

# The Dual Rounding Model: Forging Therapeutic Alliances in Oncology and Palliative Care

Carey E. Baxley, RN, BSN, OCN®

Inpatients with solid tumors at Duke University Hospital in Durham, NC, are cared for in a dynamic integrated care model that incorporates medical oncology and palliative care. This has profound implications for patients, their loved ones, medical and surgical staff, and oncology nurses. As a nurse with less than three years of experience, my participation in a setting that uses the Dual Rounding Model has accelerated my professional and personal development. During a typical shift, I am an oncology nurse, a palliative care nurse, and a hospice nurse.

Administering chemotherapy to a 34-year-old with newly diagnosed renal cell carcinoma while simultaneously increasing the dose on a morphine infusion for a 68-year-old with metastatic prostate cancer in the room next door is not unusual. This daily juxtaposition enhances skill development by offering clarity about cancer's consumption of the body and soul. But with this clarity comes some confrontation. How does treating the intractable pain of metastatic malignancy affect how I care for those patients who are newly diagnosed and hoping for a cure?

Caring for patients at the beginning and the end of their fight against cancer imparts a tangible sense of mortality—the patient's and my own. From this confrontation erupts a myriad of psychosocial concerns for caregivers, including nurses. How do nurses adequately address the conflicting physical and emotional demands of a patient receiving active treatment in one room while facilitating the quiet comfort of destiny in a peaceful death in the next? The personification of cancer results in

some patients feeling that, during every day of inaction, the tumor may be growing and they are losing the battle. On the “losing” days, the instillation of hope and preservation of physical, mental, and spiritual vitality is the task at hand. Having these experiences simultaneously provides the wisdom of knowing where patients have been and where they could be going.

**The true testament to the significance of the Dual Rounding Model is that I sincerely believe that the patients have benefited from it far more than I have.**

Regardless of the duration between diagnosis and death, nurses working with the Dual Rounding Model, developed at Duke University Hospital, are the preservers of function and the purveyors of hope. The Dual Rounding Model provides an integrative approach and a positive learning experience for oncology nurses. The model exposes nurses to the effective delivery of bad news and the establishment of individualized treatment plans consistent with the wishes of patients and their loved ones. Rather than formal training, nurses learn their roles through participation. The culture is the curriculum; it invites interdependence and values shared decision making. Ongoing dialogue between provider and

nurse is expected, and nurses are almost always present for breaking bad news. The model quickly becomes not just what we do, but who we are. This model aims to eliminate clinician and nursing behaviors that may make families feel excluded. It discourages families from viewing death as a failure. In addition, this model brings together clinicians, nurses, patients, and their loved ones as teammates while actively empowering bedside nurses to make appropriate interventions.

On a daily basis, I learn about the many roles different medications can play in the care plan. For example, we administer benzodiazepines for anticipatory nausea as well as general and situational anxiety. Another common situation involves pain control. In the model, uncontrolled pain triggers a response that is pharmaceutical and psychological. I can intervene medically and ensure that the patient's complaint is validated by reassurance and follow up, as well as by performing frequent reassessments of pain management needs. In addition, I am able to assist the providers in educating patients on the types of pain medications, indications, and expected outcomes. This gives patients a sense of autonomy and sets more appropriate expectations.

The culture of the Dual Rounding Model is that uncontrolled pain and refractory nausea are just as much of an emergency as tumor lysis syndrome and anaphylaxis.

Carey E. Baxley, RN, BSN, OCN®, is an RN at Duke University Hospital in Durham, NC. The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. No financial relationships relevant to the content of the article have been disclosed by the author or editorial staff. Baxley can be reached at [carey.baxley@duke.edu](mailto:carey.baxley@duke.edu), with copy to editor at [CJONEditor@ons.org](mailto:CJONEditor@ons.org).

Key words: palliative care; care design; cancer communication

Digital Object Identifier: 10.1188/16.CJON.215-216

When ineffective communication interferes with a patient's or loved one's care and nurses sense ineffective coping or lack of understanding, the nurse can become a steadfast resource and a communications expert, formally and informally.

Like all graduate nurses trying to acclimate to their first practice setting, thoughts about my specialty were dictated directly, and entirely, by my experience. Cancer brings intensity to life, a contemplation of one's own reality and how the patient wants to exist in it. Patients yearn for respite from the suffering. One patient captured this eloquently when he said, "I want to be present now, alive now, and, yes, remembered." The daily integration of palliative care within medical oncology alleviates some of the fears that live inside patients and nurses. I have often wondered how do I, as a new nurse, balance hope and honesty in the midst of suffering? How do I respond? When should I intervene? Have I done too much? Just enough? When do I ask for help? Whom do I ask? Palliative care gives patients a sense of control and well-being, allowing them to fight their cancer and also ask whether or not their 4-year-old daughter is capable of capturing "forever" memories. Without concomitant palliative care, moments like this can be excruciating, but with adequate symptom control and attention to detail, beneficial.

We are fortunate as oncology nurses to witness this transformation. Our intimate involvement in our patients' lives is far from mundane. The experience of palliative care gives the patient control, but the delivery of palliative measures gives the nurse control. The Dual Rounding Model has taught me to listen to and examine the whole patient, not just deliver treatment as ordered. Daily integration of comfort measures and active treatment allows patient and nurse to see each other as teammates. Their lives will continue to intersect through the memories they create together. This is often possible because "the talk" is much more likely to have taken place at the beginning, rather than the very end.

I often remember my patients that have died, the moments we shared, and the things we learned together. And although I believe that working in this model has accelerated my development as an oncology nurse in an unprecedented way, the true testament to its significance is that I sincerely believe

that the patients have benefited from it far more than I have.

Incorporating palliative care daily within our medical oncology unit helps bridge the physical and emotional distance that accompanies life's end. As symptoms are better managed, patients are able to make decisions with a clear mind. Clarity of mind promotes peace and minimizes lingering fears. As a therapeutic alliance is forged among patients, nurses, and medical oncology and palliative care teams, clear communication is the rule, not the exception.

The Dual Rounding Model of care has left an unparalleled impression on me that should inform cancer care everywhere. Working in this model as a new graduate nurse wasn't just an introduction to oncology, but also an indoctrination into a culture of compassionate cancer care. It alleviates challenges, nurtures personal and professional growth, and multiplies daily rewards with a simple mandate: Integrate the tools that heal the body with those that heal the soul.

### Do You Have a Touching Story to Share?

The Heart of Oncology Nursing presents heartfelt stories, experiences, poetry, or artwork related to patient care and the profession of oncology nursing. Authors can be nurses or other healthcare professionals. If interested, contact Editor Lisa Kennedy Sheldon, PhD, APRN, BC, AOCNP®, at [CJONEditor@ons.org](mailto:CJONEditor@ons.org).