention. Several other opportunities will be available for you to learn more about AMSN’s vision, core values, committees, and networking possibilities.

Exhibits

Opportunity abounds in our convention Exhibit Hall. Our prestigious health care colleagues will share the newest and latest in products and technology with all of us. In addition, plan to participate in the silent auction and numerous raffles throughout the convention. Posters from across the nation will outline new and innovative ideas to enhance our current nursing practice.

What Else Does Chicago Have to Offer?

Take time for yourself, spend time with old and new friends, and explore the world-famous city of Chicago. Discover unique neighborhoods, where the flavors of numerous cultures flourish, where outstanding architectural sights and a bevy of museums and galleries provide a feast for the eyes, where you’ll find music to stir your soul, and where gastronomes and shoppers alike enjoy the many outstanding restaurants and stores. Check out fantastic feats of architecture, such as Sears Tower, John Hancock Center, and Water Tower either on a walking tour or on one of several available guided tours. Museums and attractions include the Field Museum, the Museum of Science and Industry, Chicago Cultural Center, Shedd Aquarium, the Adler Planetarium, Lincoln Park, Navy Pier, and the Macabre International Museum of Surgical Science. Famous for Blues and Jazz, Chicago offers a selection of clubs so if your tastes run here, be sure to check out one or a few. For others, Chicago is synonymous with shopping, and it doesn’t get any better than along N. Michigan Avenue, also known as The Magnificent Mile. Well known, too, are the wide varieties of dining establishments. From pizza and hot dogs, to superb steaks, seafood, and ethnic cuisine, Chicago is a food lover’s paradise. These are but a small sample of the many diversions the city of Chicago has to offer. Be sure to make time to visit the many sights, tastes, and attractions of this exciting city. The magnificence of Chicago is second to none!

Well, are your bags packed yet?! Get ready to attend the 13th Annual AMSN Convention, The Magnificent Specialty of Medical-Surgical Nursing. Mark your calendar and plan to celebrate from September 9-12, 2004. We look forward to seeing you in Chicago!

The AMSN Program Planning Committee

2004 Cover Photo Contest

Capture the spirit of MEDSURG Nursing while promoting your institution! The journal is sponsoring a photography contest for AMSN members and friends of medical-surgical/adult health nursing. The first prize winner will receive $250 and one complimentary registration to the 13th Annual AMSN Convention in Chicago, IL, in September, 2004. Honorable mention photographs will also be selected. Award winning photographs will be featured on the cover of future issues of the journal. Photos may be submitted by individuals or institutions through their public relations department or agency.

Purpose: To communicate the commitment and professional and clinical excellence of adult health/medical-surgical nurses as they practice in a variety of health care settings, such as private practice, acute, general, critical-care, long-term care, outpatient, home health, sub-acute, and community settings.

Criteria

1. Submit photographs consistent with the purpose.
2. Photos must be clinically accurate as well as aesthetically sound.
3. Submit 8” x 10” color prints produced from at least 35 mm negatives.
4. Submit prints in a protective covering.
5. Obtain a signed photo release form on the agency’s letterhead or other appropriate form from all identifiable parties pictured in the photograph.
6. The deadline for receipt of entries is August 1, 2004.
7. Entries should be submitted to: MEDSURG Nursing, East Holly Avenue Box 56, Pitman, NJ 08071-0056.

All entries become the property of MEDSURG Nursing and will not be returned. For further information, contact the journal office: MEDSURG Nursing East Holly Avenue Box 56 Pitman, NJ 08071-0056 (856)256-2300 • FAX (856)589-7463 e-mail: msjrnl@ajj.com
During National Nurses Week and International Nurses Day, the nations of the world acknowledge the tireless efforts of nurses to keep our countries healthy. National Nurses Week begins May 6th and ends on Florence Nightingale’s birthday, May 12th. This year’s theme is *Nurses: Your Voice, Your Health, Your Life.* Since 1996, May 6th has been designated as National RN Recognition Day to honor the nation’s registered nurses. Nurses across the country will be honored at numerous events, such as dinner receptions and hospital functions. According to the 2003 CNN/USA Today Gallup Poll, U.S. nurses rank first for honesty and ethics. Nurses were added to this list in 1999 and have since taken the top honor every year, except in 2001 when firefighters ranked first.

International Nurses Day is celebrated around the world every May 12th, the anniversary of Florence Nightingale’s birth. The International Council of Nurses theme for 2004 is *NURSES: Working with the Poor; Against Poverty.*

Nurses are encouraged to observe and participate in Cover the Uninsured Week, May 10-16, 2004. Nurses see firsthand the consequences that stem from a lack of health insurance coverage: sicker patients who have postponed needed health care. More than 1,000 events will take place during Cover the Uninsured Week, involving nurses, doctors, union members, business owners, hospitals, members of religious groups, students, grandparents and people from all walks of life and every point of view. For more information, visit www.CovertheUninsuredWeek.org.

Traditionally, National Nurses Week is devoted to highlighting the diverse ways in which registered nurses, the largest health care profession, are working to improve health care. From bedside nursing in hospitals and long-term care facilities to the halls of research institutions, state legislatures, and Congress, the depth and breadth of the nursing profession is meeting the expanding health care needs of American society.

The Board of Directors for the Academy of Medical-Surgical Nurses and the Medical-Surgical Nursing Certification Board would like to take this opportunity to salute our medical-surgical nurse colleagues for all the work that you do year-round. Nurses work for the benefit of others. Despite this, it was very difficult to get a week of recognition established. The history of National Nurses Week follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1953</td>
<td>Dorothy Sutherland of the U.S. Department of Health, Education, and Welfare sent a proposal to President Eisenhower to proclaim a “Nurse Day.” No proclamation was made.</td>
</tr>
<tr>
<td>1954</td>
<td>National Nurse Week was celebrated October 11-16. The year of the observance marked the 100th anniversary of Florence Nightingale’s mission to Crimea. During this same year, Representative Francis P. Bolton submitted a bill for nurses week.</td>
</tr>
<tr>
<td>1955</td>
<td>The bill was introduced to Congress, but no action was taken. Congress discontinued its practice of joint resolutions for national weeks of various kinds.</td>
</tr>
<tr>
<td>1972</td>
<td>A resolution was presented by the House of Representatives for the President to proclaim “National Registered Nurse Day.” It did not occur.</td>
</tr>
<tr>
<td>1974</td>
<td>A week was designated by the White House as National Nurse Week, and President Nixon issued a proclamation.</td>
</tr>
<tr>
<td>1978</td>
<td>Governor Brendon Byrne of New Jersey declared May 6th as “Nurses Day.” Edward Scanlan, of Red Bank, NJ, had this date listed in Chase’s Calendar of Annual Events. He promoted the celebration on his own.</td>
</tr>
<tr>
<td>1981</td>
<td>The effort was made to have National Recognition Day for Nurses held annually on May 6th. This became official when President Reagan signed a proclamation on March 25, 1982.</td>
</tr>
<tr>
<td>1982</td>
<td>The ANA Board of Directors expanded the recognition of nurses to a weeklong celebration, declaring May 6-12, 1991, as National Nurses Week.</td>
</tr>
<tr>
<td>1993</td>
<td>May 6-12 was designated as the permanent dates to observe National Nurses Week.</td>
</tr>
<tr>
<td>1996</td>
<td>National RN Recognition Day on May 6 was initiated to honor the nation’s indispensable registered nurses for their tireless commitment 365 days a year.</td>
</tr>
</tbody>
</table>
The Aging Nursing Workforce: A Global Concern

While at the AMSN Convention in Reno, NV, in October 2003, an intense feeling of déjà vu overcame me while listening to the presentation by Dr. Cecelia Gatson Grindel. Listening to the many issues raised during this session, one might imagine that the participants worked in New Zealand! The situation in New Zealand appears to be very similar to that which is currently giving rise to great concern in the U.S., particularly the aging nursing workforce. AMSN members may be interested in the following data.

Nurses and midwives in New Zealand are required to hold an annual practicing certificate (APC), which is issued by the regulating body, the New Zealand Nursing Council. A workforce questionnaire accompanies the APC application form sent by the Nursing Council of New Zealand in March each year to nurses and midwives on the Register or Roll of Nurses. The 2003 nursing and midwifery workforce survey data provides statistical information about the active New Zealand registered nurses and midwives, and enrolled nursing workforce in both the private and public sectors in New Zealand who purchased an APC.

In 2003, a total of 49,308 nurses completed the questionnaire, and 36,514 of them also met the criteria of an active nurse or midwife; only 6.3% were male. Of these, 65% were age 40 years or older, and less than 9% were age 29 or younger. Many of these nurses will be retiring from the workforce over the next few years, giving rise to the concern as to how these experienced nurses can be replaced. Although many nurses work part-time, 50% work 33 hours or more a week. With respect to ethnicity, the majority of New Zealand nurses identified themselves as European (70%), and only 7.6% identified themselves as Māori (the indigenous people of New Zealand).

Data from the Nursing Council of New Zealand indicate that 23% of nurses with a current practicing certificate work in primary health care or the community. In May 2003, the New Zealand government published the results of a survey of the primary health and community nursing workforce (The Primary Health Care and Community Workforce Survey – 2001 [http://www.moh.govt.nz/moh.nsf/wpgIndex/Publications-Online+Publications+Contents]).

A number of issues were identified in the survey results and are as follows:

- The primary health care (PHC) and community nursing (CN) professions recruit and retain low numbers of Māori and Pacific Island nurses.
- The PHC and CN workforce is older than the general workforce, with relatively few recruits from younger age groups. Seventy percent of PHC and CN are over 40 years of age.
- The geographic distribution of PHC and CN does not match the regions with high health care needs.
- While educational opportunities are theoretically available to most nurses, some cannot access education because of lack of time, finance, and relief staff.
- Clinical career pathways are unavailable to over half the nurses who responded to the survey. The clinical career pathway is essential to improving the education, status, and retention of nurses in clinical practice and underpins developments such as the role of nurse practitioner.

M. J. (Nick) Nicol, PhD, BSc(Hons), RGN, RPN
Senior Lecturer, School of Health Sciences
Massey University
Auckland, New Zealand.

Preparing an Effective Poster Presentation

Posters are excellent forums for communicating creative nursing interventions, new models of delivery of services, and innovative research projects in a relatively short time to a wide audience. A poorly presented poster can easily sink the best ideas. The AMSN Research Committee recommends guidelines for all poster presentations.

General Guidelines

1. Viewing distance: The lettering should be at least 1 inch high and legible from 4-6 feet. Design the poster with bold and easily readable letters. Regular size, typed-up pages as the poster itself are inappropriate.

2. Subsections: Subsections of the posters as outlined above should be arranged from left to right to facilitate easy reading.

3. Use of graphs, models, and enlarged pictures: The uses of these techniques are highly recommended because they enhance the visual attractiveness of the poster and expedite communication.

4. Amount of information: Keep the details to a minimum. A good comprehensive abstract should be viewed within five minutes or less. It is the tidy, readable, and appealing poster that will attract viewers.

5. Resources: Regular poster board is the most common material used for posters. Avoid too bright, too light, or too dark colors unless contrasting letters are used. In addition, use of commercial or institutional graphic departments, computer software packages, media specialists, or consulting with experienced colleagues are encouraged. Also, there are a number of excellent “How to Prepare Posters” articles that may be helpful to review before preparing a poster.

Visit AMSN’s Web site (www.medsurgnurse.org) for expanded poster guidelines.
Ethical/Legal Issues at the End of Life

End-of-life care has always been a complex, multidimensional aspect of nursing care, but with increasing technology, changes in family structures, managed care, and health care choices that seem never-ending, this is even more complex than in the past. Key issues that affect nursing practice in this arena include the lack of family members available to care for the dying person, increasing fears of being sued, aging of the population, access to hospice services, palliative care and the obstacles to its use, and reimbursement concerns. Ethical dilemmas, which are everywhere, are even more clear in this aspect of nursing care as decisions about supporting or life-ending interventions are made every day. The decisions made are affected by the culture, values, and religion of those having to make those decisions, and this becomes even more difficult when a clash exists between those giving the care and those receiving it.

This article will focus on some of the ethical issues and dilemmas in end-of-life care. While this is not a complete list, nor can one article address all the permutations that occur in individual situations, it is imperative that nurses recognize their role as members of the health care team responsible for assuring that the person and significant others have the ability to make fully informed decisions with full knowledge of their options and consequences of those options.

Decision-making and Communication Issues

Issues of decision making and communication require thought about who can, or should, be making the decisions and communicating those decisions to others.

In order to take part in the informed consent process, people must have the ability to understand what they are being told, think about the options presented, evaluate the benefits and risks, and let others know of their decisions. Unless proven otherwise, adults are presumed to have the capacity to make decisions for themselves. Capacity means the ability to do these things, while competence is a legal term determining how well the person understands the decisions they are making. When a person does not have the capacity to choose, living wills, health care proxy, or power of attorney for health care decisions are mechanisms that may be utilized. The main elements involved in consent are that it is voluntary and not coerced, and that the person has the capacity to make the decision after given all the necessary information.

Confidentiality is a critical ethical issue, as nurses are involved in very intimate, private relationships with people in the end-of-life experience. A trusting relationship is essential for the work to be done during this time period, and the nurse is required to be diligent about keeping the confidences shared. Disclosure, the revealing of information about the patient’s illness, has created some concern because families sometimes ask that a patient not be told the nature of the illness or the prognosis. Research and clinical practice has shown that open and honest communication is preferable, as energy is spent with everyone hiding what they know from everyone else, decreasing the ability of the person dying to share thoughts and feelings with those around them. The patient has the right to decline information, but that request should be dictated by the patient.

Advance care planning is a process of decision making and the communication of those decisions between the person and his/her family, friends, and health care team. This assures that the patient’s choices are known even when not able to participate in discussions about how, where, and with whom to live the end of life. This also involves the person deciding and designating who should make decisions on the patient’s behalf when he or she is no longer able to do so.

Patients with dementia have been assumed to be unable to participate in decision making, but current research indicates this is an inaccurate assumption (Mezey, Teresi, Ramsey, Mitty, & Bobrowitz, 2000). An assessment tool, Guidelines for Determining Capacity to Execute a Health Care Proxy, is being tested to give people with dementia a voice in their end-of-life care. Early unpublished findings of people with mental illnesses suggest that those with severe mental illness can participate in end-of-life decisions and that their concerns are no different than anyone else’s (Midwest Bioethics Center, 2001). Adults with developmental disabilities can also make sound end-of-life treatment decisions when help is provided (Midwest Bioethics Center, 2001).

This article is the fourth in a series of articles on end-of-life issues. Education Director Sally Russell, MN, CMSRN, represented AMSN at the End-of-Life Nursing Consortium, a 3-day training program held in Pasadena, CA, in January 2003. The Consortium, which was conducted by a distinguished faculty of researchers, educators, authors, and leaders in the field of palliative care, was designed to provide nursing continuing education providers with information on end-of-life care and resources to use in integrating end-of-life content into continuing education activities.
Ethical decisions encountered frequently at the end of life deal with prolongation of life, withholding of treatment, Do Not Attempt Resuscitation orders, assisted suicide, nurses providing palliative care, euthanasia, medical futility, and pain control. While these issues do not occur in a vacuum, with more than one being a concern at any given time, the scope of this article does not lend itself to being a deep discussion on these issues, which are necessary for care givers. There should be an on-going discussion about these issues among those working with people in the end-of-life stage. In addition, a discussion between the patient, his or her significant other, and family members should be conducted in order to determine that everyone is aware of the issue and the ramifications of decisions made.

Prolongation of life actually involves more than keeping someone alive with curative treatments. For instance, an issue may arise about providing antibiotics for a secondary infection, which by clearing up the infection may prolong the life of the suffering person. Life-sustaining measures may be appropriate to relieve symptoms but may be seen as prolonging the suffering of the one who is dying. However, other aspects of this issue may have psychological benefits; using these measures may allow family members to become prepared for the person’s death and give them a chance to say their good-byes. Resuscitation may be viewed as a different aspect of life-saving measures, and it should be able to be either accepted or refused by the patient or surrogate. Access to end-of-life care should never be dependent on the code status of a person.

Withholding treatment may be a choice when the person or surrogate decides that the treatment is worse than the disease itself, and discontinuing treatment should be seen as an action that allows the disease to progress on its natural course, not one intended to cause death. Health care professionals often find this decision difficult because it can be viewed as not supporting life; however, this decision should be made by the patient and/or surrogate.

Do Not Attempt Resuscitation confirms and expresses that if cardiopulmonary arrest occurs, no measures are initiated. This is the only intervention that requires an order prohibiting it.

Assisted suicide refers to a practice where someone other than the patient provides a means to that patient with the knowledge that the patient will use it to commit suicide. The person doesn’t administer the treatment to the patient but only provides the means for the patient to voluntarily end his/her own life. The Supreme Court ruled that an individual does not have a Constitutional right to assist with dying, nor that physicians have the obligation to provide it (Vacco v. Quill, 17 Oct 2293, 1997), but a movement to protect those who do assist with suicide has begun. However, the right to palliative care is widely accepted, and the same U.S. Supreme Court decision supported the right of all Americans to receive quality palliative care.

Euthanasia has been defined as an act by which the cause of death is administered by someone other than the patient. A patient requesting euthanasia is asking the other person to take an active role by intentionally hastening the patient’s death. This action essentially creates a different pathological state than the one caused by the disease process because the agent (usually a drug) causes the patient’s death. Serious legal ramifications occur with this practice, even when done with the patient’s involvement and consent. There are other cases that blur the acceptance of euthanasia, as seen when health care givers take it upon themselves to deliver lethal doses of drugs to “put the patient out of his misery” without the patient’s request to do so.

Ethics committees are often called to consult in situations where medical futility is believed to exist. These conflicts typically result when there has been a failure in communication over prognosis or benefit versus burden of treatment options. Some institutions have developed policies in which the prognostic data is used to assist in determining when treatment is futile. Alone, this does not solve the disagreement about quality of life, but it may start the necessary discussions among the parties involved.

Pain control becomes an ethical dilemma when care givers hesitate to give full and effective doses of pain medication for fear of hastening death. A Catholic theological principle has been used as justification for this treatment use at end of life, known as the principle of double effect. When an action is taken for its intended good effects but has known harmful effects, the principle asserts that the act is not wrong and that the good is sufficiently desirable to compensate for allowing the harmful effect.

Nursing Implications

Nurses have an obligation to be knowledgeable about the ethical and legal dilemmas of professional practice, and to understand that these issues are inevitable in end-of-life care. When conflicts occur during the end-of-life experience, resolution can often be achieved through a foundation of ethical practice and thought. Standards of practice assist in guiding nurses in carrying out patient care as they establish an ethical standard for the nursing profession. Nurser Practice Acts provide essential information from the legal standpoint of nursing practice. Organizational ethics are increasingly being seen as methods for establishing standards related to pain management issues, advance care planning, treatment cessation, and resource allocation. JCAHO has been increasingly monitoring for evidence of organizational commitment and involvement in addressing the ethical dimensions of care.

Conclusion

When an ethical dilemma occurs, it is the nurse’s responsibility to assure that the patient and family understand the options available, that the patient’s and family’s wishes and desires to others on the care team are clarified, and that communication among all those involved occurs. If the dilemma cannot be resolved through care planning, using a formal case analysis or involving the Ethics Committee in the organization may be helpful. In keeping all avenues of communication open, and in searching for the answers in the most complete manner possible, the treatment of the dying person and his or her family will be more complete and honest.

Sally S. Russell, MN, CMSRN
AMSN Education Director
continued on page 27
Certified Medical-Surgical Registered Nurse is the earned credential that recognizes that the highest standards of medical-surgical nursing practice have been achieved. You can become certified by successfully completing the MSNCB examination.

EXAM DATES and LOCATIONS
October 16, 2004 and September 13, 2004
Exam is given in all sites on October 16 and in Chicago, IL, on September 13.

Scottsdale, AZ  Albuquerque, NM
Los Angeles, CA  Amityville, NY
San Diego, CA  New York, NY
San Francisco, CA  Rochester, NY
Hartford, CT  Charlotte, NC
Denver, CO  Cincinnati, OH
Pompano Beach, FL  Cleveland, OH
Orlando, FL  Portland, OR
Atlanta, GA  Philadelphia, PA
Honolulu, HI  Pittsburgh, PA
Chicago, IL  Memphis, TN
Indianapolis, IN  Nashville, TN
New Orleans, LA  Dallas, TX
Boston, MA  Houston, TX
Lansing, MI  San Antonio, TX
Minneapolis, MN  Alexandria, VA
Kansas City, MO  Virginia Beach, VA
St. Louis, MO  Seattle, WA
Omaha, NE  Spokane, WA
Freehold, NJ  Milwaukee, WI

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:
AMSN 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

CMSRN Application Deadline:
Postmark by August 28, 2004
Add $35 late fee for postmark between August 29 - September 11, 2004

For many people, the older years are far from golden. Illness, loneliness, or the death of a spouse or friends can cause depression to become a constant companion. Depression is the most common diagnosis of those who commit suicide. Although older adults make up only 13% of the population, they comprise 18% of all suicide deaths.

A study conducted by investigators at New York-Presbyterian Hospital/Westchester Division and the Universities of Pennsylvania and Pittsburgh have published findings of the PROSPECT Study (Prevention of Suicide in Primary Care Elderly: Collaborative Trial). The researchers’ results show that older patients’ suicidal thoughts and depression tend to go away more quickly when their own primary care physician uses a trained care manager to offer guideline-driven antidepressant treatment and to encourage patients to adhere to treatment recommendations.

The PROSPECT Study focused on primary care patients because two-thirds of depressed elders receive care for depression by their own primary care physicians and rarely follow through when referred to a mental health specialist. In the study, a specially trained “care manager,” who follows a set of treatment guidelines modified specifically for older adult patients, was assigned to patients experiencing depression and suicide thoughts. While trained by geriatric psychiatrists, the care manager reports to the primary care doctor, who is ultimately responsible for all treatment decisions.

The study included 598 patients age 60 years or older suffering from major depression or minor depression that persisted for at least one month. Approximately half of the patients received usual care by their own physicians, while the remaining half received the PROSPECT intervention. The intervention consisted of the services of a depression care manager who collaborated with the patient’s own physician.

The initial step-by-step treatment guidelines offered an antidepressant (citalopram) or if the patient requested it, interpersonal psychotherapy. If patients failed to respond to the initial treatment steps, the guidelines provided detailed alternative recommendations. The care managers not only helped primary care physicians with the recognition and treatment of depression, but they also followed the patients either in person or by telephone, and encouraged adherence to treatment.

Among intervention patients who reported suicidal ideation at the beginning of the study, 71% no longer had suicidal thoughts in the intervention practices eight months later. In contrast, only 44% of usual care patients who had suicidal thoughts at entry to the study lost these thoughts by the eighth month of follow-up. Practices offering the care management intervention were more effective in reducing symptoms of major depression early in treatment. The beneficial effect of the care management intervention peaked at four months.

For more information about the PROSPECT Study, contact 212-821-0566.

Reference
Nurses for a Healthier Tomorrow Launches Campaign To Increase Number of Nurse Educators

Nurses for a Healthier Tomorrow (NHT), a coalition of 43 national nursing health care associations addressing the nursing shortage, is launching a new campaign to recruit nurses to become educators. The campaign is titled, Nursing Education...Pass It On.

The goal of the campaign is to increase the number of nurse educators – a shortage of which is causing some nursing schools to turn away prospective students. “We’re in the middle of a nursing shortage in this country,” explains Ada Sue Hinshaw, PhD, RN, FAAN, dean and professor, University of Michigan School of Nursing. “We cannot afford to have colleges and universities deny nurse education to students who want to enter the profession simply because we don’t have enough teachers.”

According to the American Association of Colleges of Nursing (AACN), a Nurses for a Healthier Tomorrow member, U.S. nursing schools turned away more than 11,000 qualified applicants in 2003. This is significantly up from more than 5,000 in 2002. Almost 65% of the reporting nursing schools cited faculty shortages as the reason for not accepting all qualified applicants into entry-level baccalaureate programs.

Based on preliminary reports from the National League of Nursing’s (NLN) 2003 Annual Survey of Schools of Nursing, NLN projects that there will be more than 30,000 qualified applicants not accepted and placed on a waiting list for all three basic RN education programs (diploma, associate degree, and baccalaureate). NLN is a Nurses for a Healthier Tomorrow member. Those shortages are expected to worsen in the coming years because more nurse faculty will be retiring, academic compensation is not keeping pace, and fewer nurses are graduating with the advanced degrees needed to teach.

The campaign consists of four print advertisements, one Web banner, and an 8 ½ x 11-inch flyer. Through first-person testimonials, the new faculty recruitment ads convey the personal satisfaction and rewards nurse educators receive. They also direct audiences to the coalition’s Web site (www.nursesource.org), where visitors can learn more about nurse education careers.

“Nursing Education...Pass It On expresses the essence of what it means to be a nurse educator – to convey the academic knowledge one possesses, as well as the practical experience one has gained in clinical practice,” explains Gretta Sherman, senior partner of JWT Specialized Communications, a Nurses for a Healthier Tomorrow sponsor and creator of the faculty recruitment advertising campaign.

The nurse educators featured in the campaign are:

• Joanne Pohl, PhD, RN, ANP, FAAN, associate professor, associate dean for community partnerships, School of Nursing, University of Michigan, Ann Arbor, Michigan.
• Randolph Rasch, PhD, RN, FNP, professor and program director, family nurse practitioner specialty, School of Nursing, Vanderbilt University, Nashville, Tennessee.
• Carol Toussie Weingarten, PhD, RN, associate professor, College of Nursing, Villanova University, Villanova, Pennsylvania.
• Debi Vendittelli, MSN, RN, associate professor, Department of Nursing, Schoolcraft College, Livonia, Michigan.

“As nurses, we are essential to the health of our communities, be they local or global. As nurse educators we ensure that our communities have the nurses who are prepared to meet current and future health needs and to lead the next generation of health care providers,” said Weingarten.

In the fall of 2001, the Nurses for a Healthier Tomorrow coalition launched a national advertising campaign to address the nursing shortage. Titled, Nursing. It’s Real. It’s Life, the goal of the ads was to boost the attractiveness of nursing as a profession. According to a 2002 report issued by the U.S. Department of Health and Human Services’ Health Resources and Services Administration, if current trends in nursing-care supply and demand continue, the nursing shortage will reach 20% within the next 12 years, and 29% by 2020.

Major sponsors of the Nurses for a Healthier Tomorrow faculty recruitment campaign include Platinum sponsor Lippincott Williams & Wilkins, Gold sponsor JWT Specialized Communications, Nurse Week, Nursing Spectrum, Marsh Affinity Group Services, Helene Fuld Health Trust, and the Rollin M. Gerstacker Foundation.

For more information, visit http://www.nursesource.org/campaign_news.html

Send Us Your News!

Med-Surg Matters welcomes news from Academy 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: fordc@ajj.com

DEADLINES

<table>
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<tr>
<td>Summer 2004</td>
<td>May 28, 2004</td>
</tr>
<tr>
<td>Fall 2004</td>
<td>September 3, 2004</td>
</tr>
<tr>
<td>Winter 2005</td>
<td>December 3, 2004</td>
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Central Virginia Chapter of AMSN

The Central Virginia Chapter meets on the fourth Wednesday of each month from 7:45 -9:15 p.m. (room 8410/University of Virginia Main Hospital). Each meeting begins with an educational focus and concludes with our business items. We welcome new members!

Our ongoing goals continue to be:

Provision of Med/Surg Nursing Education

- We regularly offer professional development sessions each month, most of which credit CEUs for participation. Some of our recent topics have been: Thromboprophylaxis, Are You an Expert? – The role of the Nurse Expert, Hospice Care, Using Insulin Infusions and Insulin Pump Therapy in the Hospitalized Patient, and Understanding Cognition. Future topics include Stress Reduction and Alternative Therapies.

Community Service

- Chapter members participated in several “Fridays After Five” events in 2003 (sponsored by the Charlottesville Downtown Foundation). This is a weekly community-wide event offering entertainment and refreshment to the community. AMSN members assisted the Downtown Foundation with visitor screening. Plans are underway for the chapter to participate again this summer.
- Chapter members will be volunteering at the Charlottesville Free Clinic beginning this May. As RN volunteers, we will be staffing evening clinics providing health care to the working uninsured population of Charlottesville and Albemarle County.

Support of Certification/CMSRN

- Chapter Education Coordinator offers certification review sessions.
- Ten chapter members have taken and passed the CMSRN certification exam (100% pass rate!)

Chapter Development

- We are actively recruiting new membership (to add to our 32 members). Several members are creating informational chapter flyers.
- Fundraising efforts have largely consisted of raffling of baskets. We choose a seasonal theme and match the basket items to the specific theme. For example, we will be presenting two raffle baskets for the Spring Season. The first basket is centered on a “Gardening” theme and the second basket will consist of “Car Care” items so that both genders are incorporated.

Representation at the AMSN Annual Convention

- Two Central VA Chapter members attended the 2003 Annual Convention in Reno, NV. A chapter member displayed two poster presentations.

Legislative Awareness/Involvement

- In 2004, the chapter began incorporating regular legislative updates to the meeting agenda.
- Several chapter members became involved with legislative efforts through the Virginia Nurses Association.

Career Profile

Name: Tanya Parish
Credentials: BSN, RN, LNC
Employer: Health Texas
Years in Nursing: 14
Contact Me Via: E-mail
E-Mail: codytanry@aol.com

Challenging Aspects of Job: Paperwork, paperwork, and more paperwork! Complicated patients and trying to keep up with two very busy doctors.

Job Description: In charge of back office, triaging patients, refilling meds, answering questions, patient education (such as insulin starts, insulin device education), and keeping the back office running smoothly.

Employment Experience: I’ve worked in numerous places during my nursing career. I started out as a med-tele nurse after graduation. Since then, I’ve worked as an office nurse in a family practice, staff development coordinator, adolescent psyche nurse, med-surg nurse, dermatology nurse, pediatric office nurse, and now as an endocrinology nurse.

Education: AAA and ADN from Barton County Community College; BSN from Fort Hays State University; LNC from the College of Professional Studies.

Professional Affiliations: American Nurses Association; Dermatology Nurses Association; International Association of Forensic Nurses; Texas Nurses Association; Academy of Medical-Surgical Nurses.

Best Advice: Continue to learn everything you can in life. It’s much too short to stop learning.

AMSN Chapter: Tarrant Area Chapter, Fort Worth, TX
The fifth annual National Women’s Health Week will be celebrated this year from May 9-15, 2004. It kicks off with National Women’s Check-Up Day on May 10th, encouraging women to schedule an appointment with their doctor or other health care provider for an annual check-up and health screenings. It begins on Mother’s Day and ends the following Saturday. Many different groups will participate during this week, including national women’s groups, local and national health organizations, and businesses.

National Women’s Health Week is a national effort by an alliance of government organizations, including the Department of Health and Human Services, to raise awareness about the many steps that women can take to improve their health. The goal of National Women’s Health Week is to encourage women to take simple steps for a longer, healthier, and happier life. The focus of the week is on the importance of incorporating basic preventive and positive behaviors into everyday life. It encourages awareness about key health issues that affect all women, including women with disabilities, and especially African-American, Asian/Pacific Islander, Latinas, and American Indian/Alaska Native women. Research has shown that there are significant health disparities among these groups compared to white women.

The focus of the week is to educate women to become informed and take responsibility in improving their own health. Heart disease is the number-one killer of women, but cancer ranks first among Asian/Pacific Islander women. However, white women have the highest mortality rate from lung cancer, while African-American women have the highest mortality rate from heart disease. Stroke is the third-leading cause of death in American women, but it occurs at a higher rate among African-American and Latina women. These differences show the importance of taking appropriate preventative steps based on individual backgrounds and risk factors.

What is National Women’s Check-Up Day?
National Women’s Check-Up Day is a nation-wide effort, coordinated by the U.S. Department of Health and Human Services (HHS), to encourage women to visit health care professionals to receive regular, preventive check-ups and screenings.

When is National Women’s Check-Up Day?
The second annual National Women’s Check-Up Day will be held on Monday, May 10, 2004, which is the day after Mother’s Day, the start of National Women’s Health Week.

What is the Purpose of National Women’s Check-Up Day?
The purpose is to emphasize the importance of getting regular check-ups and asking a doctor about screenings for heart disease, diabetes, cancer, and sexually transmitted diseases (STDs). Maintaining regular check-ups is one of five health habits that can contribute to the betterment of women’s health, along with exercise, a healthy diet, not smoking, and following general safety rules.

Why Is it Important for Women To Participate in this Effort?
Many of the leading causes of death among women, such as heart disease, cancer, stroke, and diabetes, can be successfully prevented or treated if the warning signs are caught early enough.

- Heart disease is the number-one killer of American women. Often thought of as a man’s disease, more women die of heart disease each year than men.
- Cancer is the second-leading cause of death of American women. Lung cancer is the top cancer killer among American women, with an estimated 65,000 deaths in 2002, followed by breast cancer and colorectal cancer.
- Stroke is the number-three killer of American women. Each year, 30,000 more women than men have strokes.
- Diabetes is the fifth leading cause of death in women. An estimated 17 million Americans have diabetes (8.1 million women), of which an estimated 6 million are undiagnosed.
- HIV and sexually transmitted diseases also have a major effect on women’s health. There are an estimated 40,000 new HIV infections each year in the United States, with about 30% of reported infections occurring in women.

How Can Women Participate in this Important Event?
To participate in National Women’s Check-Up Day, women should contact their existing health care providers or one of the participating health care providers to schedule check-ups and screening services that day. Screening continued on page 14
tests, such as mammograms and Pap smears, can find diseases early when they are easier to treat. Some women need certain screening tests earlier or more often than others. During their check-ups, women should discuss with their health care professionals which of the tests are right for them, when they should have them, and how often.

Women can prepare themselves for their check-ups with “A Checklist for Your Next Check-Up,” developed by HHS's Agency for Healthcare Research and Quality (see Table 1). For information about hosting or participating in this and other National Women's Health Week activities, visit the National Women's Health Week Web site at www.4woman.gov/whw or call 1-800-994-WOMAN (9662), or TTY: (888) 220-5446.

Women: Stay Healthy at Any Age

Checklist for Your Next Checkup

What can you do to stay healthy and prevent disease? You can get certain screening tests, take preventive medicine if you need it, and practice healthy behaviors. Top health experts from the U.S. Preventive Services Task Force suggest that when you go for your next check-up, talk to your doctor or nurse about how you can stay healthy no matter what your age. The Task Force has made the following recommendations, based on scientific evidence, about which screening tests you should have.

- **Mammograms:** Have a mammogram every 1 to 2 years starting at age 40.
- **Pap Smears:** Have a Pap smear every 1 to 3 years if you have been sexually active or are older than 21.
- **Cholesterol Checks:** Have your cholesterol checked regularly starting at age 45. If you smoke, have diabetes, or if heart disease runs in your family, start having your cholesterol checked at age 20.
- **Blood Pressure:** Have your blood pressure checked at least every 2 years.
- **Colorectal Cancer:** Have a test for colorectal cancer starting at age 50. Your doctor can help you decide which test is right for you.
- **Diabetes:** Have a test to screen for diabetes if you have high blood pressure or high cholesterol.
- **Depression:** If you've felt “down,” sad, or hopeless, and have felt little interest or pleasure in doing things for 2 weeks straight, talk to your doctor about whether he or she can screen you for depression.
- **Osteoporosis:** Have a bone density test at age 65 to screen for osteoporosis (thinning of the bones). If you are between the ages of 60 and 64 and weigh 154 lbs. or less, talk to your doctor about whether you should be tested.
- **Chlamydia Tests and Tests for Other Sexually Transmitted Diseases:** Have a test for Chlamydia if you are 25 or younger and sexually active. If you are older, talk to your doctor to see whether you should be tested. Also, talk to your doctor to see whether you should be tested for other sexually transmitted diseases.

Should You Take Medicines to Prevent Disease?

- **Hormones:** According to recent studies, the risks of taking the combined hormones estrogen and progestin after menopause to prevent long-term illnesses outweigh the benefits. Talk to your doctor about whether starting or continuing to take hormones is right for you.
- **Breast Cancer Drugs:** If your mother, sister, or daughter has had breast cancer, talk to your doctor about the risks and benefits of taking medicines to prevent breast cancer.
- **Aspirin:** Talk to your doctor about taking aspirin to prevent heart disease if you are older than 45 and have high blood pressure, high cholesterol, diabetes, or if you smoke.

Table 1. Screening Test Checklist

<table>
<thead>
<tr>
<th>Screening Test</th>
<th>The last time I had the following screening test was: (mm/yy)</th>
<th>I should schedule my next test for: (mm/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram</td>
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<td>Pap smear</td>
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<td>Cholesterol</td>
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<td>Colorectal cancer</td>
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<td>Osteoporosis</td>
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<tr>
<td>Chlamydia</td>
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Source: U.S. Department of Health and Human Services, The Agency for Healthcare Research and Quality

Take this checklist with you to your doctor’s office and fill it out when you have had any of the tests listed above. Talk to your doctor about when you should have these tests next, and note the month and year in the right-hand column. Also, talk to your doctor about which of the other tests listed below you should have in the future, and when you need them.
• Immunizations: Stay up-to-date with your immunizations:
  • Have a flu shot every year starting at age 50.
  • Have a tetanus-diphtheria shot every 10 years.
  • Have a pneumonia shot once at age 65.
  • Talk to your doctor to see whether you need hepatitis B shots.

What Else Can You Do To Stay Healthy?

• Don’t smoke. But if you do smoke, talk to your doctor about quitting. You can take medicine and get counseling to help you quit. Make a plan and set a quit date. Tell your family, friends, and co-workers you are quitting. Ask for their support. If you are pregnant and smoke, quitting now will help you and your baby.

• Eat a healthy diet. Eat a variety of foods, including fruit, vegetables, animal or vegetable protein (such as meat, fish, chicken, eggs, beans, lentils, tofu, or tempeh) and grains (such as rice). Limit the amount of saturated fat you eat.

• Be physically active. Walk, dance, ride a bike, rake leaves, or do any other physical activity you enjoy. Start small and work up to a total of 20-30 minutes most days of the week.

• Stay at a healthy weight. Balance the number of calories you eat with the number you burn off by your activities. Remember to watch portion sizes. Talk to your doctor if you have questions about what or how much to eat.

• Drink alcohol only in moderation. If you drink alcohol, one drink a day is safe for women unless pregnant. If you are pregnant, you should avoid alcohol. Since researchers don’t know how much alcohol will harm a fetus, it’s best not to drink any alcohol while pregnant. A standard drink is one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled spirits.

For More Information

For more information on staying healthy, order the following free publications in the Put Prevention Into Practice (PPIP) program from the Agency for Healthcare Research and Quality (call the AHRQ Publications Clearinghouse at 1-800-358-9295), or visit http://www.ahrq.gov/clinic/ppipix.htm


• The Pocket Guide to Staying Healthy at 50+. Publication No. AHRQ 04-P001, November 2003. Also available in Spanish, AHRQ Publication No. 00-0010, January 2000.

This information is based on research from the U.S. Department of Health and Human Services (HHS) and the U.S. Preventive Services Task Force (USPSTF), the leading independent panel of private-sector experts in prevention and primary care. The Task Force conducts rigorous scientific assessments of the effectiveness of a broad range of clinical preventive services. Its recommendations are considered the “gold standard” for preventive services delivered in the clinical setting. Additional details about the recommendations can be obtained from the HHS Agency for Healthcare Research and Quality Web site (http://www.ahrq.gov/clinic/uspstfix.htm) or by calling the AHRQ Publications Clearinghouse (1-800-358-9295).

The Put Prevention Into Practice (PPIP) program of AHRQ is designed to increase the appropriate use of clinical preventive services, such as screening tests, chemoprevention and immunizations, and counseling. The PPIP program is based on the recommendations of the U.S. Preventive Services Task Force. PPIP tools and resources enable doctors and other health care providers to determine which preventive services their patients should receive and make it easier for patients to understand and keep track of their preventive care.

Excerpts from this article are reprinted with permission from The U.S. Department of Health and Human Services, The Agency for Healthcare Research and Quality (2004). Women: Stay Healthy at Any Age—Checklist for Your Next Checkup. For the full text of this article, visit http://www.ahrq.gov/ppip/healthywom.htm

Marlene Roman, MSN, RN, ARNP, CMSRN
Editor, Med-Surg Matters
One challenge a medical-surgical nurse faces is to be proficient in many aspects of nursing, not in just one particular system or area of nursing. The care of the postoperative patient is one example of this challenge. A medical-surgical unit may be limited to general surgical patients, thus leading to a proficiency in one area. In addition, the unit may be a mix of general surgery, orthopedic surgery, vascular surgery, or ENT surgery, creating a greater challenge to being proficient in postoperative care.

There are many factors that can influence the postoperative course. To name a few, these factors include the stress response, poor pain management, co-morbidities, age, social habits, and length and type of anesthesia. The Agency for Healthcare Research and Quality published a study in the *Journal of the American Medical Association* (2003) stating that over 32,000 U.S. hospital deaths and over $9 million in extra costs per year are due to postoperative infections and surgical wounds that dehisce or eviscerate. The study reported that postoperative sepsis costs an extra $57,727 per patient. Surgical wound openings added an extra $40,323 to a patient’s medical bill, increased the length of stay by nine days, and increased the postoperative death rate by 10%.

Florence Nightingale instructed nurses to “do the sick no harm.” It is important that medical-surgical nurses understand the physiological response to surgery and the principles of postoperative care to prevent harm to patients. Clarke and Aiken (2003) take the “do the sick no harm” philosophy to another level by defining failure to rescue as the nurses’ “inability to save a hospitalized patient’s life when he experiences a complication” (p. 43). Failure to rescue can occur when early signs of distress are not recognized or acted upon by nurses (Clarke & Aiken, 2003). A medical-surgical nurse needs to assess the patients assigned to them for evidence of progress and/or signs of complications and respond in an appropriate and timely manner.

The Ws of Postoperative Care concurrent session at the 2004 AMSN Annual Convention in Chicago will focus on the physiological response of the body to the surgical process, the assessment and interventions, and the application of critical thinking skills needed for this patient population. The goal of this session is to provide the medical-surgical nurse with the knowledge needed to anticipate and prevent possible complications in the postoperative patient. Be sure to register for this session to learn exactly what the Ws of postoperative care are!

Janet Burton, MSN, CNS

References


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Welcome New Members

AMSN would like to extend a warm welcome to our newest members!
The following individuals joined our ranks between January 1 and March 31, 2004.

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Sheila Bohnett
Tanya Brown
Sandra Carlson
Tarilee Deutmeyer
Mary C. Doolin
Nichole Dueweke
Jen Swinton
Dolly J. June
Sharon Eisenbeis
Judy Evans
Amy L. Fontan
Sarah R. Grich
Kathleen Haas
Nancy Holstein
LaNeil Hull
Deborah J. Ellinger
Hope E. Kelly
Teresa Kisch
Rebecca K. Kline
Janna LaMarre
Maria Leah C. Manuel
Diana T. McDaniel
Rachel E. McLaughlin
Pamela McCaughan
Jennifer Morin
Nancy Neal
J. Accueille Novak
Lina Nuss
Maureen O'Connor
Nell Peyronnin
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Rebecca Rooker
Margaret Rosano
Paula Spoonmore
Nancy Stephanek
Mary Sutherland
Kathy Taborovsky
Melissa Trafton
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Robert Tuley
Cheryl Whitfield
Cathy Wittkauener
Margaret Wohrer
Jennifer L. Woolard

Cindy Boles
Sally Bonet
Deborah L. Bridges
Laura Briz
Patricia Brown
Linda Brown-John
Cynthia Burkhardt
J. Illa Burroughs
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Andrea Chery
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Cind Dirlng
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Robert Van Dyken
Eva Velasquez
J. Jacqueline Inchauspe Vicks
Jean Voeg
Jeanette Walker-Johnson
Paula Washburn
Paulos Welde
Katherine Wylie
With all that has happened and the challenges of the future, how do we grow and never lose sight of the basis of nursing? By caring.

After 28 years of nursing, I reflected back on one of our symbols, the Florence Nightingale lamp. This lamp always portrays a glowing light. I remember watching the last Winter Olympics Opening Ceremonies, when my heart was touched by the young boy skating around the ice in a darkened arena, with a single bright light. The announcer said, “This light symbolizes the light of life within.” The remembrance of the lives lost during the World Trade Center tragedy on September 11th is now symbolized by two broad beams of light. Light symbolizes our hopes, our dreams, our visions, and our lives. Light beams give us direction and show us how to change direction when we encounter obstacles. As parents, we often leave a light on in the bathroom for our children to find their way in the dark of night. However, if we look down the hallway, the light beams out the door and often around the corner. If you take an evening stroll by flashlight and something is in your path, the light beams curve around it so you can continue forward. Many of my patients have asked me, “Please leave the small light on,” and patients who have had a near-death experience often speak about seeing a bright light or being drawn toward a bright light. Our light inside is the driving force of our lives. Focusing on our dreams and ideas, our light will move us forward and around the challenges we face. I believe nurses are initially drawn into the profession of nursing because of a light from within.

Nursing’s future and your future are dependent on you keeping your light lit and lighting the light of others to follow in our footsteps.

Thanks for caring! Thanks for being a nurse!

Jo-Ann Wedemeyer, BSN, RN
Director of Clinical Services
The Pediatric Group and Families Too
Crofton, MD

Suggested Reading
More than 20 years ago in 1980, Linda Aiken PhD, RN, addressed the American Academy of Nursing on the hospital nursing shortage and the dangers to the health and welfare of our nation. Nurses provide 95% of a hospitalized patient’s care. This care will suffer if the hospital is unable to attract and retain competent and experienced professional nurses. The Governing Council of the American Academy of Nursing appointed a task force to study successful hospitals that succeeded in creating nursing practice organizations that served as magnets. In other words, they were able to attract and retain a staff of well-qualified nurses to consistently provide quality care. Forty-one hospitals were originally selected as magnet hospitals for the descriptive study.

In 1990, the American Nurses Association approved the Magnet Hospital Recognition Program, with the first hospital being designated in 1994 – the University of Washington Medical Center in Seattle (also one of the original magnets). As of this printing, there are 104 magnet hospitals in the U.S. and Internationally (1 in the United Kingdom).

The American Nurses Credentialing Center (ANCC) is a subsidiary of American Nurses Association. The Magnet Recognition Program is one of the branches in ANCC’s structure, and a further branch of that being the Commission on Magnet Recognition. There are nine Commissioners representing eight different areas of nursing and a consumer. I received my notification of my appointment to the Commission as Staff Nurse Representative in the fall of 2001, shortly after my arrival home from the AMSN convention in Kansas City, Missouri. It has been the experience of a lifetime, and most definitely, of my 25-year nursing career.

The purpose of the Magnet Recognition Program is to recognize excellence in:

- Management, philosophy, and practices of nursing services.
- Adherence to national standards for improving the leadership of the nurse administrator in supporting professional practice and continued competence of nurses.
- Understanding and respecting the cultural and ethnic diversity of patients, their significant others, and health care providers.

The goals of the program are to:

- Identify excellence in the delivery of nursing care.
- Promote quality of health care services in an environment that supports professional nursing practice.
- Provide a mechanism for disseminating best practices in nursing services.

In order for a hospital or long-term care facility to receive Magnet Recognition status, the facility must submit an application and written documentation. If these steps are approved, a site visit is completed by Magnet Appraisers. After this visit, the Appraisers submit a final report to the Commission on Magnet Recognition, who will make the final decision as to whether or not Magnet status should be awarded to that health care organization. The phrase taking the journey is used to symbolize the process of self-reflection, learning, and evolving that is apparent with the determination of readiness to apply and during the review process phases to determine if the Forces of Magnetism are present.

Plan to attend my concurrent session at the 13th Annual Academy of Medical-Surgical Nurses Convention in Chicago, IL September 9-12, 2004, where I will:

- Describe the Forces of Magnetism.
- Identify an excellent work environment.
- Explain the process of obtaining Magnet recognition/assessing readiness to apply.
- Discuss the benefits of employment in a Magnet organization.

Diane Daddario, BSN, RN, BC, CMSRN

AMS 2005 Annual Convention Willingness-to-Serve Program Planning Committee

We are currently recruiting AMSN members who wish to serve on the 2005 Annual Convention Program Planning Committee.

The role responsibilities of the Program Planning Committee include:

- Assess the education needs of the membership.
- Plan the convention program at the committee meeting and during conference calls.
- Assist in promoting the convention.
- Contact potential speakers and obtain required information.
- Assume assigned responsibilities at the convention (e.g. moderating, assisting speakers and attendees).

If you are interested in serving on this important committee, please contact Sue Stott, Association Administrator, at the AMSN National Office (856-256-2323; stotts@ajj.com).

Chapter Reports Due

Chapter Officers, submit your Chapter Achievement Reports to the national office to arrive by June 30, 2004. Six awards will be given this year.

Details coming soon!
**Did You Know…**

…that Men and Women Differ in Symptoms of Unstable Angina?

The National Center For Health Statistics (NCFS) has consistently shown that heart diseases claim the lives of more Americans than any other disease. In 2003, NCFS data once again showed that heart disease was the number-one cause of death in the United States, claiming 700,142 lives (29% of all deaths). By contrast, cancer claimed 553,768 lives (22.9% of all deaths) during the same period.

Research has also shown that there were differences between women and men in the epidemiology, symptom presentation, and clinical outcomes of coronary heart disease (CHD). For example, it has been estimated by Lloyd-Jones, Larsen, Beiser, and Levy (1999) that the life-time risk of developing CHD at the age of 40 was one-in-three women and one-in-two men. Moreover, the risk for women for CHD increases after menopause and equals that of men at about the age of 70. However, the symptom models for CHD and unstable angina (UA) have been based on data from males in spite of the evidence that the pathophysiology of heart disease is different in women than men. As a result, women may be misdiagnosed, receive a delay in treatment, or not be given the same treatments options as men.

Two nurse-researchers (DeVon & Zenvic, 2003) undertook an explanatory study to further examine the differences between women and men in the symptoms of UA. The specific purpose of their study was to determine if there were gender differences in the symptoms of UA, and if there were, to determine if these differences were still present after controlling for age and comorbidities (such as diabetes mellitus, anxiety, depression, and functional status).

A convenience sample of 50 men and 50 women, hospitalized in various units with UA, were recruited for the study from urban and suburban medical centers. Only those patients hospitalized through the emergency department (ER) and who were free of chest pain for at least 12 hours were included in the study. Each patient’s medical record was examined to ascertain the admitting diagnosis, the history of the symptoms, and diagnostic information. Myocardial infarction (MI) was ruled out by the presence of two negative cardiac markers, CK-MB, or troponin I levels. The patient’s UA diagnosis was further confirmed by consulting the patient’s nurse or physician. Afterwards, interviews were conducted in the patient’s hospital room. The Stable Angina Symptoms Questionnaire (measured symptoms and their severity), the Canadian Cardiovascular Society Classification of Angina (measured ability to perform activities of daily living), and The Hospital Anxiety Depression Scale (measured mood) were the instruments used to collect the data. Risk factors were also recorded to ascertain their correlation with the UA symptoms. The age range for women was 41 to 88, and the age range for men was 42 to 85. Women and men did not differ in terms of age and education level.

Results showed that there were differences in the number, severity, and types of symptoms that women and men experienced during UA. Specifically, women reported more severe shortness of breath (74% vs. 60%), weakness (74% vs. 48%), difficulty breathing (66% vs. 38%), nausea (42% vs. 22%), and loss of appetite (40% vs. 10%) than men. After adjusting for age, diabetes, anxiety score, and functional status, women still remained more likely to experience these symptoms than men.

In addition, although women and men reported similar locations for the symptoms, women reported upper back pain significantly more often than men. There were also differences in the quality of pain and discomfort (for example, women reported significantly more stabbing and knifelike pain). Hence, significant gender differences in the UA symptoms were found among the 50 women and 50 men in the sample of this investigation. Researchers reported that finding women experiencing knifelike and stabbing pain was unexpected as these types of pain have not been associated with UA in the past.

Among the limitations of the study was not selecting the participants with random sampling method, selecting only those patients admitted thorough the ER, interviewing those patients who had medical treatment or surgery several days after admission, and not confirming if the discharge diagnosis matched the admitting diagnosis. However, the study had a strong design in terms of having a large sample, measuring over 20 classical UA symptoms, controlling for age and co-morbidities (such as diabetes and depression), and using reliable instruments to collect data. These findings can assist medical-surgical nurses and other health care professionals to better assess and monitor UA symptoms among women.

**References**


Poster Abstract
Submit by June 1 to be considered for oral presentation.

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☐ Management/Education

I would ☐ would not ☐ like to be considered for a 20-minute oral presentation.

I certify that all requested information is accurate. I certify that the material contained in the abstract has the consent of all authors and that clearance to present the material has been obtained, if necessary. I am aware that if the abstract is accepted for presentation it will be included in the Convention Program and may be published in MEDSURG Matters, official newsletter of the Academy of Medical-Surgical Nurses.

______________________________

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CMSRN News

CMSRN Application Available Online
Certification in Medical-Surgical Nursing demonstrates to nurse colleagues, patients, employers, and others in the health care system that you are knowledgeable of, experienced in, and committed to medical-surgical nursing specialty practice. Download the application for the CMSRN examination by visiting the AMSN Web site at www.medsurgnurse.org.

Examination Exemption Application Available
Nurses who are currently certified as a medical-surgical nurse through another certification board may be eligible for CMSRN certification by meeting the following criteria:
• Current RN licensure
• Current medical-surgical nursing certification
• 90 contact hours of continuing education over the past 5 years. 75% must be in the medical-surgical nursing specialty.
Visit the AMSN Web site at www.medsurgnurse.org to download the application, or contact the AMSN National Office at 866-877-AMSN (2676).

AMSN Nurses Nurturing Nurses Logo Pin
AMSN is pleased to offer a logo pin featuring our Nurses Nurturing Nurses philosophy. AMSN is committed to nurturing our members and this conviction is highlighted on our logo pin. Show your support and dedication to the specialty of medical-surgical nursing and AMSN by proudly wearing your own pin. It measures 7/8” x 3/4” and is available to AMSN members for only $15. The pin features a teal-colored band around the outer edge and the words “Academy of Medical-Surgical Nurses” in gold lettering. The center oval is gold with the words “AMSN Nurses Nurturing Nurses” in teal.

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Greater NY Chapter Presents Funding to China-bound Member

The Greater New York Chapter of AMSN was pleased to present Joan Waldron, MS, RN, CMSRN, with a check for $1,000 to offset the expenses surrounding her nursing ambassadorship to China. The delegation of medical-surgical nurses embarked on its journey to China on April 25, returning home on May 7, 2004. There, the delegation had the opportunity to discuss medical-surgical nursing in China, delivery of care to medical-surgical/adult health clients, alternative/complementary therapies, nursing education, health promotion, and the advancement of medical-surgical nursing practice through research. Pictured here from left to right: Simone Stein, RN, CMSRN (Secretary – Greater NY Chapter), Joan Waldron, MSN, RN, CMSRN, and Ann Y. DiAgostino, BSN, RN, CMSRN (President – Greater NY Chapter).

MEDSURG Nursing: The Journal of Adult Health is offering a new Student Writer’s Award to encourage and recognize excellence in medical-surgical nursing as well as inspire students to write. The winner, who will be chosen by an awards committee, will receive a plaque, $250, and a complimentary registration to AMSN’s 13th Annual Convention in Chicago, IL, September 9-12, 2004. The award will be presented at the convention and the author(s)’ name will also be announced in MEDSURG Nursing.

Nursing students who are interested in submitting a manuscript for publication should contact the journal office for author guidelines and more information: Editor, MEDSURG Nursing, East Holly Avenue Box 56; Pitman, NJ 08071-0056; (856) 256-2300; FAX (856) 589-7463; e-mail: ford@ajj.com

Strategic Governance continued from page 3

1. Change the role and title of the “Regional Director” to “Director.” The title of “Director” highlights the expanded Board role wherein all Board members are responsible to the entire membership. It also allows competency-based assignment of duties to each of the Board members.

Concerns About the Restructure

Members may have questions about the change from a regional-based structure to a knowledge-based strategic governance structure. Some possible questions and responses are proposed below.

Who will be responsible for chapters and individual members? It is currently the perception that only the Regional Director is responsible for chapters and members in her/his region. With the transition to the Director role, all members and chapters have access to all Board members. An AMSN committee will work directly with chapters to support their growth and development.

What will the Directors do? Directors will focus on strategic direction necessary to move AMSN into the future and assure the development and delivery of value-added programs and services for members, prospective members, and customers. In addition, the President will have the flexibility of assigning each Director specific responsibilities based on her/his experience and background. Two examples are:

- A Board member who has experience in research would be asked to be the liaison to the Research Committee.
- A Board member who has experience with bylaws and policies would be asked to be the liaison to the Bylaws & Policies Committee.

Who will represent our region on the Board? All Board members represent the membership. The issues that are dealt with at the Board level are not specific to any region, but to the membership as a whole.

There are differences in practice in my region. How will these be dealt with? The Board of Directors does not address regional differences in practice but forwards practice issues to the Clinical Practice Committee (and/or another appropriate committee) and to practice experts within the membership. Committees will continue to have representation from all four AMSN regions.

Many other questions may come to mind regarding the restructuring of the Board of Directors. The Board of Directors invites your comments, concerns, and questions regarding the transition to a knowledge-based strategic governance model and the required restructure of the Board of Directors. Please address your inquiries to the AMSN Board of Directors (amzn-bod@ajj.com).

“That our organizations survive is not enough. Members who rely on associations need them to prosper…We must create new methods to speed up responsible governance in our organizations or expect to lag behind competitors and frustrate the members we serve.” – Andrew Lang, Reengineering Governance

The AMSN Board of Directors
Medical-Surgical Nursing Certification

A commitment to excellence in practice

The Medical-Surgical Nursing Certification Board (MSNCB) was established to promote the highest standards of medical-surgical nursing practice through the development, implementation, and coordination of all aspects of certification for medical-surgical nurses.

MISSION: The Medical-Surgical Nursing Certification Board exists to establish credentialing mechanisms for validating proficiency in medical-surgical nursing.

CMSRN: Certified Medical-Surgical Registered Nurse 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.

BENEFITS: Certification benefits the individual, the profession, and the public through:

- expanded career opportunities
- peer recognition
- increased self esteem and satisfaction

ELIGIBILITY: To be eligible to participate in the examination, candidates shall meet the following requirements:

- Hold a current and unrestricted license as a registered nurse (RN) in the United States, or any of its territories, or
- Hold a current, full, and unrestricted license to practice as a first-level, general nurse in the country in which one's general nursing education was completed, and meet the eligibility criteria for licensure as a registered nurse (RN) in the United States in accordance with requirements of the Commission on Graduates of Foreign Nursing Schools (CGFNS).
- Have 2 full years (of the last 5 years) of experience practicing as an RN in an adult medical-surgical clinical setting.
- Have accrued a minimum of 3,000 hours of clinical practice as a staff nurse, clinical nurse specialist, clinical educator, faculty, manager, or supervisor.
- BSN not required.

Nurses who are currently certified as a medical-surgical nurse through another certification board may be eligible for special dispensation to earn the CMSRN. Please contact the Medical-Surgical Nursing Certification Board, 856-256-2323, www.medsurgnurse.org for more information.

EXAM DATES
- September 13, 2004 (Chicago only)
- October 16, 2004

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This course was presented by Sally Russell, MN, RN,BC (AMSN Education Director), at AMSN’s 12th Annual Convention in Reno, NV, October 15-16, 2003. It includes a review of anatomy and physiology, as well as objective and subjective data to gather. A review of all the body systems and important nursing interventions are also covered. It is designed as a review for preparing for the medical-surgical nursing certification exam, with practice questions included.

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Hartford Institute Hosts Audioconference on Pharmacologic Implications in Older Adults

On January 21, 2004, the Hartford Institute for Geriatric Nursing hosted an audioconference for members of the Nursing Competence in Aging initiative. The two presenters were Dr. Ginny Pepper and Dr. Mark Beers. Dr. Beers is a geriatrician and is editor/chief of Merck Manual of Geriatrics, while Dr. Pepper is a geriatric nurse practitioner and faculty member at the University of Utah. The following is a summary of the information they presented in this hour-long session.

Studies published recently confirm that information learned in the past regarding inappropriate medication use remains a serious problem for older adults. Effectively monitoring adverse effects requires nurses to remain alert to high-risk medications while participating in collaborative relationships with other primary care providers.

Polypharmacy has been defined by experts and regulatory agencies by the number of drugs or doses per day. However, because there are currently elders taking 6 or more preventative doses per day without a diagnosis (for example, taking aspirin for MI prevention; vitamin C or E, and statins for reduction of cholesterol), polypharmacy needs to be considered as more than an arbitrary number.

Several problems may be encountered when caring for older adults who are simultaneously receiving many drugs. A major concern is that medications used in the care of all older persons, regardless of the illness or the care required, are commonly used inappropriately. This may be caused by the patient’s forgetfulness or inadequate teaching by the care giver about the rights of medication usage (especially the right drug, right amount, and right time). Another problem is that the physiology of aging is known to affect pharmacokinetics (what the body does to a drug), such as decreased excretion by the kidneys and decreased liver function. For instance, the half-life of flurazepam (Dalmane®) may be 8 to 12 hours in a young person, while it may be as long as 96 hours in an older adult. The pharmacodynamics (what the drug does to the body) may also be changed in older adults, with the affects of disease on medications being the most problematic.

Polypharmacy can also include irrational drug use, such as treating the side effect of one drug with another drug, or the continuation of a drug despite evidence that it is ineffective (Pepper, 2004). The quantity of the medications taken is also important when assessing and planning care for older adults. Therefore, the most significant risk factor for adverse effects is the number of drugs being taken by one person (rather than the age-related pharmacokinetic changes). The second most important factor to consider is the number of diseases for which the drugs are being given.

Falls can be used as a good example of a problem where drugs and diseases interact as causal factors. In some studies, diseases rather than medications were more likely to have been the cause of the fall (Kelly, Pickett, Yanniakoulas, Rowe, Schopflocher, Svenson et al., 2003). Research has also shown that almost all drugs can be related to falls, but inconsistencies in the studies make it difficult to determine the importance. Inconsistencies can occur because of the broad categories of drugs and small sample sizes.

There are methods that can be used to decrease the effects of polypharmacy (Pepper, 1999), such as being alert to those drugs most likely to cause problems to older adults, assuring that patients have a medication record that is easy to carry with them, and consistently and thoroughly evaluating the drug response. When a new symptom or a change occurs in an older adult’s health status, health care providers must consider the potential role of current medications before thinking that another medical diagnosis is necessary.

Patient safety in this arena is identified as freedom from harm from the health care that is meant to help patients. A recent report of the United States Pharmacopeia (USP) provides evidence that older adults are more at risk for medical errors because they experience more harmful errors (3.47%) than younger individuals (1.67%) (Hicks, Cousins, & Williams, 2003). More than half of medication-error fatalities (11 out of 20) were in persons over 65 years of age, while the majority of errors (55%) occurred during drug administration. In addition, prescribing errors most commonly resulted in harmful errors. When comparing drugs involved with the U.S. General Accounting Office (GAO), 20 drugs were considered “generally inappropriate”; 17 of these 20 drugs were involved in a reported error, with four resulting in harm.

Outcomes of polypharmacy may be depression, delirium, falls, decreased appetite, and increased need for sleep. Studies have demonstrated that length of stay in the hospital can be expected if adverse drug reactions are not recognized early, which demonstrates the enormous impact that nursing can have on this issue.

The nurse must be alert to observing the effectiveness of a drug; however, the nurse must also be aware that expected symptoms of toxicity may be far more subtle in older adults. In addition, it is necessary for the nurse to be concerned about drug-drug interactions, especially if there are several physicians prescribing medications for a patient. Because symptoms of toxicity may present differently and there may be many prescribers involved in the care of a patient, the nurse must always review all medications being taken by older adults, including any over-the-counter medications the patient is using.

Patient safety is of great concern, and health caregivers must aim to avoid harm from medications that are meant to help. Knowing why the drug is being administered is only part of the assessment. Observing for subtle signs of toxicity and
remembering that the patient is taking medications that may interact with each other is vitally important.

Sally S. Russell, MN, CMSRN
Education Director

References

Ethical/Legal Issues
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References

Additional Readings

Congratulations to Rene Lavoie, RN, who was chosen as one of the great Louisiana nurses of 2004! Rene is Unit Manager/Head Nurse at Ochsner Foundation Hospital, New Orleans, LA, and a member of AMSN.

AMSN and Research:
Your Research Committee at Work

Among the objectives of the Academy of the Medical Surgical Nurses (AMSN) are the promotion of research and development, and the dissemination of new ideas. Through its newsletter Med-Surg Matters, its official journal MEDSURG Nursing, and its Research Committee, AMSN strives to promote “the development of research-based medical surgical practice.” In addition, AMSN involves its members in research-related activities by soliciting membership in its Research Committee.

Consistent with AMSN’s aim of dissemination of new ideas, in 2003, the Research Committee reviewed 33 poster abstracts for AMSN’s 12th Annual Convention in Reno, Nevada. Further, the committee members were challenged to select the very best from these excellent posters. In 2003, the poster awards went to Karen Ennis and Sharron Joyner for Management; Maureen Johnson, Ann Marie Dose, and Diana Inman et al., for Clinical Practice; and Mary Boucher for Research.

In an effort to serve you better, the Research Committee has developed guidelines for the online research consultation. Please follow these guidelines if you need any assistance with your research projects. Similarly, to enhance your success with your poster presentations, a set of poster guidelines was published in Med-Surg Matters (Spring 2003, p. 10). These guidelines are based on a broad literature search and can assist you in poster presentation in other settings as well (see page 7 for a shortened version of these guidelines).

During 2003, members of the Research Committee published the following articles in Med-Surg Matters: “How to Find the Best Evidence for Your Practice” (Lash), “Smallpox: The Big Problem” (Osborne); “Show Me the Data: The Role of the Institutional Review Board (IRB) in Research” (Crum & Osborne); and “Calcium Channel Blockers” (Siomko).

Also in 2003, Research Committee Members Ayhan Lash and Cecelia Grindel offered a pre-convention workshop on evidence-based practice (EBP). This workshop presented various dimensions of EBP as well as offering hands-on practicum to find the best evidence for your practice questions.

During the year 2004, the Research Committee will continue its research-related activities. For example, during the 13th Annual Convention in Chicago, you will again see informative posters on clinical practice, management, and research. In addition, we are in the midst of organizing a pre-convention workshop on how to conduct clinical research. This workshop will be offered by one of the members of the Research Committee, Linda Yoder, PhD, MBA, RN, AOCN, a highly recognized researcher and an associate professor of nursing at the Uniform Services University. The title of this workshop is, “Clinical Research Skills to Enhance Your Practice and Your Career.” Watch for the announcement of this workshop and register early.

The success of any program depends on the active participation of its members. AMSN and the Research Committee invite you to participate in research-based projects. The Research Committee invites you to share your expertise with colleagues on topics of common interest to medical-surgical nurses. The Research Committee is eager to assist you in your research endeavors. Send your inquiries to me at alash@anet.com or to AMSN. I will make sure you get input from at least two Research Committee members who have the expertise in the area of your inquiry. Also watch for the “Call for Abstracts.” Most importantly, please send us your questions and suggestions. We look forward to seeing you in Chicago. Above all, keep an inquiring mind.

Ayhan A. Lash, PhD, RN, FAAN
Chair, Research Committee

AYAN A. LASH, PHD, RN, FAAN
**mission:**
The Academy of Medical-Surgical Nurses enhances the knowledge, skills, and professionalism of medical-surgical/adult health nurses in all practice settings.

**vision:**
The medical-surgical/adult health nurse is a valued health care professional and a vital part of the health care continuum committed to leadership, quality care and advocacy for patients, their families and the community in which they live and work.

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