RN First Assistant

The Perioperative Role of the Future

By Dr. Jane C. Rothrock, RN, MSN, BSN, DNSc

Let me begin by stating that the role of the Registered Nurse First Assistant is not the only perioperative role of the future. It is a vitally exciting potential role of the future, one rich with varied opportunities. There are lots of other things that perioperative nurses could be doing in the future, also very rich and varied in their potential. We call this role changing the transforming and recreating of ourselves, that is 1995 language. It is re-engineer, restructure, rede… and transform.

An RN first assistant and a… one day and having a philoso… whose profession was the o… "well, in the beginning God t… created Eve; obviously God … RN first assistant thought abo… turned to the surgeon and … remember also in the begi… confusion, turmoil and disar… created order; obviously Goc…

The world that we are livi… is constantly changing, and i… feel incredibly uncomfortable. … and it's coming so fast we really haven't time to truly anticipate it.

Very recently some Canadian OR nurse managers were interviewed in *OR Manager*, and some Canadian vice-presidents of nursing were interviewed in *Nursing Economics*. From these articles I gather you are going through changes almost exactly like we are in the United States. Some of these changes happened to you even more quickly than they happened to us because you have a federal health system that is able to tell you what you are supposed to do tomorrow, with the expectation that you would have finished it yesterday. The U.S. federal health care system takes at least four years to figure out what we should be doing tomorrow and they change their mind the day after that. Nonetheless, the changes are coming at us from the local level and the state level, and it is extremely confusing. The messages are not always the same, but some of the messages are pretty universal and some of the messages are pretty consistent. We will look at messages later in this article. But, in the midst of all of this change and chaos there are incredible opportunities. I call them strategic opportunities because many of those opportunities require us to have ourselves

ght: Newly elected t President Jackie ng: Treasurer, Mar- Hilda and Gloria fter many years of

ference. The conference was a su… because the delegates attended educ… al sessions, showed an interest in the… nical displays and networked with… leagues. Exhibitors provided their su… to our organization, and their particip… in a time of financial constraint is a… tive indication of their commitme… perioperative nursing.

The future of ORNAC depends u… sional development and the promoti… nursing. This conference proved that… dence.

- Sandra Grimwood, Vancouver C…

we have given thought and questions that are going to complications that we are g contentious debate that ursing community. They the opportunity that we ally have now as you are tion of the role of the RN You have the opportunity urselves in places where e what kinds of things are e things that we have had very exciting to know that within weeks to begin an RNFA program in cardiac surgery in Quebec, and so it has begun. It has begun and it will continue.

I have talked with people from Canada seriously for four years about the RN first assistant - the Canadian Nurses Association, many, many people from Quebec, the people that are behind this whole thing, and have brought it to fruition. We have become friends as well as allies and colleagues as we have worked together and worked through how the RN first assistant fits into perioperative patient care. One of the reasons that we haven't had RN first assistants from Canada in programs in the United States or perioperative nurses who are looking to that as part of their future career development is because you haven't had a place to come home to and practice the role.

There is no easy solution to all the problems that we are experiencing in the health care system, but nursing has a lot of the solutions, and that is part of the opportunity that we have, especially in terms of the evolution of the RN first assistant role. So, let us begin by clearly understanding that as we look at opportunities we can be brave about this whole thing. We can be brave, we can harness our power and we can really talk among ourselves freely as we hash out the complex issues of how this role is going to evolve.

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Don't Kill The Messenger

The other advice that I would give you as you move into these kinds of dialogue… …AC and within the provincial assoc… messenger, and this is not ju… could be the hospital admin… Surgeons are often misinfo… talking about in terms of an… can be incredibly collaborati… supportive but that is only … them. Often in the beginning… they feel very threatened, … threatened because this pot… issue, and they feel also pro… that here is a nurse who is goi… of that intellectual stuff that p… footing when they are both together at that OR bed at the patient's side. So we have to promise that we won't kill the messenger and that we won't kill the message when the message is one of resistance, when the message is one of confusion. You will not necessarily have the same contentious raging debates that we had in the U.S., but some of them will be somewhat the same. The last thing that we always do at the end of any kind of discussion with someone is make sure we have given that person our message, so whether it is a hospital administrator that is taking it back to the CEO group, whether it is a surgeon who is taking it back to the medical staff committee, whether it is a perioperative nursing director who is taking it back to the nursing executive committee, or whether it is a colleague who is going to be taking it back to our peers, we have to make sure that we keep on giving people our message.

Barriers to Practice: Reimbursement

Now I want to address three substantive issues. In the U.S. we have a system of federal health insurance. We are not nationalized. We have a lot of private health insurance and it is very confusing. We have two kinds of national health insurance, neither of which reimburse for the services of an RN first assistant. They reimburse the hospital and part of that reimbursement is for nursing care, or nursing service delivered. So when we try to talk with this group about getting reimbursement for the nurse as assistant at surgery, it is their contention they are already paying for that. You see the nurse is bundled, the nurse is included in whatever that fee is they give the hospital for taking care of a surgical patient. Now somebody figured this out once and said it was about 88 cents for the nurse to assist at surgery. That is pretty impressive, isn't it? So one of the barriers to practice is that federal insurance will pay surgeons to first assist at surgery, …physicians who are credentialed as a physician's assistant. You …nada, do you? I have not read …literature. So, you do not have …r non-physician provider. But …ibility in the future. It is some- …thinking about as you develop …entials and responsibilities for …terms of what is left that is still … because whenever there is a …cy in reform is going to be to …eap to fill that service gap. So …look at with role evolution and description, is to begin with the broadest possible role you can. It doesn't mean that every nurse who is an RN first assistant in Canada is going to fulfil that role in its broadest implications, but you want to look at the biggest possible picture and describe what that biggest possible picture is. From there you can credential down within institutions and put limits on scope of practice and institutional privilege for the RN first assistant. Look big and hard to ensure there are no service gaps and you obviate the risk of having other non-physician providers try to create themselves to fill those service gaps, otherwise you'll find you are out of part of the role, or that you have competition that you never wished to have.

So, how are you going to get your health service to pay for an RN first assistant? How are we going to get

U.S. Medicare to pay for an RN first assistant? To us we have a serious barrier and it is a legal barrier because it is illegal to bill Medicare for an RN first assistant's service. So that is a huge barrier that we have to overcome. We also know in our country, and you are much better at this than we, we have been focused on specialization. You have been a country that has done a much, much better job of primary care. Most of our physicians are specialists. You have a huge population of generalists, primary care physicians or family doctors. We don't, so we have ended up with a huge glut of surgeons and with surgical residencies that are taking up space when we should really be educating primary care physicians. We are going to change that. So one of the things that we have had to look at as we look at barriers to practice is as the number of surgical residencies go down, and they will, our government has told us that, the slots for surgical residents are going to decrease, the slots for primary care physicians are going to increase. That means a service gap. That means that what that surgical resident ordinarily does...now think about what a surgical resident ordinarily does...admitting, history and physicals, preoperative rounds, physical assessment, review of laboratory and diagnostic studies to make sure the patient is adequately and safely prepared for the surgery, and safely in terms of hemodynamic status and electrolyte status, and all of the other things you and I are concerned about. That resident comes up to the OR and assists at surgery, does postop rounds, discharges the patient and gives the patient a prescription. As we look at what is going to happen in the future and what are the strategic opportunities, one of those strategic opportunities is for the RN first assistant to move into the service provider roles that residents have previously filled. Now for us that means advanced practice.

I was not a bit surprised to hear the results of ORNAC's survey on advanced practice for the surgical nurse and advanced practice for the nurse in anesthesia.(See National Survey Report, page 31 of this issue). For us the advanced practice nurse and advanced practice role is different. It almost unilaterally requires a master's degree and we have categories of advanced practice nurses:

- nurse practitioner,
- clinical nurse specialist,
- certified nurse midwife, and
- certified registered nurse anesthetist.

They are the four recognized groups of advanced practice nurses in the United States. So for us , part of our debate is about where the RNFA fit into the advanced practice role. It is not a raging and contentious debate, but it is passionate and that is healthy, that is wonderful, that we can engage in debate in the community of nursing. Because if the RNFA fits into advanced practice, they have to get a master's degree and they are going to be able to do all of those things, they are going to do the admitting histories and physicals, and in fact in one of our hospitals in New York, our nurse practitioners have admitting privileges. In rural parts of the U.S. nurse practitioners who assist at surgery, master's prepared, perioperative nurses who assist at surgery, who are also RNFA's, not only get paid by Medicare but also have privileges to do minor surgery. Why? Because it is rural, other people don't want to work there, it is sometimes an undesirable place to be, and that is how we have gone about things, obviously not an ideal system. We have taken nurses, nurses willing to go to places where no one else wants to go, and we treat them pretty well. We make sure they get reimbursed and we make sure they have decent privileges so they can provide the services that are required by their patient population. If you work anywhere else, you can't do any of those things because guess what?...that place is full of physicians and they get first shot. So when we talk about legal barriers to practice, for us and maybe even for you, one of the things that is under consideration and that we have debated in the nursing community is, should we go for a federal practice act?

National Practice Act

Should Canada go for a national practice act so that instead of having this spotty, this often inadequate structure that grows up from the local level, depending on what is required at the local level, and therefore becomes absolutely different all over the country. That is the situation that we are living with. You can be an RN first assistant in one state and do certain things, and move to another state and you are not allowed to do them anymore. Or you can be an RN first assistant in one state and have been required to have X, Y, and Z as part of your educational preparation, and then move to another state and they require something else as part of your educational preparation. So it is very confusing, it is very difficult for nurses who are in advanced practice roles or in an evolving role like the RNFA to have mobility across the country and know they are not always going to be able to do the things that they have done in the past.

I will give you an example. Until recently, one of

the states said RN first assistants could do everything that we consider normal intra-operative behaviours except for suture. Well, you know an RN first assistant loses an awful lot of value at the surgical field if they can't suture, and yet if you move to that state they won't let you put a needle holder with a needle in your hand and put it in somebody's tissue. It wasn't allowed. In other states, RN first assistants in cardiac surgery harvest the vein. They have been doing that for quite a while. They are starting to harvest the radial artery as a conduit in bypass surgery. RN first assistants are doing that. They do it, they do it well, and we have even begun some research on how you can identify patent veins when you go to assess what leg, what vein you are going to take as an RNFA. Nonetheless, in one state you can perform a specific function and it is written into the *Practice Act*, yet in another state it is denied. So what you have been permitted to do somewhere for years, suddenly you move, and you are no longer permitted to do it. So this is an option then, to get rid of all of these changing circumstances and changing rules and what you are allowed and not allowed to do based on where you live in the country.

Now there are a lot of down sides to such an option, but it certainly is a consideration and it is something during health care reform that our nursing community spent a good two years dialoguing over and we finally decided **not** to go for it. In Canada you have your provincial Health Professions Act. What we decided to go for was supporting state level, or for you provincial level, licensure and scope of practice and privilege decisions. However, with strong federal incentives to see that these were under the jurisdiction of the Board of Nursing. You see for RN first assistants and others who practice in an area where our roles overlap that of medicine, sometimes decisions about what we can and cannot do are made by the Board of Nursing and the Board of Medicine. My experience is that the Board of Nursing and the Board of Medicine are committees. One is made up of nurses and the other is a committee made up of surgeons. You give them each something to decide separately and they come back with two totally different answers. So it is not easy when you have joint jurisdiction over this role of the first assistant who does perform some delegated medical tasks, as well as many, many nursing tasks. Who decides what they get to do? We would like to move with total nursing jurisdiction over this role, to get rid of some of the restrictions, to get nursing speaking together, to get all of those boards from all of those states to come together because they do have a national board, to come together and work through practice decisions.

So this is going to be one of the barriers to the practice of the RN first assistant in Canada. You may wish to at least play out whether it even a possibility to have a federal practice act, and if not...what can you do then to see that nursing has most of the jurisdiction in the province, to get medicine working with you, but to give nursing the authority to make the practice decision rulings. It is a strategic position that you want to get in so that you don't have to go through the things that we have gone through. I would strongly urge you that while I sense a federal practice act won't work, I also know that the best thing to do is to get nursing in control of all of the decisions about the role, and again that means working with different messages and different messengers.

Prescriptive Authority

Now, prescriptive authority. Surgical resident discharge patients and give them prescriptions. There are institutions in our country where the RN first assistant has a role that is very similar to that of the surgical resident but without a master's degree. Some institutions in the U.S. have a latitude within a broad scope of practice, they have latitude in describing role responsibilities, and there are some institutions that are looking to develop a formulary, a list of the things that the RN first assistant could prescribe. It would be some kind of protocol for the surgical patient that was being discharged. Some people get pretty alarmed about that, that a nurse is actually going to write a prescription for an antibiotic! I admit we have not done a good job with giving our advanced practice nurses prescriptive authority. It makes no sense for these nurses not to have prescriptive authority. It duplicates services and it drives up costs. Canada can learn our lessons, so that as you look at what the Canadian role is going to be, look at the big picture, where will the service gaps be, and how are you going to ensure they are met and they are filled. If you choose that it is not part of your role, that is your choice, but you won't have positioned yourself without having given consideration to another service requirement.

Physician Supervision

Now what about physician supervision. When the Association of Operating Room Nurses came up with our very first official position statement on the RN first assistant in 1983, that position statement very clearly said that the RN first assistant works under the direct supervision of the surgeon. Now we know what that was interpreted to be in many institutions. The surgeon could not leave the room while the RNFA was finishing closing the wound. Even if there were only four skin sutures left, the Surgeon was supposed to be directly supervising. That kind of language became very limiting. You don't have anybody to compete with you yet, so as you create yourselves think about using language that is going to allow you to constantly evolve, to constantly transform and to not be in the situation that we were where a surgeon would say:

"I have got to stay in the room the whole time the RNFA is there. Once we get on skin, I want to drop out. I want to go talk to the family, I want to go dictate, I want to go have a coffee and get ready for the next patient. Now if I have an RNFA in the room and I have to stay in the room, I can't do those things, so baby get me somebody else. Get me a non-physician provider like a PA that doesn't live with all of those rules that I, the surgeon, can control. I am the master."

The surgeon is often the master of a non-nurse. It is nursing with all of its rules and regulations that the surgeon cannot intervene in and say, oh sorry we are not going to follow that rule today, they can't do that. And so you need then to think about what kind of supervision are you going to require. Are you going to use words like 'direct supervision'? We changed our statement in 1994 and it now says "collaborates with", we rid ourselves of all the statements about supervision and direct supervision so that one can't infer that the surgeon has to stay in the room.

How much physician supervision is required? Is it required by direct presence or can a physician, surgeon, be somewhere in the hospital by beeper in order to supervise and answer a question or a concern. Can supervision be carried out by protocol? Can you have protocols written? California, interestingly enough, requires protocol for certain things. So a RNFA in California has to function under protocols for certain nursing behaviours. They have protocols for achieving hemostasis and protocols for suturing. Those protocols are broad guidelines, they kind of give a directive as to what can be sutured, when it can be sutured, and what kind of hemostatic adjunct the RNFA can apply. Can the RNFA just tie knots? Can she just put a hemostat on or can she put a hemostat on and tie a knot, can she put a hemostat on and buzz it with the ESU, can she use the Argon beam coagulator on it ? How do we define hemostasis? In some states we have protocols, and you could have protocols for specific functions in Canada. Here is one of the favourite questions:

What are you going to do if the surgeon drops dead? And you only have another RN, you know, just a nurse. Just an RN first assistant is in that room at that OR bed and the surgeon drops dead. Now you know when people ask me that question, I usually say to them- "well .... you really ought to worry about what happens if the anesthesiologist drops dead".

Because I am a director of an educational program I am often asked, "What will happen if a surgeon drops dead, will the RN first assistant finish the surgery?" I love to answer these questions. And I say to them, "now if the anesthesiologist drops dead, one of my perioperative nurses will bag you, will see that you aren't oxygen-deprived, and will maintain you in a living semi-comatose state, they will even talk to you while you are asleep because they have read the research that patients can hear under general anesthesia, so they will comfort you during this crisis while everyone is running around during the code, they are going to let you know that everything is going okay, everything is alright until another anesthesiologist gets there". And then I say to them, "but ... if the surgeon drops dead, my RNFA will not finish the surgery, but, if you are bleeding I promise they will stop it. If they are in the middle of an anastomosis, I promise you they will try to get things back together, they will throw a wet sponge on, they will keep you stable, physiologically they know exactly what to look for until another surgeon comes in". And then I conclude with "now what you really should worry about is, what if the perioperative nurse dropped dead!". That is called being in deep do-do! You don't really think that there is anybody else in the room that can do all the things that OR nurses do. There isn't. Do you think the anesthesiologist could run around and open all the supplies, know what the female and male adapter look like, and be able to find the last two? The surgeon would have no idea where the equipment is stored or how to operate them. When lap choles were started there were these wonderful one week courses that the surgeons went away to, right? They came home and overnight by a miracle that nobody talked about, you had to know how to operate the equipment. Now nobody sent us away for a week, did they? But the next day let's talk about coherent light, let's talk about trouble-shooting, let's talk about what camera can be replaced with this piece of equipment and what video we could steal from what room so we could do lap chole #2 since we only had one working video

system. It was a miracle, wasn't it, but you and I learned to do all that and survive. So when people ask me this big question, I say to them "hey you know what, easy, let's just write a protocol for what happens if the surgeon has a heart attack during surgery". We'll write a protocol for it and we will have general broad guidelines and then nobody has to worry about that question any longer. So again, think about physician supervision, how much, when, in what situations, and how are you going to handle it so that there isn't a huge service gap and so that you don't make the RN first assistant a person who can't best fill in for another physician assisting, because obviously we want the RNFA to be in the best possible position to substitute for, to replace another physician who would ordinarily have assisted at that surgery.

Reimbursement

Let's go back to reimbursement and finance issues. Obviously we have a problem with federal insurance and getting reimbursement. We have not won that battle yet, and frankly I am not sure if we will. I am not sure if we are going to win it with the system that we have right now. If you have read anything about health care reform in the U.S., you read that we say Medicare is a stand-alone program, it will not be folded into health care reform. However, you know we are also working on things like balancing our budget (what a concept), balancing our budget, and in order to do that, we are looking at saving money in Medicare. So while we say that Medicare is not part of health care reform, other committees are looking at balancing the budget and saying "well, we are not going to raise taxes so where are we going to get this money?". Well, we had better be able to save some from Medicare. Medicare is our flagship federal program...and it is an embarrassment; it is an inequity and it is wrong that our flagship federal program does not treat service providers equitably.

Now we also have private payers, as we talk about reimbursement. The majority of private payers, 16,000 of them you know, so every time we go for reimbursement for the RN first assistant, it is like we deal with insurance company "A", we finally win that battle and now let's deal with insurance company "B", and it takes you your whole life to deal them all. It is battle after battle, like the war that will never be won. However, the good news is that many of our private insurance companies pay RN first assistants. We have RN first assistants who have their own businesses, they contract with hospitals and they contract with physicians, they bill the insurance companies themselves and they support themselves

Now to the question of "how much should we charge?". Think about strategically positioning yourselves and get these debates out of the way. Talk about them now and come to a consensus now because one of the questions you are going to ask is the same question that we have asked. Well, let's see now this is pretty simple. Same service, same pay. Well, if a physician assists at surgery and we provide the same service that that physician provided, shouldn't we get paid the same thing? A very interesting and a very complex question. Certainly equal pay for equal work is a philosophy that has enormous appeal. On the other hand, I caution you that as you process the worth and value of an RN first assistant, you also look at what is happening in your external environment. Your external environment is into cost-containment.

It is incredible the things that we do and the kind of patient assessment and the nursing diagnoses that we make. If a hospital administrator or a consultant looked in a door and saw you slapping a sticky pad on somebody's thigh, hooking a piece of equipment to a table, they would have no understanding of the intellectual processes that you engaged in when you made the decision about where to put that ESU pad. You never put on that pad without a thorough assessment but, it doesn't look like you are doing an assessment. You go to get the patient comfortable and you may say to the patient, "I am going to put my hand on your thigh", you lift up the blanket or the sheet that is on the patient, you take a look at the skin there, you determine what kind of contour, what kind of muscle mass, whether it is oily, whether it is hairy, all of the other things, scar tissue, that you need to know, everything is fine—boom, put the pad on. The person that is watching you saw you move a patient onto an OR bed, rip open a gel-pad, take off its back and stick it on somebody's thigh. They assume they can get somebody else to do that. That is how they see our role, they see it as very mechanistic. So yes, I think that this rumour is one that we need to be extremely concerned about in OR's across the world, not just in Canada and the U.S., because the move is on. I believe also that what we are going to have to do is start quantifying events that occur to patients because lesser qualified people were taking care of them. Now that is going to require courage.

Canadians probably read about the hospital in the United States where they took the wrong leg off a patient. A week later they operated on the wrong knee.

They unhooked the wrong patient from a respirator. Now this is all in the same hospital. Pretty unbelievable isn't it? They almost lost their license to operate. In the OR, part of their corrective action plan in order to be allowed to resume doing surgery was hiring more OR nurses. You hear that message!! That is what we have to quantify. And that is what I am sorry and afraid is going to happen. Those kinds of errors are going to take place and then we will get the nurses back. So what we need to do is grab those stories, grab that information, and when your hospital administrator suggests that you do this, honey you march in and say: "I feel obliged to share with you what happened in this hospital in Florida", and say "I hope we don't have to go through the same kinds of things here". Again, data, data, data...data talks. So let's not make it our own tragic data, let's bring somebody else's tragic data and show the administrator.

The RNFA Program

The RNFA course I teach is one year long. Now, it is two academic semesters. However, it is almost all long distance learning. So while I was not able to persuade the college to do teleconferencing, I was able to persuade them to do very nontraditional education. Students reside in Pennsylvania with me at the college for only six days. If you were to start in September of 1995, by August '96 you would have received in the mail all of your assignments that have to be complete before you show up for your six days. You have about thirteen papers to write and they have everything to do with nurse practice acts, scope of practice issues, with pain assessment, etc. and they are very in-depth assignments that have to be completed. You receive your first anatomy and physiology exam in the mail and it is mailed back to the college. Then you come for six days of very intense course work, you have about three or four books to read before you get there so that you are very well prepared to sit through nine hours of very intense lecture with a physician-nurse team-taught course. You go back home, you finish up the rest of your course work by December. The following January you start your internship. You must complete 200 hours of assisting, so that means for five months (that's how long the next semester lasts from January through May), you have to have 200 hours at the OR bed and you keep logs of every single procedure you assist at, you develop some of your own objectives as well as have competencies you must meet by the college, you have to be rated on those competencies for every single surgical procedure and then you have about another fifteen assignments. You have to do rounds, write sample postop notes, go to the surgeon's office and pick up a patient, do a complete case study, and follow a patient through their surgical experience and back either to the surgeon's office or to their home. So it is two academic semesters or what we consider one academic year but very, very non-traditional. They are held all over the United States.

Comment from the Convention Floor:

> "At the Toronto Hospital, there is an RNFA employed by a cardiac surgeon to harvest the vein for CABG or CABS (however you refer to it), she is a graduate of a postdiploma OR program, she is very good, and trained in RNFA by the surgeons. She has been employed for a year and a half and is doing well. She also has her BScN, and she is the first that we know of in Toronto".

How wonderful, now is this not a good model for role evolution? When you think of who this person is going to be and what is this person going to look like, this RNFA, we have one. We have someone who didn't go to a formal program—why?—there wasn't one. But the person went through a post-basic program in perioperative nursing, was trained by the surgeons, has a Bachelor's Degree, so is doing a lot of things right, again so that people can't say, "gee, you went away to school for two days and you are a two-day wonder; who died and made you queen that you can suddenly, do this". This is someone that you might want to talk about, you want to be able to connect with that nurse in Toronto. This is how we begin forming our RNFA networking groups. We find this nurse, find out what her job description is, and then we start growing and going on a new adventure together. I support very strongly the RNFA role, but we need to start our debate. We have to ask the hard questions among ourselves, we can't afford to get out there in public and have people ask us hard questions that we haven't thought about answers to.

I am very concerned about the future of perioperative nursing when most of the college/university courses have dropped perioperative content. Look at the mean age of nurses here today, how depressing. What we need to remember is what attracts people to nursing in the first place. What attracts people to nursing is often the opportunity for an autonomous role, the opportunity for continued clinical growth. If we look at how we are going to attract nurses to the OR, what better than to tell them there is a new clinical role, and that you need to be an experienced perioperative nurse to move into it. Let's assume you wanted to go get a master's degree, was there any place for you at the bedside in the OR? Not usually. You got transferred right out and right away from the bedside. You became a manager, you became an educator, you became a QA person, you became whatever...but you didn't have a chance for clinical

growth. It was scrub or circulate and that is all its been for a long time. We will now attract people into perioperative nursing with the RNFA program.

What are the legal implications of and RNFA assisting with surgery if he/she is not properly certified? In Canada you are just getting into certification for perioperative nursing. You will also have to deal with certification for RN first assistants at some point in time and ensure they are properly educated and credentialed according to whatever the province or jurisdiction says is required.

First of all, in an emergency situation, in the U.S. almost all State's have a clause for what is called 'a delegated medical act'. What that means is if you are in a situation where you need to assist during an emergency, the physician in that situation may delegate medical acts to you to have you assist and that is perfectly within your scope of practice as a nurse and perfectly within the physician's scope of practice as a physician. Now, what the physician can't do is routinely delegate those medical acts to you in a way of getting around the requirements for an RNFA.

No 'Specialized' RNFAs

Are there specialized RN first assistants? Well, yes there are but let me tell you our program doesn't prepare them that way, not in the didactic part of their course. They hate it because of course all the cardiac perioperative nurses have to learn about gallbladders and where the cystic artery is, and where the cystic duct is and the node of Calais. All they want to do is hearts. Well guess what, that is not all they are going to be tested on in their certification exam and so it is a generalist's course. They are allowed to specialize in their internship and yes of course many of them assist in just one specialty, that is a very risky thing to do. We are talking about re-engineering here, restructuring, we are talking about career security. The perioperative nurse of the future will be multi-competent generalist/specialist, which means you don't just do hearts, and my message to my RNFA's is get out of that heart room, get yourself able to assist in other things because as we go through mergers and acquisitions, what if they get rid of the hearts in one of those hospitals that just got acquired and merged, and all you can do is hearts. You don't have a job. You need to be career-secure and I say be a generalist/specialist, your general specialty is perioperative nursing, but be a specialist within that field in a number of areas, not just one.

How much is it? Let's just say the maximum for somebody from out of the country would be $200.00 U.S. dollars. So it is six credits at $200 each and then of course you have to think about books, telephone because you to talk to your faculty facilitator during your internship every two weeks. Also you would have to fly or drive, stay in a hotel

The final message is that we need to cooperate, we need to collaborate, but we will not capitulate. We will cooperate with our physician colleagues, we will cooperate with our colleagues on jurisdictional boards of nursing, we are extremely well positioned. The question we have to keep asking ourselves is - can we move? Can we move, are we ready to move? We can't sit still. To progress is to choose, but to choose is very difficult. Many of you may have heard of Mia Angelo, poet laureate in the United States. Now this is what Mia has to say from one of her stunningly meaningful books called *Wouldn't Take Nothing For My Journey Now* and it is called *New Directions.*

> "Each of us has the right and the responsibility to assess the roads which lie ahead and those over which we have travelled and if the future road looms ominous or unpromising and the roads back uninviting, then we need to gather our resolve and carrying only the necessary baggage, step off that road into another direction. If the new choice is also unpalatable, without embarrassment, we must be ready to change that as well. You and I have to commit to not paving the cow path. You know what is behind us that didn't work, that was bumpy. That is not where we want to spend our time, paving our road. And if it means that we have to find our new path and create new roads, we can and we will. Together we can do anything."

The other thing that we have to remember is that we are the only group of people in the whole world that can do something like this and feel incredibly proud of it. Now if you can do that and be proud of it, you can create any road, follow any path and find any place that you wish to find. I just can't tell you how many times I have talked, maybe this is the third time, about the RN first assistant with you, ORNAC, to watch your growth, to see the things that have happened, I just cannot...and I say to you again with the most humble sincerity, I am so privileged to have been a part of you, to learn these lessons, to watch you grow and to go a little bit of this journey with you, I am so proud of you. I hope that you are proud of yourselves. You have done something that is so important for the future of health care in Canada. It is not just for the future of the perioperative nurse, it is for the future of perioperative nursing care. You are well on your way to the place that you want to be, to see that you give quality, safe, cost-effective care. There is no better place to be. ■

The ORNAC Legacy

Reflections on the association's roots with an eye to the future

By Joan Donald, R.N., B.Sc.N.

Introduction

Many operating room nurses are struggling these days to keep up their enthusiasm and faith in our health care system when so many difficult changes are underway in our hospitals.

The question remains, is our health care system being threatened or simply being streamlined? There are as many answers to that question as there are people and the one true answer will lie with the future. Lately, it seems politically dangerous to offer an opinion. But are there traditions that will provide us with better insights and courage to face the future, whatever lies beyond? I believe there are and I believe that they are here in our own organization and in our own people, both past and present. I have called this presentation "Our legacy" - a time together to reflect on our roots as we prepare to branch into the future.

The metaphor of a tree has certain appeal when attempting to look at "Tradition and Beyond" in the Operating Room Nurses Association of Canada (ORNAC). The pioneers of the past have provided the basis for our traditions and roots. The sap, which runs from the roots to the branches, can be likened to the spirit of operating room nursing. This in turn feeds the branches as they reach for the sky and beyond. Branches go in many directions which can be compared to our nursing practice which is constantly evolving and changing. Just as each leaf is a unique creation of nature, so too each nurse is a unique creation, depending on their heredity and life experiences.

Just as a tree has its fresh, green foliage, so too nurses have fresh, new, and innovative ideas. Leaves change colour in the Fall and the tree becomes a display of vibrant colour - a mosaic - a kaleidoscope of brilliant tones. Nursing is made up of nurses who provide vibrancy and diversity. Each has a different personality, different point of view, and a different approach to patient care. But each and every nurse contributes to the well-being of the organization. Just as a leaf brings breath and nourishment to the tree, so too each operating room nurse brings life to OR nursing and to ORNAC. No one nurse is more valuable or less valuable than another.

As the leaves age or drop from the tree they return to the earth valuable nutrients that are taken up in the root system. The circle of life for the tree is complete. As nurses retire or move on from ORNAC, they leave behind valuable gifts that provide essential elements for the growth and development of the organization. We may not always recognize or appreciate these gifts, but we are the richer for them. Our circle of life is complete.

Traditions or Roots

Reflecting on our roots could take us back a very long way and involve many people. For fear of omitting someone, I will not attempt to name the many pioneers of the past. ORNAC is a mere child of 12 years. Not even a teenager, yet. However, national conferences were held in various centers across Canada for many years prior to ORNAC's beginnings. The national conference (planning) committee was comprised of nurses from various provinces who planned and organized national conferences. These nurses were just as confident, capable, dedicated, and committed as national committees have been since 1983.

Joan Donald, RN, BScN, B.Ed., M.A. (Ed), was formerly Director of Ambulatory Care, The Moncton Hospital, Moncton, New Brunwick. She is a past president of ORNAC and is currently enrolled in a doctoral program at the University of Toronto. This is an abridged version of her Closing Address to the 1995 Vancouver Conference, without benefit of numerous cartoons, historical slides and the dramatic and beautiful music of its original live presentation.