

Stand Up to Anonymity

I had to turn off the television the other night. I watched “Stand Up for Cancer” for over an hour and did not hear the word I was so desperately waiting to hear: nurse. Although I applaud the efforts of those who made history by getting the network giants to come together and tackle the national cancer epidemic in front of the American public, I could not bear to watch the show a minute longer. The gaping hole representing the absence of nursing was too much for me.

I sat back, attempting to analyze my feelings. Why was I so upset? Nursing is unrecognized in **all** of health care. This void is a huge problem in our entire profession. I wondered: Do nurses react similarly when documentaries on spinal cord injury, the emergency room, critical care, solid organ transplantation, or high-risk perinatal care fail to integrate nursing into programs targeting the public? Why should I expect anything different from a television show on cancer? My ultimate reflection prompted an even stronger conviction of passionate outrage. I had numerous good reasons to be mad.

Of all of the existing subspecialties in health care, cancer care has historically been recognized for its team orientation to care delivery. Early in the evolution of medical oncology, in particular, interdisciplinary care was exemplified by joint decision making among nurses, pharmacists, and physicians. They relied on the complementary expertise of each discipline, in large part because of the lack of an existing blueprint that defined best practice (Boyle & Engelking, 2003). But that early teamwork also prevailed because of a healthy respect for the distinct body of knowledge and skills that each brought to the bedside to render optimal care. Hence, taking care of, and assuming credit for, patients’ care was a true collaborative team effort, incomprehensively undertaken by one person.

Although the joint effort remains true today, the realization and definition of multiple professionals practicing interdependently have changed. Currently, some construe an interdisciplinary team as comprising medical, surgical, and radiation oncology disciplines only. I argue with semantics whenever possible and remind physician colleagues, in particular, that “interdisciplinary” means among disciplines, not within your own.

The perception of the nurse as an indispensable member of the cancer team has waned. I postulate that this change has evolved for several reasons. First, to a great

degree, technology has disguised the scope and complexity of nursing decision making and critical thinking. The detailed assessment of evolving patient complications and the prevention of potential clinical sequelae are not captured in pump settings and electronic medical record checkmarks. Secondly, as a profession, we have not assumed responsibility for quantifying what we do, nor have we sufficiently disseminated the outcomes of our work. We know what we do, but do others?

No aspect of clinical cancer care can be completed without a nurse. Even with the newest laser device or minimally invasive surgical approach, operative therapies cannot transpire without nurses in the operating room or caring for patients pre- and postoperatively. Dosimetry advances and radiation-delivery technologies continue to evolve in quantum fashion. Yet the assessment, management, and ongoing evaluation of radiation-related toxicities remain the purview of nurses. Clinical trials cannot be conducted in the absence of nurses. The assessment of eligibility, informed consent, administration of study drugs, timely blood draws for pharmacokinetic parameters, and clinical evaluation of toxicities remain the responsibilities of nurses. Even with the advent of robotics to administer chemotherapy in the future, nurses in medical oncology will be required to ensure the safety of the infusate, assume responsibility for the creation of protocols that electronically monitor the patient’s response in the home setting, and evaluate results of automated telephone follow-up (Boyle, 2008).

The practicality of collaborative cancer care remains. Now more than ever, a concerted effort to elevate and market nursing skill is required in today’s healthcare arena. Here is a list of seven actions that oncology nurses can take to reduce the anonymity of their practice. Pick one strategy from the list to counter nursing’s invisibility in your environment of care, in your region, or nationally.

- Save and disseminate on a quarterly basis letters from patients and families that provide testimony to nursing excellence in your practice setting.
- If you practice at a comprehensive or community care center, access the Web site of your center and critique if, and how, nursing is portrayed; provide written suggestions on how the contributions of oncology nursing can be highlighted.
- Lobby for the creation of a nursing annual report that describes the scope of nursing in-

novation, quality initiatives, and professional activities engaged in by your colleagues.

- Uniformly use symptom distress rating scales to evaluate pre- and post-treatment patient accounts of their symptoms; delineate the nursing interventions and decisions that were employed to manage symptoms; consider making flow sheets of symptoms similar to those used to record vital signs; and, at monthly office meetings, review symptom management case studies that demonstrate nursing expertise.
- Speak up at tumor boards and other physician-dominated meetings to share your opinions or add critical information.
- Keep a log of telephone triage and problem-solving activities conducted by nurses; create a log grid that captures and tallies the overall number of phone contacts and volume of phone-related nursing interventions; record the reason and nature of the call, advice given, and actions undertaken by nurses during and following the call, as well as the amount of time spent on the call.
- If you are an advanced practice oncology nurse, refuse to be called a “physician extender” or “midlevel provider.”

We do not expect, nor do we want, to be canonized for what we do. But we do aspire to *be realized*. *Being realized* is a better descriptor than seeking recognition as it connotes more than acceptance and appreciation. *Being realized* acknowledges characteristics of respect and honor. *Being realized* extends global sanction to nursing’s necessity to win the war on cancer. *Being realized* means I can eagerly anticipate the next television special where oncology nursing expertise is prominently displayed up front and central in winning the war on cancer.

Reference

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Deborah A. Boyle, RN, MSN, AOCN®, FAAN, is a practice outcomes nurse specialist at Banner Good Samaritan Medical Center in Phoenix, AZ.

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