

Canadian **Operating Room** Nursing Journal

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2001 World Conference Speakers



Canadian OR Nurses at the World

***Tonsillectomy:
A Comparative Study***

Health Ethics

***Papillary
Fibroelastoma***

***Infected Cardiac
Myxoma***

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Cover: Top photo shows the Canadian speakers at the 2001 World Conference. (LtoR) Muriel Shewchuk, Moderator; Pat Pocock, Presenter, Val Zellermeier, Presenter; ORNAC President Mary Knight; and Catherine Bustard, Presenter. Lower photo shows some of the Canadian contingent at the International night.

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The New Millennium: From Fellowship to Tragedy

By Mary Knight, RN, BScN, MN, CPN(C)

As I write this message, I have just returned from attending the 12th World Conference on Surgical Patient Care in Christchurch, New Zealand. 1,439 participants represented 41 countries at the conference. The theme of the conference was "Vision for the New Millennium: A New Beginning".

As an elected member of their Executive Board, I was fortunate to be funded to attend that meeting by the International Federation of Perioperative Nurses. Many exciting events occurred at their meetings, including the adoption of three new international standards: handwashing, the surgical scrub, and surgical site skin preparation. The development of standards that can be used around the world is a challenging process! Standards will now be developed on sterilization and disinfection, on the reuse of single use items, and visitors in the OR.

A Resolution was unanimously passed by IFPN's Council of National Representatives condemning the use of child labour in the manufacture of surgical instruments or any other surgical supply. This resolution is in keeping with the position of the International Council of Nurses, and is intended to raise global awareness of this issue.

IFPN Resolution against the use of Child Labour

Whereas the International Federation of Perioperative Nurses (IFPN) has learned from the International Council of Nurses that child labour is being used to manufacture surgical instruments;

Whereas child labour is reprehensible and robs children of their childhoods and their futures; and

Whereas it is impossible to deliver ethical healthcare using supplies manufactured using child

labour.

Therefore, be it resolved that the IFPN condemns the use of child labour in the manufacture of surgical instruments or any other surgical supply.

And, be it further resolved that the IFPN join the ICN in efforts to urge governments, funding agencies, and industries to work toward eradication of child labour and to support economies as they move to an adult labour base.

And, be it still further resolved that the IFPN urges perioperative nurses to request full disclosure during the purchasing process regarding the use of child labour by manufacturers and subcontractors.

And, be it finally resolved that the IFPN urges all perioperative nurses to inform purchasing agents, surgeons, and others in their facilities about this practice.

Adopted: September 2001

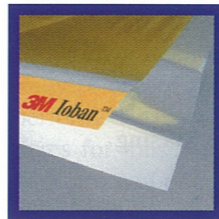
IFPN also conducted an International Forum with discussion on perioperative nursing roles, visitors to the OR, risk management, recruitment and retention, and research priorities. Two networking sessions were held on sterilization and disinfection and the reuse of single use items. These late-day sessions were attended by hundreds of perioperative nurses!

After a week of global fellowship and incredible hospitality from our New Zealand perioperative nursing counterparts, the unimaginable tragedy struck.



Mary Knight, RN, BScN, MN, CPN(C), is President of the Operating Room Nurses Association of Canada. She is Project/Systems Coordinator, Adult OR, Health Sciences Centre, Winnipeg, Manitoba.

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I would like to share with you the contents of a letter sent to Sheila Allen, AORN President, for the members of AORN in the aftermath of the events of September 11th.

"The entire world watched the events of that day unfold with horror and disbelief. Our hearts go out to those who lost loved ones and friends, and to all affected by that senseless act of terrorism. This was truly a global tragedy and we mourn with you for the lost lives, from the United States as well as all the other nations.

In the first days, many of our thoughts were with our perioperative nursing colleagues as

they awaited an influx of casualties, which never materialised in the numbers we all would have liked to have seen. We know that our colleagues provided their patients with the best care possible, and commend them for their efforts under incredibly difficult conditions.

Please pass on our thoughts to our AORN colleagues and staff, especially to those in New York, New Jersey and Washington, DC."

ORNAC extends its thoughts and condolences to all those affected by the events of September 11th, wherever they reside. □

N&LORNA Conference Report

The Newfoundland and Labrador Operating Room Nurses Association (N&LORNA) held its twenty-second Annual Provincial Conference in St. John's from September 27th to 29th, 2001. We were honoured to have Mary Knight, President of ORNAC, give our keynote address.

The theme was Communication: The Key To Unmasking Perioperative Nursing with emphasis on Recruitment and Retention.

An invitation was extended to nursing students of Memorial University's School of Nursing and we were pleased to see several students in attendance

Our theme paralleled our provincial tourism's year-long theme, "Receiving the World - Celebrating Communication", in honour of Guglielmo Marconi who received the first wireless trans-Atlantic message on Signal Hill, St. John's, NF on December 12, 1901. Little did our provincial government know when they decided on a theme that on September 11th we would literally "receive the world" when some 70 aircraft carrying over 13,000 international passengers descended on Newfoundland and Labrador. People slept in crowded hotels, on cots in school gymnasiums, on church pews and in private homes. Most of them had never heard of Newfoundland and Labrador before they experienced our hospitality for the first time, but I am certain that it has been unmasked and communicated around the world.

Our OR conference's topics included:

- RNFAs in Newfoundland

- CJD
- Anaesthesia/Hypothermia
- Operation Smiles
- The Future of Perioperative Nursing

Some of the main topics of our Annual General Meeting were:

- Membership Fees
- Review of Certification and Re-Certification Funding
- Election of Officers

The social highlight of our conference was the dinner and dance, which continued our "Communication" theme. There were costumes with the dots and dashes of Morse Code, kites and aials, cell phones, a couple dressed as black and white TVs and even Marconi himself made an appearance.

Send-Off for the United States Military

After the dinner, some members of a Squadron of United States military personnel staying overnight at the hotel (on their way to parts undisclosed) were invited to join our dance and celebrations. They were very appreciative of our invitation and of the warm send-off from North America.

Evaluations received from all our OR nurses rated the conference a huge success.

Submitted by: Lynn Anderson, RN, CPN(C), Past-President (2001 -2003)

Tonsillectomy

A Comparative Study of Dissection/Snare vs Suction-Cautery

By Colleen Young, R.N. and Dr. John MacRae, M.D., F.R.C.S.(C.)

Abstract

In an optimal situation, a surgical procedure would be one that generates minimal post-operative pain, incurs little or no bleeding, and allows the patient to return to their normal daily activities in the shortest time period. A tonsillectomy is one of the most common operations performed in the world. Various surgical procedures for tonsillectomy are performed with a wide array of opinions to support the pros and cons of each technique.

Objectives/Goals:

To determine if there is a significant difference between two methods of tonsillectomy.

Methods and Materials:

A prospective single blinded randomized control study using (i) A dissection/snare technique, and (ii) A suction-cautery method. Measured outcomes such as blood loss, surgical time, post-op pain, post-op hydration, pyrexia, and the length of time to resume normal daily activities will be assessed.

Results: In total, 50 patients were studied, 23 in the dissection/snare technique, and 27 in the suction cautery technique. Inclusion criteria was, the patient must be at least 2 years of age and not older than 16 years of age. Data was collected intra-operatively, at 2 and 4 hour post-op intervals, as well as a 2 week follow-up questionnaire completed by the parents.

Conclusions: The suction cautery group had statistically significant differences in blood loss, surgical time and pain in the immediate post-operative period.

Introduction

Tonsillectomy represents one of the most common surgical procedures performed in North America, and most certainly one of the most common for children under the age of 16. As with any surgical procedure, associated risks are a reality and may play an integral part of a patient's recovery. The fact that there are many different surgical techniques available, a surgeon must determine which method is best suited to minimize such risks. Currently at Joseph Brant Hospital in Burlington Ontario, tonsillectomy is performed by either a dissection snare or suction cautery method. This prospective single-blind random controlled study was designed to determine if there are significant differences between the two methods, thus allowing the surgeon to make an informed decision as to which method is best suited for his patients. The measured outcomes include blood loss, operative time, pain, post-op hydration, pyrexia oral intake and resumption of normal activities.

Materials and Methods

All surgeries were performed by the same surgeon. A week prior to their child's scheduled surgery the parents were contacted and the study was outlined. All participation was completely voluntary.

Patients included were children 2 years of age and not older than 16 years of age, undergoing a tonsillectomy.

Authors

Colleen Young, RN, is a staff nurse, and Dr. John MacRae, MD, FRCS(C), is an Otolaryngologist at Joseph Brant Hospital, Burlington, ON. This study was presented by the authors at the Nursing Symposium at the Canadian Society of Otolaryngologists and Head and Neck Surgery in Vancouver, BC, May, 2001.

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tomy, either alone or possibly in conjunction with an adenoidectomy. Children with any bleeding disorders or craniofacial abnormalities (i.e. cleft palate) were excluded from the study.

All parents were asked to sign an informed consent allowing either surgical technique to be used. Parents would be blinded as to which technique was used at any point in the study. Their responsibilities involved keeping a diary for two weeks post-operatively, and returning the data by mail. They were made aware their participation was completely voluntary and could withdraw it at any time.

In total, from September 4th, 2000 until January 17th, 2001 - 50 patients in total participated. In the Dissection/Snare group, 23 patients, 11 male and 12 female. In the Suction Cautery group, the total was 27, 16 male and 11 female.

Once the patient had been brought into the O.R a random draw was made to determine which method would be used on that patient.

Surgical Technique

In the Dissection/Snare method, the operative time was recorded from the insertion of the Boyle-Davis mouth gag. Adenoids were removed by curettage after direct palpation, using an adenotome. The tonsil was then grasped using a curved allis forcep. blunt scissor dissection was carried out along the superior pole to expose the capsule. The tonsil was regrasped and using a Fischer Knife, the tonsil was dissected from the tonsil bed to the lower attachment at the base of the tongue. The tonsil was then snared out in a guillotine fashion. Homeostasis was achieved by packing the tonsil bed with a Bismuth Subgallate and topical adrenaline paste mixture. Cautery with a monopolar bayonet forcep set at 20 coag. on a Valleylab Force 2 machine was used to cauterize point bleeders. The end of the operative time was noted once the Boyle-Davis gag was removed.

In the Suction Cautery method the palate was retracted by 2 size 10 fr. red rubber catheters passed through the nose and brought out the mouth. The ends were clamped to a head drape to provide the traction. The tonsils are grasped with a curved Allis. A suction cautery size 10 fr. by Valleylab was used to incise along the anterior portion of the tonsil. Dissection continued along the tonsil bed separating the capsule from the bed, aided by traction on the tonsil with the

allis.. Settings on the Valleylab cautery machine was Cut @30 Coag @ 55 blend 2. Under indirect visualization with a laryngeal mirror the nasopharynx is examined. The suction cautery is the used to vaporize and coagulate the adenoid tissue. Care is taken around the area of the eustachian tube and posterior choana. Cautery of the posterior mucosa of the palate is also avoided to prevent a circumferential burn. The settings for the Valleylab are Cut @ 40 Coag @ 65 on blend 2.

All blood loss for both techniques was recorded in a cone and read by the same investigator. Operative time was recorded from the time the Boyle Davis gag was in place until the tonsils were removed and homeostasis was established, and the gag was removed.

Decadron .1 mg./kg. was given to each patient in both groups. Analgesic given intra-op was codeine or fentanyl, given by weight - mg/kg. ratio and was given either during the procedure, or immediately upon arrival to the recovery room depending on the anesethist on that day. Both groups were treated the same.

Upon returning to the day surgery unit, a record was kept to record fluid intake and pain levels by a simple word description pain scale. Readings were taken at 2 hours and 4 hours post-op. The nurses recording this data were blinded to the technique used and the records were collected after the patients were discharged. Hospital policy requires the tonsillectomy patients to remain in hospital for a minimum of 4 hours and may be discharged only after being examined by the surgeon.

Using a simple descriptive word pain scale the nurses would categorize the pain levels as none, mild, moderate, severe or excruciating. Upon discharge the parents were given a questionnaire, in which they were responsible for recording their child's pain level and temperature twice daily for 14 days. The same simple descriptive word scale applied. Agreeably, a parents' interpretation of their child's pain may be subjective, however, the consistency in which they rate the pain in the post-operative period would help to eliminate any bias. The questionnaire also included 3 short questions pertaining to when the child first ate solid food, resumed a "normal diet" and returned to their normal activities. Parents were also asked to provide details of any complications or any concerns they may of had and if there was ever a need to seek further medical attention.

Results

In total, 49 patients completed the study. In the dissection/snare group, there were 11 male patients and 12 female. The youngest was 2 years and 8 months old and the oldest was 15 years. Average age: 7 years and 2 months. In the cautery group, there were 15 male and 11 female patients. The youngest was 2 years and 10 months. The oldest was 12 years old. Average age in this group was 6 years and 1 month. One parent left the questionnaire behind upon discharge, so that data was excluded from the study.

The average blood loss in the cautery group ranged from 2 ml to 10 mls. The standard mean was 4.92 mls. (S.D. 2.21). In the Dissection/Snare group the range of blood loss was 5 mls. to 120 mls. The mean was 32.17 mls. (S.D. 22.4) with the use of the t-test the calculated $t = 5.81$, ($p < .05$) which proves to be statistically significant.

Operative time in the cautery group, ranged from 4 minutes to 14 minutes. The mean is 7.18 minutes. (S.D. 2.88) and in the dissection/snare group a range from 11 minutes to 25 minutes, the mean time is 16 minutes (S.D. 3.98) Calculated ($t = 2.37$, $P < .05$) in both of the parameters above the results are statistically significant.

Post-operatively the patients were cared for in the day surgery unit. The next phase of the study, data was collected for post-op pain and fluid intake at 2 and 4 hour intervals. The nurses were given direction to record the patients pain level and using the simple word descriptive pain rating scale, circle the appropriate word best suited to how the patients were feeling. After the data was collected the descriptive were given a numerical indicator to calculate the significance.

At 2 hours post-op the dissection/snare group, the standard mean was 1.66 and the standard deviation was .623. The cautery group the standard mean was .869 and the standard deviation .536. Using again the Student's t test the calculated $t = 4.57$ $p = .001$ indicating that with the snare procedure patients had more pain. At 4 hours post-op the calculated $t = 4.18$ $p = .001$ once again indicating that the measured outcomes of these parameters, the snare procedure is significantly more painful.

Fluid intake at 2 and 4 hours post -op did not appear to have any significant differences, however one might wonder if the design of the outpatient tonsillectomy policy might play a major role and lend some bias unknowingly. It is understood that the criteria needed to be met for these children to be discharged home after 4 hours is they must have adequate fluid intake. Nurses on the floor would likely "push fluids" to ensure their discharge. Those patients under the age of 3 or those residing longer than 30 minute drive are required to stay in hospital overnight. We did not explore any possibilities in to this theory, as the numbers of those patients were minimal. (See Table 1).

When using the data to perform a multiple correlation analysis, pain at 2 and 4 hours post-op were described as the dependent variables. The model used states that pain is a function of technique, age gender and surgical time. Predictions concluded that at 2 hours post-op:

- females had less pain than males,
- as males got older, the pain worsened, and
- pain was statistically significant in the snare technique.

The questionnaire portion of the study involved the parents to answer three short questions and keep

a log of their child's temperature and pain level. Of the responses returned in the dissection/snare category there was a 52.1% return. In the cautery group, there was 53.8% return. The questions were:

1. When did your child first eat solid food?
2. When did your child return to eating "normal"?
3. When did your child return to normal daily activities, (i.e. school or daycare)?

Once again using a student's t-test to calculate the responses, there were no significant differences between the two groups.

In the pyrexia category, the cautery group, 42.8% of the group experienced fever not higher than 100.8 and only one had a fever later than post-op day 3. In the snare/dissection group, 75% of the group had a fever but 7 were noted past day 3, and 3 patients had a fever as late as days 10 to 13.

Parents were also given a opportunity to provide any details of any complications or any comments about their child's recovery. Both groups noted that their child experienced ear pain equally and those who did visit their family physician were often given a prescription for antibiotics without proof of infection. Interestingly, they also claimed immediate relief.

It was also noted that some parents were not giving sufficient pain medication. When this was noted and sufficient pain medication was given their child greatly improved. Neither group reported any indication of secondary bleeding in the recovery stage.

Discussion

Ultimately the challenge is to find the ideal method of tonsillectomy. The patient undergoing surgical procedures deserves to be treated with the optimal technique that provides minimal morbidity.

Our conclusion is that through valid statistical analysis, measured outcomes such as shorter operative time, less blood loss and less pain in the immediate post-op recovery period with the use of the suction cautery technique would make this the technique of choice. The relationship between the amount of time per surgery to the number of surgeries in a day could easily have clinical significance as well. Arguments could be made, that minimal blood loss and lowered pain levels could demonstrate shorter length of stay required in the Day Surgery unit. These parameters would likely have to be reviewed in accordance with hospital policies, but the evidence does lend credibility.

This study did not research post-op hemorrhage in the two week follow-up, however none were reported in either group.

As with any surgery, the anesthetist plays a vital role. With the suction cautery technique, the benefits to the anesthetist include a shorter anesthetic. For the patient, a virtually dry nasopharynx upon extubation, which minimizes the risk of aspiration, as well minimal volume depletion from blood loss intra operatively.

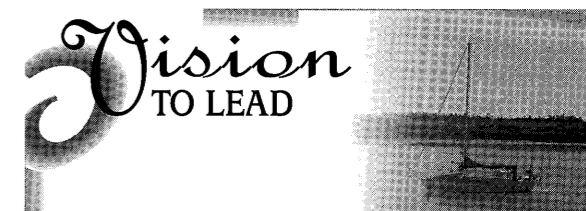
Acknowledgements

We gratefully acknowledge the Joseph Brant Hospital Operating Room staff, the nurses from 3 West and 3 South for their support throughout this study. Thanks also to Bette Zeran for providing great resource materials, and to Tom Remegio for his assistance with the statistical analysis. Finally, to the children and parents who volunteered to participate, our gratitude for allowing us to further our knowledge in this area. □

Table 1.

	Suction-Cautery X ± S.D.	Dissection/Snare X ± S.D.
Blood Loss	4.92 ± 2.21	32.17 ± 22.4
Operative Time	7.18 ± 2.88	16 ± 3.98
Fluid Intake 2 hrs post	279.56 ± 141.38	226.66 ± 113.38
Fluid Intake 4 hrs post	321.3 ± 227.8	256.25 ± 107.09
Pain Level 2 hrs post-op	.869 ± .536	.623 ± 1.66
Pain Level 4 hrs post-op	.826 ± .636	1.58 ± .571

N = 49 P = .05



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Health Ethics in Cross-Cultural Settings

By Al-Noor Nathoo

The increasing cultural diversity in Canadian society has given rise to a range of ethical issues in the proper delivery of health services.

Avoiding Stereotyping

Perhaps the most important consideration for healthcare providers working in cross-cultural settings is to maintain a balance between stereotyping individuals as having certain beliefs or practices because they belong to a culture or tradition, while at the same time maintaining sensitivity to the particular needs of those individuals. Often ignored is the fact that there is frequently as much variation within cultures and religions as between them. Not all people born into the Muslim faith for instance, will wish their bodies to be turned towards the east at the time of death, although this may be true for some. To make a statement about the rituals surrounding the end of life for all Native peoples, as a case in point, would be about as instructive as making a statement about the birth control practices of Christians - the group is too diverse in itself and composed of too many different sub-faiths or communities to make generalization meaningful or helpful.

Treating Each Person as an Individual First

Thus each care recipient should be treated as a unique individual who may interpret the circumstances of his/her family, community, religious, cultural and racial background very differently from that of someone else with the same background. Factors such as the level of adherence or commitment to certain cultural

or religious practices, the extent of his/her exposure to predominantly "Western" values and the depth of his/her connections to family and community of origin greatly influence the extent to which his/her behaviour and wishes will actually conform to "cultural norms". In fact, these "cultural norms" are themselves constantly changing in North America in the process of their interaction with other cultures. So, while health care providers would be well-advised to learn as much as possible about the differing traditions of the cultural groups with whom they interact, they should be careful to keep these in mind only as sources of potential tension or concern rather than as definitive indication of the wishes of individuals or residents, which only direct contact and communication with individuals and families will reveal.

Ethical issues that arise as a result of cultural diversity can be divided roughly into two general areas - the first involves the process of care delivery, the second deals with the content of the values in tension.

Accommodating Cultural Practices

If we take seriously the claim that health care should be equally accessible to all regardless of race, culture, religion and sexual orientation, an ethical onus exists on health care providers to take reasonable steps to accommodate any individual's particular val-

Author

Al-Noor Nathoo is currently the Southern Alberta Coordinator and Executive Director for the Provincial Health Ethics Network. This article is a summary of his presentation to the 17th National ORNAC Conference in Banff, Alberta, April, 2001.

ues and customs in order to provide optimal care, equal access to care, and to allow the person to feel as comfortable as possible so as to restore or maintain health. Health care providers working in institutions may wish to consider that such settings, because they are predominantly based on Western life-styles, can be particularly alienating to users from other cultures. Where possible, accommodating preferences of diet, providing translation services, flexibility in visiting regulations and - where not counterproductive to existing treatments - consideration of preferences for complementary or alternative therapies, will go a long way towards establishing trust between health care providers and consumers, and ultimately towards improving the well-being of the users themselves.

Are We Furthering the Goals of Care?

But how far should health care workers go in accommodating individual preferences based on cultural or religious difference? This is impossible to answer as a blanket statement, but health care providers, in answering for themselves, may wish to consider the questions: Will accommodating these preferences further the ultimate goals of care for this individual? Will it compromise the care of this or other users of the health service? In answering the first question, it is important to ask what the goals of care are as seen from the perspective of the care recipient - which can often be different from those of the health care team. If the goals of life or of care for a specific individual involve maintaining honour, experiencing absolution through suffering, or dying with dignity, these may not suggest the same care plans as a purely "medical model" might. In these cases, care providers might respond in the same way they would to a client who was not a member of a minority - in a way that respected the wishes and values of the individual and their right to determine the course of their own care.

Indeed, in some cases, making accommodation for cultural difference may turn out to be a strong requirement rather than merely prudent. For instance, in cases where language is a complete barrier to communication between healthcare provider and care recipient, informed consent becomes virtually impossible. In these situations, there is an even stronger ethical obligation on the part of the health care providers to seek competent translation either through family or through other care providers.

What Ethics Can/not Achieve

Ethical issues fall into the general category of questions which rarely succumb to hard and fast rules. The fact that there is usually no one right answer to a difficult ethical question does not, however, suggest that all answers are acceptable. Ethics is the process of trying to determine which, of several possible and palatable courses of action will most likely produce the most good or be the most right. This is a difficult task, and the best we can do is to ensure that we explore the various options thoroughly, that we explore the question in a systematic way, that we attempt to lay bare the values that underlie our final decision and that we provide reasonable and defensible reasons for our choices. This is what we hope to accomplish by analyzing difficult issues from the point of view of ethics.

Values in Tension

The most difficult issues that arise out of health care practice in cross-cultural settings probably involve circumstances in which a person's wishes clash with the values of the health care provider. This gives rise to the question of whether health care providers can rightly use their positions of relative power to "trump" the values of others in cases where those values are seen to be particularly objectionable. Failing this, can the provider ethically withdraw from the case?

Female Genital Mutilation or Modification

An example involves a request from a couple to have "circumcision" performed on their young daughter. Circumcision is a practice common in some areas of Africa and is often referred to as female genital mutilation. The procedure varies from an incision into the clitoris or, in its more extreme forms, the sewing together of the labia majora. Predictably, this procedure is known to be the source of a litany of future physical, sexual and psychological ailments aside from the pain caused as a result of the procedure itself. Legislation to ban the procedure has been passed in several countries, including Sweden and the Netherlands. Canada has no specific legislation dealing with female genital modification, although bodies such as the Ontario College of Physicians and Surgeons have prohibited their members from assisting with the procedure.

Seven Things I've Learned About Ethics

1. Most of us believe we are good.
2. There is rarely ever only black and white.
3. Moral understanding and thinking makes choices even more difficult.
4. Ethics involves the search for consistency.
5. Ethics involves seeing things from the perspective of the other.
6. Never trust an ethicist - moral decision making belongs with each of us.
7. Respect for autonomy is crucial.

The Limits of Cultural Accommodation

From an ethics perspective, there are two possible approaches to this question: the first is to assert, correctly, the claim that health care providers have no ethical obligation to provide a service which they see to be morally objectionable. This response however is not always regarded as appropriate or practical, particularly in situations where no other health care providers are available to provide the requested service and a "monopoly" in health care provision exists.

The second approach, also equally valid in this case, is to claim that the harms caused by the procedure are so extensive and compelling that they provide sufficient reason for the health care provider to deny a request for assistance with the procedure on the grounds that it is always mutilation, and should be made illegal in Canada. Added to this is the valid question of whether parents requesting female genital surgery of this sort are indeed acting in the best interests of their daughters.

Four Things I've Learned About Resolving Cultural/Value Differences

- Avoiding the extremes of relativism and absolutism is often a good thing.
- Talking to the person, or finding out as much as possible about their needs and beliefs, is crucial.
- Very often there are creative ways to approach differences.
- Value differences can be blessings in disguise.

It is important to remember that even in cases where care providers refuse to assist in requested procedures such as female genital mutilation, compassion, tact and respect for other's values and lifestyles can still be practiced. Often, the language used (e.g. "female genital modification" versus "female genital mutilation") can make the difference between insensitivity to others' values and acknowledging the importance of other chosen ways of life, however incompatible with one's own.

Examples of Value Clashes

- Truth-telling, informed consent
- Cessation of treatment
- Rejecting care due to color/race
- Religious beliefs
- Caring for family members
- Abortion
- Patient who has apparently committed a crime

Our values reflect what we believe is important. Values fill the gap between what is the case and what ought to be the case. Because values are intimately involved with how we perceive the world, and people with different experiences and backgrounds may have different values, very often there is potential for a conflict of values. In health care practice, it is not unusual for a care recipient's values and those of the care provider to clash. The situation may become more difficult because the relationship has an unequal power dynamic. In the examples listed above, can the health care provider, being in a position less vulnerable than the patient, simply override the patient's wishes? Or, in trying circumstances, is it ethically acceptable for the provider to just withdraw from the case?

An example of a clash between the values of a person and the health care provider in a cross-cultural care setting is the case of a parent who requests that female genital modification be performed on the daughter. This procedure is common in some areas of Africa but is banned in several other countries. There are two possible approaches to seeking an ethical resolution to the conflict. First, one may claim that health care providers have no ethical obligation to provide a service which they see as morally objectionable. This approach is not always regarded as appropriate since there may be no other health care providers available to provide the requested service. This is obviously

problematic if we hold as a society that members are entitled to meaningful health care. Second, one may claim (probably rightly so) that the harms caused by the procedure are so extensive as to outweigh any benefits. In addition the question arises, in requesting this kind of female genital surgery, are parents really acting in the best interests of their daughters?

Examples of Issues in the Delivery of Care

- Food
- Diet
- Dress/Jewellery/Trinkets
- Alternative therapies
- Visiting regulations
- Notions of time
- Response to pain and suffering
- Language/communication/eye contact/frankness

Promoting conditions that are conducive to restoring the health of a person unfamiliar or uncomfortable with a Western setting may include accommodating preferences regarding food or diet, dress (and others listed above). Consideration of the patient in these ways greatly facilitates a positive rapport and establishes trust between health care providers and consumers.

Limits to meeting specific individual preferences may be necessary when considered in relation to broader issues of care. Focusing on what could be more narrow care issues may impede the realization of the ultimate care goals for the individual or, compromise others' ability to use the health service. Here, no line may be clearly drawn.

It may be helpful to ask what the goals of care are as seen from the perspective of the patient. These may be quite different than those seen from the perspective of the health care team. In those cases, just as for the client who is not a member of a minority, the response of the care team might be in such a manner as to respect both the wishes and values of the individual and the right of the individual to determine the course of his or her own health care.

Autonomy and the Role of Family/Community

A commonly noted difference between Anglo-Saxon cultures and others is the emphasis placed on individual autonomy, independence and self-control. In many non-Anglo traditions, the family

Six Things I've Learned About Cultural/Value Differences

1. The idea of human equality must be the starting point.
2. An attitude of respect and sensitivity is the result.
3. The attitude must translate into action.
4. Clashes in value (and thus ethical issues) are happening everywhere, all the time.
5. Avoiding ethnocentricity and stereotyping is a delicate balancing act.
6. The role of individuals, families and communities is an important difference to be aware of and maintain respect for.

and larger community to which the individual belongs plays a much greater role in decisions about care. These underlying differences may take different forms in health care settings. A family may request that a person not be told the full extent of his/her poor prognosis (in which case it might be prudent to attempt to diplomatically determine whether the person wishes to know the prognosis). Some cultural groups may have low utilization rates of advance directives -not unexpected in peoples for whom decision-making is made by family members and for whom written instructions by care recipients about future care may be unnecessary. Health care providers should recognize that the decision to allow family members or community elders to make health care decisions on one's behalf is in itself an exercise in personal autonomy. In such a case, the individual may have made an autonomous decision, either actively or passively, to allow others to decide on their behalf.

"The ethical system of any culture is morally defensible because it is grounded in truths which transcend that culture; it is not morally defensible simply because it is the product of a particular culture. Respect for culture and ethics other than our own is the beginning of any intercultural dialogue, not its ending".

(Edmund Pellegrino)

Recognition of the differences in value placed on individual decision-making between cultures is therefore an important part of the ethical provision of health services. Most conflicts of value arising out of cultural differences, as might be expected, are extremely complex and difficult to resolve. The greatest danger lies in assuming that certain cultural practices, because they are unfamiliar, uncommon or generally unacceptable in this part of the world, are necessarily unethical.

The flip side of the coin is the danger involved in assuming that because each culture or geographical region has its own customs (including Canada, of course), those customs must necessarily be ethical. This is the misguided idea that all values are culturally relative, and that members of one culture or nation can never judge the actions of others. Murder and rape, for instance, are everywhere murder and rape, and it is difficult to argue that they could be less morally repugnant anywhere else in the world than they are in Canada, even though various cultures may perceive the acts differently from each other.

Balancing Sensitivity and Integrity

What are health care professionals to do then, given the need to strike a balance between being culturally sensitive on the one hand, and abstaining from assisting in cultural practices that seem clearly

Guidelines in Cross-Cultural Encounters

- Assess the language used to discuss the patient's illness, e.g. degree of openness in discussing diagnosis, prognosis, and death.
- Determine whether decisions are made by the patient or a larger social unit.
- Consider relevance of religious beliefs.
- Consider issues of generation/age, gender and power relationships, both within the patient's family and with hcp's.
- Take into account the political and historical context, particularly past discrimination and access to care.
- Make use of available resources, including community or religious leaders, family, translators.

morally objectionable on the other? While there can be no easy answer of course, there is much to be said for taking the route of greatest sensitivity and dialogue. Taking time to get to know the recipients of one's care, learning about their cultural practices and the explanations behind the refusal of certain treatment or unusual requests may go a long way to finding courses of action that are mutually acceptable. Along the way, what may have appeared to be difficult either/or situations may emerge as having various acceptable alternatives compatible with the goals of care.

Decision-Making Approach

(A) Identify goals of care

- central aims that hcp and patient bring to encounter
- requires gathering information about values and culture.

(B) Search for mutually agreeable strategies

- consistent with both care provider and patient's beliefs.

(C) Re-examine personal values

- consider reinterpreting, reordering or changing them in light of the case.

(D) Engage in formal dialogue/discussional adjudication

- Ethics committee, care team and patient meeting.

(Based on Framework developed by Jecker, Carrese & Pearlman)

The Basis for Discussing

Cross-Cultural Ethics:

All individuals are equally entitled to care regardless of:

- skin colour
- culture
- ethnicity
- mother tongue
- gender

We begin with an important question: Why should we be concerned about issues that arise when the health system involves people of diverse cultures or beliefs? Why is this an ethical issue?

A fundamental claim of secular ethics is that every person is morally equal and worthy of respect and dignity. This implies that every person has entitlement

to care that is equal to that of someone else in the same position. In other words, if someone is entitled to care, we must be careful not to restrict care to that person for reasons based on their language spoken, color of skin, ability to communicate, etc. In fact, in some cases, where language or other barriers create "difficulties" for care providers, there is special onus on those providers to take positive steps to ensure that these barriers are overcome, as much as possible, so that clients or patients receive the same level of care as someone else who does not experience such barriers. Care providers, then, have an ethical obligation, within reason, to accommodate individual requests for care.

Opportunities for Growth

Difficult ethical questions arising out of culturally diverse healthcare settings, rather than being seen as a burden which further complicate already-difficult situations, can also be approached as opportunities for learning. Cultural groups have much to learn from each other. Human beings, like cultures, are not static in time or always attached to specific sets of beliefs. The kinds of intense interaction that take place within health settings provide opportunity for personal growth for both providers and recipients of care. Seen in this light, ethical dilemmas arising from cultural differences may begin to lose some of their more onerous undertones. □

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“ For every human problem there is a solution that is simple, neat and wrong. ”

(H. L. Mencken)

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Open Letter to all nurses who wrote the 2001 CNA Certification exam

The staff of the Canadian Nurses Association (CNA) Certification Program would like to take this opportunity to apologize to the perioperative nurses who wrote the 2001 certification exam and **received incorrect performance profiles** with their results. We are truly sorry for the distress our error may have caused the affected nurses. We have reviewed the internal process for preparing and mailing of performance profiles and steps are now in place so this error will not reoccur.

Several nurses contacted the certification staff to express their concern with the CNA Perioperative Prep Guide. Nurses told us that the degree of difficulty of the practice questions in the Prep Guide does not adequately reflect the degree of difficulty of the actual exam questions. CNA will be reviewing the Prep Guide this summer in order to strengthen it for those nurses who will be writing the 2002 Perioperative Certification exam. We plan to include additional practice questions as an addendum to the Prep Guide that will better reflect the actual exam.

We take this feedback very seriously. All Perioperative

The author should submit the original manuscript and two(2) copies for reviewers. A copy of the edited text will be sent to the author for final approval.

References are arranged in alphabetical order by author surname. References are cited in the text by author-date method of citation, e.g. (Smith, 1987). Follow the APA Manual for style when typing the list of References, e.g.:

Smith, M. & Curtis, J. (1987). *Ethics in Nursing* (2nd ed). New York: Oxford University Press.

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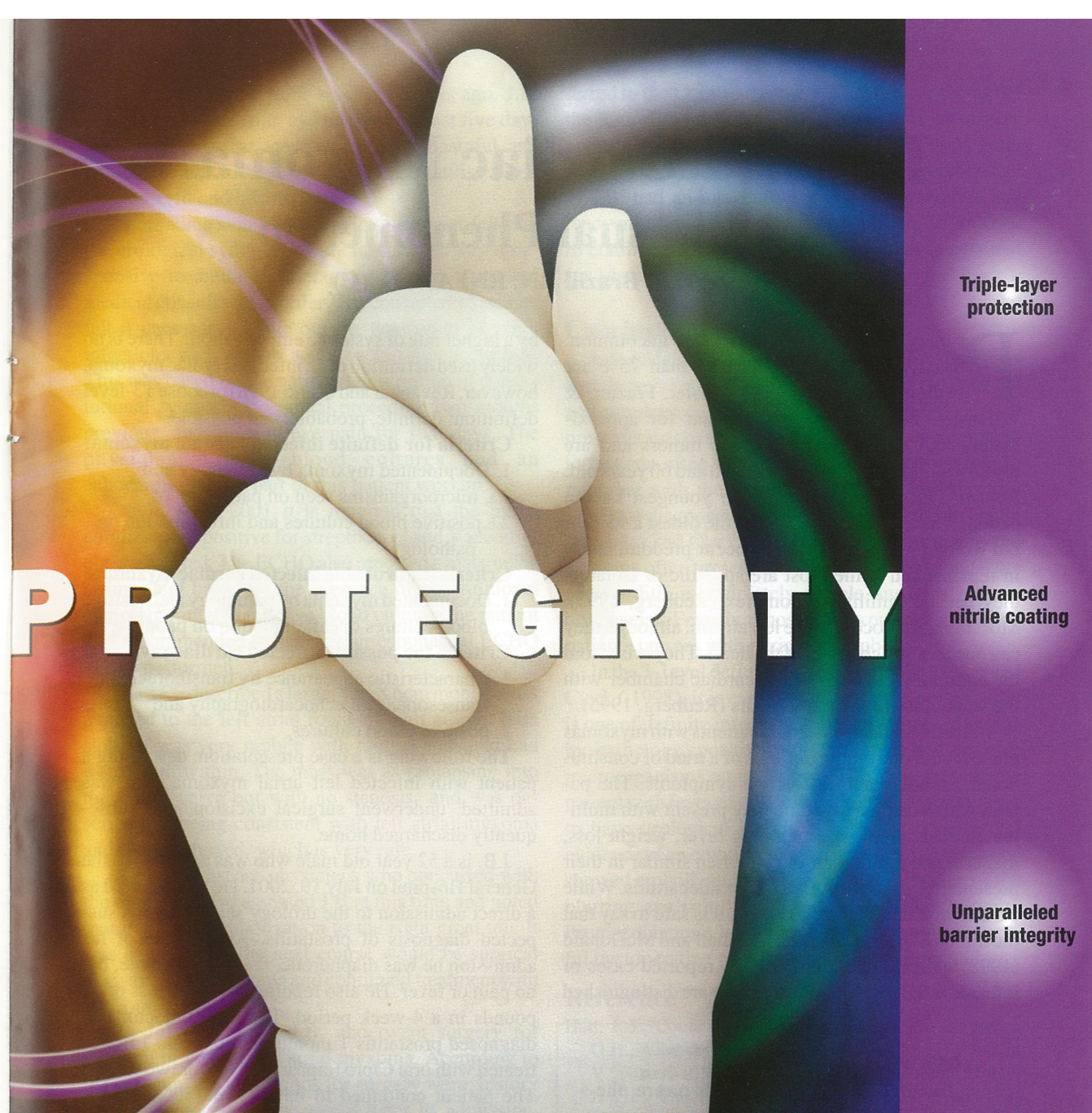
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erative nurses who were not successful in writing the 2001 exam will be offered a **free re-write for the 2002 Perioperative exam**. Those individuals will also receive the revised addendum to the Prep Guide free of charge. The perioperative nurses affected by the above will receive a letter from the CNA this summer.

For more information contact the CNA Certification Program Staff at 1-800-450-5206 or by email: certification@cna-nurses.ca.

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The prerequisites for the Registered Nurse First Assistant program offered through the British Columbia Institute of Technology are changing as of January 1, 2002. After this date it will be necessary to have achieved Canadian Nurses Association Certification in Perioperative Nursing prior to acceptance into the program. Registration for the certification exam will no longer be accepted as an admission criterion. For further information, please contact: Karen Sheehan, Course Facilitator, BCIT Perioperative Nursing Program at 1-800-663-6542, local 7079.



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Infected Cardiac Myxoma: An Unusual Phenomenon

By Perri L. Brazill RN, RNFA, CPN(C)

Primary tumors of the heart are uncommon, usually intracavity, and more than 75% are benign (Hall, Cooley, McAllister, Frazier, & Wilansky, 2001). Myxomas account for approximately half of the benign cardiac tumors and are usually found in patients between 30 and 60 years old. Reynen (1995) indicates that the youngest known patient was a stillborn infant and the oldest a 95 year old woman. Cardiac myxomas occur predominantly in females and while most are sporadic or isolated, they can be familial or complex (Redberg, 1995). Most myxomas occur in the left atrium, although they can occur in any chamber of the heart. They arise from the endothelial surface of the cardiac chamber with the stalk close to the fossa ovalis (Redberg, 1995).

Hall et al. indicate that most patients with myxomas present with one or more effects of a triad of constitutional, embolic and obstructive symptoms. The patient with a cardiac myxoma may present with multiple clinical symptoms, including fever, weight loss, malaise, and arthralgias and are often similar in their presentation to sub acute bacterial endocarditis. While cardiac myxomas are uncommon, it is safe to say that the infected myxoma is rare. Marshall and McDonald (1998) indicate that there are few reported cases of infected atrial myxoma and that they are distinguished

by a higher rate of systemic embolization. There is no widely used definition of an infected cardiac myxoma, however, Revankar and Clark (1998) propose a 3-level definition: definite, probable, and possible.

Criteria for definite infected cardiac myxoma:

1. Documented myxoma by pathology and
 - 2.a. microorganisms seen on pathology or
 - 2.b. positive blood cultures and inflammation on pathology.

Criteria for probable infected cardiac myxomas:

1. Documented myxoma by pathology and positive blood cultures or inflammation on pathology.

Criteria for possible infected cardiac myxoma:

1. Characteristic appearance by transthoracic or transesophageal echocardiography and
 2. positive blood cultures.

The following is a case presentation, describing a patient with infected left atrial myxoma who was admitted, underwent surgical excision, and subsequently discharged home.

J.B. is a 52 year old male who was admitted to the General Hospital on July 19, 2001. He was referred as a direct admission to the urology service with a suspected diagnosis of prostatitis. At the time of his admission he was diaphoretic, feeling miserable, but no pain or fever. He also reported a weight loss of 18 pounds in a 4-week period. The family doctor had diagnosed prostatitis 1 month previous and J.B. was treated with oral Cipro (ciprofloxacin) for two weeks. The patient continued to have fever (39C), rigors, severe fatigue and decreased appetite at which time the medication was changed to levaquin (levofloxacin). J.B. remained weak, ill and the fever continued. Past medical history indicates that J.B. is a non-smoker, abstains from alcohol and has a penicillin and morphine allergy. He had an appendectomy in 1975, right ankle surgery many years ago, and is a manic-depres-

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sive. He had dental work six-eight weeks ago. J.B. complained of blurring eye pain for the last five days and his right great toe was also very painful and reddened. J.B. has no history of prostatitis. He is otherwise fit and healthy.

Upon admission, the attending urologist felt that the urological symptoms were minor. J.B. was unresponsive to antibiotic therapy, therefore, a general medical consult was in order. The consulted physician felt it necessary to rule out the possibility of other infections such as sub acute bacterial endocarditis. This was based on the patients' description of constitutional symptoms, a dental procedure two months previous, and blurring eye pain for five days. The physician ordered blood cultures and an echocardiogram as part of this patient workup.

On July 23, 2001 it is reported that the blood cultures were positive for streptococci and Vancomycin was started. The ECHO also reported a mass in the atrium, and based on the presence of constitutional symptoms and the positive blood cultures the patient was recommended to have a transesophageal ECHO (TEE) performed.

The TEE described a large, 4cm x 6cm mobile mass attached to the left atrial foramen with a 7mm base stalk. It was very mobile with ragged ends and had ++calcium within. The mass was prolapsing into the mitral valve but with no stenosis and was described as being consistent with left atrial myxoma and likely infected, which is very rare.

Infectious disease physicians who concurred with the diagnosis also assessed J.B. at this time and noted that there was embolization to the right great toe. It was decided that the next course would be surgical excision of the myxoma and continued treatment with vancomycin.

On July 27, 2001, J.B. underwent surgery for excision of an infected atrial myxoma. According to the surgeon, the indications for surgery were: history of dental procedure six weeks prior to admission, malaise and fever of unknown origin. Blood cultures were positive for viridans streptococci and TEE revealed a 4cm x 6cm left atrial myxoma.

Open heart surgery was performed through a median sternotomy. The patient was placed on cardiopulmonary bypass and the left atrium was opened through the interatrial septum. The left atrial myxoma was exposed, the stalk transected at the level of the fossa ovalis and the tumor removed. The resulting atrial septal defect was repaired with a Dacron patch and the interatrial septum closed. Cardiopulmonary bypass was discontinued, the patient stabilized and trans-

ferred to the Cardiac Intensive Care unit. A section of the tumor was sent for culture at the time of surgery and the results showed a moderate growth of gram positive cocci, with growth of viridans streptococci.

J.B. had an uneventful postoperative course and recovered well. He was discharged on August 3, 2001, to continue intravenous antibiotics as an out-patient for 14 days.

Conclusion

Infected myxomas are rare. The literature indicates that there is little to distinguish between the infected and uninfected myxoma. Due to the varied clinical presentations patients can be difficult to diagnose and in fact can often be misdiagnosed. It is important to note that with the advent of TEE and transthoracic ECHO, a diagnosis and effective treatment can begin. Revankar and Clark (1998) indicate that the infected myxoma often present in a similar fashion to subacute endocarditis, is completely curable, and usually leave no sequelae. Fever is almost always present, and many patients present with peripheral emboli.

In the 3-level definition proposed by Revankar and Clark (1998), it is evident that this case presentation is one of definite infected cardiac myxoma. Myxoma by pathology, positive blood cultures and positive microorganisms on pathology. This case presented a patient with fever of unknown origin who was thought to have urological infection. There is documented evidence of an embolic event, in that the right great toe showed embolization and possibly the episode of the blurring eye pain, which did resolve after surgery. Prompt diagnosis led to the patient having an uneventful postoperative course and discharge home. □

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Papillary Fibroelastoma: A Rare Cardiac Tumor (A Case Presentation)

By Perri L. Brazill RN, RNFA, CPN(C)

Cardiac papillary fibroelastoma (CPF) is a rare, benign, primary tumor of the heart and accounts for seventy-eight percent of cardiac tumors (Redberg, 1995). The majority of patients with papillary fibroelastomas are asymptomatic although there is a significant risk for cerebral embolization (McFadden & Lacy, 1987).

Reports have associated CPF with coronary, cerebral, pulmonary, and retinal artery emboli (Sun et al.). Papillary fibroelastomas usually arise from the cardiac valves or occasionally from the ventricular endocardium and are most commonly seen in patients over age 50 (Hall, Cooley, McAllister, Frazier, and Wilansky).

Shahian, Labib, and Chang (1995) indicate that studies show a varied age range from the neonate to a 92-year-old patient and that before the availability of the transthoracic and transesophageal echocardiography, papillary fibroelastomas were predominantly discovered on autopsy. The general consensus is that the CPF is being discovered

during life with the increased use of echocardiography and transesophageal imaging.

The following case describes one patient at our institution who underwent surgical excision of a papillary fibroelastoma.

A.H. is a 45 year old male who initially was seen in the emergency department on May 5, 2001. A.H. had, what he described as chest pain for a "full day". He had been at a party the night before, had a "few drinks" and thought his pain and discomfort were related to this excessive activity. His EKG on admission showed some changes and the attending cardiologist felt these changes might be due to pericarditis. A.H. was admitted to the coronary care unit for overnight observation. After some discussion with the cardiologist, A.H. was discharged the next day with the understanding that he would require an echocardiogram and he would be notified of the date of his appointment. The following day, Monday May 7, 2001, A.H. received a call and was told his appointment was scheduled for July 26, 2001. A.H. felt that this wait was inconsistent with what he had been told by the cardiologist and expressed this fact to the secretary. He still had yet to have a diagnosis and was concerned with this. The secretary called him a short time later and had been able to arrange an appointment for the next day, May 8, 2001.

A.H. returned to the hospital on May 8, 2001 for

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the echocardiogram (ECHO). The ECHO showed a small growth on the aortic valve. The cardiologists in attendance felt this growth was consistent with endocarditis and A.H. was once again admitted to hospital for a course of intravenous antibiotics.

Two and a half weeks after the start of treatment, a repeat ECHO showed that there were no changes to the growth on the aortic valve. At this time, the cardiologist elected to perform a transesophageal echocardiogram (TEE). The TEE also showed a small growth which the cardiologist felt was now consistent with findings of papillary fibroelastoma. It was decided at this time that A.H. should be discharged home for one month. He was to "take it easy" and not do anything too strenuous. This was to allow the cardiologist time to confer with colleagues and decide on a further course of treatment. Within the month, the TEE was repeated and again it showed no changes to the tumor. It was decided at this time that surgery would be the next step.

As part of the work-up for surgery, the history and physical for A.H. indicated that he had not experienced any neurological symptoms, with the exception of an occasional headache, no numbness, transient ischemic attacks, or stroke. There was no history of hypertension, diabetes, myocardial infarction, peripheral vascular disease, or congestive heart failure. A.H. had had a tonsillectomy at age 16 years, and previous abdominal surgery in 1984 or 1986. A.H. was a pack a day smoker, who is trying to quit, enjoys a social drink of alcohol, and has a history of increased cholesterol. He is not overweight, does have occasional headaches which he attributes to the stress in his day to day life.

On admission, there was no evidence of carotid bruits, no shortness of breath or cyanosis, the S1 S2 sounds were audible with no S3 S4 or heave or thrill. Prior to surgery, it was felt by the attending physicians, that A.H. should also have a cardiac catheterization, in the event that there was coronary artery disease, coronary artery bypass could be performed at the same time. The cardiac catheterization also ruled out the possibility of valvular damage.

Excision of a CPF

On August 2, 2001, A.H. underwent surgery for excision of a cardiac papillary fibroelastoma. Open heart surgery was performed through a median sternotomy. Cardiopulmonary bypass was instituted and an incision was made in the aortic root above the cusp of the aortic valve. The papillary

fibroelastoma was identified on the ventricular surface of the left coronary cusp of the valve and subsequently excised. The aortotomy was repaired, the patient stabilized, and cardiopulmonary bypass discontinued. It was during this time that the patient experienced ventricular fibrillation, was unstable, and cardiopulmonary bypass was reintroduced. Fibrillation occurred during protamine administration and the patient was extremely unstable during this time.

Once again, the patient was stabilized and cardiopulmonary bypass was successfully discontinued. It was discussed between the surgeon and the anesthetist and they agree that the patient may have had an allergic type reaction to the protamine. This could potentially explain the patient sudden response, fibrillation and instability for an otherwise stable situation. The patient was then transferred to the cardiac intensive care where he had an uneventful postoperative recovery. A.H. was discharged home on August 6, 2001 to return for follow-up in six weeks.

Conclusion

Literature is scarce when searching for information on the cardiac papillary fibroelastoma. One thing that all evidence points to, is that the CPF is a rare tumor with the majority studied after autopsy and that only recently with the advent of transthoracic and transesophageal echocardiography, is diagnosis during life possible. Patients with CPF are usually asymptomatic however, neurological sequelae is a common presentation. As demonstrated with this case presentation, the use of the echocardiography and the TEE led to the detection, diagnosis, and subsequent treatment of the tumor. Sun et al (2001) certainly indicate that there are many CPF that go undetected with ECHO. The reasons they give are:

- 1) the tumor was masked by an associated lesion;
- 2) the tumor was too small to be seen;
- 3) the examination was not done carefully with a sufficient amount of suspicion; or
- 4) there were no significant characteristics to differentiate the CPF from the degenerative valve disease.

This could very well have been one of the reasons for this case to initially to be diagnosed as endocarditis and also indicates the rarity of the

Abstract:

Cardiac papillary fibroelastoma is a rare, benign, primary tumor of the heart and accounts for seventy-eight percent of cardiac tumors. Patient are usually asymptomatic although there is a significant risk for embolization. Papillary fibroelastomas usually arise from the cardiac valves. This is a case presentation of a patient who was admitted to our institution and his course of treatment leading to excision of the cardiac papillary fibroelastoma.

tumor when the growth is thought to be part of the infection process rather than tumorous. Hall et al (2001) explain that the papillary fibroelastoma may mimic vegetations and bacterial endocarditis.

A.H. had an uneventful post-operative recovery and was discharged home, and he will be followed by the cardiologist for recurrence of the tumor. In the study by Sun et al (2001), they indicate that there is no information regarding recurrence of the CPF after surgical excision. In their study, no patients were found to have recurrent CPF. What is interesting to note, is that when interviewing A.H. prior to discharge, he felt he may have had some symptoms that he ignored. He did describe an incident where felt like he was "going to have a heart attack" when he was shovelling snow. He had seen his family doctor in January, 2001 for episodes of malaise and tiring easily. This episode was put down to a "hard winter" and A.H. decided to hire someone to plow his driveway instead. It is easy now to wonder if the episode is similar to the chest pain that brought him to the emergency department in May. □

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The Canadian RNFA Odyssey

By Thomas Blunt, RN, CPN(C), RNFA; Jane Radey, RN, CPN(C), RNFA; and Robyn McKenzie, RN, CPN(C), RNFA

The Registered Nurse First Assistant (RNFA) is an experienced perioperative nurse with additional education and skills, functioning at an advanced level of nursing practice. The RNFA is a unique position that may encompass all areas of perioperative patient care, (preoperative, intraoperative and postoperative).

Past History

During the years 1989-1992, discussions about expanded roles for perioperative nurses began in British Columbia.

In 1992-1993 national surveys were conducted by the Operating Room Nurses Association of Canada (ORNAC) to explore the scope of practice of the perioperative nurse and the need for expanded roles.

Data collected confirmed the need and interest for the RNFA role.

Present Status of RNFA's in Canada

Within the Yukon and the North West Territories there are no practising RNFA's.

British Columbia (8 RNFA's, 1 student)

In 1990 the British Columbia Operating Room Nurses Group (BCORNG) had the support of the Registered Nurses Association of British Columbia (RNABC) in verifying that the RNFA role was within the scope of nursing practice.

A meeting was held with the provincial Ministry of Health in 1997 & 1999. In 2000, approval was obtained from the Health Risk Management Committee and the RNFA role was accepted as safe practice and within the scope of nursing practice.

In 1999, the RNFA role was challenged by a group of General Practitioners from the BC Medical Association.

In March 2001, an RNFA position was initiated at the BC Children's Hospital.

Alberta (3 RNFA's, 1 RNFA student)

In 1993 the Alberta Association of Registered Nurses (AARN) approved a document entitled "Determining the Appropriate Scope of Practice for Particular Practice Settings: Guidelines for the Registered Nurse", stating that no additional legislation was required for RNFA's to practice in Alberta.

Alberta does not have any RNFA's functioning in this role at present.

Saskatchewan (2 RNFA's, 4 RNFA students)

In 1996 the Saskatchewan Registered Nurses Association (SRNA) supported the role of the RNFA, however it took until June 21, 2000 to have the Hospital Standards Act revoked, which stated that only physicians could assist during surgery.

In December, 2000 an RNFA pilot project was accepted involving three RNFA's at the Royal University Hospital, Saskatoon City Hospital and St. Paul's Hospital.

Manitoba (6 RNFA's, 1 RNFA student)

In 1999 amendments to both the Medical Act and the Registered Nurses Act brought the role of the RNFA into the scope of nursing practice.

In July, 1999 an RNFA pilot project was approved by the Winnipeg Regional Health Authority. This was renewed in July, 2000.

Ontario (25 RNFA's, 23 RNFA students)

In July, 1999, the College of Nurses of Ontario recognized the RNFA role to be within the scope of nursing practice.

On January 20, 2000, the "RNFA Committee" of the Operating Room Nurses Association of Ontario (ORNAO) was formed.

In November 2000, two (2) RNFA's were hired by Trillium Health Centre in Mississauga.

Orillia Soldiers Memorial Hospital in Orillia hired

two (2) RNFA's in December 2000.

A pilot project involving one (1) RNFA began in March, 2001 at the Hamilton Health Science Corporation.

Québec (34 RNFA's, 16 RNFA students)

In September 1994, the Ordre des Infirmières et Infirmiers du Québec wrote a position paper clearly supporting the RNFA role, being the first to do so in Canada.

In 1996 the Heart Institute of Montreal implemented the first Canadian RNFA pilot project.

In 1996 an RNFA program began at the Three-Rivers University of Québec.

In December 2000, official provincial legislation about the delegation of medical acts and the function of the RNFA was proposed and accepted.

Newfoundland

In 1996 the Association of Registered Nurses of Newfoundland and Labrador (ARNN) endorsed registered nurses functioning as first assistants, and they have recently established a recognized RNFA program through Memorial University: **The Centre for Nursing Studies**.

Prince Edward Island,

Nova Scotia,

New Brunswick

These three provinces do not have any practising RNFA's at this time.

The RNFA's Future

The challenges that RNFA's across Canada seem to be facing at this time are physician acceptance and reimbursement.

ORNAC is currently working on developing a national RNFA competency statements.

April, 2001 was the date set for the first National RNFA Meeting held in Banff, Alberta, at the 17th National ORNAC Conference.

It has been projected that Canada will have a decrease in the number of surgical residents and a shortage of physicians across the country in the near future. This, coupled with the need to look at cost savings and optimal patient care, leads us to believe that the RNFA will become a significant contributor to the health care of surgical patients in Canada in the near future. □

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All graduated from the BC Institute of Technology RNF program in December, 2000. They are currently members of the Operating Room Nurses Association of Ontario-RNFA Interest Group and are seeking employment as RNFA's.

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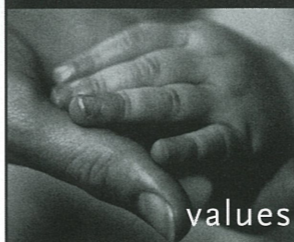
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