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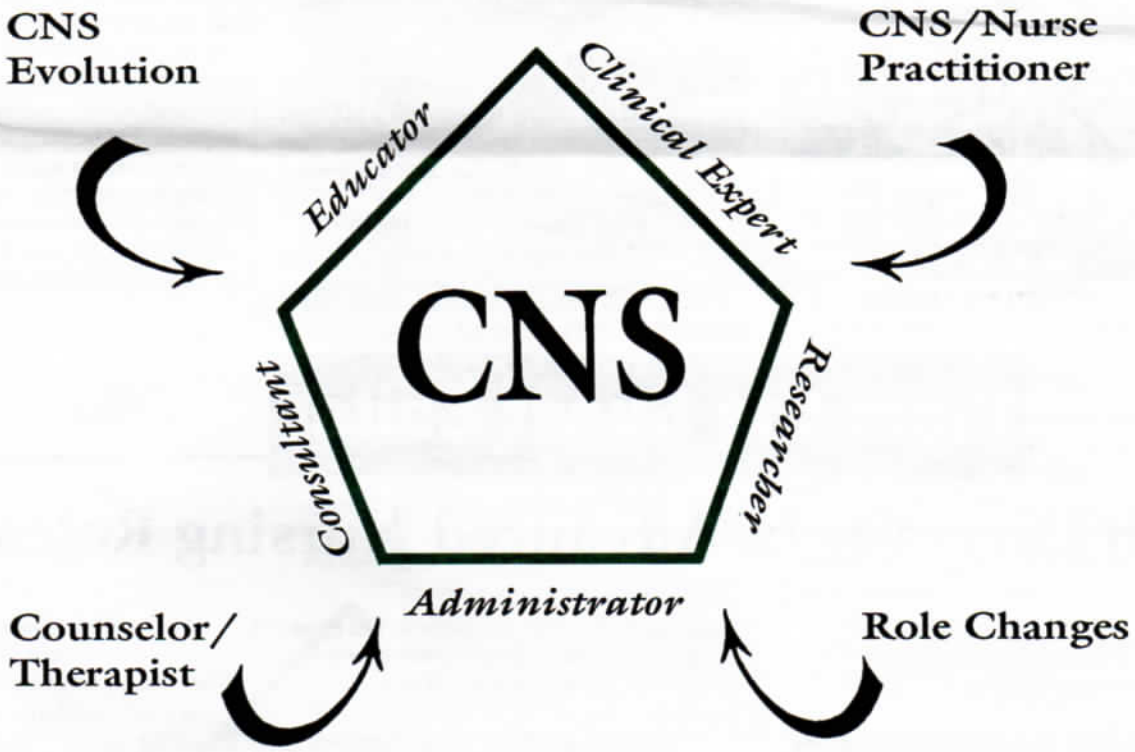
ONCOLOGY NURSING SOCIETY

Diversity in Advanced Nursing Practice:

The Wave of the future?



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Board of Directors' Message

If You Can't Trust Your Hairdresser, Who Can You Trust?

Susan Ford
Chapter President-Elect

Do you know what I did this last weekend? I got my hair cut. Now, this was not just any old haircut, I *experienced* a haircut! I walked in and sat in the chair. Then someone pampered me. As I sat, she ran her fingers through my hair fluffing it out. That felt good. Hairdressers just love naturally curly hair, you know. She washed my hair. The peaceful feeling of laying my head in the wash basin and feeling the streams of warmth as the water found its way through my locks and onto my scalp. Such a feeling of relaxation, not a care in the world at this point.

She then escorted me back to the chair of honor. As I sit and she clips, I focus on the woman staring at me in the mirror, I am the center of the universe. She remembers what was going on the last time I was in, she asks me how things are going today, she tells me an interesting tidbit about the person who just walks by the window. She gives me advice about what I should wear, raising my kids, what to eat, and an update on that gray stuff invading my once brown locks. She then shows me what the back looks like and asks if I approve?

So you say to yourself, Sue what does this have to do with our chapter anyway?

When I left the shop, just for moment I pondered the notion that all the patients I have ever treated who have lost their hair either due to surgery, radiation, or chemo, they also lose for a time, *that* experience. The much needed escape from the world's hassles and the ability to relax for a bit, the pampering, the visit to the hairdresser. Not only have these people, our patients, been assaulted by the diagnosis of a lifethreatening illness, but as part of treatment we rob them of a very pleasurable little life experience - like getting your hair cut.

I also thought about the way I felt, the focus was on me, if even for a few minutes. Now, think for a moment about the reorganization of health care delivery we are seeing. We are witnessing the creation of leaner and meaner systems of care. As nurses, we are expected not only to be providers but, managers of care. At this point it is difficult to give any extra attention to our patients. Sometimes we feel we can't focus on our tasks, let alone the patient.

But, I see a glimmer of opportunity. The system as we know it can only stretch so far. I believe nurses will be given the opportunity to demonstrate how we can impact the system and maintain the human component of care. As oncology nurses, will we be prepared to demonstrate these skills? What as an organization like PSONS can we do to prepare one another for this challenge? In July you received a survey asking you what direction you see the future of our chapter going. Your input is important in helping the Board make decisions which will impact how we can strengthen oncology nursing practice in the Northwest. Please take the time to find the survey and fill it out if you have not done so. If you have returned it, Thank you.

From the Guest Editor

Rich Diversity in Advanced Nursing Roles

Margaret Brown, RN, MSN, OCN
Oncology Clinical Nurse Specialist
Good Samaritan Hospital

I remember as I made choices about the profession I would pursue in college, one of the pros to nursing was the variety of specialties it offered. I could go into oncology, critical care, OB, surgery, rehabilitation, and on and on. Though I was thinking only of various medical specialties within which nursing could function, that perspective of nursing's diverse nature is still growing. Within the scope of practice for LPN's, two-year and three-year RN's, and BSN RN's there are many specialty and role options. But even more options are available in the scope of practice for the masters and doctorally prepared nurse.

The goal of the *Puget Sound Quarterly* is conveyance of how some of the nurses in advance practice in PSONS have evolved into and defined their roles. What becomes clear from the following articles is that role definition is dynamic. True, there usually are significant components of expert clinical practice, consultation, education, research, collaboration and leadership (Hamric & Spross, 1989). However, an individual remaining in the same positions often finds the percentage of role components changing as institutional needs change.

As we witness health care agencies "right-sizing" to meet decreasing budgets, there will be redefinition and clarification of many roles. All have heard discussions about the necessity and appropriateness of various advanced practice nurses. Some physicians convey skepticism toward independent advanced practice nurses (Schwarz, 1993). Institutions have laid off or not hired clinical nurse specialists because their administrators do not believe they are cost effective or essential to quality care. Another supposition is that the clinical specialist role will become obsolete while evolving into that of either case

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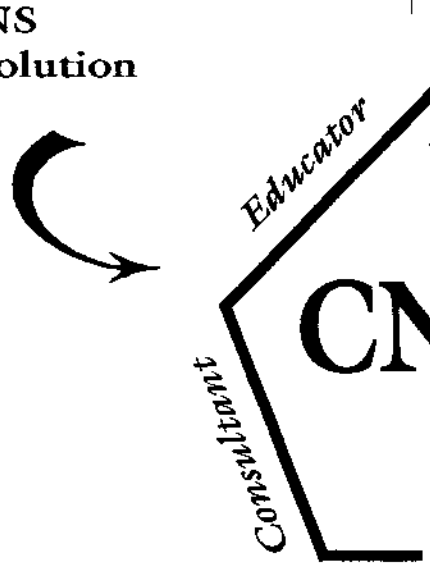
Evolution of a CNS Role

Barbara Fristoe, RN, MN, OCN
Oncology Clinical Nurse Specialist
Tacoma General Hospital

Traditionally, the components of the Clinical Nurse Specialist role have consisted of expert practice, consultation, education and research. In some institutions, administrative responsibilities are included as part of the role. In reality, CNS roles vary from institution to institution and within institutions, from one CNS to another depending on the needs of the institution and the individual goals and strengths of the CNS.

In my current position my role has changed and developed tremendously over the past five years. When I first started in my position, I spent a lot of time getting to know the staff and learning about the oncology unit and learning about how things are done at Tacoma General. I spent the majority of my time in direct patient care, teaching about disease process and treatment, chemotherapy effects and side effects, options available for vascular access devices, how they are used and cared for at home. In my consultant role, I saw oncology patients on other units to provide information, education and support. As the first Oncology CNS at Tacoma General Hospital, I discovered that there were several areas that needed development. I felt that staff would have more satisfaction if they were more involved in patient teaching and worked on standardized care of vascular access devices and patient teaching. I became involved in developing standards for vascular access devices, chemotherapy administration, treatment of extravasation, and radiation therapy. We also started a chemotherapy certification program for RNs to document competency in chemo administration.

For the first year or so, the focus of my job was on providing patient care, developing standards, and providing inservices for staff with the goal of strengthening professional practice and involving staff in patient education. With the arrival of a new nurse manager, together we began to develop a philosophy and plan for staff support. We began working on team building, conflict resolution and care for the caregivers. We felt that this foundation was necessary to develop a staff who will be able to survive and thrive in caring for cancer patients and their families. Over the past four years, staff support and education have been ongoing to continue to build on the interactions, skills and knowledge that staff will need in the future.



With staff development on the oncology unit, my role has changed to focus on more hospital-wide projects such as developing an epidural analgesia education program and skills lab for staff, development and implementation of a clinical ladder, involvement in a total quality improvement demonstration project funded by the hospital Board of Directors to develop a "seamless" system for the transfer of patient information from outpatient to inpatient to home care, and the development of a housewide pain management committee.

During the past year, in response to changes in health care, the hospital has been undertaking a "Patient Focused Work Design" approach to patient care to provide more efficient, cost-effective and patient focused care. On the oncology unit, we changed our care model from an almost all RN staff to teams of RNs and LPNs with support partners who provide transportation, housekeeping and some basic patient care. RNs and LPNs have acquired skills in phlebotomy, venipuncture and respiratory therapy. Staff on the oncology unit have shown tremendous growth in taking on new skills and leadership, developing self-governance with self scheduling and active clinical practice and education committees.

Our oncology unit is also undergoing renovation which will be completed in September of 1993. The new unit will be home-like with natural woods and fibers and an open nursing station, and is designed to promote patient control and provide a healing environment. Now we are trying to determine what is a "healing environment" and how do we provide caring in this environment. We plan to do research in this area, in part with funds we obtained from an endowment for oncology nursing education and research. Staff education in this area will be ongoing.

With recent health care changes and future predictions for health care, the role of the CNS is under scrutiny as are almost all hospital positions. At Tacoma General, our Assistant Administrator has been working to strengthen our position. We have been accountable for the past two years to demonstrate cost saving and/or income generation equal to our salary. This has been difficult, but a very important part of our jobs and is something that we work on together to capture revenue generation. What we have been able to claim are cost-saving equipment and procedure changes, development of a skin care program, and epidural analgesia and pain management programs. The CNAs are also involved in examining quality care issues on individual units and hospital wide. We are all working on care management and will be key in developing multidisciplinary research-based "Best Practice" for specific

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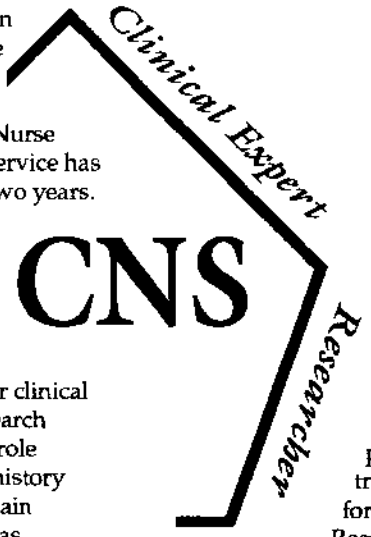
The Clinical Nurse Specialist/ Nurse Practitioner Role: A Collaborative Practice Model

Anna R. Williams, RN, MN
Stuart L.Du Pen, MD

The role of the Clinical Nurse Specialist (CNS) has been easily translated into the specialized practice of oncology. At Swedish Medical Center the position of Clinical Nurse Specialist for the Cancer Pain Service has been operational over the last two years. As is traditional with the CNS role, the position has components of clinical practice, education, research and administration. The position was created by the Pain Service in 1990, initially for clinical program development and research support. The developing CNS role included pain assessment and history taking of patients referred for pain management. A major effort was undertaken to develop a standard for pain assessment among the physicians and nurses caring for the oncology patients. This program development piece encompassed inpatient, outpatient, and home care. "Pain Rounds" was instituted on three inpatient units, co-facilitated by the Hospice CNS, with the goal of enhancing nursing education in pain management. A clinical research component was inherent in the role. Co-authoring protocols, facilitating identification of eligible patients for pain research studies, obtaining informed consent, and coordinating details of ongoing research were part of the original role. Administratively, the quality improvement arena in the 1990's was lending itself well to pain management outcome studies, correlating pain assessment scores to treatment approaches and patient satisfaction, leading to the development of a hospital wide pain management committee. And most notably over the last two years the growing numbers of patients referred for pain management created a dramatic increase in the need for expert clinical management. As is common with clinical nurse specialists, the demands of the job were out of proportion to the time available. Both physician and nurse agreed that while education and research are important, the development of the clinical practice component of the service would be our first priority. As time progressed, more and more effort was directed towards patient care. Today the diagnostic and interventional strategies of the medical model and the patient/family focused nursing process method have evolved into a collaborative practice model.

Late in 1992 a decision was made to reshape the CNS role, cutting back on some of the educational, research, and administrative components, and incorporating some of the primary care



CNS/Nurse Practitioner

philosophy inherent in the nurse practitioner role. The physician partner facilitated the time off and tuition necessary for the nurse partner to obtain the training necessary to sit for the Advanced Registered Nurse Practitioner (ARNP) exam. This training has allowed for advanced clinical training in the area of differential diagnosis and treatment planning. While the combined CNS/ARNP role allows for expanded clinical practice, the more traditional CNS components are still in evidence. Input and collaboration in clinical research projects is available, the use of the "rounds" format for nursing education and consultation continues in inpatient and outpatient settings, and the measurement of quality indicators as an administrative function are still ongoing. The ARNP role, more often utilized in primary care, will bring a role development challenge into the tertiary care setting. It is hoped that the strengths of the specialization of the CNS role and the breadth of generalized knowledge that has historically defined the ARNP role will blend together to strengthen this practice even further.

A "collaborative practice agreement" was recent signed by the physician and nurse partners. After several drafts the document was formalized by corporate attorneys. The agreement attests to the joint nature of the practice — distinguishing the legal scope of practice of the separate parties — but equally describing the interdependency of the medical and nursing practice. The parties agreed that 1) patient care decision making shall be by consensus, taking all relevant patient and family data into account; 2) clinical program development priorities shall be determined jointly and workloads shared, 3) academic and research projects shall be supported, but reviewed as secondary to patient care time and energy constraints. Contingencies are made for lack of consensus, whereby a third practitioner (and/or administrator as the case may be) may have a deciding vote. This document

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A Mid-Manager in Transition — CNS

Pat Jordan, RN, MN, OCN
Oncology & Palliative Care Community Health Specialist
Group Health Cooperative

In 1992 the organization I work for, like so many others, changed. I was a coordinator of a fairly large hospice home care program. In this role I supervised Nurses, Social Workers and Spiritual Counselors. I talked and worked with patients/families and all levels of the organization. I was the point person for a team of professionals. Although the position seemed vast, and at times overwhelming it was rewarding and challenging. I provided clinical as well as managerial leadership.

Within the organization a new structure was proposed to address the existing and future needs of a diverse division and organization. These needs reflect those in health care and in oncology nursing specifically. Patients are moving out of the acute care setting earlier, receiving treatment in clinics and the home care setting. Our organization was looking at increasing growth in clients, and requests for diverse services. The increased number of "high tech" care in the homecare settings, the diversity of clinical issues, the provision of services in rural and urban environments and "off hour" requests provided challenges to the established structure. In reviewing the challenges with colleagues I realized this was not an isolated issue but a transition in the world of health care. It can be observed throughout the Seattle area and country.

There were two challenges to be addressed. The first challenge was to let go and grieve the elimination of a position that I enjoyed and was successful in. The second challenge was to create a new position and role which met the needs of the organization. Letting go of the old position of clinical coordination required a time of disorientation as Bridges (1988) refers to in his book **Transition Making Sense of Life's Changes.** There is also a reorientation which makes for the turning point to a path of growth. Engle (1965) describes this as the grief work and resolution following a loss. Keeping a perspective that reflects on the effects of loss and change can empower the individual to move through the time of change more effectively.

Bridges (1988) also speaks of a checklist for transitions within both Love and Work. This checklist can provide a framework to the work needing to be completed in order to grow and move on. These include:

1. Take your time
2. Arrange temporary structures
3. Don't act for the sake of action
4. Recognize why you are uncomfortable
5. Take care of yourself in little ways
6. Explore the other side of the change
7. Get someone to talk to
8. Find out what is waiting in the wings of your life
9. Use this transition as impetus to new kinds of learning
10. Recognize that transition has characteristic shapes

Bridges goes on the say that the transitor moves into a time of acknowledging the endings, needing to "pause" and making a beginning. This review of the transitions was also part of the framework to the creation of a new position/job. The position in my case was that of a Community Health Specialist in Palliative Care and Oncology. For the organization, a work group looked to the model of the Clinical Nurse Specialist (CNS) to see how the new position would fit in the structure. The oncology nurses and the Oncology Nursing Forum were great sources for a framework of the role of CNS (Hamric, 1992; Krumm, 1992). The key elements in these articles were the educator, the scholar, the consultant and the practitioner (clinical expert).

The organization/division established a work group of staff interested in developing the role definition. The work group reviewed the literature and projected an outline for the role which was modified to the four CNS roles. It is important in role development to go from the general to the operational. This process required an organization assessment. In the world of total quality management (Walton, 1986 one of the first steps of a process is to define the "customers" of the new role. The next step is to develop a mission statement. Mine was to provide consultation and clinical information/ support to enhance the care provided to Group Health Consumers who have cancer and/or a palliative focus to their care and were receiving services from Community Health and Long Term Care (my Division of the organization).

With a mission statement and an outline of the possible roles, I then went to my customers and did a needs assessment. Formally and informally I facilitated inservices/focus groups and coffee breaks to identify needs related to this position. With this information I developed a more formal and consistent needs assessment with a scale for priority of inservices, procedure development, and patient teaching tools. The wide range of needs assessment categories allowed for the development of a number of inservice modules which met staff needs. This established the educator/scholar role.

The consultation role required special attention to establish a perceived level of expertise and resourcefulness to staff. This was developed through inservices, attendance and active participation in case conferences, visibility and availability. The voice mail system was used to communicate to the clinical staff regarding updated information and news. In developing the new role it was important to reach all levels of the organization and to develop key relationships at each level.

The practitioner (clinical expert) role evolved in the new role at clinical consultation with staff regarding specific patients, joint visits and mentoring. Then, contact with patients and families in the acute care setting was added, with direct contact and consultation with staff to ensure the continuity of services and care planning.

The role of researcher has been called upon when quality assurance, utilization management plans and outcomes were reviewed. There was also the need to translate research from journals, conferences and experts into clinical

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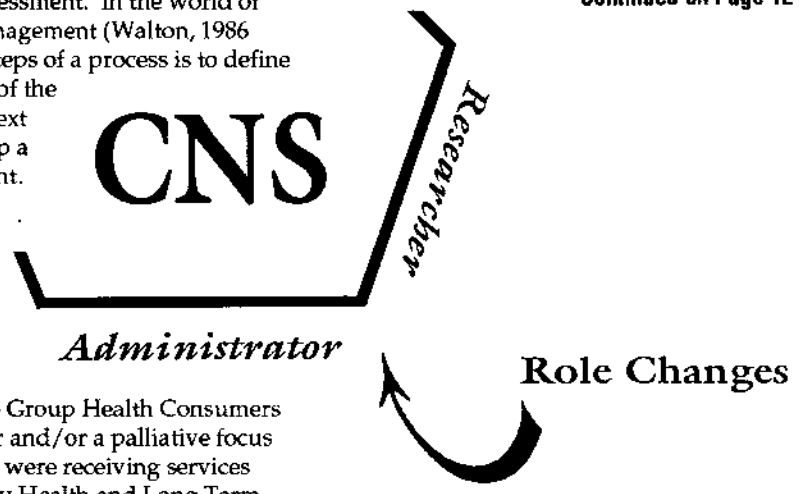


Oncology Nurse Counselor/ Therapist: An Emerging Role

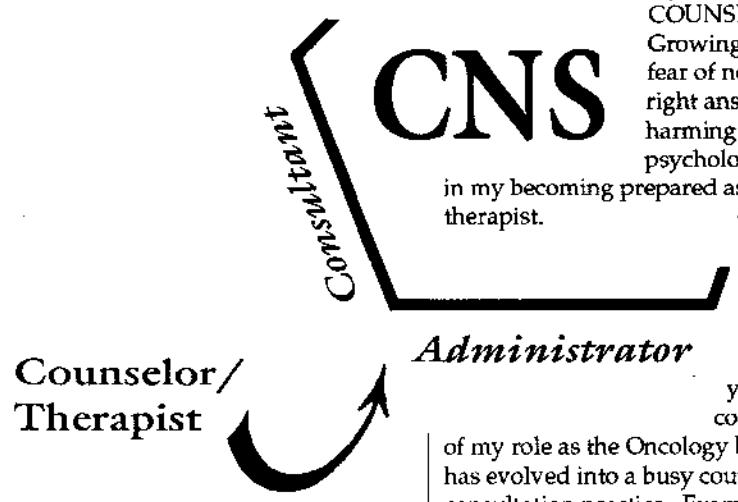
Julia Fanslow, EdD, RN
Oncology Nurse Specialist

Role

One of the newest advanced practice roles in oncology nursing today is that of counselor/therapist. As an Oncology Nurse Specialist prepared at the masters level back in the late 1970s, my preparation was broadly based, multifaceted and included experiences in all oncology patient care settings.

Virtually all of my clinical experience as an Oncology Nurse Specialist (ONS) has been in the hospice setting, working with patients and families experiencing end stage disease, the process of death and dying, anticipatory grief, symptom management and a multitude of ethical issues. Once death occurs, I then work with the bereaved as they struggle to integrate profound loss into the fabric of their lives.

It was a wonderful experience in those early years, running support groups, managing the physical effects of end stage disease and the dying process. It became apparent however, that my preparation was lacking as I identified all of the psychosocial effects of the disease and dying process and its effects on self, relationships, families, job, society, etc. I felt woefully inadequate to counsel as I interacted in difficult patient and family situations — but soon found myself doing just that — COUNSELING! Growing discomfort, fear of not having the right answers or harming someone psychologically resulted in my becoming prepared as a counselor/therapist.



Role Evolution

Over the past fifteen years the counseling aspect of my role as the Oncology Nurse Specialist has evolved into a busy counseling and consultation practice. Examples of the type of problems experienced by the patients and families I see as a counselor/therapist include:

- anticipatory grief issues
- knowledge deficits related to disease process, treatment modalities, symptom management, prognosis
- inadequate coping strategies
- dysfunctional family and/or relationship issues
- bereavement
- ethical dilemmas
- end of life issues
- unrelieved pain
- need to learn relaxation and/or guided imagery
- depression
- stress and anxiety
- prolonged grief reactions

Examples of the type of consultations I provide include:

- Oncology program/services evaluation and implementation
- team building
- evaluation of need for and development and implementation of oncology related education for oncology staff, patients' families, etc.
- legal case review
- program development and implementation with eight hospices in the United States

Where is the Role Going?

While the role of nurse counselor/therapist is a new role in oncology, it is not a new role in nursing. I see it as an emerging role, vitally important to the health care outcome for patients and families forced to live with cancer. As we see health care reform take shape and greater emphasis placed on prevention, and when that is not possible, promotion of optimum coping, then there will be a recognized and crying need for the oncology nurse counselor/therapist.

The greatest strength I have as a counselor/therapist is the fact that I am also an Oncology Nurse Specialist with all the expertise and knowledge related to both roles. This reality allows me to relate to cancer patients, families, physicians, staff, etc. in a vitally different way than I might if I were only singularly prepared.

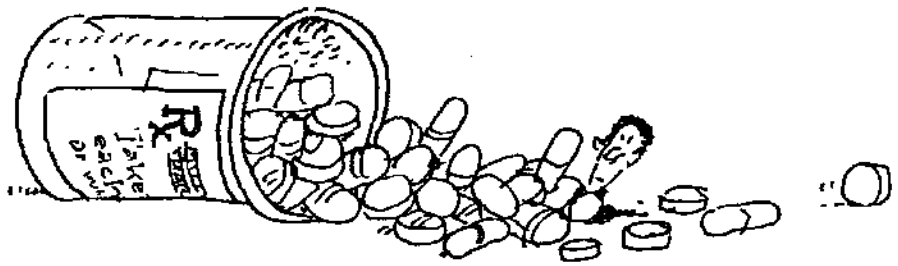
My practice as a counselor/therapist and consultant continues to grow. I neither advertise nor solicit clients. Clients come to me via referrals from past and present clients, physicians, other health care professionals, hospices and simply by work of mouth. As a counselor/therapist, I have a sliding scale fee for service due in part of reimbursement and the clients ability to pay. Reimbursement is resolving but still somewhat of an issue because some insurance companies cover counseling and therapy provided only by a psychologist or psychiatrist.

The growth of my private practice continues to be supporting evidence of the need for oncology nurse counselor/therapists and as a result I continue to be an advocate for the role, its implementation and further development. Clearly it has a valuable place in the delivery of health care as we work together to provide individualized quality based care.

Clinical Practice Review

Use of Zofran (Ondansetron) in Treatment of Chemotherapy Induced Nausea & Vomiting

Judy Petersen, RN, MN
Northwest Hospital



We all know that emesis can be one of the most distressing side effects associated with chemotherapy. Patients in fact are often fearful of this side effect. Research in this area has increased significantly over the past decade as health care providers focus more on quality of life issues. The '80s brought fairly effective combination antiemetic regimens, but they were often accompanied by their own side effects (sedation, dystonic reaction, restlessness, agitation and hypotension). Now Zofran (ondansetron), a new class of antiemetic, has been available for over a year and is proving to be a very effective antiemetic, even in preventing emesis from the highly emetogenic cisplatin.

Investigation has shown that Zofran works by antagonism of serotonin, specifically the 5-HT3 receptor which has been identified as a key receptor involved in chemotherapy induced emesis. These receptors are located in the central nervous system and in the gastrointestinal tract. Traditional antiemetics like Reglan are primarily dopamine antagonists associated with distressing acute dystonic reactions. Zofran's selective blocking of 5-HT3 receptors, with no effect on dopamine receptors, avoids the dystonic reactions. Zofran's most commonly reported side effect is headache.

What have our clinical experiences been with the use of Zofran?

Agreement overall is that Zofran is highly effective with some real advantages over combination antiemetics. "It's a wonderful drug," says **Joy Miller-Knopp**, Oncology CNS at Overlake Hospital. "Our night nurses are no longer on emesis patrol." Joy also pointed out that because patients are not sedated as with other antiemetics, they can safely and independently get up for those frequent trips to the bathroom after receiving hydration for cisplatin therapy.

In my discussion with nurses about dosing and administration of Zofran, I found that there are some variations. For cisplatin based therapy a common schedule is 10 mg. Zofran IV 1/2 hr. before chemotherapy, then repeat 10 mg. Zofran IV q 4 hours x 2. (Drug prescribing information recommends .15 mg/kg/dose). **Veneta Christensen**, Oncology RN at Highline Hospital's outpatient cancer clinic reports that some physicians are now prescribing a single high does (30 mg) of Zofran prechemotherapy. "We're getting just as good results (in preventing N/V) but we've seen more headache and some complaints of blurred vision with the single high dose. Slowing the rate of infusion helps diminish the headache and blurred vision," **Tammy Clark** reports that Swedish Hospital is also beginning to administer more high dose Zofran at initiation of chemotherapy, but following this with 10 mg. q 8 hours.

Cathy Thomas, Oncology RN at Northwest Cancer Center reports that in their office practice they have been finding that lower doses of Zofran (as low as 4 mg) are as effective in preventing nausea and vomiting. This would certainly lower the cost as well as decrease risk of side effects such as headache, which the literature reports increases with higher doses as Veneta's experience validates.

All nurses I spoke with were administering IV Zofran in 50 cc of D5 or NS over 15 minutes as recommended by prescribing information. Uniformly decadron 10-20 mg has been given with the first dose of Zofran. Clinical studies have shown the use of decadron to increase the effectiveness of Zofran. **Sue Alderson**, Oncology CNS at Northwest Hospital reminds us, "For patients receiving consecutive doses of chemotherapy, don't forget to give the decadron dose each day as you repeat chemo and antiemetics, it makes a difference!"

A few hospitals were trying Zofran for nausea and vomiting unrelated to chemotherapy, results were mixed effectiveness.

Oral Zofran has been recently made available. "Hurrah," you might respond, but oh, it is expensive! I surveyed six Puget Sound area pharmacies to find out just how expensive it is. For a single 8 mg tablet, the cost ranged from $16.56 to $27.39. Of course a "deal" can be had if you bye in bigger quantities. For 10 tablets the cost ranged from $153.97 to $225.00. They are packaged as a package of 3 pills or in bottles of 30. Two pharmacies I called did not carry Zofran because of the cost. The outpatient clinic nurses I spoke with all commented that free tablet samples have been available for patients from Glaxo. I would conclude that practice in the area is to prescribe oral Zofran for only very highly emetic chemotherapy drugs and often only after other antiemetics have been tried.

Concern was raised by more than one nurse I spoke with about inappropriate overuse of Zofran as we all try to curtail high costs of health care. **Ann McElroy**, Oncology CNS at Virginia Mason Hospital explained their hospital's proactive approach to this issue. They are developing guidelines outlining when Zofran should be used based on patient risk for nausea and vomiting. I know I'll be anxious to hear how effective the implementation of this is!

Next issue's topic: Needle localization for breast biopsy: Is local anesthetic being used? Yes, no, what do patients think, what do you think? How can we as nurses impact how procedures are done?

Please mail info to my home address: 4027 Woodland Park N., Seattle, WA 98103 or call me (days) M,T, W at work: 368-1608 or Th, F days and eves at home: 633-1326.

Governmental Affairs Update

Pat Jordan
Group Health Coop.

The Washington State Congressional session is over and the biggest piece of legislation to effect health care is the Washington State Health Services Act of 1993, which was signed into law on May 17, 1993. Key points of the bill included: 1) A Uniform Benefit Package which will be determined by a new state commission. 2) Supplemental Benefit Packages may be offered by Certified Health Plans 3) All employers must provide health care for their employees and their dependents, paying at least 50% of the premiums. 4) A full time employee is one who works at least 30 hours a week and 5) Long term care will be included by 1999. Another bill, Senate Bill 5948, passed which standardized the health professionals board disciplinary procedures regardless of discipline.

Health care reform on a national level continues to be unknown. As of June only 13 bills were presented to the House and Senate related to health care and the ONS priority issues. This lack of activity is a result of **President Clinton's** request to hold on the presentation of bills until after the Health Care Task Force completed its work. The recommendations are to be announced in September (or so!!)

The Ways and Means Committee has agreed to ban physician referrals to agencies in which they have an ownership or investment interest. ONS has endorsed a proposal to ensure medical research is a key component of any health care reform package proposed. The NIH re-authorization bill has been approved. NIH is in the process of looking for a replacement for **Dr. Healy** who resigns as of June 30, 1993.

The health subcommittee members are attempting to cut Medicaid by making it more difficult to transfer funds to become eligible for Nursing Home coverage. The subcommittee voted to create a new entitlement for children under six to receive free vaccines if their parents are uninsured or eligible for Medicaid. Medicare costs are being cut by a freezing for 2 years any inflation adjustment in reimbursement in some categories of services.

An issue of cost containment, which we all need to be aware of, is the way the California higher education community is dealing with cuts in funding--by cutting education of nurses. At UCLA (the only public RNB program in the State) they are eliminating the BSN program from the curriculum. If you want to write a letter regarding this, address it to:

Charles E. Young
Chancellor's Office
2147 Murphy Hall UCLA
405 Hilgard Ave.
Los Angeles, CA 90024-1405

We hear from ONS that they are endorsing efforts of the National Breast Cancer Coalition to collect 2.6 million signatures to present to President Clinton declaring a national emergency of breast cancer. On pages 13 and 14, there are two pieces of info from ONS-Government Relations. One, a sample letter for you to copy and send to President Clinton. There is also a petition for you to have people sign and return to the ONS office by **October 1.** Please Xerox the petition form.

Editor's Note:

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manager or nurse practitioner. Yet, while I hear all this, I am also recognizing entrepreneurial spirit and determination among nurses in advanced practice as they prove their value within the changing healthcare scene. They are not waiting for a consensus statement on the role of the advanced nurse.

The authors in this issue have demonstrated such character: **Julia Fanslow** has established an independent practice as a nurse counselor in which she is paid a fee for service. **Anna Williams** has just legally formalized a collaborative practice agreement with a physician that will enable her to practice as an ARNP with pain management. **Pat Jordan** has redefined her role/position to accommodate a changing organization. and **Barbara Fristoe** has kept her position by varying her responsibilities according to organizational need and by demonstrating her cost savings to the institution. When this kind of adaptability is shown to meet the current needs, I believe advanced nurses will continue to be in demand.

I hope that as you read the articles you will be inspired by the possibilities for advanced practice. Perhaps too, those of you who are in advanced practice will be consoled to know you are not the only one subjected to change.

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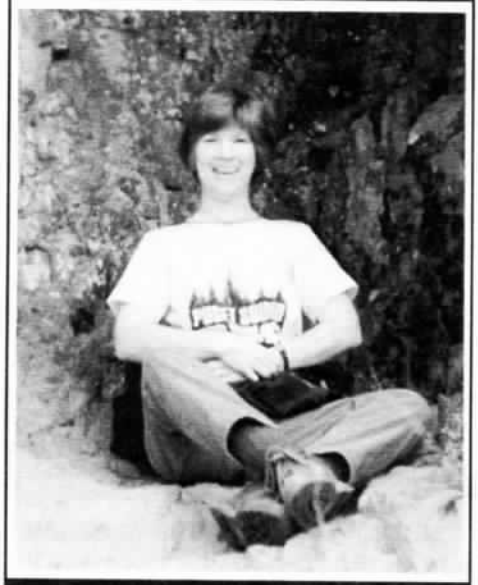
PSONS Profile



Bev Davis, RN, MSN, OCN

Louise Granger
St. Joseph's, Bellingham

One was apt to run into **Bev Davis** if you were at all involved in PSONS, or if you frequented the University of Washington Medical Center, where she had worked for 10 years. You will not see her at UWMC now, as she has just taken a position as Oncology Clinical Nurse Specialist and Transition Coordinator for Visiting Nurse Services of the Northwest. Try to run into Bev sometime, for she is an interesting and energizing person to meet. Meanwhile, let me tell you a bit about her.

In the late '70's "many years ago," Bev was working in an ambulatory care clinic which included all of the medical specialities, including medical oncology. The hospital developed an Oncology Clinician position and they asked her if she was interested. Bev was, but was not sure if Oncology was what she wanted to do full time. She always loved oncology patients, so she tried it, liked it, and has done Oncology Nursing ever since.

This hospital was located at Indiana University in Indianapolis. The department included a **Dr. Lawrence Einhorn**, who developed the Einhorn regimen for testicular cancer treatment. He was a superb teacher in disease process and Bev gathered most of her initial information from this oncologist.

For the next seven years Bev did lots of symptom management, chemotherapy, and telephone assessment and triage. During the last three years she was also going to graduate school part-time or full-time for a major in Nursing Administration and minor in Medical/Surgical/Adult Nursing. She finished in 1983 and wanted to relocate...but only where there was **great** oncology nursing and **great seafood**. Seattle was the mecca for oncology and, of course, has wonderful seafood, so when someone sent her a newspaper from Seattle with an ad for a position at University of Washington as a Clinical Nurse Specialist, she responded.

What followed was a whirlwind of activity: a telephone interview, and a night flight which included a lightening storm and stopover in Chicago because lightning struck the control tower. She finally arrived in the early morning, rented a car, found the U.W., and interviewed. She accepted the position "without knowing it rained here" and without knowing a single person who lived in Seattle. Back home she packed up her 14 year old son, Craig, all their belongings, and the cat, put the house on the market and drove out in three days so Craig could start high school in time. September was beautiful, and then they found out about *THE RAIN*.

Bev learned how to ski for the first time. She hiked to her heart's content in the mountains. She found Skagit Valley where she hopes to retire someday. And she met and married **Norm Davis** three years ago.

What Bev likes about oncology is the balance of technical skills with psychosocial skills. She loves both; not each alone, but together. Interacting with the people, and learning how they cope with having cancer is also a benefit of the work. "We learn as much (or more) from patients, as they learn from us, especially about what is important about life. The opportunity to work with people who have cancer is a privilege and an honor. They will take you into their lives and tell you what they've learned.

Bev is recently outgoing president of PSONS. Someone called her soon after starting at the UW and asked her if she would serve on the Symposium Planning Committee. That's how she began Seattle acquaintances. She feels that the PSONS Chapter was tremendously helpful in getting her started here. She also has served on this same planning committee a total of 5 times.

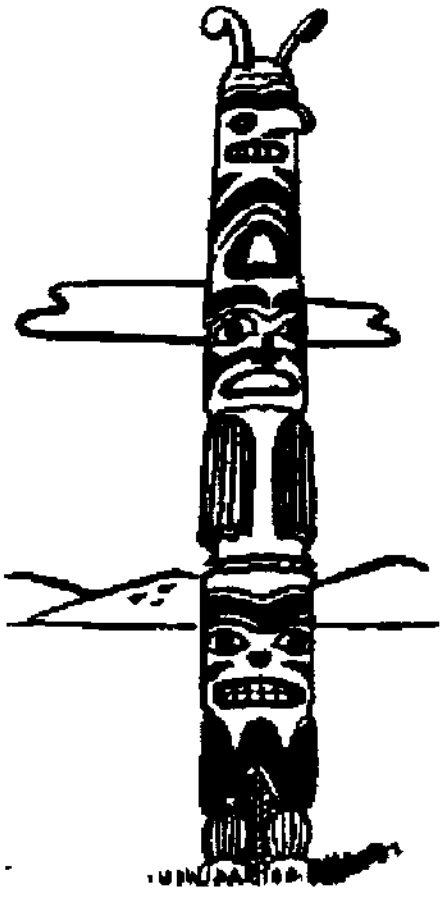
Presently, she is looking forward enormously to learning home care and getting involved in that community. She wants to continue to be actively involved in Chapter activities and is now on the Nominating Committee. She thinks that home care is going to be tremendously important in the future of health care.

Personal goals include finding the time to constantly learn and do "a zillion interests" including canoeing on Lake Union, learning a new language, tending flower beds, and taking tap and jazz dance lessons to name a few. "Do what the patients teach us: Enjoy life now, don't put it off."

Business Beat

Judy Kornell, RN, MN, OCN
Fred Hutchinson Cancer Research Center
Washington State Cancer Pain Initiative

Fall Institute '93 — Ann McElroy The local Arrangements Planning Committee wants to welcome you to the Fourth Annual Fall Institute which will be held October 29-31, 1993. There are 32 concurrent sessions on pertinent and timely subjects offered in the ONS program. The Planning Committee is responsible for providing the 72 room monitors for the sessions. so we are asking members to volunteer to monitor at least one session. This means that you will be the resource persons to the coordinator of the session and help with door traffic which will be important in the fifteen minutes prior to and the first fifteen minutes o the session. In order to be a room monitor, you need to be attending the Fall Institute. Please call **Debbie Morris** of St. Joseph's at 206-584-2957 in Tacoma or **Mary Weber** at 206-235-1497 of Valley General Medical Center and let one of them know which sessions you would be interested in monitoring. You would only be asked to do on session, but we need some options to do the assignments. The remaining members of the Local Arrangement Planning Committee are: **Cherie Tofthagen** of Amgen, Inc., Mona Stage of Highline Community Hospital, **Rosemary James** of UW Medical Center and **Ann McElroy** of Virginia Mason Medical Center. See you in October!!



Education Committee — Carla Jolley The Fall education schedule is filling up, and will be kicked off on **September 8** with a dinner meeting on Advanced Pain Assessment sponsored by Janssen Pharmaceutical — watch your mail for the flyer. **October 13** will be at Evergreen Hospital and will consist of a panel on Sexual and Reproductive Issues. **November 10** we'll be meeting at the U.W. and discussing oncology Nursing and Ethical Issues of Assisted Suicide. Mark your calendars for these interesting meetings!!

As we get closer to the OCN certification test...Tacoma General & Good Samaritan are conducting a Review Series September 16 at the Good Samaritan and September 23 & 30 at Tacoma General. All sessions are at 5:30-8:30 p.m. Cost is $50 for all three or $20 per session. Watch your mail for the brochure — PSONS members are eligible for two scholarships.

Symposium Committee — Mary Underbrink The planning for the '94 symposium continues with lots of exciting ideas — and great food! The meetings are very productive and interesting — and something for the membership to keep their ears open for and to help with.

If anyone knows any salesperson who would like to exhibit on March 25 & 26, 1994 for our yearly symposium, please call **Meredith Tuller** at 386-2064.

Newsletter Committee — Renee Yanke **Mona Stage** of Highline Community Hospital will be the new advertising editor for the PSONS Quarterly. If you know of people who want to advertise job positions, educational offerings, products, etc. have them call Mona at 439-5577. We try to keep advertising to a minimum so we don't detract from the newsletter content, but it does help offset the cost of the publishing. If you need information about the rates, call Mona. The usual ad runs about $25-45 for a business card size ad and one twice as big, respectively. This year, we also decided to make subscriptions available to non-members (exhibitors, hospitals, offices, etc.) who are interested in keeping up with what is happening with PSONS. Five issues a year will be available for $50 — so please keep that in mind when talking these people.

Governmental Affairs Update — Pat Jordan The next issue of the PSONS Newsletter will be guest edited by the Governmental Relations Committee. We invite you to examine your professional life and see what concrete ways it has already been changed by health care reform. Send your insights to **Pat Jordan** by September 7, 1993 at 8621 5th N.E., Seattle, WA 98115. We not only would like to include this information in the newsletter, but it is helpful information when you are talking to your legislators.

Research — Donna Berry Congratulations to PSONS member, **Ann Caudell**, recipient of the first PSONS Research Grant! Ms. Caudell is currently working on the effect of acute stress on neuroendocrine and immune function in women. The grant money provided by PSONS will partially fund analyses of certain immune cells. **October 1** is the next application deadline for the Research Grants Program. Support is available to any member interested in developing a research study. The Research Committee will meet **October 4** at 5:30 p.m. at the University of Washington T612. All interested members are welcome. Please call **Donna Berry** at 782-3433.

Info from National ONS: Nominations letters for the ONS Public Service Award and nomination packets for the ONS Distinguished Service Award are due in the National Office by **August 15.** Public Service awards are to be directed to the ONS Board of Directors. Distinguished Service Award nominations are to be directed to the ONS Membership Committee.

Public Service Award: The nominee must be a publicly prominent individual who has created, delivered, or promoted an oncology service that influenced public perceptions, attitudes, and awareness.

Distinguished Service Award: The nominee must be a current member of ONS and demonstrate outstanding contributions to ONS. Additionally, the Review Committee will consider to what degree the nominee assists ONS in fulfilling its mission.

Nominations for the ONS Excellence Awards are due August 15 (except for the Distinguished Researcher Award — due October 15). Nomination packets are available from the National Office for the following:

Schering Clinical Lectureship
Quality of Life Fall Institute Lectureship
Linda Arenth Excellence in Cancer Nursing Administration
Excellence in Cancer Nursing Education
Excellence in Patient/Public Education
Excellence in Biotherapy Nursing
Excellence in Office Nursing
Excellence in Breast Cancer Education
Excellence of Scholarship and consistency of Contribution to the Oncology Nursing Literature
Excellence in Radiation Therapy Nursing

Please take the time to nominate your colleagues. Nominations can come from a chapter, a committee, or as an individual ONS member.

EDUCATIONAL OPPORTUNITY:

Members of PSONS are involved with ACS and SNOW (School Nurse Organization of WA) in the planning of the 1993 Fall Conference, on October 8-9 in Yakima. They are devoting their entire two days to issues of Cancer and the School Age Child!! **Kathi White** (Group Health) from PSONS and ACS has been helping with this seminar — Non-members of SNOW are also welcome to attend, if you're interested...

Call **Roberta Bigalk** (ACS)
or
Donna Lovins in Yakima
h: (509) 248-6778, w: (509)678-4173.

Welcome to PSONS!

Robin Fiedler	Centralia	Assured Home Health
Forrest McGriff	Seattle	
Olga Logan	Bellevue	Evergreen Hospital
Nancy Runzer	Richmond, BC	British Columbia Cancer Agency
Teri Lyman	Port Orchard	
Lorene Wiggins	Seattle	Group Health Coop

Puget Sound Chapter of the Oncology Nursing Society

PSONS NEWSLETTER
Published five times a year by the Puget Sound Chapter of the Oncology Nursing Society with the support of the American Cancer Society.
Editor: Renee Yanke

Letters, articles and announcements are requested from all PSONS members and other readers on topics of interest. Neither Puget Sound Chapter of the Oncology Nursing Society, the Oncology Nursing Society, the editorial board of the Quarterly, nor the American Cancer Society assume responsibility for the opinions expressed by authors. Acceptance of advertising does not indicate or imply endorsement by either of the above-stated parties.

Submit materials for publication to Renee Yanke, PSONS Editor, Lake City Professional Center, 2611 N.E. 125th St., Suite 305, Seattle, Washington, 98125-4357. (206) 386-2013

Call PSONS @ (206) 361-4736
between 9 a.m. and 5 p.m.

Transition:

Continued from Page 5

indicators for quality assurance and the daily work with patients and families.

The final task in the midst of the transition has been tracking the work that is being done, to ensure that the role is a viable and cost effective part of the organization. As health care changes and there is a shift from the specialist to the generalist the CNS's need to demonstrate the importance for the generalist to have resources and mentors in specific situations. Tracking tools such as monthly reports containing the number of conferences, inservices, key projects, and meetings can provide a baseline of information for the importance of the CNS position. another means of cost effectiveness is to use your leadership and knowledge base to influence, purchases/use appropriate product lines, pro-active interventions to decrease frequency/duration of visits, and help contribute to the quality care indicators as they are developed.

The role of a CNS and other advanced practice positions continue to change. Successful change requires diligence in and attention to the CNS's customers (staff, managers and patient/families), inter-organizational changes, the changing climate of health care, and CNS's individual strengths/gifts and areas of growth. If requires documentation and supportive data to the effectiveness of the role. The work (and it is work) of self awareness in order to transition through and into a new role and position is a challenge. However, this review and awareness of the processes individuals go through in the midst of change can encourage us to be the more effective clinicians. Health care and nursing are changing the current climate of reform. The clearer the understanding the nurses have of their roles and CNS role, the easier it will be to work toward the goal of quality care.

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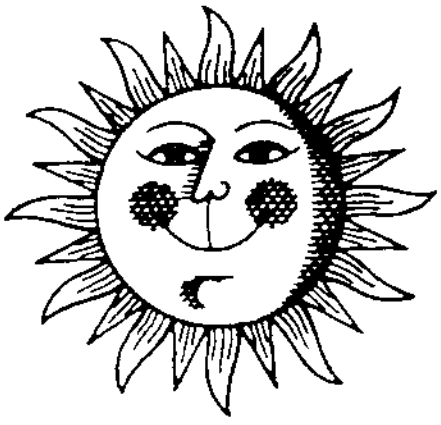


HAPPY SUMMER SUNNING!!

Petition to President William Jefferson Clinton
to implement a Comprehensive National Strategy to End the Breast Cancer Epidemic

182,000 women in this country will be diagnosed with breast cancer this year and 46,000 women -- one every 12 minutes -- will die as a result of this disease. Without a comprehensive strategic plan to end this epidemic, the loss of human and financial resources to the nation, already of staggering proportions, will only escalate. Through this petition, the women of this country, and those who care about them, ask that President Clinton bring together leaders from his administration, the Congress, the scientific community, private industry and women with breast cancer and other breast cancer advocates, to put in place a comprehensive plan to end the breast cancer epidemic.

Name & Signature	Street City and State		Why You Care
Print Your Name:	Street:		I am a: □ Survivor □ Spouse or Partner □ Daughter, Son □ Parent, Sister or Brother □ Other Family Member □ Friend, Co-Worker of someone who has been affected by this disease, or □ Healthcare Provider □ a person concerned about this epidemic.
Sign Your Name:	City and State:	Zip Code:	
Add your personal message here:			

Name & Signature	Street City and State		Why You Care
Print Your Name:	Street:		I am a: □ Survivor □ Spouse or Partner □ Daughter, Son □ Parent, Sister or Brother □ Other Family Member □ Friend, Co-Worker of someone who has been affected by this disease, or □ Healthcare Provider □ a person concerned about this epidemic.
Sign Your Name:	City and State:	Zip Code:	
Add your personal message here:			

Name & Signature	Street City and State		Why You Care
Print Your Name:	Street:		I am a: □ Survivor □ Spouse or Partner □ Daughter, Son □ Parent, Sister or Brother □ Other Family Member □ Friend, Co-Worker of someone who has been affected by this disease, or □ Healthcare Provider □ a person concerned about this epidemic.
Sign Your Name:	City and State:	Zip Code:	
Add your personal message here:			

This campaign has been sponsored in part by a grant from Revlon

Return by October 1, 1993 to Oncology Nursing Society, c/o Cynthia McCormick, 501 Holiday Dr., Pittsburgh, PA 15220-2749

Sample letter to reference when writing President Clinton, regarding breast cancer issues.

President Clinton
c/o The National Breast Cancer Coalitions
P.O. Box 66373
Washington, DC 20034

Dear President Clinton,

The breast cancer epidemic must become a national priority. There are an estimated 2.6 million women in this country today with breast cancer, one million of whom have yet to be diagnosed with the disease. In 1993 alone, 182,000 women will be diagnosed with and 46,000 women will die of breast cancer; during the decade of the 1980's, breast cancer killed more than 450,000 women. The epidemic proportions of this disease wreak havoc not only on the women and their families and friends, but also on the nation. The cost to this country in lost productivity and economic resources due to breast cancer is staggering.

The incidence of breast cancer has been rising since the 1940's, and no one knows why. There is no known cause of or cure for breast cancer. We do not know what to tell our daughters and granddaughters to do to prevent this disease. While a diagnosis of breast cancer carries with it the constant fear that a woman's daughter and granddaughter will hear the same words some day, 80 percent of women who are diagnosed fall into no known high risk category.

Last year, Congress appropriated an increase for breast cancer. Funding alone is not enough. We must make a commitment to end the epidemic. We need a nationally focused comprehensive strategy to combat breast cancer.

I urge you to commit to such a strategy, to bring together selected leaders from the Executive branch, the Congress, the scientific community, private industry and women with breast cancer and other breast cancer advocates to design and implement a comprehensive plan to end the breast cancer epidemic.

Sincerely,

_____ (signature)

_____ (print name)

_____ (address)

_____

The Last Word

Sue Ford, RN, MN
Tacoma Community College (at last word)

Now that all the nostalgia-type movies are either out in the theater or on video, we thought you all would be interested in a tidbit from "down memory lane" - did you know that **Sherry Hayes** was one of the earliest feminists in our group? Her short and illustrious career in the Girl Scouts was cut short by some not so good girt-type behavior.

Travel Update — If you ever get stuck in an unknown airport, better hope it's with **Fran Lewis. Pat Jordan** found being stuck in Washington D.C., due to bad weather, much more tolerable when Franny was prepared for an unexpected overnight stay. Patty, without an overnight bag found dental floss on her doorknob, courtesy of 'Mom' Fran. Speaking of travel, we forgot to mention a couple more globe hoppers. **Denise Coy** spent some time in Europe, before she started the new staffing pattern education marathons at Valley Medical. And **Margaret Brown** did some back country sight-seeing in the Philippines last December.

Dr. Donna Berry is taking a well deserved break this summer after writing and winning all those grants from ONS. But, after the summer with four kids, is that really time off??

Doing the Kangaroo Job Hop:

A new member to the government dole — **Ann Marie Maguire** is at the Seattle V.A. Medical Center.

After 'a number' of years as an in-patient nurse, **Bev Davis** is now the CNS at Visiting Nurse Service (Thomas Guides are only $20 at Costco)

The sun light has become too intense for **Penny Bivins**, she now works in the XRT basement at Virginia Mason Clinic.

Wedding bells are once again in the air, this time heard back in Chicago. **Lynn Ann Bauman** has become engaged, and plans to marry in November of this year. Congrats!!

Lastly, the FAA reports stork feathers are messing up things once again in the skies above the Puget Sound area:

Down in Tacoma you can see **Kathy Rusk** bringing in little **Zack** to check up on things at the I CAN office over at Tacoma General. And we should be seeing a stork landing any day over at St. Joe's when **Keenan Ketzner** makes his debut with mom, **Pam.** A little farther north (in Seattle that is) **Mary Ellen Shands** is awaiting the arrival of a little person too!

CNS/Nurse Practitioner:

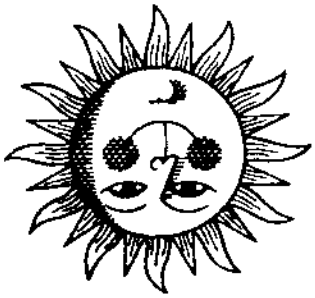
Continued from Page 4

represents a serious commitment on the part of this physician and nurse to share jointly in a true collaborative practice. It is our hope that the future holds many such partnerships for enhanced patient care.

Evolution:

Continued from Page 3

diagnoses or patient populations. As a group, the Clinical Nurse Specialists are increasing their visibility in the organization. We are all challenged from now on to do more with less. I believe the value of clinical nurse specialists to organizations comes from our commitment to quality patient care and our ability to demonstrate improved patient outcomes on an individual and population basis as well as our fiscal effectiveness.



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