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 whenever pos-
sible and remind physician colleagues, in par-

ticie, that early teamwork also prevailed because
of the lack of an existing blueprint that defined
the responsibilities of nurses. Even with the

avant of robotics to administer chemother-
pies, 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
infuse, assume responsibility for the cre-
ation 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 concert-
ed 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 prac-
tice. 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.

• 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 interven-
tions; 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 cano-
nized for what we do. But we do aspire to be realized. Being realized is a better descriptor than seeking recognition as it con-
notes 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
ogy Supportive Care Quarterly, 2(2), 14–25.

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