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Oncology Nursing Society · Vol. 24, No. 1 · Spring 2001

THE HEART IN POLITICS

Gloria Winters, RN, MN

What's government got to do with it? This issue was born in the throes of the election of 2000. While we began planning for it, we had yet to know who would be the next president, or who would be chosen. The fate of the Washington State race for the US Senate was to be determined by mailed-in ballots, and that race was likely to affect the balance of the US Senate.

But those of us in the Government Relations Committee knew that "politics" was just a portion of what was affecting our everyday lives. Indeed the everyday decisions, regulations, policies, and research priorities were all a part of what we could expect to change. And while the election results might alter those choices, it was the daily choices that we made to participate or not that also effected change.

The elections of 2000 are now behind us, and the everyday work of politics and change remains. Decisions made now will affect generations to come. When Dr. McGee spoke to the PSONS membership last fall, we were reminded that the philosophy and practice of medicine in the 1950's is what continues to be reflected in Medicare today, without a commitment to advances in research and practice. I was struck by the image that what was good for President Eisenhower then should still be good for my next-door neighbor, as long as it was cheap. Until then I had not recognized the historical parallels between welfare and Medicare, and how both reflected the social values of their eras.

And so politics does come back to values.

Where we spend our time in life is just one reflection of those values. When I graduated from nursing school, I wanted to work in the best cancer center I could possibly find. I wanted to be a part of providing the best possible care imaginable to those enduring this disease. I struggled with the ethics of making someone sick to make them better. Nonmaleficence vs. beneficence. I fought in my institutions for high standards of care. I valued an aggressive race to cure cancer. I saw my patients as partners in that race.

I knew my perspective was changing when the most powerful reason for leaving nursing in a research setting was that I could no longer justify the public and private costs that were being incurred. It meant that even as I kept a cancer focus when I went back to nursing school, I couldn't help noticing that there were other areas of disease and poor health that preyed on our social structure, that tore at the fabric of our communities. I was still an oncology nurse, but I had begun to wonder where oncology fit into the big picture. My values became centered on the larger community. My partners were now a diverse group of community and health organizations, and colleagues in the teaching community.

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President's Message

Asking the Questions

Margot Hill

Margot Hill BSN, RN, OCN

I began my year as president with the duties of selling ONS foundation raffle tickets and writing this column. Now I am asking myself, why have I chosen this responsibility? Where will I find the time required? Why did I choose nursing as a career? And why oncology? We have all probably asked ourselves these questions at one time or other. We all have our reasons for involvement. I witnessed the extent and enthusiasm of this involvement as I sold raffle tickets at Symposium. Everyone I approached cheerfully bought tickets right then or took a book or more to sell later. This is a warm, caring organization and what an honor it is to be president. I am in awe of, inspired by, and thankful for this year's board members who all have multiple personal and professional commitments yet volunteer their time and energy to this wonderful organization, Puget Sound Oncology Nursing Society.

As I explore these why questions, I am aware there are other ways we could be spending our time. The reasons I choose to be active and involved in PSONS are not altruistic such as the "betterment of man/womenkind". It is more personal. My nursing career has always giving meaning and perspective to the rest of my life. It shaped my three children's lives. I was constantly reminding them that life was fragile, "you never know when one could become ill or worse" and we needed to be there for each other as a family and in community. Six years ago I was diagnosed and treated with stage one breast cancer. It was not life threatening, however, I have not wanted to forget the lesson I learned: to value my time and to choose carefully my activities. In summary nursing and cancer give meaning to my life, making me ask those existential questions.

As always, Symposium validates and energizes my commitment to oncology nursing and this year more than others because the future of nursing seems to be in question. There is a nursing shortage which will last longer than in the past because the baby boomers are retiring early. You are probably aware of this through articles in the media, nursing journals and conference topics. Linda Hohengarten, co-chair of the symposium with Jormain Cady, led a "Table Talk Questions" discussion at Friday's lunch. Briefly summarized are some of the questions:

✔ Give three reasons why each per-

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Guest Editorial

Cherie Tofthagen, RN, MEd., BSN, OCN
PSONS Government Relations Co-Chair
ONS State Health Care Policy Liaison

Many who know me, know one of my passions is politics. I get "fired up" debating the issues and take seriously the issues that impact my profession. I have enjoyed this past year as the co-chair of the government relations committee. In this role, Ian Anderson and I have attempted to bring to you, the viewer, a resource for information. Ian has spent endless hours on our web page. This page provides information, addresses and phone numbers for our elected officials. Ian has also provided links to other pertinent sites that might be of assistance to the membership. With the help of Gloria Winters, Ian has worked on an email alert system, enabling crucial legislative and policy information that requires immediate attention to get to our membership in a timely fashion. As a team, the Legislative Committee sponsored an educational dinner program. The membership was privileged and honored to have Dr. Rick McGee, Immediate Past President of the Washington State Medical Oncology Society, speak to us in regard to the issues affecting reimbursement in oncology and how it directly impacts oncology nurses and patients. His perspective as a physician practicing in a community setting was timely and informative. Ian and I look forward to providing another dinner program in the fall. As well, we will continue to strive to provide the membership with timely information on what is happening in Washington State as well as Washington D.C. We will continue to take what I call, the FOX NEWS approach, fair and balanced, YOU decide.

I would also like to take this opportunity to introduce myself as the ONS State Health Care Policy Liaison. As I learn more about this new role, I will communicate with the membership on what you might expect from me in this position. I understand not everyone is as politically charged as I am. One saying I always remind myself of is this, "If you always do, what you've always done, you'll always get, what you've always gotten." If you want to make a change, if you don't like what policies are being implemented, or what laws are being enacted, take a stand and let your voice be heard. If lawmakers do not know what is important to health care providers, how can we expect them to make choices that are meaningful? Has a politician ever knocked on YOUR door to ask your opinion? If you have any ideas, give me a shout . . . ctofthag@amgen.com.

Heart of Politics: Finding the Place to Get Involved

Continued from page 1

I'm living yet a different life now, and change continues. You see, I'm no longer a nurse, first and foremost. I don't write that on my tax return anymore. I've even let some of my nursing memberships lapse. I'm a mom, with a school age child and a toddler. I experience health care more often as client than as provider. I spend a lot of time focusing on how to promote individual, family, and community health.

For example, several years ago I joined a community sponsored agriculture farm. Issues of health and community that had motivated my nursing practice were colored in a new way. I began to pay attention to the way food was used in our culture to promote homogeneity instead of diversity, to crowd out attention to basic needs rather than meeting them. I started to care about the soil around me. I started to care about where my potatoes came from, and how they had been treated on the way to my plate.

Suddenly, wars about growth management acts, farms vs. soccer fields, urban agriculture, genetically modified foods, park lands and waterways became an integral part of who I was. This, from someone who three years earlier had only smiled at the pea patches as I walked by. Food had become a story of the cycles of life. And just as I had previously held my patients' stories as a priceless lesson and treasure, now I spent moments to honor the earth as it was tilled under for the winter. "My" farmer was a key to my health, and a lesson in allowing the earth to yield what I needed, not what I wanted.

I've been associated with political issues for some time now, and my nursing career was checkered with experiences in political action from the first days in nursing school. In each phase of my career, different political issues were crucial. I've never thought of myself as an activist. I'm more comfortable reflecting than acting. I was okay joining a group of marchers, but my admiration for non-violent protesters was more often from my chair. I liked being in a position to encourage others, much as we seek to do in this issue of the Quarterly. Somehow, other things always seemed more important than my sending a letter.

And then about a month ago I received an email from one of my brothers. He stated that the settlement school where we had first lived in Kentucky had a proposal before the state to prohibit strip mining in the valley. I knew that I would not rest until I had responded to this issue. I finally got the letter written. It took me several weeks, and public commentary had closed the week I finished it. But I sent it. (Email, of course, requiring an envelope might have been just too much!) And I got a reply stating that it had been entered into the record.

And then I wondered, why is it that this issue finally got me off my personal place of political inertia?

You see, politics is about speaking from the heart – and one must know one's heart to speak it. I still am restless in my relationship to oncology. So much in our society calls out. And I think that in all my days in oncology, the moments of individual differences were the ones that made it all worthwhile. I wasn't trying to win the war on cancer nearly as much as I was wanting to make life good for those I met. And so I find my political heart is driven by a desire to maintain, restore, and recreate a harmonious community. One that I can wonder in. One that breathes health into its people.

I urge you to consider what is your political heart. Listen to the authors here. Consider the primary elements of your life, and those of your patients. Reflect on the ways cancer is created, impacted, and vanquished, and what the stories are that accompany it. Seek out change in ways that are meaningful to you. You might be surprised that nursing takes place in so many different facets of life. You might be surprised by the letter you write.

CORRECTION

Two errors occurred in the last issue of the Quarterly. In the article by Maggie Hoyle, not only was the name of the drug misspelled in the title of the continuation of the article on page 3, but this header also misrepresented the material presented. The header, "Itraconasole: Effectiveness against aspergillus found to be more effective than fluconazole" suggests that there is an outcome or efficacy data from a study that is still ongoing. As described in the article, the purpose of the study is to determine whether or not itraconazole is more effective. This may not be determined until, at the earliest, the 50% interim analysis is performed. More likely, we will not know until the study is completed. Thank you, Maggie for calling this to our attention. My sincere apologies both to you and to our readers for failing to catch these errors before it went to press.

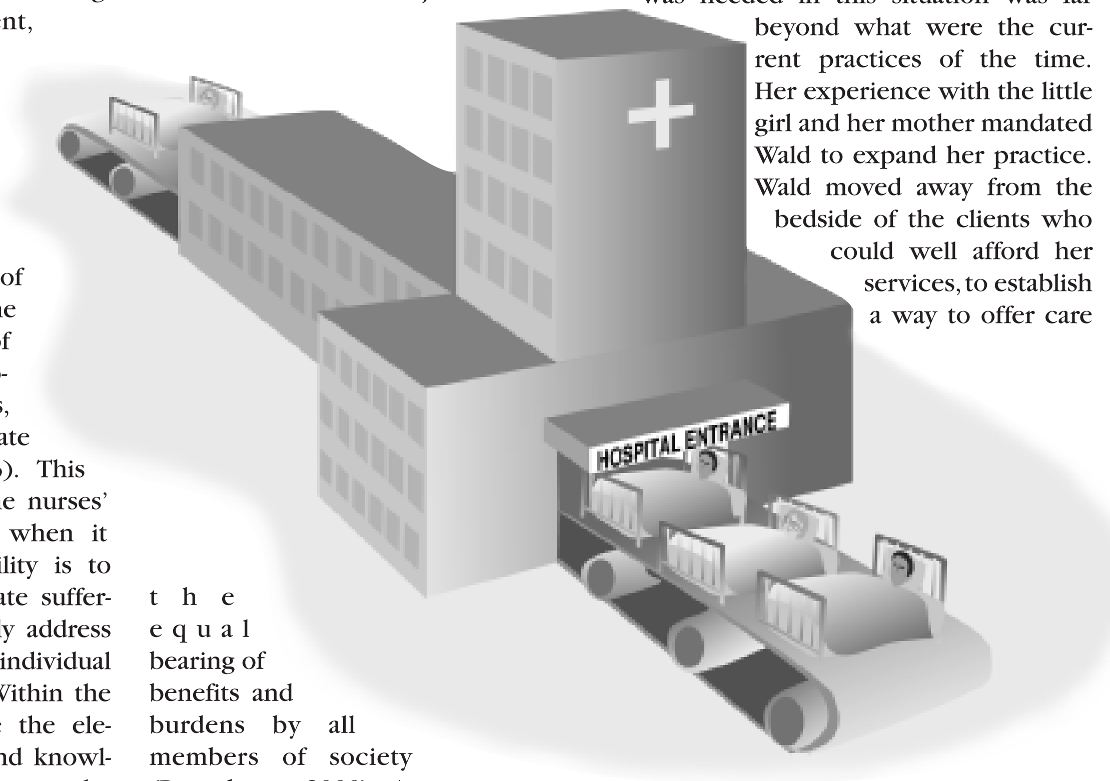
Politics and Policy Implications for Oncology Nurses

Kathleen Shannon Dorcy, MN, RN and Kathryn Grindeland Keegan, BSN, RN

The current practice of healthcare is influenced by multiple changes that have occurred in the past ten years. These changes include health care policy, economics, and advances in research. A significant change is the decreased length of hospitalization, which has shifted the delivery of care from an inpatient setting to an outpatient setting. Now even very complex care for oncology patients is administered in the clinic setting. In the changing healthcare environment, nurses have shouldered much of the responsibility for caring for the increasingly acute care patient, both in the actual giving of care and in educating oncology patients and their families.

The International Council of Nurses (ICN) declared that "the fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health, and to alleviate suffering" (Geneva, ICN, 1973). This declaration fully illustrates the nurses' scope of personal practice when it states the nurses' responsibility is to "restore health and to alleviate suffering." These two tenets clearly address the care nurses deliver to individual patients and their families. Within the scope of individual practice the elements of clinical expertise and knowledge as well as commitment to the patient nurse relationship are paramount. When examining the first two tenets, however, "the responsibility of the nurse…is to promote health and prevent illness," the foci of that responsibility rests on a larger world view moving away from the single patient/nurse relationship. In order to implement these tenets one must look to see how health and illness are defined within the societal view and then address what can be done to effectively "promote health and prevent illness." So it is that professional nursing encompasses care of the individual as well as the health of general populations.

Integral to the broader view of nursing held in the tenets of "promoting health and preventing illness" is the concept of distributive justice, which is the principle utilized for the evaluation of societal resources and allocation of such resources. Distributive justice refers to the equal bearing of benefits and burdens by all members of society (Beauchamp, 2000). Access to quality health care would be one of the benefits that one could expect to have in society. A burden in society could be the compensation for healthcare for those whose need for care exceeds personal resources. The rights and responsibilities of people within a society are often where conflict erupts. How can equitable healthcare be a possibility for people in the United States of America?



Historically in the profession of nursing we have great examples of people who possessed the courage and the vision to persevere in the search for equitable health care for all people. One such exemplar is Lillian Wald, a nurse in New York in the early 1900's.

Wald was a nursing leader of her time and tells the story of a little girl taking her home to see her mother who was living in a tenement house. "A sick woman lay on a wretched, unclean bed, soiled with the hemorrhage two days old…" (Wald, 1915). Wald bathed the woman and cleaned the bed, and the grateful woman "kissed her hands". This event led her to establish a home called the "Henry Street Settlement" which would offer health care to the very poorest of the city's population. She had learned well the technical and scientific skills of nursing, however, what was needed in this situation was far beyond what were the current practices of the time. Her experience with the little girl and her mother mandated Wald to expand her practice. Wald moved away from the bedside of the clients who could well afford her services, to establish a way to offer care to those forgotten and deemed undeserving by most of the care providers of the times.

In order to expand her practice Wald had to work with lawmakers, volunteers, city agencies, and benefactors.

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President's Message: Strive to Get More Involved

son **went** into oncology nursing. Have each person share why they are **staying** in oncology nursing.

✔ What incentives would guide you into a nursing career today? What partnerships could you envision to address the nursing shortage challenge?

✔ Identify some strategies that could be used to recruit into the nursing profession.

✔ Share some strategies to prevent burnout in nursing, especially bedside nursing.

✔ In what ways has the nursing shortage impacted you?

✔ What are the positive attributes of oncology nursing that should be promoted to encourage it as a chosen profession?

✔ What do you wish you had learned in Nursing School to have better prepared you for your oncology setting/career?

We could all give more thought to these questions. The responses from the luncheon will be collated and reported in future PSONS publications and sessions. Thank you Linda for initiating this discussion.

The PSONS mission statement is the framework to explore these questions and work toward some answers. "The Puget Sound Chapter of the Oncology Nursing Society (PSONS) is committed to the advancement of oncology nursing practice through education, communication and research." All our chapter activities work towards these goals. I invite you to meet the new board members:

- The education committee, headed by Pam Ketzner, offers monthly educational programs with CEU's,
- The Oncology Nursing Education Cooperative, led by Vicki Whipple, sponsors two 4-day courses on Fundamentals in Oncology.
- Symposium Committee is chaired by Linda Hohengarten for 2002.
- Pat Buchsel will head Nominations, which will be expanded to address other leadership and scholarship positions besides the board.
- Terri Cunningham is newly elected to chair the research committee which supports and sponsors research participation and projects.
- Toni Floyd is our new treasurer who plans to upgrade our software, initiate computer based record keeping and begin online banking and statement retrieval.
- Janet Bagley, our present secretary, is continuing despite working as a manager and going to graduate school.
- Karen Brandstrom continues as a committee of one to maintain our membership.
- Cherie Tofthagen and Ian Andersen are co-chairs of government relations. Look on the PSONS web for their activities and discussions.
- Gloria Winters, communications chair, holds the organization together and makes us visible to the community with the PSONS web page and the Quarterly.
- Cathy Goetsch is the president-elect. She will bring her experience, expertise and enthusiasm to the organization.
- Martha Purrier is our out-going president. Under her leadership we had a very successful year. She will continue to chair the Presentation Skills Workshop Task Force, with its first time offering in May.

I am eternally grateful for all of you who have said yes to becoming and continuing as board members. You will succeed with the help of other board members, your committee members and the general membership. More members are needed. Each of us needs to look at our own interests and goals when considering where and how active we want to become.

This year during my presidency I will support each committee as it works to meet its goals. In addition, I will encourage the following activities.

✔ Continue to explore the Table Talk Questions in sessions and publications.

✔ Strengthen and expand partnerships with other cancer and nursing organizations through joint sponsorships and liaisons.

✔ Facilitate and encourage member participation in the political process. Those who participate in the Skills Presentation Workshops will be well prepared.

✔ Develop a strong mentorship program beginning with our sponsorship of SPU student nurses.

✔ Inspire, motivate, and encourage member interest and participation on committees by having occasional brief business meetings at education programs.

Right now all aspects of medical care are in the forefront of news. This week the Seattle Times featured a series of articles on Fred Hutchinson Cancer Research Center. No organization or profession is protected from criticism. The community is now aware, more than ever, of the importance of nurses. For example, a Chicago Tribune article in September 2000 had a headline: "Study: Nursing cutbacks kill patients" with a caption "Officials with the American Hospital Association, the trade group for 5,000 hospitals, acknowledge that patients are being at risk due to inadequate staffing and insufficient training." That gets people's attention. Our image as nurses does count. Our voices as nurses need to be heard. We as nurses need to respond to the present day crisis in health care with our stories, and backed with our research. Together we can have an impact. It just takes a few minutes to e-mail, call or write our government officials on pertinent health care legislation, identifying ourselves as nurses. How we respond individually as we come into contact with many people during our day also counts. What we communicate as nurses to our family, friends, patients and colleagues is important. Those around us are interested in our roles and our thoughts.

Hopefully, exploring these questions will continue individually and with our colleagues. If you have questions, comments, suggestions or ideas or would like to be more active in PSONS please contact a board member or myself. I am available and would welcome your response by email: marghill@home.com or by phone: 206-364-5355.

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The Washington State Department of Health: Data Systems and Cancer

Juliet VanEenwyk, PhD
State Epidemiologist for Non-Infectious Conditions

The Institute of Medicine's The Future of Public Health Report (1) outlined three core functions of public health: health assessment, policy development and assurance. Assessment involves the collection and analysis of health and health-related data for the purposes of program planning and formulating policy to reduce the burden of disease. The Washington State Department of Health (the Department) maintains four major data systems that can be used to determine how many people in Washington get cancer, how many die from cancer, how many are hospitalized for cancer treatment and what proportion of people have lifestyles and other behavior that are compatible with prevention and early detection of cancer. The systems are

- The Washington State Cancer Registry (WSCR)
- Washington State Vital Statistics Mortality Data
- The Comprehensive Hospital Abstract Reporting System (CHARS)
- The Behavioral Risk Factor Surveillance System (BRFSS)

These data systems have been used by the Department to assess morbidity and mortality from specific types of cancer in order to inform program development; to respond to citizen cancer concerns related to environmental and other factors; to determine the potential effect of cancer-related legislation; to identify populations at risk for cancer due to lifestyle or at risk for late stage cancer due to lack of screening; and to identify disparities in cancer incidence, mortality and treatment by race, age and socioeconomic status. Data from each of these systems are available to those outside the Department for public health surveillance and for research, with appropriate institutional review to protect confidentiality.

Data Systems

The Washington State Cancer Registry

In 1990, the Washington State Legislature made cancer a reportable condition in Washington and mandated the Department to compile these reports. Thus, in 1991, the Department established the Washington State Cancer

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Registry (WSCR). The registry is dedicated to fulfillment of the legislative intent "...to establish a system to accurately monitor the incidence of cancer in the state of Washington for the purposes of understanding, controlling, and reducing the occurrence of cancer in this state." (2) Since 1994, funding for WSCR has been provided, in large part, through the Centers for Disease Control and Prevention's (CDC) National Program of Central Cancer Registries.

Cancer cases are collected through a combination of contracts with two regional cancer registries and cases from independent reporting facilities (such as hospitals and clinics) with in-house cancer registry programs. The contractors and reporting facilities are responsible for case-finding, abstracting information on cancer from medical sources, and reporting cases to the statewide registry. Cancer cases are identified through reports from hospitals, pathology laboratories, radiation oncology centers, ambulatory surgical centers, cancer treatment centers, and physicians.

The Cancer Surveillance System of the Fred Hutchinson Cancer Research Center provides data on cancer cases from 13 counties in northwestern Washington, covering about two-thirds of the state's population. This system has been in operation since 1974 as a participant in the Surveillance Epidemiology and End-Results (SEER) Program of the National Cancer Institute. The remainder of the state is covered by reporting facilities with in-house cancer registry programs and the Walla Walla-based Blue Mountain Oncology Program (BMOP). BMOP is a consortium of 14 hospital-based cancer registries and provides the state with data from hospitals in the Walla Walla, Tri-Cities and Spokane areas. In addition, under contract to the Department, BMOP provides staff to collect cases at facilities that do not have in-house cancer registries. WSCR conducts regular data exchanges with state cancer registries in Oregon and Idaho to gather data on Washington residents traveling across state lines for cancer diagnosis and treatment.

WCSR compiles the dataset in compliance with national standards. WSCR contains identifying information, including name, sex and date of birth. It also includes information on race and residence at diagnosis, primary site, stage at diagnosis, planned first course of treatment, and hospital where treatment occurred.

Washington State Vital Statistics Mortality Files

The Washington State Death Certificate System gathers information about each death that occurs in Washington State. There are 63 items on the death certificate, including age, date of birth, place of birth, race, education, occupation, residence, place of death, disposition of the body, causes of death, whether the decedent was referred to a coroner or medical examiner, and whether the person had an autopsy. Information about Washington state residents who die out of state is collected from other states and added to the database.

The upper portion of the death certificate is completed by the funeral director and is based on information provided by an informant (usually a family member or close personal friend of the deceased). The lower portion pertains to the cause(s) of death and is completed by the certifying physician, medical examiner, or coroner. International rules are used to determine the underlying cause-of-death using data supplied by the certifier in the 'cause of death' and 'other significant conditions' sections of the death certificate.

The death certificate system was established to provide a legal document to verify the facts of the death of a particular individual and to carry out the disposition of a person's remains. Public health practitioners analyze causes of death to gain insight into ways to reduce morbidity and premature mortality.

The Comprehensive Hospital Abstract Reporting System

The Department collects and maintains data on inpatient hospitalization occurring in non-federal Washington state hospitals in the Comprehensive Hospital Abstract Reporting System (CHARS). The data in CHARS are taken from the billing form (Uniform Billing format) created after the patient is released. By law, hospitals are given 45 days after the end of each month to submit the records. The Department quality assures the submissions and compiles them into the CHARS database. Individual records are included in the year the patient was released from the hospital.

The CHARS system originally was designed to aid in cost containment and rate regulation in hospitals. Although inpatient hospitalizations reflect relatively severe illness and injury, these data are often useful in helping the Department answer questions pertaining to public health.

The CHARS data can be analyzed by hospital or zip code of where the patient lives. Counties with veterans and military hospitals and a large military population, such as Island County, will find their populations underrepresented in the CHARS data, as will counties where a large portion of the population is hospitalized in Oregon or Idaho.

The data include the patient's sex and age and zip code of residence at discharge; the reason the patient was hospitalized and comorbid conditions affecting the hospitalization; the major procedures the patient underwent during hospitalization; hospital; and length of stay, admission source, discharge status, and charges and payer information.

The Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System is a statewide telephone survey supported by the CDC. The Department contracts with a survey research firm that gathers information from a randomly selected sample of adults living in households with telephones. The research firm conducts interviews in English following survey administration protocols established by CDC. The questionnaire includes core questions used by all states and questions on topics of specific interest to Washington State.

Survey administration procedures (e.g., call-backs to difficult-to-reach households) are used to improve the representativeness of the sample, efforts are made to achieve response rates recommended by CDC, and computer-

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Curing and Caring, together.

www.washington.edu/medical/uwmc

The Seattle Cancer Care Alliance (SCCA) is a dynamic collaboration among three organizations known nationally and internationally for their patient care and research: Fred Hutchinson Cancer Research Center, University of Washington, and Childrens Hospital and Regional Medical Center. The SCCA offers nurses the opportunity to work in a state-of-the-art environment, provide the most advanced care and use up-to-date technology and equipment.

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Politics and Policy:
Moving Upstream to Respond to Healthy People 2010 Goals

Continued from page 4

The model for health promotion and prevention she exemplified was foundational for the Public Health movement in the United States (Swanson, 1993). Wald led the way in establishing new paradigms for practice in public health nursing. She used sharp assessment skills, she created a plan for intervention that engaged the people themselves with caregivers and possibilities for social change, and established objectives that would allow for an increase in the health status of the very poor community of the Henry Street Settlement in New York.

A look at the current field of oncology reveals that many of the changes in care are driven by research. Research on drugs, monoclonal antibodies, new investigational devices, radiation therapy, immuno-therapy, and a myriad of other areas. At the national level there is a federally established policy called, "Healthy People 2010" which has two primary goals:

Goal 1: Increase Quality and Years of Healthy Life. This goal is to help individuals of all ages increase their life expectancy and improve their quality of life.

Goal 2: Eliminate Health Disparities. This second goal of Healthy People 2010 is to eliminate health disparities among different segments of the population. (Healthy People 2010).

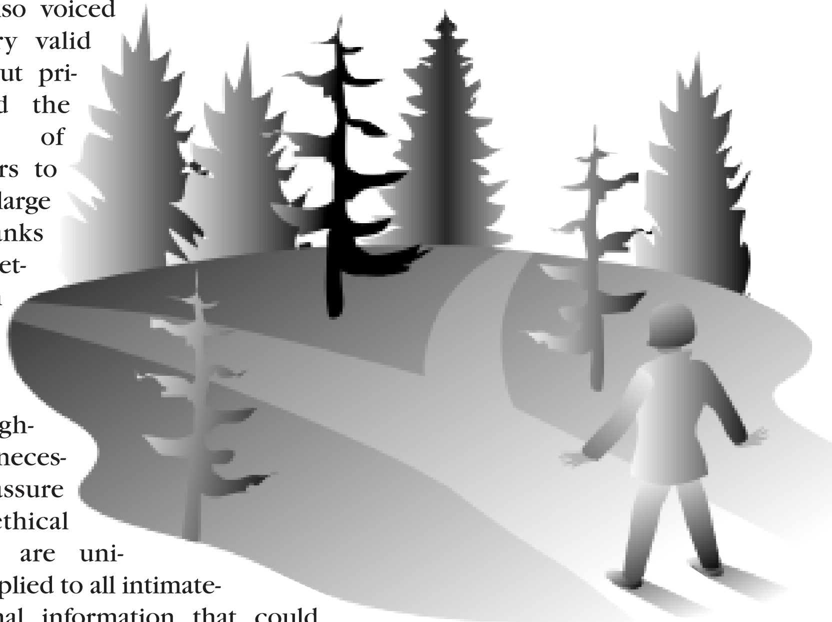
There are 28 focus areas within this document that specify focus area goals. One of those areas is cancer and one of the stated goals is "Reduce the number of new cancer cases as well as the illness, disability and death caused by cancer" (Goal 3, Cancer Goals, Healthy People 2010). Obviously this goal has a broad focus and speaks to the need to continue research and treatment to decrease the incidence, morbidity, and mortality associated with a diagnosis of cancer.

Nurses are on the front lines of caring for patients with cancer and travel the road of treatment and remission in some cases, and relapse and death in other cases, with the patients and families. We see first hand the price of human suffering caused by cancer and the wake of the devastation for those who lost a loved one to the disease. In these instances nurses reflect on what can be done beyond developing and maintaining clinical skills and human compassion which directly meet those tenets offered by the ICN, "nurses' responsibility is to restore health and to alleviate suffering." As vital as is this provision of immediate care to the individual patient, there still exists a need to take the broader societal view with the first two ICN tenets," a nurse's responsibility is to promote health and prevent illness." These two tenets are the starting point where nurses can begin to shape political policy and influence practice on a wide scale moving "upstream" in care of oncology patients.

Examples of how nurses can move "upstream" in their efforts to provide care is in maintaining an awareness of legislative issues relative to health care and research spending. Our national agenda for budget allocations is placed primarily into the hands of those officials we elect at the polls. Thus our vote is integral in the appropriations and allocations of state and federal funds. After the election we as citizens can stay in the position of dialogue with elected officials by utilizing the legislative hotlines and emails to communicate our values on issues that are currently before the House and Senate. Another way to optimize the exchange of information between our profession and our lawmakers is to follow the Public Hearings established by different committees to examine issues of importance.

In August of 1999 special legislative hearings were held to address concerns

of genetics in research in Washington State. A wide array of people, including individuals representing only themselves as well as those from agencies with interest in the subject, came to present their specific concerns. These concerns ranged from outrage that any one would research genetics to those who felt that genetics research is critical to reaching for a cure for those afflicted with cancer and other diseases. Also voiced were very valid fears about privacy and the rights of researchers to maintain large data banks with genetic data on many people. These fears highlight the necessity to assure that ethical practices are uniformly applied to all intimately personal information that could possibly lead to identifying members of our society. This potential for invasion of privacy could result in discrimination in the work place and/or on the part of health insurance providers. In this scenario oncology nurses are informed advocates for patients as well as for research. By definition the scope of care mandates protection of the rights of the individual while also looking forward to the possibility of improving the morbidity and mortality of disease processes.



Clearly oncology nurses must be not only clinically and technically competent but also must be aware and informed of the politics and policy related to issues of health care. We stand as translators of the complex care in which patients and families participate in order to reach for maximum quality of life. Therefore it is of paramount importance that we stand together as a profession in advocacy for our patients and for society as a whole. Standing together may not mean that we have immense support, in fact the road of advocacy may be a rather solitary journey at times:

"…Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference"
Robert Frost

So may we as oncology nurses possess the courage to travel those roads that will make the difference.

Reference List

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Welcome to New Members

Welcome to new and returning members:

Armi Evangelista
VA Medical Center
Laura Floodeen
Valley Internal Medicine
Adelle Lines
UW Medical Center
Trisha Marsolini
Overlake Hospital Medical Center
Jorga Martin
Providence Everett Medical Center
Kristin Mullen
Kathleen Shannon Dorcy
Fred Hutchinson Cancer Research Center
Michele Trygg
Evergreen Healthcare
Diane Whetstine
Ortho Biotech Oncology
Dora Woodward
St. Francis Hospital

Calendar of Events

April

5 Board meeting - 6-8 pm, VMMC

19 Educational meeting. Lillian Nail speaking on fatigue at Cancer Lifeline.

May

1 Quarterly deadline - Symposium issue

4-5 The Communication game: Workshops to improve presentation and writing skills. Special workshop for PSONS members sponsored by the Seattle Bone Marrow Transplant Consortium.

August

1 Quarterly deadline - Women's Health Issues. Guest editor: Cathy Goetsch.

November

1 Quarterly deadline - Patient education or mentorship. Guest editor: pending.

The Political Grapevine

Cherie Tofthagen, RN, MEd., BSN, OCN
PSONS Government Relations Co-Chair
ONS State Health Care Policy Liason-Washington State

If ever you have wondered, "Does my vote truly count?" 2000 was the year you could definitely answer with a resounding, "YES." Whether Republican, Democrat, Independent, Green or otherwise, as a country, we were fixated at the ongoing election and courtroom drama. With the election over and a new government at the helm, it is time to look forward to the issues that impact nurses and their patients directly. There are currently almost five hundred policies, bills, or proposals involving health care in Washington State alone (1). Outlined below is a sampling of current legislature, which may be of interest to health care providers.

Medicare Coverage of Oncology Services

The 106th congress made one final attempt to alter the manner in which oncology services are reimbursed for Medicare recipients. Fortunately, due to efforts from the oncology community, ACCC, ASCO, and ONS, these efforts were stopped. ASCO demonstrated to the Health Care Financing Administration (HCFA), that Medicare WAS NOT providing appropriate levels of reimbursement for chemotherapy administration and thus cuts in drug reimbursement would jeopardize seniors' access to outpatient chemotherapy services.

After thousands of letters from oncology providers and patients and bi-partisan pressure from Congress, HCFA sent a letter to Congress halting the proposed redefinition of average wholesale price (AWP) for certain oncology related drugs. In this letter, HCFA concluded that Medicare payments for services related to the provision of chemotherapy drugs and clotting factors to treat hemophilia are inadequate. HCFA stated that the agency will also take administrative action to "increase payments for cancer chemotherapy administration" as apart of the 2002 fee schedule. Congress took further action by passing the Benefits Improvement and Protection Act (H.R. 4577) on the final day of the session, instructing HCFA to halt the redefinition of AWP for all Part B covered drugs. H.R. 4577 authorizes the general accounting office (GAO) to

initiate a 9-month study examining drug pricing and practice expense payments (2).

One may wonder why is this important? First and foremost, all patients should be afforded the best treatment as prescribed by their physicians. Physicians should not feel compelled to limit treatment based on reimbursement. In the original reimbursement model, older chemotherapy agents were reimbursed generously while newer treatments were not. This action, propelled by the oncology community, reemphasizes the importance of a combined effort between physicians, nurses and patients. Who knows best why we do what we do in oncology? It certainly is not a group of politicians in Washington D.C., as outlined by the fact that ASCO is now working with HCFA and the GAO to collect and evaluate data on payments for chemotherapy administration. Our efforts did make a difference, our voices were heard. It is paramount that reimbursement for oncology services is maintained and preserved, not only for our patients, but also for our own survival in the workplace.

Patient Confidentiality

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) which required Congress to pass comprehensive medical records privacy legislation by August of 1999. In the absence of action, legislation gave the Department of Health and Human Services (DHHS) the authority to issue privacy regulations for electronic medical records transactions. Congress failed to act and DHHS issued draft regulations in November of 1999. After reviewing over 50,000 comments, DHHS released final rulings in December of 2000.

These regulations apply to health plans, health care clearinghouses, and health care providers who transmit health information electronically. The final regulations were then modified to include paper records as well as oral communications by any of the above listed groups. This includes any oral communication, regardless of whether the information transmitted is recorded in the patients' record.

Physicians have a number of new responsibilities under the new regulations. They must (1) develop and post privacy practices, (2) train employees, (3) provide patient access to records, (4) appoint a privacy official responsible for ensuring compliance with regulations, and (5) provide an accounting of the release of medical records by the office. A significant shortcoming of the regulations is that it does not preempt state law. The cur-

rent Washington State Privacy Act is best documented via the Health Privacy Project (Error! Bookmark not defined.. This Act is well over 15 pages and outlines the state's stance and requirements for confidentiality. The concern is that state and federal law may differ and place an undo burden on the health care provider who will be required to comply with both state and federal regulations.

HB 2798: Requiring That Prescriptions be Printed, Typed or Computer Generated

As continued press is given to medication errors, the State has declared a need to bring about greater safety for patients who depend on prescription drugs. The bill defines a "legible prescription" as a prescription or order issues by a practitioner that is capable of being read and understood by the pharmacist filling the prescription or nurse or other medical practitioner implementing the medication order (3). As nurses, we have all had the opportunity to decipher orders by an illegible source. This legislation, with good intention, offers no means of actions to be taken or outlined steps for a consistent pattern throughout the state to deal with such orders. As health care providers, we must continue to take it upon ourselves to clarify, clarify, and clarify written and verbal orders for our patients' safety and our own.

Needlestick Safety and Prevention Act (HR 5178/S. 3067, Washington SB 6416)

The Needlestick Safety and Prevention Act amends the existing Bloodborne Pathogen Standard administered by OSHA to require the use of safer devices to protect from sharps injuries. This legislature also requires that employers solicit the input of non-managerial employees responsible for direct patient care, who are potentially exposed to sharps injuries. The U.S. Government estimates that there are between 600,000 and 1 million needle stick injuries per year. HIV is the most common pathogen transmitted by needle sticks but Hepatitis B and C pose the most serious threat to health care providers (4). It is recognized that needless devices or safety mechanisms prevent needle sticks and the FDA has recognized over 250 such devices. Safe devices include needleless systems, shielded-needle devices, self-sheathing needles, self-blunting needles, and plastic capillary tubes. While OHSA recently set forth a directive that mandates the use of such devices, local rules are necessary to provide additional safeguards for medical personnel. Of interest, the field of dentistry is excluded from this act as well; this requirement only applies to employers with more than 20 workers. This legislation should assist in decreasing the likelihood of needlestick injuries in the workplace by health care providers. This law becomes effective in May, 2001.

NIH Appropriations

On the last day of the 106th Congress, lawmakers approved a $108.9 billion fiscal year 2001 Labor, Health, and Human Services, Education and Related Agencies appropriations bill as part of a final budget agreement. Included in this bill is $20.3 billion for the National Institutes of Health, an increase of $2.5 billion or 14.2% over the fiscal year 2000 funding level. The National Cancer Institute received $3.76 billion for fiscal year 2001; a 13.5% increase over fiscal year 2000 funding. Also included in the budget was $185 million for the National Breast and Cervical Cancer Early Detection Program at the Centers for Disease Control and Prevention (CDC), which provides screening for low-income women for their entire life. $8.9 million was appropriated for the CDC's Colorectal Cancer Program and $36.4 million for Cancer Registries. In addition, important language was included encouraging the CDC's efforts in the area of Prostate Cancer education and awareness, particularly among underserved, minority and other high-risk populations (5). The passing of this appropriations bill represents a great victory for ONS, cancer patients, and their families.

Mandatory Overtime HB 1527

The Washington State Nurses Association (WSNA) is supporting HB 1527; sponsored by Rep. Steve Conway, D-Tacoma, which would prohibit health care facilities from requiring employees (nurses and others) to perform overtime work. The bill defines overtime as any hours worked in excess of an agreed upon, predetermined, regularly scheduled shift or work week. The bill prohibits mandating extra shifts and requires employers who schedule extra shifts to pay at the overtime rate (this includes part time workers). Any employer who violates the provisions would be subject to sanctions and whistleblowers would receive a portion of any fines levied. The Washington State Hospital Association opposes this legislation and believes the prevalence of mandatory overtime has been overstated (6). The WSNA efforts in Washington State are part of a nationwide effort by the American Nurses Association. Other states such as Connecticut, Hawaii, Nevada and New York are also facing similar legislation. HB 1572 was not yet scheduled for a hearing at the time of this writing.

There are many areas in which our practice may be impacted by new rules, regulations, bills and policies. It is imperative as an organization, as a profession, as a community, we become active in our own destiny versus a silent bystander. For those who are dissatisfied, find a way to become involved. Find your passion and exercise your 5th amendment rights. The Puget Sound Oncology Nursing Web Page has a Government Relations page which will assist you in contacting officials, legislators and Congress men and women who ARE making decisions that impact our lives. Remember, these elected officials work for YOU!

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PSONS Profile

Anne Ankrom

My first impressions of Anne were of a quiet and very direct person. She seemed to have a sense of what she was about. We've interacted a number of times since then, and that impression has yet to be changed. I had never taken the opportunity to ask her much about herself, and so this interview was an eye-opening experience. We have many gems among our PSONS members. But the processes which have brought Anne to shine among us are among the more unusual.

OK, she's from Oregon. That's not too unusual. And she had a life before nursing. Again, not too unusual. She was an AD Nurse first, then BSN. Okay. But did you know that she once spent time sailing the Inland Passage in a 361 sailboat that she and her husband built? That her husband also turned to nursing as a second career? That she has often held three nursing jobs instead of one? That she rose to management positions in both her pre-nursing and nursing careers? And then left them to return to the clinical space? That the biggest shock for her to living in Durham NC was the weather?

I asked Anne about her most exciting job, and she paused. Instead, she shared that the most fulfilling job she has had was in Central Oregon, working in home-care hospice. She liked seeing people in their own environment, helping them live out their lives surrounded by the people and comforts that they loved. She liked repeated visits, and getting to know not only her patients, but also their families. She liked "whole person" nursing.

We had a conversation about the path of her nursing career. It began when she moved to Seattle with her husband Dan in 1980 when Bend, Oregon was experiencing hardships related to the lumber industry. They came here in search of better work, and Anne had thought that she would be going into nursing. Instead, she ended up putting her accounting skills to work in an art publishing company, and ended up as the VP of operations.

She entered the nursing program at Shoreline in 1986. During this time she did some clinicals at Stevens Hospital on their oncology unit. She discovered that she loved the patients on this unit, and was drawn to the multi-organ systems involved in oncology practice as well as the psychosocial dimensions. She also noticed that the staff on this floor were special, different from other nurses she had encountered.

Anne Ankrom

When Anne graduated from Shoreline, she started on the evening shift in oncology at Swedish hospital. Within six months, she entered the RN-BSN bridge program at the UW, and kept up her work at Swedish. During her tenure at school her resourcefulness led her to find her own clinical placement site with the Seattle Indian Health Board, and she continued to work there after she completed her BSN. Oh, and this was one of the times when she had three jobs, since she was also working in home care. Her Swedish supervisor thought she might do better finding some focus in her career!

In 191 Anne and her husband moved back to Oregon to be closer to her parents. This turned out to be the time when she worked in hospice. She also became the director of nursing in a rural hospital in NE Oregon. But she missed oncology, and could no longer do floor nursing due to back problems. She decided to go back to school and obtain her nurse practitioner degree specializing in oncology. This led her to Duke University in Durham, NC, and she came out with a dual CNS/NP degree.

Upon discovering that she could do her nurse practitioner residency wherever she wanted to, she began looking for positions in Seattle. She returned to the are in the fall of 196, working with Dr. Doug Lee at NW Hospital and with Dr. Stuart DuPen and Anna DuPen, ARNP in the Swedish Pain Management Center. By the time she was done with her residency, no clear jobs were available in oncology. She took an occupational medicine job at Highline Hospital for the first year. In the next few years, Anne stayed connected with the DuPens, working off and on at the pain service. She covered for Jormain Cady at Valley Internal Medicine while she was out on maternity leave, and they subsequently job-shared that position as Oncology Nurse Practitioner. Anne also worked weekends with Hospice of Seattle during this time. The day that she drove two miles toward the wrong job in the morning, she decided that life was a bit too complicated. She quit all three jobs, and took a single position.

"Now I think I've found home." Anne is now the nurse practitioner and teaching associate in the department of

radiation oncology at the University of Washington. She's the first nurse practitioner to hold this job. As such, it requires some definition, and both she and the department are gradually getting comfortable with her expanded role.

I found it telling that when I asked Anne to describe who family was to her, her definition was broad and encompassing. Her husband, Dan, had been woven throughout the conversation. He has worked throughout the range of nursing practice. He started in telemetry, but is now at VM doing IV therapy. He hails from Ohio, and a family tradition of working in the wood industry. He came into nursing as a carpenter/cabinet-maker/furniture-builder and had owned a lumber company. I suspect that these skills were well utilized in the sailboat that they built. Dabbling in the sciences, and curiosity about the systems of the human body led him into nursing.

Anne's parents were living in Poulsbo this past year, until her father's death last fall. Her mother has since moved to The Czech Republic, where she lives with Anne's sister, whose husband is president of Radio Free Europe. A brother lives on Bainbridge Island, and other extended family members live in Oregon. Anne lost an aunt, uncle, and cousin along with her father this past few months, and while the loss of one generation is difficult, she finds it helpful to concentrate on the next generation to help her through these transitions.

And so the next members of her family that she mentions are her children. Anne was married earlier in her life and had two children by that marriage. Her daughter is married and has two children, ages 2 and 4, and her son and his wife are expecting their first child in July. Both families are in Oregon, as is another important family member – her best friend from first grade. Other long-term friends also fit in her description of family.

And so Anne came to answer that another part of family for her is "you guys" at PSONS. She first joined PSONS when she worked at Swedish. The ADN program had not provided her much information about nursing positions other than inpatient staff nursing. Anne was curious about the other positions she saw, and made a point of interviewing Irene Karlsen. She considered a number of the people she met during that time her mentors, even though they were not specifically identified as such. Anne stayed connected with ONS and its chapters when she was not in the Seattle area, attending Fall Institutes in Seattle and Nashville, and participating in the Triangle Chapter in NC. Fellow PSONS member Brenda Nevidjon was COO at Duke when she was there, as well as distinguished alumna of the year. PSONS and ONS have extended her understanding of oncology nursing, and her membership has been a way to meet inspiring people. In the Fall of 1999 she attended the ONS Leadership Development Institute, and returned with a desire to promote and encourage others in nursing as a mentor. She plans to stay involved in PSONS.

Anne has given back to PSONS as well through her participation in the education committee for the last few years. She served as the Education chairperson for the year 1999-2000, completing an educational interests survey of the membership which continues to guide programming. When she was consulted regarding an article for the newsletter, she offered her services, and came onto the editorial board when it was reinstituted this past year. Anne has kept up her interest and expertise in pain management, and has participated in professional conferences and individual lectures on this topic.

Making time in this full life is tough, Anne acknowledges. This past year, when she has been sharing her nursing wisdom in the context of family illnesses and loss, has been particularly difficult. In addition to drawing on her family for strength, she likes to read and participate in outdoor activities: cross-country skiing, walking, hiking, biking. And yes, she also likes to sleep.

Anne, we salute you, your quiet articulate ways, your dedication, and your professionalism.

■

Puget Sound Chapter of the Oncology Nursing Society

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Letters, articles and announcements are requested from all PSONS members and other readers on topics of interest. Submissions and questions should be sent in electronic format to **newsdesk@psons.org**.
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between 9 a.m. and 5 p.m.

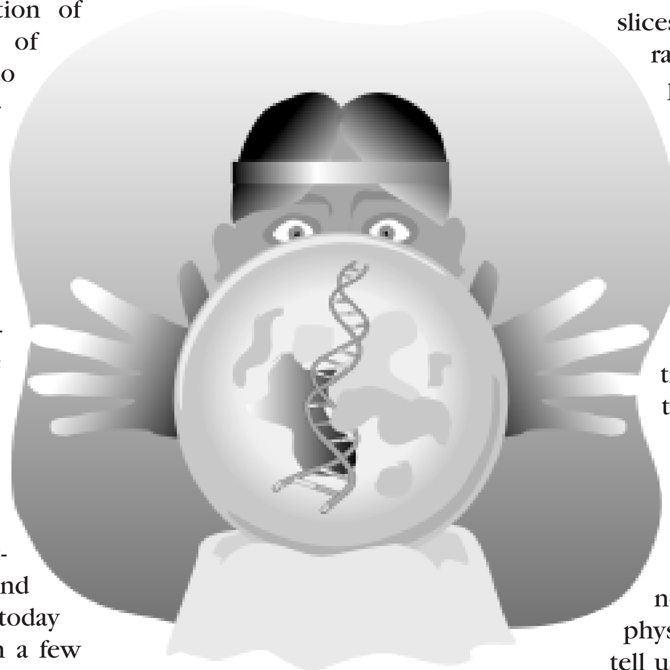
Oncology Tomorrow

Richard A. McGee, MD, FACP

I was going to title this essay "Oncology in the 21st Century" but really that seems very presumptuous. I can barely figure out what will be happening in the next six months let alone the next 100 years. What could someone in 1900 have predicted about how we live and what we do today? No cars, no airplanes, no radio, no TV, no refrigerators, no antibiotics, well.... No nothing. I have a 1905 edition of William Osler's "Principles of Medicine". What did they have to work with then? The organization of the text is instructive. There are chapters on parasites, chapters on specific infections such as typhoid and cholera, vaccinia and vaccination, chapters on constitutional diseases such as diabetes mellitus but no chapters on cancer. None. The entire remainder of the book is broken down by what happens to specific organ systems. While tumors were recognized in each organ, there was little understanding of any unifying character to them. Cancer, our second largest cause of death overall today has just a very brief mention in a few organs in the entire 1,114 pages. Things were very different then. It was in the late 1890's that physicists had predicted that there were only a few, maybe only one or two, phenomena left to explain and then all the rest of the scientific work of physics would be just "clean up". You know- delivery of the details but no new knowledge or insights. One of those yet incompletely explained phenomena was radioactivity.

The explanation of radioactivity led to the opening of a whole new world of thought and spurred the beginning of the most spectacular understandings of how things work for the next 100 years, really until just now. I was musing on this last week as I attempted to explain to my daughter how a PET Scanner works. I was not trying to explain the details, just the principles. I started with the name- Positron Emission Tomography- PET. Well, I guessed that I needed to define each word.

"Positrons. Those are positively charged electrons. Well, not just positively charged, they are actually anti-matter electrons. They are electrons by



weight and behavior but they are the opposite of electrons- they have a positive charge." I could see I was losing her. I pushed on. "Emission." Well here was an easy one, I thought. "Emission refers to the fact that a positron shoots out of the radioactive Fluorine nucleus." Wait a minute I thought, is that right? " Or maybe it refers to the encounter event between the positron (or anti-matter electron and a regular electron)," I reminded her. "When the matter and anti-matter particles encounter each other they produce annihilation radiation." This was not getting me out of the hole, I thought. I felt like I was walking uphill against a strong wind. I plunged on. "Annihilation radiation comes out of the positron-electron annihilation event as two exactly oppositely directed gamma ray photons. You see," I said hoping she would see or at least pretend to understand and give some nod of comprehension, "there's nothing left but energy. The mass of the two particles has been converted into energy! E=mc2", I said. "You know that one don't you?" She nodded to me tentatively. Good. Maybe I could make the finish line yet. "Then there's tomography." Now I did have a problem. Real tomograms never seemed to me to be understandable without a ten-minute diagram and considerable geometric cognitive skill. I chickened out. "Tomography means they create optical slices of the spaces where the gamma rays are originating by using computers." At last, I was on territory that is more familiar for her.

"Cool," she said. "So what's different about PET Scanners than CT Scanners?" OK I had a choice. I could now start topic 1B about CT Scanners but that way led to a hall of mirrors of ever more devolving explanations. I was determined to stick to the main topic and leave the detailed understanding of the rest of the world to another day.

"Well PET scanners let us look at the metabolic activity or metabolism of the cells while CT scanners or MRI scanners look at the physical size of things but they don't tell us anything about what the cells in the tissue area are actually doing." I threw the MRI stuff in for good seasoning, "You can't PET scan dead tissue." I beamed.

"Cool," she said again and got up to leave the room.

Should I push on with further explanations? I had been warned about this tendency before by almost every one in my family. I left well enough alone and silently smiled as she walked to the stairs.

Back into my thoughts, I mused. In 1900 who would have understood anything about what I just said. Well, really, no one, not even Marie Curie or Albert himself. I had just delivered my own

summary of quantum physics, anti-matter, cell biology and metabolism and a dozen other concepts that did not begin to exist until well after the end of the first thirty years of the 20th Century. It became clear to me that long term projections of future science are not likely to be very accurate.

What about just the broader concepts, I thought. Could I just pick broadly held desires of mankind? Although desire drives creation, even if I were to list just what we desire, I had not much hope I could get further along in my predictions. After all, mankind has thought about travel to the Moon (Jules Verne you know) and while that did work out, Verne also wrote "The Time Machine". Except for Area 51, I have not heard of nor seen any time travelers yet. I was not going to get much useful progress here.

OK. Let me shorten the range. Yes, that felt better. What is coming in the next few years? Well, many things are being talked about. Oral anticancer drugs are a big one. They promise low toxicity and convenience. Patient compliance is a worry though, and especially if the medicine needs to be taken more than once a day. Cost may be a major problem, too. The irony of supporting a huge research establishment with unprecedented funding to develop improvements, conveniences, and even cures which we then decide neither individuals nor society can afford crowded into my meditation. A whole new branch of nursing care for Oncology Nursing may expand. It might be the detailed education and personal compliance supervision for oral anti-cancer agents. We already make our study patients return and our research oncology nurses check the daily oral agent bottles to ensure that the medicine was at least taken completely.

Outpatient therapies at community centers seem likely continue to expand at the expense of regionalized institutional based facilities. Even today over 70% of all cancer therapy is delivered at community centers in the United States. Every one prefers simpler therapies and every one wants to travel as little as possible to get it. Every one likes to sleep at home where they are most comfortable. Oncology is and will remain a primarily knowledge-based discipline with a strong drive toward what I think of as "portable technology." It is based upon knowledge and skill of the providers. The providers are mobile and the costs to set up their tents are relatively low compared to the costs of other high technology medical treatments. Then too the knowledge upon which oncology is based is portable or easily transferred. Our treatment devices and therapies have tended toward more portable and manageable systems. Hospitals, on the other hand, will need to redefine themselves and their mission to a much narrower range of the very ill patients, who will require of them increasingly sophisticated support systems and nursing intensity. The bulk of cancer treatment will accelerate its exodus from the hospitals.

The government will put more energy and attention into controlling the development and delivery of cancer care systems, perhaps. Despite the next four Republican years, only government can knit together all of the widely disparate delivery systems. And government can have the mandate from the population and the vision to make it part of their own political agenda. There will be consolidations in the cancer care deliverers. There will be a kind of consolidation of resources, an agglutination in some cases and outright consumption, digestion and assimilation in others as has taken place in other major systems from airlines to farming. Delivery systems will network and consolidate because of political, economic, political and societal pressures. These will be turbulent developments, as ways of life and strongly held beliefs are tested in the coliseums of the market, public opinion, legislature, and the economy.

What are my predictions? - Exciting times for science and medicine and nursing. Wonderful new treatments from caring professionals. Turbulent struggles over control of and access to these wonderful developments. Ethical and moral challenges over knowledge about human biology and limited fiscal resources. Stressful consolidations. Hey, that sounds just like the last twenty years.

■

THINKING OF YOU

Gloria Winters RN, MN

Linda Cooper received an ONS scholarship to work toward her master's at Gonzaga University. She and her husband are expecting a baby at the end of May, a long awaited event that has all her friends and co-workers excited for her. And if that weren't enough, she was also selected for a Leadership Development award. Linda, we know we're just beginning to hear your story!

■

Pat Buchsel has been awarded the ONS Mentorahip award for her work in supporting authors to publication. Pat, as ever we're proud – and not surprised, but just pleased that others also recognize all that you do to help our profession.

■

POSITION POSTING

Clinical Development Specialist-Oncology
JOB TITLE

**JOB DESCRIPTION/
DUTIES, RESPONSIBILITIES:**

- Collaborates with nurse manager of units to promote optimal, cost effective patient care
- Develop and support the professional nursing staff
- Ensure successful strategies for ongoing staff development from novice to expert
- Provide leadership for quality improvement process
- Provide leadership to enhance nursing practice given the change in health care delivery, innovations suggested by nursing research and technological advances.
- Analyze patient data

JOB REQUIREMENTS:

- Oregon RN license, BSN required.
- Oncology certification preferred
- Masters degree/current enrollment or commitment to attaining Masters
- Appropriate clinical experience in Oncology
- Course work in areas of Adult Education and Quality Improvement
- Experience in designing quality assessment programs preferred

NO. OF BEDS/ROOMS/SUITES: N/A   NO. OF FTE OR STAFF: N/A

POSITION REPORTS TO:
Assistant Administrator, Nursing & Patient Care

OTHER INFORMATION:
•Ideal candidate would be a CNS
•Nurse Educator OK

Contact: Avril M. Green, RN, MPA, CHE
(916) 989-2238
avrilg@pacbell.net

Continued from page 7

assisted interviewing is used to minimize errors by interviewers. CDC pretests core questions and optional modules for validity. Interviewers are trained professionally and calls are monitored regularly.

The BRFSS may under-represent the poorer and more mobile portions of the population since they are less likely to live in homes with telephones. Additionally, respondents may underreport health risk behavior due to social acceptability norms. Use of preventive services may be influenced by recall errors. Despite the limitations, these data provide statewide estimates of the prevalence of health risk behaviors, use of preventive services, and use of and access to health care.

Bringing the data together: Two examples of using the data for prevention and control of colorectal cancer

Need for outreach for colorectal cancer screening

The Department's routine cancer surveillance activities include an annual assessment of incidence using WSCR data and mortality using the vital statistics mortality files for the 24 leading cancer sites in Washington state. The assessment includes a special focus on the five leading sites: female breast, prostate, lung, colon and rectum, and melanoma.

With almost 3,000 cancers of the colon and rectum diagnosed each year, colorectal cancer is the fourth leading cancer site in Washington, and the second leading cause of cancer death, responsible for the deaths of almost 1,000 Washingtonians each year. Colorectal cancer screening tests, including fecal occult blood testing, sigmoidoscopy, or colonoscopy, are highly effective. Regular screening cannot only detect cancer in early, more treatable stages, but it can also detect noncancerous growths in the colon or rectum that may become cancerous if left untreated. BRFSS data indicate that fewer than 40% of Washingtonians aged 50 and older meet the guidelines for screening recommended by the National Cancer Institute and the American Cancer Society. (By contrast, about 75% of Washington women aged 50 and older meet the guidelines for mammography.)

Given the large burden of disease from colorectal cancer, the underutilization of colorectal cancer screening, and that the Department already had statewide programs in place to address breast and lung cancer, the annual surveillance data pointed to the need to address colorectal cancer through efforts to increase screening. In response to this finding, the Department successfully recruited a public health prevention specialist from CDC to organize a statewide task force to focus on sustainable strategies for increasing colorectal cancer screening in Washington state. The task force includes members from various regions of the state representing non-profit organizations, colorectal cancer survivors, senior centers, local health jurisdictions, health insurance companies, professional associations, and hospitals. As one of their first actions, the taskforce is more closely reviewing BRFSS and WSCR data for baseline measurement of screening behavior, needs assessment, and priority setting.

Variation in treatment for colorectal cancer by demographic and socioeconomic factors

This study examined the relationship between socioeconomic and demographic factors and type of treatment for cancers of the colon and rectum. The National Institutes of Health and the National Cancer Institute recommend surgery followed by adjuvant chemo and/or radiotherapy for stage III colon and stages II and III rectal cancer (3,4).

Using WSCR, we identified people diagnosed in 1996 or 1997 with stage III colon and stages II and III rectal cancer who had surgery as part of their first course of treatment. We also obtained information on age, race and zip code of residence at diagnosis from WSCR. We linked this information to CHARS data to obtain information on comorbid conditions, source of insurance, and whether the hospital had a cancer program approved by the American College of Surgeons Committee on Cancer. We used 1990 US census data to classify people as living in rural or urban areas depending on the population density of their zip code. We also assigned people to quartiles of income depending on the per capita income of their zip code as reported in the census data. We analyzed these data to determine which factors were associated with an initial treatment plan that did not include adjuvant therapy.

Our initial results indicate that older patients and patients living in zip codes in the lowest quartile of per capita income are at higher risk for a treatment plan of surgery without adjuvant therapy compared to younger patients and those living in more affluent areas. These findings suggest disparities in the provision of life-saving medical procedures related to socioeconomic and demographic factors. We need to confirm these findings using more recent years of data. We will repeat these analyses using more recent data from WSCR and CHARS when information from the 2000 US census is available.

For more information:

- WSCR: visit the WSCR website at http://198.187.0.44/WSCR/ or call The Washington State Cancer Registry at 360-236-3676.
- Mortality Files, BRFSS and CHARS: visit http://www.doh.wa.gov/Data/data.htm or call the Washington State Center for Health Statistics at 360-236-4301.

References

1.Institute of Medicine. The Future of Public Health. Washington DC: National Academy Press; 1988.

2. Statute Law Committee, Revised Code of Washington, 1998 Edition, Volume 6. RCW 70.54.230, Cancer Registry Program

3. Office of Medical Applications Research. NIH Consensus Conference. Adjuvant Therapy for Patients with Colon and Rectal Cancer. JAMA. 1990, 264:1444-50.

4. National Institute of Health, National Cancer Institute. CancerNet [online]: Treatment Options for Health Professionals. http://cancernet.nci.nih.gov/treatment.html; September 2000.

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GOVERNMENT RELATIONS

WASHINGTON STATE RESOURCES

Resource	Address / Website	Phone	Notes
Access Washington	http://access.wa.gov/		General entrance site into Washington state legislation and information
Voter Information Hotline		1-800-448-4881	
Washington State Legislature	http://www.leg.wa.gov/	Legislative Hotline 1-800-562-6000 TDD 1-800-635-9993, BILL ROOM direct phone (360)786-7573	To leave an opinion or concern about government, or for information on the status of bills, or to obtain copies of bills, call the Legislative Hotline of Bill Room. To facilitate inquiries, provide your district number or the name of at least one legislator in your district.
Washington State Senate Web	http://www.leg.wa.gov/ www/senate.htm		
Washington State House Web	http://www.leg.wa.gov./ www/house/members/housepg.htm		
Governor Gary Locke	Legislative Bldg./P.O. Box 40002 Olympia, WA 98504-0002 Email: governor.locke@ governor.wa.gov	(360)902-4111/ (360)753-6780, FAX (360)753-4110, TDD (360)753-6466	
State Public Disclosure Commission	http://www.washington.edu/pdc/		Campaign contributors are listed. Activities of various political action committees are shown.
Washington State Nurses Association	http://www.wsna.org	(206) 443-9762	King County Nurses Assoc. - (206)535-0997 Pierce County Nurses Assoc. - (253)535-8559 ANA - (202)554-4444
Washington - Alaska Cancer Pain Initiative	http://www.fhcrc.org/cipr/wacpi/		

NATIONAL RESOURCES

Resource	Address / Website	Phone	Notes
THOMAS	http://thomas.loc.gov		Provides searchable information about the US Congress and the legislative process. Search bills by topic, bill number, or title
US White House	http://www.whitehouse.gov/		
President George W. Bush	The White House 1600 Pennsylvania Ave, Washington D.C. 20500-0003 Email: president@ whitehouse.gov, Website: http://www.whitehouse.gov/	main (202)456-1414, comments (202)456-1111 FAX (202)456-2461	
Vice President Richard Cheney	Office of Vice Pres./Old Executive Office Bldg. Washington D.C. 20501-0001 Email: vice-president@ whitehouse.gov	(202)456-7044	
US Congress: Congressional Switchboard		(202)224-3121	
US House	http://www.house.gov/		This site will also link you to your representatives
US Senate	http://www.senate.gov/		This site will also link you to your representatives

COMMUNITY & PROFESSIONAL RESOURCES

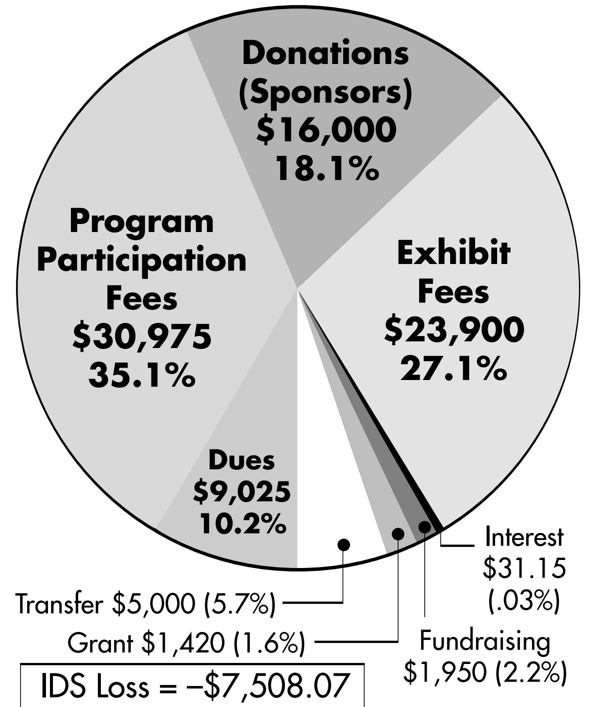
Resource	Address / Website	Phone	Notes
American Cancer Society Action Alert Network		1-800-729-1151, ext. 3309	ACS Northwest Area Office - (206) 869-5588, East King - (425)869-5588, Pierce County - (253)272-5767, Statewide Office - 1-800-ACS-2345, Eastern Washington Area Office - (509)326-5802
CapitolWiz	http://congress.nw.dc.us/ana		a service of the American Nurses Association
ON-Stat	501 Holiday Dr., Pittsburgh, PA 15220-2749 ONS website: http://www.ons.org	(412) 921-7373	a program established by ONS to establish a group of grassroots members who can respond to specific issues. To sign up call ONS.
League of Women Voters of Seattle	1402 18th Ave., Seattle, WA 98122-4126 http://scn.org/civic/lwvseattle.	Citizen Information Service: (206) 329-4848 FAX (206) 329-1273	Click on "They Represent You" to contact local and state officials. There is also a connection with the State League of Women Voters at this site Open weekdays: 9:00 AM - 3:30 PM.
Seattle Community Network	http://www.scn.org/		Various community groups and activist organizations have links with SCN. The political parties can be reached through this site.
The Children's Cause	http://www.childrenscause.org	The Children's Cause is dedicated to being a consumer-based, independent advocacy voice of families and survivors on national policies that affect research, health care, and services for pediatric cancer survivors. You can sign up at this site to receive their email alerts.	

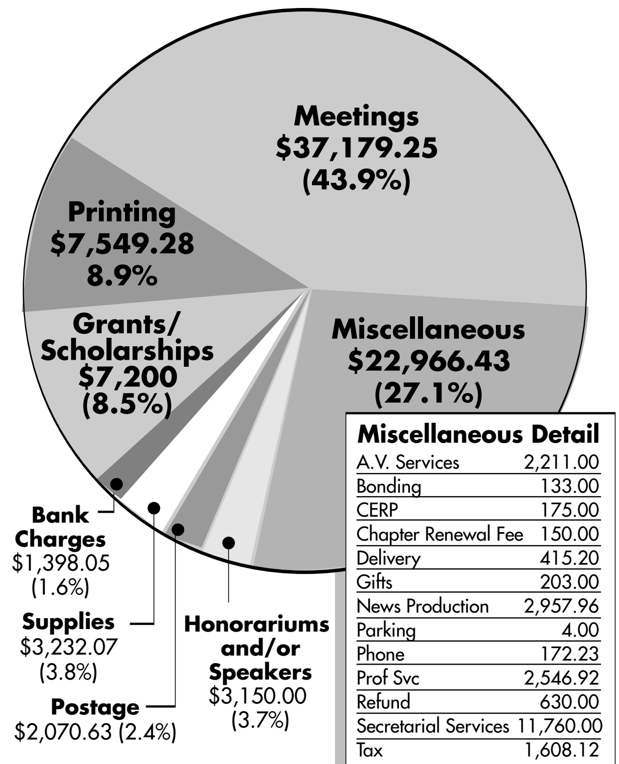
Treasurer's Report

for Fourth Quarter 2000, ending December 31, 2000

A. **BEGINNING BALANCE** (Ending Balance Last Report)		**$59,811.24**
REVENUES		
Dues		2,717.50
Program Participation Fees		750.00
Interest (Checking/Savings/Certificate		4.18
Donations		
Exhibit Fees		5,400.00
Fundraising		175.00
Miscellaneous Other		
Gain (Loss) IDS	(4,632.86)	
Sponsors	4,800.00	
Transfer	5,000.00	
Total Miscellaneous		5,167.14
B. TOTAL REVENUES		**$14,213.82**
EXPENSES:		
Printing		2,314.67
Postage		428.67
Supplies		317.68
Meetings		4,577.25
Bank Charges		500.00
Grants/Scholarships/Awards		
3,974.57		
Miscellaneous Other		
Delivery	98.00	
News Production	660.00	
Phone	20.00	
Professional Services	327.83	
Secretarial Services	2,197.50	
Tax	671.24	
C. TOTAL EXPENSES		$**13,468.84**
D. ENDING BALANCE THIS PERIOD		$**60,556.22**
Outstanding Checks		515.05
BALANCE IN BANK AND INVESTMENTS		**$61,071.27**

Year 2000 Report





PSONS 2001 Budget

Income

	Gen. Admin.	Membership	Symposium	Education	Research	Communication	Govt. Rel.	Nominating	PSONEC	Total
Advertising	500					1,500				$ 2,000
Donations						800				800.00
Dues		8,000								8,000.00
Exhibitors			13,500	1,600					12,000	27,100.00
Program Fees			22,500	13,000					5,000	40,500.00
Sales	400									400.00
Sponsors			3,500	800	3,000	2,000			3,000	12,300.00
Transfer	1,000									1,000.00
Subscriptions						500				500.00
Interest Income	4,000									4,000.00
Total	5,900	8,000	39,500	15,400	3,000	4,800	-	-	20,000	$ 96,600

Expenses

	Gen. Admin.	Membership	Symposium	Education	Research	Communication	Govt. Rel.	Nominating	PSONEC	Total
Bank Charges	100									$ 100
Grants	3,600		600	2,800	2,000	250				9,250.00
Honorariums			5,500	4,200	150		500			10,350.00
Meetings	360		18,695	5,000	3,200			25	12,000	39,280.00
Miscellaneous	1,100		2,000			800		25		3,925.00
ONS	2,280								175	2,455.00
Phone		20	70	20	20	50	10	10		200.00
Photocopying	20				5050		25	10		155.00
Postage	60	600	500	100	100	550	50	50	100	2,110.00
Printing		400	2,000			4,300			2,200	8,900.00
Prof. Services			2,000			3,125				5,125.00
Secretarial	5,000	1,300	1,000	1,500	300	600		300	2,000	12,000.00
Supplies	100		500	500	50				1,600	2,750.00
Total	12,620	2,320	32,865	14,170	5,870	9,675	585	420	18,075	$ 96,600

PSONS is Living the Vision

THE COMMUNICATION GAME:
Workshops to Improve Presentation and Writing Skills

May 4 and 5, 2001 • Marriott, Sea-Tac Airport

Faculty are the Brents Consulting Group and Brenda Nevidjon, RN, MSN

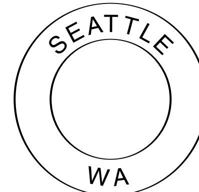
Contact Alliance Strategies at 206-282-9292 for an application.

This workshop is made possible through a grant from the Seattle Bone Marrow Transplant Consortium

The workshop will be presented again in fall 2001

Puget Sound Quarterly appreciates the generous support of ***AstraZeneca***

American Cancer Society
P.O. Box 19140
Seattle, WA 98109



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