Oncology Nursing Essentials: Then and Now

Ellen R. Carr, RN, MSN, AOCN®

In the past 40 years, the foundation of cancer care has evolved, adjusting to the growing number and complexity of patients diagnosed with cancer and to combination and novel treatments, more effective symptom management, and technology that enhances and improves care and its delivery. However, the essentials of oncology nursing practice remain the same. This article reviews these essentials and highlights factors that will advance oncology nursing practice in the coming years.

At a Glance
• The foundation of oncology nursing has been built from a core knowledge base about the latest in prevention and detection, clinical care delivery, targeted care toward a variety of populations, basic science of cancer diagnostics, treatment, and psychological support.
• The essentials of oncology nursing will continue to be driven by technologic advances and evidence-based practice.
• Moving forward, nursing must be vigilant and transformative in leadership, education, and practice.

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“Study the past if you would define the future.”
—Confucius

Forty years ago, in 1975, if you were a practicing clinical oncology nurse, you may have been working in an inpatient setting, acting as a primary care nurse during your 8- to 10-hour shift, and caring for patients with lymphoma or leukemia who were receiving multiple-day infusion treatment. These patients, most of whom were receiving a variation of standard chemotherapy regimens, were treated as inpatients because they were or would be very sick, based on their reaction to chemotherapy and their need for urgent symptom management.

If you were a surgical nurse, some of your patients diagnosed with cancer underwent major surgeries if the tumors were resectable. If your patients received radiation treatment, the protocols were somewhat limited, with many leading to extensive radiation side effects.

For patients in 1975 who had been diagnosed with cancer, their perception—and, in many cases, reality—was that cancer treatments would be arduous, with limited assurance for long-term success. Adjuvant chemotherapy was just being introduced as a standard component of treatment. If you practiced in one of the first bone marrow units, the patients being treated there were unbelievably sick. If you were caring for patients at the end of life, the terms hospice, palliative care, and quality of life were infrequently used, despite patient status.

What was important during that time as a foundation for oncology clinical practice? Based on oncology nursing peer-review literature from 1975, those early years focused on review articles about the general care of broad classifications of patients (e.g., those in pediatric and radiation oncology), psychosocial and educational needs of patients, and supportive strategies intended to provide sometimes effective symptom management care for pain or side effects from chemotherapy.

Current Trends

Fast-forward to 2015, the 40th anniversary year for the Oncology Nursing Society (ONS). The essentials of oncology nursing practice have become broad and deep. To put these 40 years in perspective, this article provides a review of what have become practice essentials, evolving and transforming oncology nursing practice.

In 2014, the Clinical Journal of Oncology Nursing’s Oncology Essentials column included the topics of electronic cigarettes; re-evaluating the neutropenic diet; cancer genetics and genomics; lactic acidosis in patients with cancer; psychosocial care for lesbian, gay, bisexual, and transgender patients; and the bioavailability of tyrosine-kinase inhibitors. As evidenced by these topics, the essentials of oncology nursing encompass knowledge about the latest in prevention and detection, clinical care delivery,
targeted care toward a wide variety of cancer populations, the basic science of cancer diagnostics and treatment, and the psychosocial support required to provide excellent care to patients and families from initial diagnosis through end of life.

Patients

Since 1975, the way that healthcare providers care for the population of patients with cancer has changed significantly. For example, the majority of nonsurgical patients are treated in outpatient settings. In addition, the treatment strategy for most cancer diagnoses frequently focuses on cancer as a chronic condition requiring repeat, modified, combination, and newly minted treatment protocols (American Cancer Society [ACS], 2015; American Society of Clinical Oncology [ASCO], 2015a; National Cancer Institute [NCI], n.d.).

As for the many types of malignancies, what has happened to incidence and death rates in the past 40 years? According to NCI (2012) data, since 1998, the overall rate of cancer incidence has declined. Of note, overall incidence rates are less for colorectal and prostate cancers, although specific gender, cultural, and racial cohorts have increased rates (namely African American men with prostate cancer). Death rates for the four most common cancers (i.e., prostate, female breast, lung, and colorectal), as well as for all cancers combined, continue to decline. However, incidence rates for some cancers are rising, including melanoma of the skin; non-Hodgkin lymphoma; certain childhood cancers; leukemia; myeloma; and cancers of the kidney and renal pelvis, thyroid, pancreas, liver and intrahepatic bile duct, testis, and esophagus. Death rates for cancer of the pancreas, liver and intrahepatic bile duct, and corpus and uterus are increasing (NCI, 2012).

Diagnostics and Treatments

The population of patients with cancer for which healthcare providers now care has benefited from remarkable breakthroughs in prevention and early detection, diagnostics, and treatments. These breakthroughs have significantly advanced treatment and care (see Table 1). Clinical trials have validated various improvements in care, based in large part on multimodality treatment approaches.

Breakthroughs since 1975 include more refined and specific imaging technology, expanded reach and effectiveness of early breast cancer detection using mammography, vaccines preventing cancer-causing hepatitis B, tamoxifen and other adjuvant therapies, the prostate-specific antigen test, hematopoietic supportive therapies, laparoscopic surgeries, intraoperative radiation therapies, the CyberKnife® robotic radiosurgery system, image-guided radiation therapy, use of taxanes as a basis for chemotherapy regimens, neoadjuvant protocols accompanying surgeries, and a full portfolio of targeted therapies (ASCO, 2015a).

Moving forward, treatments based on molecular properties—with an emphasis on immunotherapies, targeted therapies, tumor biologic markers, vaccines, and genetic-specific cellular features—will leapfrog into prominence as effective core or complementary components of diagnostics, surgery, radiation therapy, and metabolic-based treatments. More reliable tumor markers will lead to decisions to better tailor and personalize treatment and evaluation over the trajectory of disease (ACS, 2015; ASCO, 2015a; NCI, n.d.).

Essentials of Oncology Nursing

Since its inception in 1975, ONS has prioritized the education and development of oncology nurses, as well as the advancement of oncology nursing as a specialty (McMillan, Heusinkveld, Chai, Miller-Murphy, & Huang, 2002). With the establishment and continued review of the core curriculum for oncology nursing certification, which was first drafted in 1984, specific oncology nursing knowledge as a

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<th>Year</th>
<th>Advance</th>
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<td>2006</td>
<td>Vaccine approved to prevent cervical cancer.</td>
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Note. Based on information from American Society of Clinical Oncology, 2015b.

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<tr>
<td>Cost of cancer ($)</td>
<td>Not available</td>
<td>216 billion</td>
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<tr>
<td>Five-year survival rate for all cancers (%)</td>
<td>49</td>
<td>68</td>
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<tr>
<td>Life expectancy (years)</td>
<td>76.6 (women) 68.8 (men)</td>
<td>81 (women) 76.2 (men)</td>
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<td>Obesity (%)</td>
<td>17 (women)* 13 (men)*</td>
<td>36 (women) 36 (men)</td>
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<td>Smoking among adults (%)</td>
<td>37</td>
<td>19.3</td>
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<tr>
<td>Survivors</td>
<td>~3 million</td>
<td>14.5 million</td>
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<td>Treatment strategies</td>
<td>Chemotherapy Radiation therapy Surgery</td>
<td>Chemotherapy Genomics-based therapies Immunotherapy Radiation therapy Surgery Targeted therapies</td>
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* Statistic is from 1976–1980.

Note. Based on information from American Cancer Society, 2013, 2015; Centers for Disease Control and Prevention, 2011; Murphy et al., 2013; National Cancer Institute, 2012; One Voice Against Cancer, n.d.; U.S. Department of Health and Human Services, 2013.
foundation for oncology nursing practice became clear, validated, visible, and, most importantly, achievable.

The 2014 test blueprint for the oncology certified nurse (OCN®) includes the categories of health promotion, screening, and early detection; scientific basis for practice; treatment modalities; symptom management; psychosocial dimensions of care; oncologic emergencies; survivorship; palliative and end-of-life care; and professional performance. Categories are regularly reviewed and updated. The Oncology Nursing Certification Corporation (ONCC), established in 1985, has broadened certifications for oncology nursing beyond the basic practice OCN® to include certified pediatric hematology/oncology nurse, or CPHON®; certified breast care nurse, or CBCN®; advanced oncology certified nurse practitioner, or AOCNP®; advanced oncology certified nurse practitioner, or AOCNS®; and blood and marrow transplant certified nurse, or BMTCN™ (ONCC, 2014).

A core body of knowledge is important, but many essentials of practice of oncology care take place in the environment of a huge, rapidly evolving healthcare system. As Table 2 shows, this profession deals with numerous factors that affect daily oncology nursing practice and the body of knowledge considered specialized oncology nursing.

Much of this change has been driven by technology. Data—sometimes in overwhelming volumes—dictate the course of care for patients with cancer and their families. Evidence-based outcomes are one of the pillars of care. However, the intangibles of essential and excellent oncology nursing remain, pulling it all together for patients and families. These essentials include unparalleled basic technical nursing skills, thoughtful and effective communication skills that are geared to socioeconomic and cultural backgrounds and concerns, nuanced and appropriate advocacy, and teamwork and collaboration with a multidisciplinary team. Also essential is coaching and mentoring colleagues, championing safety and thoroughness, determining and following standards of care, and practicing efficient, comprehensive symptom management.

Nursing must be transformative in leadership, education, and practice (Institute of Medicine, 2010). Regardless of the passing of 40 years and the changes that time brings, as my friend and esteemed oncology nursing colleague Cheryl Kosits, RN, MSN, says, “All cancer patients deserve to have an oncology nurse.”

The author gratefully acknowledges Cheryl Kosits, RN, MSN—an oncology nurse for 34 years—for her dedication to patients and family members.

References


Do You Have an Interesting Topic to Share?

Oncology Essentials provides readers with a brief summary of oncology nursing basics. Length should be no more than 1,000-1,500 words, exclusive of tables, figures, insets, and references. If interested, contact Associate Editor Ellen R. Carr, RN, MSN, AOCN®, at ecarr@ucsd.edu.

Credits


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