Northwest/Alaska Oncology Nurses

Vol. 1, No. 1 — Fall 1978

PRESIDENT'S MESSAGE

As the acting president of the Regional (Northwest/Alaska) Oncology Nurses, I plan to communicate with you during my term of office through this newsletter. In this first issue, I want to share with you how cancer nursing has become important to me and some aspects of what might be in this field of nursing for you.

Patients, professionals, acquaintances, friends, and my family periodically ask me what I do. When I respond that I work with people with cancer and their families, and I teach other nurses to do the same; they exclaim, "Isn't it depressing?" My response is, "No, I really like it." Most people may ask another question or two, but few really want me to expand on my feelings.

The first experience that I can remember with a cancer patient came when I was a second year nursing student in a diploma program, working nights. I had finished report and was in the process of making rounds to see if all thirty-two patients were comfortable when the woman in room 410-bed two put her light on to summon me. I quickly approached her room but abruptly came to a halt as I entered. The odor of fecal material permeated the air and caught my breath. The woman asked if I would do something to help. I lifted the covers to find fecal material pouring from underneath the dressings that covered her abdomen. I had never seen so much "feces" in my life and I knew if I stayed in the room I was going to pass out any minute. I excused myself and told the lady that I would return with help when I found out what was wrong with her. I immediately paged the supervisor and when she responded ten minutes later, she informed me that there was a "real emergency" in the E.R. and she would be there as soon as she could. In the interim, I decided to read the patient's chart to find out what had been done to her. She was two days post-operative with a transverse colostomy for an adenocarcinoma of the sigmoid colon. I quickly referred to my Merck Manual to look up colostomy and carcinoma. I was sure that we had not had that in class. Forty minutes passed before the woman summoned me again with her call light. This time when I appeared she was in tears, sobbing that she wanted only to die. Again, I told her I could not stay but would return. At this point, my fear turned to anger. I was angry with the supervisor for not coming, angry with myself for not knowing, angry with the patient for having something wrong that I did not know about, and angry with the doctor for doing such a thing to that patient. My last resort was to find the nursing aide that was working with me. I asked her if she knew anything about changing colostomies and she quickly reassured me there was nothing to it. She told me to get warm water, and a wash cloth, toilet paper, and the bed pan and go to work. It sounded simple enough so I armed myself with the equipment and returned to the patient. I told the patient I had never seen anything like this before, but I knew that I could get her cleaned. She was relieved to see me. The ABD pads and fecal material were quickly disposed of and the patient's abdomen cleaned and clean dressings applied. Her bed linen and gown were changed. Somehow I managed to finish the task without even thinking about the odor. We talked very little that night because when I returned from removing the soiled linen and dressings, the woman had collapsed into a sound sleep. It was that night and the next few that will always remain important to me. Consequently, I found myself coming twenty minutes early to talk with this lady and to see that what had happen-

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ed once would not be allowed to happen again. At the end of my rotation, I shared with her how much I had learned from her and how much I appreciated her trust in me. It was not until some years later in my career that I came to realize just how much this patient taught me. People in states of crisis need someone to help them, to listen to them, and to give them opportunities to express their concerns.

Some six years later, I was working evenings in a small hospital on a general medical-surgical floor. I had assumed primary responsibility for a woman who had an abdominal-perineal resection with post-operative wound healing complications. We became good friends over the weeks that followed and I planned to see her in her home after discharge. There I continued to help her with her colostomy irrigations and her sitz baths when she was too tired to do them herself. I became fascinated with her husband's willingness to help but the wife's reluctance to have him see her so helpless. I soon realized that maybe I had been short-changed by not having a public health experience and decided to complete my baccalaureate education. So, six years after my training, I found myself being supervised in a nursing arts lab on the techniques of catherization and nasogastric irrigations. It seemed strange to me for anyone to question my ability to maintain aseptic technique, but I forged ahead because my goal was in sight. However, my three months in public health was not what I expected. Emphasis had been placed on infant care and I soon realized after a month in the well-baby clinic that it probably would be a good idea if I never became a mother. I decided at that point the answer had to be graduate education, but I wanted to find the right program--one that would primarily prepare me to take care of people with chronic health problems. The role of the clinical specialist was emerging and preparation was available even though it was not abundant. In some ways I feel I selected my program, but inadvertently the program selects you by how well your qualifications are a fit with the admission criteria. The timing was right. When I graduated I was accepted for a position as a clinical nursing specialist in oncology in a large midwestern university medical center. However, let me assure you that just because I assumed the role, in no way did it mean that I was clinically competent. Fortunately, I worked in a system that allowed me a great deal of flexibility to develop at my own pace. It took me over a year to become comfortable with working with patients and their families. During that time, I primarily worked with women with metastatic and far-advanced breast cancer which meant the majority of them died. Gradually, I became aware of how little we as nurses really do know about how to help people live on a day-to-day basis with cancer and especially how to die. The writings of many of my colleagues were extremely helpful during that time when I was searching for answers and guidance to my conflicts and questions, but I soon was confronted with the reality that there is no substitute for experience. Experience in the sense of establishing a number of relationships with people who cope differently with the consequences of disease and treatment protocols. The essence of any relationship is the support both parties involved give and receive. By support I mean an ongoing process of communicating with an individual that he/she is a unique person with values, beliefs, and goals in his/her own right. Support is an intangible quality that occurs within a person when two people interact for the purpose of understanding each other's strengths. In my experience, many nurses only see themselves as being supportive if they know all the answers. It is important to remind ourselves that there is no way that we as nurses will know everything to anticipate about cancer and its consequences so problems for our patients will be avoided. Instead, we need to develop a sense of confidence in our own problem solving abilities that whatever occurs we will continue to work with them to find their own solutions or find alternatives acceptable to them.

Working with people who are living with a chronic disease such as cancer offers each of us an opportunity to share in another human being's life at times of crisis and periods of increased vulnerability. It is a field of nursing that will not be for everyone, nor should it be. But for those of us who are challenged to help people through a time of crisis, it can be ex-

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tremely rewarding and fulfilling. As Benoliel and I have found the delivery of nursing care respectful of the human capacity to face and cope with life threatening experiences depends on professional nurses who have learned not to treat people as patients, but rather as fully competent social beings capable of enduring the pain of human existence instead of being protected from it.

Ruth McCorkle, R.N., Ph.D.

LETTER OF ENDORSEMENT

To: Chairperson
Regional Oncology Nurses

I understand that a Northwest Regional Oncology Nurses organization is in the formative stage and that participation by British Columbia and Alaska nurses, as well as neighboring states has already occurred.

The group is to be commended for bringing structure and organization to cancer nursing in the region and I heartily endorse the formation of this professional organization for cancer nurses. I'm sure that full regional participation and representation in the organization will occur.

This center has a mandate to the citizens of the region--and I know that 55,000 of those citizens are also registered nurses--to provide coordinating and supportive activities. Therefore, let me assure you that I personally, as well as the other staff members of the center, are willing to provide these kinds of assistance as you grow and develop.

I wish your organization the best in the years to come.

Sincerely,

Wm B Hutchinson

William B. Hutchinson, M.D.
President and Director
Fred Hutchinson Cancer
Research Center

REGIONAL MEETING

The Fred Hutchinson Cancer Research Center hosted the second meeting of the Regional (Northwest/Alaska) Oncology Nurses' group on October 18th. The minutes of the meeting appear below.

October 18 meeting

I - Fifty-five nurses were present at the second organizational meeting of the Regional Oncology Nurses. The states of Montana, Washington and Oregon were represented and a nurse from Idaho called saying she was unable to attend as planned due to illness. The "flu" also prevented representation from British Columbia, Canada.

II - The group was supportive of having acting officers during 1979 until people know one another better and until the leadership for the group emerges.

III - The acting treasurer, Celeste Tucker, stated that to date forty membership applications have been received. A mailing of 1,500 brochures recently went out and this will generate many additional memberships throughout the region. An account is being opened in the Regional Oncology Nurses' name with the assistance of volunteered (CPA) time.

IV - Anne Katterhagen, Patient Care Coordinator of Hospice of Tacoma, gave a report on the National Hospice Organization meeting held October 5 and 6, 1978 in Washington, D.C. Anne reported that the theme of the meeting "The Coming of Age of the Hospice Movement in North America," was validated by the registration of 1,100 program participants. The meeting had organizational goals which were achieved: 1 - To bring together the voting members of NHO (52 at present); 2 - To elect a National Board of Directors. One of the National Board members is John Hackley, MSW of Hillhaven Foundation, located in Tacoma. There were 18 people from the Pacific Northwest who learned from the many fine speakers and enjoyed hearing from celebrities: Senator Edward Kennedy, Senator Robert Dole and Secretary (DHEW) Califano. It was reported that Secretary Califano has designated Linda Miller in his office as liaison person for Hospice activities.

V - Pat Gonzales, from Olympia, Washington,

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Chair of the Nurse-to-Nurse Telephone Submittee, reported on how the system is functioning. Calls are accepted only from health professionals. Others will be referred to Cancer Information Services. Calls will be taken Monday through Friday from 8:00 A.M. to 5:00 P.M. and all calls will be answered as promptly as possible and none will go unanswered 48 hours without referral to a consultant. Phone stickers showing the WATS and collect call numbers were distributed. Prior to any publicity the system received 3 - 4 calls daily.

VI - Mary Jo Hunt, Newsletter Editor, asked for contributing editors from each part of the region so that the newsletter can best serve the constituency. There are now contributing editors in Washington, Montana and Idaho. Hopefully, by the time of the first issue, there will be participation from Oregon and Alaska. Items for inclusion were requested from all in attendance.

VII - Kathy Young reported on the XII International Union Against Cancer. There were 10,000 papers presented and Kathy's was one of those. This meeting was the first at which there was a cancer nursing session, 350 attended. Some items presented were patients' Bill of Rights, Role of the Nurse in Cancer Research. Kathy announced that the XIII International Congress will be held in Seattle in 1982. It would seem likely that the Regional Group could assist in planning the cancer nursing sessions.

VIII - Gail Hongladarom announced that Marilee Donovan and Ann Paulen, both cancer nurse clinicians, will be keynoters at the First Annual Cancer Nursing Symposium to be held in Seattle, January 19 and 20, 1979. Negotiations continue for a third keynoter. People were asked to volunteer to chair and/or work on the Symposium and Bylaws' Committees. People interested should communicate with Ruth McCorkle (206) 543-7134.

IX - Ruth McCorkle introduced Charlotte Wright who was here from the Oregon Comprehensive Cancer Program in Portland. Charlotte was the Director of "Project One," a cancer nursing continuing education program in Waterbury, Connecticut and has submitted a proposal to implement cancer nursing education in Oregon.

X - Gail Hongladarom encouraged anyone in attendance with something they wanted or needed to share with the group, to please take the opportunity before the meeting adjourned to the refreshment table. Meeting days and places were discussed with no concrete plans set. Jean House, President of ONSO questioned the need for a regional group versus grass roots groups and cautioned the group to wait for guidelines from the National Oncology Nursing Society. For the group to evolve while waiting for the national guidelines seems very reasonable.

XI - The formal meeting was adjourned at 8:05 P.M. and people continued to meet informally until 9:00 P.M.

Notetaker: Meredith Boldt, R.N.

THE BIG SKY COUNTRY

Montana, the Big Sky Country, is a vast state with a relatively small population. The distances between major cities are fairly great, especially during winter when road travel is impeded by weather conditions.

The Billings area medical community in Southcentral Montana draws from a large geographical region including eastern Montana, northern Wyoming, and the western Dakotas. We see large numbers of cancer patients yearly and are utilizing the most sophisticated treatment regimes. Billings has five physicians with oncology specialties and two Radiation Therapists. These physicians in turn have nurses skilled in administering chemotherapy as well as providing total comprehensive outpatient care.

Our two community hospitals (about 200 beds each) employ a full time oncology nurse at each facility. These nurses are involved in all aspects of care of the cancer patient including pain management, symptom control, rehabilitation, family support and counseling, terminal care, etc., as well as outside community involvement. With all the various kinds of cancer represented, these nurses must be aware of various treatment protocols and are available to staff as resource persons and educational contacts. Billings also

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has an active Public Health community and our patients are referred liberally to their various services, including contacts to agencies in other counties.

Each Thursday morning the oncology physicians meet to discuss problem cases. The nurses are continuous attendants at these meetings, which helps create a clearer picture of the total patient.

The Northern Rockies Regional Cancer Treatment Center houses equipment for radiation therapy including a linear accelerator. The two full time radiation therapists manage treatment plans for patients. Each Thursday noon at their facility there are conferences relative to cancer in general. Each meeting is a different focus, Journal Club where nurses and physicians discuss articles in their respective journals; educational programs; patient presentation, psycho-social or community resource support. These are informal sessions whereby all relax and enjoy sack lunches which are available.

As a group, the oncology nurses in Billings have not met on a formal basis, although recently we have designated our first such session to begin in November. We will maintain our existing network-gathering at meetings and telephoning one another.

We all recognize the need for a more tightly woven support group among ourselves to share information which will enable us to better care for our cancer patients in every regard. We look to the Regional Oncology Nurses' Group to help us in achieving this goal.

Christine Manning, R.N.
Montana Contributing Editor

MSTI'S ONCOLOGY NURSE OUTREACH PROGRAM

Through its Oncology Nurse Outreach Program, the nursing department of MSTI extends its expertise to registered nurses, student nurses, and lay audiences throughout Idaho to guarantee educational update and cancer nursing information as a means of improving nursing care for the patient with cancer.

The MSTI nursing department staff plans, coordinates and presents outreach programs focusing on the issues, techniques and therapies involved in cancer nursing. They utilize lectures and films from the library of cancer nursing education audio-visual materials available at MSTI. These materials are expanded continually with donations from private sources and community service organizations.

Programs are offered on a request basis to hospitals, nursing homes, public health departments, schools of nursing, and many organizations. Current literature is surveyed for each request to insure that the latest research and interventions are presented. Thus far in 1978, programs have focused on: nursing care knowledge of chemotherapy; radio-therapy; the dying patient and grieving family; the MSTI philosophy and modalities of therapy; non-verbal communication; pain--assessment and management; and psychological support of the cancer patient. The number of programs presented by the MSTI nursing department increased from 46 in 1974 to 79 in 1977.

The National Cancer Institute division of nursing sets as a primary goal of cancer nursing the dissemination of information regarding cancer. Following this lead, the MSTI nursing department programs present concepts which focus on the impact of cancer on the patient, family and community; a positive attitude toward cancer and the cancer patient; an understanding of early signs and symptoms of cancer and preventative measures; an awareness of resources available to assist the cancer patient; and on the nurse's role as a member of the team providing care during all of the cancer patient's transitions.

Amy Savage, R.N.
Mountain States Tumor Institute
Boise, ID

CANCER CONTROL AGENCY OF BRITISH COLUMBIA

The Cancer Control Agency of British Columbia is responsible for the range of services aimed at controlling cancer. Unlike most general hospitals, its programs range from prevention to treatment, rehabilitation and follow-up. Its overall goal as expressed in the constitution, is to establish a coordinated, province-wide program of cancer care, control and research to provide residents of the prov-

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ince of British Columbia with services and facilities for the prevention, detection treatment of all forms of cancer as promptly, effectively and efficiently as modern knowledge, skill and technology now make possible. In order to reach that goal, the Agency has the following objectives:

1. To identify and define the total care and control needs and resources required to carry out a comprehensive and highly effective program.

2. To mobilize all resources for cancer care and control and effectively utilize them by employing modern methods and advances in management, social, health and computational sciences.

3. To establish criteria for high quality cancer care and control measures together with the necessary procedures for ensuring that such measures are adopted and maintained throughout the province.

These objectives are based on the belief that the patient's comfort and wellbeing are the ultimate aim. While the services the Agency are geared mainly to active treatment and follow-up, it is recognized that palliative care and the provision of services to meet social, emotional and spiritual needs of patients are important aspects of total patient care. Coordination for utilization of a wide range of services is necessary to provide continuity of care.

The Cancer Control Agency currently operates three permanent clinics and 18 regional consultative clinics. The Victoria Cancer Clinic, situated in the Royal Jubilee Hospital provides residents of Vancouver Island with a full range of diagnostic and treatment facilities, including radiation therapy and chemotherapy. Consultative Clinics on the island are staffed by the Victoria Clinic. Similarly, the Interior Cancer Clinic is located in the Royal Inland Hospital in Kamloops, but is part of the overall Agency operation. Patients seen at the Interior Clinic must travel to Vancouver for radiation therapy.

A.M. Evans Clinic in Vancouver, with inpatient beds and extensive outpatient and treatment facilities, is the major referral centre for the province. Here, more than 3,500 new patients are seen every year for consultation, diagnosis, treatment and/or follow-up. Patients requiring radiotherapy, chemotherapy, or immunotherapy may attend the Evans Clinic as an outpatient or, when special nursing care or procedures are required, as an inpatient.

In addition to the medical care provided, there are other services available at the Agency. The multi-disciplinary Human Support Committee acts as a coordinating body to initiate and implement educational and support services for patients and their families. These include:

1. a 15 minute slide tape orientation to the Evans Clinic which is shown daily in the Admitting Department and monthly at Information Night;

2. a weekly "Living with Cancer" group which is held to provide patients and their families with an opportunity to talk openly about their disease, its treatment and the implications or effects on their lives;

3. a patient information library which provides reading material for patients and their families.

Nurses in the hospital units and the outpatient department provide direct care to patients and in the past few years have taken on the added responsibility of administering intravenous chemotherapeutic agents. In addition to extending responsibilities, the nursing department has expanded to include new positions. In the past year a nurse research assistant, a paediatric oncology nurse and a clinical nurse specialist have been added to the Agency staff. Each of these positions is unique and their development is an indication of the enthusiasm of nurses and the recognition on the part of administration of the variety of roles that nursing can play in the health care system.

Barbara Warren, R.N.
Clinical Specialist
in Oncology

THE GREAT LAND

Alaskan nurses interested in cancer nursing are pleased to be a part of the Regional (Northwest/Alaska) Oncology Nurses and to participate in your newsletter.

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Gail Hongladarom from the Fred Hutchinson Cancer Research Center, Seattle, visited the Alaskan communities of Fairbanks, Anchorage and Ketchikan in late October. She met with local nurses in each area to inform them of educational opportunities available through FHCRC.

Her visit and information were well received. It is easy for Alaskans to feel isolated from you in the "lower 48." Many of us feel a positive hunger for more knowledge about cancer management. There is a growing community of nurses here who have a keen interest in giving high quality care to persons who are living and coping with cancer.

One group is in existance that has an ongoing effort to provide information and various types of education to the state. The Nursing Committee for Professional Education is sponsored by the Alaska Division of the American Cancer Society. Ten local nurses representing such varied agencies as hospitals, physician's offices, home health, extended care facilities, continuing education, an insurance company and the Air Force make up the Committee.

The group hopes to take advantage of the many exciting happenings in the Seattle area. Two of us plan to attend the Cancer Nursing Symposium in January.

We look forward to meeting many of you then.

Sandi Kreitner
Family Nurse Practitioner

GYNECORPS TRAINING PROGRAM

The Gynecorps Training Program is an educational program designed to prepare nurses and physician assistants to function as practitioners in ambulatory obstetrics and gynecology. After completion of the 18 week didactic portion of training, students enter a 6 month preceptorship with their sponsoring physician or agency. Students are certified as women's health-care specialists after successful completion of both phases of training and are able to provide primary health care to women, including cancer screening, management of common gynecological problems, routine pre and post natal care, counseling and client education. In addition, WHCS receive training in directed screening physical exams, including heart, lung, thyroid and abdomen.

Gynecorps also offers GUS (Gynecorps Upgrading of Skills), a continuing education workshop for nurse practitioners and physician assistants to improve skills in gynecological assessment. Additional information about these programs may be obtained by contacting the Gynecorps training facility, 1131 14th Ave. S., Seattle, Washington, 98114. Phone - 329-3444. Janet Lukacs, R.N., M.N.

POSITIONS AVAILABLE

Oncology Nurse - The community of Longview, Washington is seeking an oncology nurse to plan and develop an oncology unit at St. John's Hospital.

Contact: Rich Kirkpatrick, M.D.
1320 - 18th
Longview, Washington 98632
206/636-0040

Director of Hospice Activities - Hospice of Snohomish County Washington is recruiting a registered nurse to assume full time position of director.

Contact: Chris Reheis, R.N.
Providence Hospital
P. O. Box 1067
Everett, Washington 98206
206/258-7123

Director, Cancer Lifeline - recruiting R.N., M.S.W. or equivalent with management skills, clinical knowledge of cancer and its treatment, background in counseling.

Contact: Cancer Lifeline
500 Lowman Bldg, 107 Cherry
Seattle, WA 98104
206/ 447-4542

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The Northwest/Alaska Oncology Nurses newsletter is published quarterly by the Fred Hutchinson Cancer Research Center.

Editor: Mary Jo Hunt, R.N.

Items for inclusion in the newsletter are requested from all states in the region. Submit material for publication to Mary Jo Hunt, Editor, c/o Extramural Program, Fred Hutchinson Cancer Research Center, 1124 Columbia, Seattle, WA 98104.

Membership in the RON's group now exceeds 70. Use this convenient tear off portion to activate your 78-79 membership, annual dues $5.00. Return form with payment to Celeste Tucker, R.N., Treasurer RONS c/o Extramural Program, Fred Hutchinson Cancer Research Center, 1124 Columbia, Seattle, Washington 98104.

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