Ellen Giarelli, EdD, RN, CS, CRNP
Terry A. Throckmorton, RN, PhD
Associate Editors

Oncology Nurse and Dental Hygienist: Finding Success at the Crossroad of Two Professions

Deborah S. Manne, RDH, RN, MSN, OCN®

Symptom management for patients with cancer is complex. One set of symptoms that varies considerably among patients and is especially difficult to manage is oral complications from cancer therapy. Oral complications have major effects on treatment, quality of life, and overall survival (Borbasi et al., 2002; Miller & Kearney, 2001; Shih, Miaskowski, Dodd, Stotts, & MacPhail, 2002). Oral complications include mucositis, infections (viral, bacterial, and fungal), severe pain, xerostomia, and difficulties eating, swallowing, and speaking. These complications can affect course of treatment, treatment dose, location of head and neck radiation therapy, and ability to continue treatment (National Institutes of Health Consensus Development Panel, 1990). If a treatment course or dose is halted temporarily or stopped completely, the risk of tumor recurrence increases and can affect morbidity and overall survival (Borbasi et al.).

This article presents the innovative way that I combined expertise from my professional preparation as a registered dental hygienist (RDH) and an RN to meet the oral needs of patients with cancer. I use a metaphor of travel to illustrate how I began my journey as an RDH, became an oncology nurse, and finally synthesized the strengths of each practice to care for my patients.

Comparing Professions

RDHs and RNs have similar educational preparation and requirements for licensure to practice and must continue education to maintain competency. Both have almost identical prerequisite courses before admission to their respective programs (e.g., biology, chemistry, English, psychology, anatomy and physiology, mathematics, humanities). Both participate in classroom, laboratory, and clinical experiences that prepare them to care for a diverse patient population in a variety of healthcare settings. Both must understand different disease processes and how they affect individual patients. Both study pharmacology and are expected to apply concepts to patient care. Although the clinical experiences of each are different, both are taught to provide the best care for their patients, offer direct patient care and one-on-one patient education, and focus part of their practice on health promotion and disease prevention.

After graduation, RDHs and RNs take comprehensive licensure examinations to practice their professions. Both are able to continue education in their fields at baccalaureate and master's levels. They also are able to develop expertise in their professions through continuing education and pursuit of advanced degrees. In most states, RDHs must complete 10–12 hours of specialized continuing education each year to maintain a license to practice. For RNs, this varies from state to state, but most RNs attend continuing education to maintain competency and learn new skills.

RDH training gives students the skills and knowledge to provide oral care to a wide variety of patients. The training prepares new practitioners to assess, identify, plan care for, treat, and evaluate oral health needs. However, RDHs lack the specialized knowledge to assess and manage the complex needs of patients with cancer.

Oncology nurses have the knowledge and expertise to care for the special population of patients with cancer. They know the goals of cancer treatment and the biophysiologic effects of chemotherapy and radiation therapies. Even with this experience and knowledge, many nurses believe that they face barriers as they try to solve patients' oral care problems (McGuire, 2003). Oral symptom management remains one of the most demanding and challenging responsibilities of oncology nursing. Significant knowledge and experience are necessary to correctly assess and provide for patients' oral care needs. Yet oncology nurses sometimes may feel less prepared in this area of patient care (McGuire; Nieweg, van Tinteren, Poelhuis, & Abraham-Inpijn, 1992; Sadler, Oberle-Edwards, Farooqi, & Hryniuk, 2000).

The two professional paths have more similarities than differences, and I knew that combining both would bring me closer to realizing the vision of my future practice.

The Journey

My journey began in 1975 when I received a bachelor of science degree in dental hygiene from the University of Missouri-Kansas City (UMKC). During the next 15 years, I had the opportunity to care for a wide variety of patients. Many were healthy, but others had many types of diseases, including cancer. I was able to see how good oral health contributes to good overall health and stable disease. I was limited, however, in my ability to practice comprehensive dental hygiene care. Unlike nursing, dental hygiene is not self-regulated. Dental hygiene practice, education, and licensure are controlled by state administrative boards of dentistry and the Commission on Dental Accreditation, a nationally recognized accreditation agency run by organized dentistry. Recently, in a few states, legislatures have created dental hygiene committees. The committees advise the Board of Dentistry on matters related to dental hygiene licensure, education, and practice. Because of the practice restrictions, I decided to return to school and study nursing so that

Deborah S. Manne, RDH, RN, MSN, OCN®, is a clinical nurse at the David C. Pratt Cancer Center of Excellence at St. John's Mercy Medical Center in St. Louis, MO; a clinical assistant professor in the Division of Dental Hygiene at the University of Missouri–Kansas City School of Dentistry; and a consultant and oral care specialist.

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