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 ownership, 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

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

Digital Object Identifier: 10.1188/08.ONF.867

ONCOLOGY NURSING FORUM – VOL 35, NO 6, 2008
867