GUEST EDITORIAL

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Desperate Nursewives

Cancer nursing is a highly specialized vocation characterized by a profound dichotomy. We change peoples' lives. Yet our rhetoric seldom acknowledges this reality. During a career, each of us has made an impact on thousands of patients and their families (Boyle, 2002). Lobbying for a new medication, orchestrating a patient's pain-free transport to radiation, spending time with a wife to explain the rationale for a procedure, or identifying a new and less complex strategy for wound care offer us daily testimony to the execution of highly competent oncology nursing care. Why, then, the personal absence of recognition and credit for these successes? Perhaps it is because of our continuous exposure to heartrending sadness that ablates our ability to recall those triumphs. As Brown-Saltzman (1994) described,

> We live on the edge with our patients and families. We walk the tightrope of survival, tasting death, vulnerability and intimacy, victory and joy, and brokenness and repair. We have shared people's lives abundantly enough to write volumes, yet sometimes, we forget how extraordinary our work is (p. 1001).

I worry about the intensity and recurrent nature of this anguish within our specialty. At times, its presence seems to suffocate our expressions of caring. I think that we might be submerged in an epidemic of compassion fatigue. But for many of us who have been doing this work for decades, you might ask, "Why now?"

Cancer nursing today is far different from the era of its genesis. Emphasis on technology, time constraints, clashing generational values among colleagues, and shortages all predominate now, making nurses' work more cumbersome. Also, what many of us had and relied on in the early days of oncology nursing's evolution is not present now. We had a team, a committed group of colleagues working together in the trenches. Those of us who got started in the 1970s grew up together with medical oncologist and pharmacist colleagues who were novices just like us. We experienced a spirit of collaboration and reliance on each other that extended beyond the mundane. We belabored how to help the anxious wife who constantly called the clinic, we admitted our frustrations that we did not do enough, and we talked about our losses.

The emotional debilitation caused by persistent compassion fatigue also can be traced to a historic omission. We have failed to realize that a mandatory competency of oncology nursing is to be a skilled hospice nurse. The possibility of premature death is what all patients with cancer and their families have in common. Dying is central to all that we do. Half of our patients will die while under our watch. Yet those of us who exemplify excellence in the nursing care of the dying have mastered it on our own. Unlike other common domains in health care, we have not benefited from a review of the evidence base nor skills training in end-of-life care that accompanies formal learning of other sciences.

Having been both a hospice nurse and a recipient of hospice care as a wife, I know well the scope of expertise that hospice nurses possess. These professionals have embraced the reality that, throughout the entire continuum of the cancer experience, it is the quality of dying that families remember most. This end-of-life scenario is retained as a vivid snapshot that is easily recalled and predominates over earlier phases of the cancer experience. Hospice also embodies the philosophy that professional caregivers must "know where they are coming from" before being able to effectively minister terminal care to others. Hence, current workplace characteristics, the absence of focus on a required subset of skills inherent within our specialty, and the lack of attention to our own affective needs and grief establish a formidable platform of risk for oncology nurse caregivers.

The prevailing burden of melancholy has rendered us "desperate." Yet our sustained presence at the bedside makes patient-centered psychosocial skill and sustaining our own emotional health mandatory competencies for nurses. Fagin and Diers (1983) eloquently described this phenomenon to physician colleagues in an editorial in the *New England Journal of Medicine.*

> Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of patients' lives and they cannot hide behind technology or a veil of omniscience as other practitioners in hospitals do. Nurses do for others publicly what healthy persons do for themselves behind closed doors (p. 116).

The fundamentals of compassion fatigue are generally unknown. However, this term more readily applies to what transpires in oncology nurses. We do not necessarily "burn out"' as the more historical corollary implies, nor do we experience the disabling firsthand rigors of post-traumatic stress disorder. Although the dynamics of our coping remain obscure, we must continue to nurture and sustain as much emotional reserve as we can (Welsh, 1999).

The art and science of nursing emanate from expertise in caring for, caring about, and being with those we nurse. While we continue to make a difference in patients' and families' lives, we must concurrently pay attention to our own psychological endurance. In the absence of attention to the affective domain of our practice, distress will only heighten and further compromise will ensue (Boyle, 2000). So, what can be done? Replicate hospice offerings of counseling and peer support. Articulate the rationale and need for instruction in communication skill-building. Integrate emotional care into acuity ratings and caseload expectations. Document the nature and outcomes of psychosocial interventions that you provide to patients and families. Admit to feeling desperate, as, for now, it is all in a day's work.

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