

Introduction

The Oncology Nursing Society (ONS) has been defining the scope and standards for oncology nursing practice since 1979. Over the years, these standards have evolved to reflect changes in cancer care in general and in oncology nursing practice more specifically. The purpose of this current document is to provide oncology nurses, administrators, legislators, other professionals, and the public with a clear description of the appropriate and expected scope of oncology nursing practice. Oncology nursing practice will be addressed at three levels: the registered nurse (RN), the graduate-level-prepared RN, and the advanced practice registered nurse (APRN), with detailed practice requirements and expected competencies for each of these practice levels.

Cancer is the second leading cause of death worldwide (Heron, 2018). Although the incidence of cancer in the United States has been slowly declining, it is estimated that cancer incidence throughout the world will rise by 70% by 2030 (American Cancer Society [ACS], 2015). In the United States, approximately 1.7 million new cancer diagnoses were estimated for 2019, or more than 4,700 new cases each day. In addition, cancer survival has steadily increased since 1991, resulting in growth of the cancer survivor population (ACS, 2019; American Society of Clinical Oncology [ASCO], 2017).

As of early 2016, more than 15.5 million cancer survivors were alive in the United States (ACS, 2019). The majority of survivors were diagnosed years ago and remain cancer free, but other survivors live with cancer as a chronic disease. The number of cancer survivors in the United States is expected to increase to 26.1 million by 2040, with older adults constituting a significant majority of this group (Bluethmann, Mariotto, & Rowland, 2016). Survivors have needs that require qualified healthcare providers to detect and manage these challenges (Smith, Yates, & Ewing, 2017). In addition, the growing population of older adult survivors presents a challenge, as they often have concurrent chronic diseases and complex needs (Bluethmann et al., 2016).

Oncology nursing encompasses nurses who work in a wide variety of roles and settings, but all have a common purpose: to help people at risk for or with a cancer diagnosis achieve the best quality of life and outcomes (ONS, 2016a). This includes not only nurses who identify as an oncology nurse but also those who care for people at risk for or with a cancer diagnosis in nontraditional, generalist, and other specialty areas.

Scope of Oncology Nursing Practice

Definition of Oncology Nursing

Oncology nursing is a nursing specialty that seeks to reduce the risks, incidence, and burden of cancer by encouraging healthy lifestyles, promoting early detection, and improving the management of cancer symptoms and side effects throughout the disease trajectory.

Oncology nurses advocate for people at risk for or with a diagnosis of cancer, coordinate care delivery, ensure safe delivery of cancer treatments, help manage symptoms, optimize quality of life, support people with cancer and their caregivers, advocate for the unique needs of people with cancer, and collaborate with the interprofessional team to improve outcomes and reduce the impact of cancer on people, families, communities, and populations.

Historical Perspective of the Oncology Nursing Specialty

Advocacy for the needs of people with cancer in the United States began with the building of the first specialized cancer hospital in New York City in 1887. Unfortunately, the stigma of cancer as an incurable, and likely contagious, disease earned the hospital a poor reputation despite its full occupancy within the first month of opening its doors. Concurrently, the first research laboratory devoted to cancer began its work at the University of Buffalo and, in 1913, eventually led to the development of a hospital associated with the research facility. In 1912, another hospital devoted to cancer research and the care of patients with cancer opened in Boston and was associated with the Harvard Medical School (McDon-

nell, 2011). These early hospitals were crucial to the advancement of understanding about the disease but were still considered places where people with cancer went to die.

By the 1920s and with advancements in technology and medical-surgical specialization, hospitals had become centers for the development of new surgical and radiologic techniques to treat cancer. However, they remained unwilling to accept patients with advanced cancers because of the care burden they represented. During this time, most people with advanced cancers died at home without the benefit of caregivers trained to provide palliative and end-of-life care. Subsequently, the need for and number of homecare nurses caring for people with cancer grew (Lusk, 2011).

Over the first 30 years of the 20th century, death rates for infectious diseases declined, and the focus on cancer as a public health concern increased. The American Association for the Control of Cancer, a precursor organization to ACS, devoted effort to educating the public on early recognition of cancer, when cure may be possible (ACS, 2017). Nurses were heavily recruited to join the “war on cancer” and become educated about cancer, inform the public about early recognition, and care for those with advanced disease. Nursing care of patients with cancer occurred in two situations: postoperative care for those with operable cancers and palliative care for those with inoperable cancers (McDonnell, 2011). As technologies advanced and radiation therapy was developed, cancer treatment began moving from end-of-life care at home to the hospital setting, and specialized nurses were in even greater demand (Lusk, 2011).

Evidence supports that early oncology nurses were charged with critical responsibilities in the care of patients with cancer, including early recognition of oncologic emergencies, intense symptom management (occurring in the absence of antibiotics or antiemetics), and limiting exposure to radioactive materials during their duties (Lusk, 2011). Care of patients with cancer was recognized by cancer care physicians of the time as intense and demanding work, requiring a unique set of specialized skills (Lusk, 2011).

By the early 1940s, the “curative era” of cancer care began, as clinical trials using nitrogen mustard to treat Hodgkin lymphoma commenced. Although venous access was, at this time, strictly the domain of physicians, oncology nurses began including admixture of chemotherapy agents in preparation for physician administration as part of their duties (Haylock, 2011). By the 1950s, nurses

in research hospitals were routinely administering cytotoxic agents intravenously.

The emergence of antibiotics and antiemetics also changed the focus of oncology nursing care. The use of these supportive care drugs increased patient tolerance of treatment, allowing for more aggressive and immunosuppressive treatment with more patients completing treatment. The role of the oncology nurse shifted from traditional bedside care to more complex integration of technological advances and psychosocial care. However, throughout the 1940s, cancer nursing as a specialty was supported through initiatives such as the Russell Sage Foundation to identify current and future nursing needs for people with cancer, and an increasing recognition of the oncology nurse's role in psychosocial support emerged (Haylock, 2011).

From 1950 to 1980, cancer treatment consisted of extensive surgery, such as modified radical mastectomy; radiation therapy; intensive cytotoxic drug therapy; or a combination. The toxicities associated with these regimens required skilled nursing care management by highly specialized nurses. Further, oncology nurses routinely administered IV chemotherapy, operated radiation therapy equipment, and provided intensive patient and caregiver education and psychosocial support. Although nursing care was recognized by the 1940s as integral to patient and caregiver needs at the end of life, it was not until 1950 that a commission was established to study the effect of nursing care at that point in the care continuum (Haylock, 2011). The commission concluded that more nursing time and enhanced quality of nursing care were needed in hospitals and homes to meet the needs of this patient population.

In 1937, the National Cancer Institute (2016) was established with a charge to conduct and encourage research on cancer and to provide training and instruction. As an outgrowth of this charge, the Cancer Chemotherapy National Service Center was created in 1955, with a subsequent rapid growth in clinical trials in the 1960s. Throughout the 1960s, as it became clear that many nurses would at some point be caring for individuals receiving chemotherapy agents, the need for education of nurses about cancer and cancer care became more pronounced. Although no formalized definition of oncology nursing was yet established, nurses began to fulfill roles in clinical trial teams, reporting outside of the nursing administrative structure and directly to the principal investigator. These relationships provided foundational specialty training for oncol-

ogy nurses. The Nurse Training Act of 1964 encouraged development of master's degree training programs and increased enrollment. This legislation was crucial to the founding of many specialty nursing organizations at the time, including the Association of Pediatric Oncology Nurses in 1974 and ONS in 1975 (Lynaugh, 2008).

Nurse practitioner and other advanced practice roles in oncology nursing began to develop in response to a shortage of acute care physicians, which began in the 1960s and became critical in the 1970s. Coupled with this physician shortage was an increasing public awareness of expanded roles for women in the workplace, promoted by the women's movement of that era. As a response to public need, advanced practice education for oncology nurses began (Wilson, 2005).

ONS's priorities have focused on promoting excellence in cancer care through the advancement of the oncology nursing specialty by defining the scope of practice of the oncology nurse and providing education and practice resources to oncology nurses at all levels. In 1979, ONS published the first set of oncology nursing standards, *Outcome Standards for Cancer Nursing Practice*, in collaboration with the American Nurses Association (ANA). This was followed by several revisions, with the most recent titled *Statement on the Scope and Standards of Oncology Nursing Practice: Generalist and Advanced Practice* (Brant & Wickham, 2013). In addition, to ensure the consistency and standardization of educational preparation for oncology nurses, in 1982 ONS developed *Standards of Oncology Nursing Education: Generalist and Advanced Practice Levels*, now in its fourth edition (Jacobs & Mayer, 2016). ONS also has developed *Standards of Oncology Education: Patient/Significant Other and Public* to provide guidance to nurses as they develop, implement, and evaluate cancer-related education for patients, caregivers, and the public (Blecher, Ireland, & Watson, 2016).

In 1981, ONS established a certification task force to explore the development of an oncology nursing credential that recognizes nursing expertise in oncology nursing. The Oncology Nursing Certification Corporation (ONCC) finalized its corporate status in 1984 and awarded the first oncology certified nurse (OCN[®]) credential in 1986 (Nielsen et al., 1996). Additional certifications for advanced practice and subspecialty roles have since been developed.

ONS has developed competencies for many oncology nursing roles. The first competencies, for the oncology nurse practitioner (ONS, 2007) and the oncology clinical nurse specialist (ONS, 2008),

were developed to delineate the knowledge and skills needed by nurses starting in these practice roles. Since then, ONS has developed competencies for oncology clinical trial nurses (ONS, 2016c), oncology nurse navigators (ONS, 2017b), and oncology nurse generalists (ONS, 2016a). In addition, ONS has created leadership competencies to address the leadership knowledge and skills needed at all levels of oncology nursing practice (ONS, 2012).