



PUGET SOUND QUARTERLY

Oncology Nursing Society

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INSIDE

President's Message	2
New Members	9
PSONS Profile	12
Around the Puget Sound	13
Treasurer's Report	15

2003 McCORKLE LECTURE

Taking a Risk and Sharing Our Creative Side

Judy Peterson, RN
NexCura

I am honored to have been chosen by my peers to present this lecture and I thank you for being here. I believe much of what I have to offer you today are merely reflections of what I have learned from you my nursing colleagues.

My goal is for you to think about some strategies for applying and sharing creativity in your own nursing practice, and perhaps challenging yourself to take risks as you do that. I hope my talk will stimulate your thinking and move you to action.

First I want to say, I don't pretend to be an "expert" on the concept of creativity, (and believe me there are many out there who define themselves as an expert on this topic). I am an oncology nurse, like you, interested in advancing my profession, improving the care of cancer patients and today, sharing with my colleagues; this is just the topic through which I've chosen to explore and share my thoughts with you.

"All of us yearn to be creative, but few of us feel we truly are" (Howard Hendricks, *Color Outside the Lines*).

I believe that all of us can foster the creative spirit in ourselves and share that with each other. There are untapped possibilities in each of us. Amazing things can happen when we look with a different perspective; when we go beyond what is comfortable and predictable.



Defining Creativity

The dictionary defines creativity as "The quality of being able to produce original work or ideas in any field" (Funk S Wagnalls, 1995). I can agree with that, but I believe creativity also means taking something we do all the time and changing it a little or adding a new twist to it.

Gilmartin, writing about creativity describes creativity as a "process of becoming sensitive to problems...identifying the difficulty; and searching for solutions" (Gilmartin, 1999). I think of nurses as constantly challenged to find

solutions and yes, we are being creative! We've had to be creative to solve patient care problems with ever shrinking resources.

Another nursing author, Hall says, "One of the greatest enemies of creativity is the inner critic. It is vital that nurses work with gentleness and respect toward themselves, and honor their many abilities and strengths" (Hall, 2001). I've got one of those inner critics; I bet many of you do too. Many times as I thought about this talk my inner critic told me I didn't have anything to share, but here I am, taking the risk that you

Continued on page 3

Angela Hall RN, MSN, OCN

Natasba Hauptman RN, MSN, OCN

Communication is vital in all aspects of our life. The recent CPSONS symposium held in March demonstrated how valuable communication is for us as oncology nurses. The conference provided up-to-date information on new treatments using gene therapy, chemoprevention, hormonal and drug therapies. The treatment of patients with cancer has changed over the years from single to multidrug regimes and more recently includes drugs that have novel mecha-

nisms of action. The syllabus also included presentations on complementary therapies that help to maintain the well being of our patients as they go through their treatments. These therapies includ-

Symposium: Be Willing to 'Step Outside the Boundaries'

Continued from page 1

will hear something today that will inspire you to think about your own creativity!

Who are creative people?

Think of someone you know whom you consider creative. Why do you consider them creative? What characteristic is it that makes you identify them as creative? I bet you have some of that in you too.

When we think of a creative person we often think of the super artists, creative geniuses who paint pictures and sing songs and write volumes. Personally I don't know a lot of nurses that are creative in those very artistic ways but, nurses are creative people in many other ways, that's you, that is the person next to you.

What are some of the characteristics of creative people that came to your mind?

Here is the list I came up with. Creative people are willing to take risks, share ideas, step outside boundaries, that describes many nurses I know.

Creative people...

- "are intuitive, self-confident, and able to tolerate ambiguity." (Simon, 1999)
- have a willingness to take a risk and share their ideas.
- go beyond the boundaries.
- Are willing to break with convention.
- are flexible.
- are open minded, possess a positive attitude.
- able to let go.
- have self-esteem.

Which of these characteristics describe you? We can unleash our creativity, and share it with each other. I believe this will strengthen us as a profession and help us to help ourselves in the ever-changing health care environment.

How do you unleash the creativity you have inside you? What does it take to be creative?

I believe we can start by giving each other permission. We stifle each other at times, often unintentionally, discouraging or just by not encouraging each other to

questions the rules and consider tipping the sacred cow

Ask each other for help! Don't be afraid to do this and do it often. If you are a new nurse, find a mentor. If you are an experienced nurse, who do you share your ideas with? It can take support and encouragement to be creative. I believe we should get that from each other.

Creative strategies in nursing

Now as I share some examples of risk taking and creativity think about your own nursing practice. Let's start by looking at some examples of risk taking.

Trying a new path

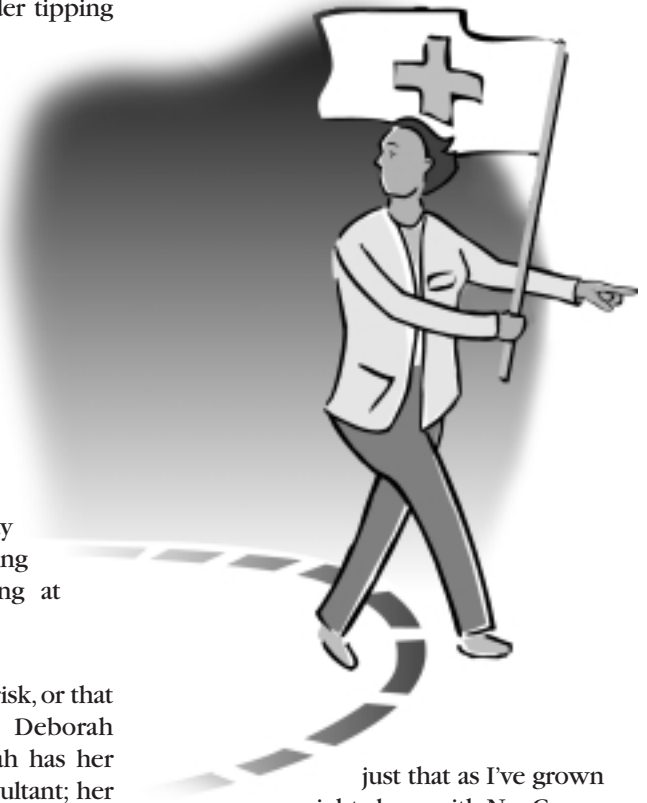
Some of us really can take a risk, or that is how I see the example Deborah Hodges has set for us. Deborah has her own business as a nurse consultant; her principle services are oncology nursing education and performance improvement. She wanted to forge her own direction to see what would happen. She was willing to break with convention and take a risk.

This is the 4th year of Deborah's successful entrepreneurial business.

I asked Deborah for advice on being creative. She wants to remind us that we need to trust ourselves, we are of value! We have a lot to contribute in so many ways. She encourages trying something new, but also know what your comfort level is, what can you live with. If you need constant change, don't be afraid of the unknown. Set up, organize and go after what you want in a planned fashion. Deborah, congratulations on your successes and thank you for allowing me to share your story (and your picture).

There are many of you within our PERSONS family with this same creative, and entrepreneurial spirit willing to take risks

It felt risky to me too as I left my safety zone, the community hospital I had worked in for 17 years. Three years ago I resigned my position there and set out to do something different, to face new challenges, hoping I could stretch in new ways as an oncology nurse. I have done



just that as I've grown right along with NexCura, a small company of 30 employees here in Seattle, NexCura's mission is to provide healthcare education and information to patients, caregivers, and providers, that is individually-tailored to a patient's situation. We develop online interactive tools that enable patients to make better informed decisions about treatment options. When I began this venture 3 years ago, the internet was a new arena for nurses like myself. There have been few role models for me in my current work environment, but my own clinical knowledge and experience have served me well in this oh, so foreign business environment.

I am very proud of the work I've done to support NexCura's mission. We have reached over 200,000 cancer patients. I am happy in my current position, but yes, I sometimes do still miss the direct interaction with patients and you my nursing colleagues, but I know from the comments we receive from those who use the Profiler, our decision support tool, that I still am able to make a difference in patients lives, just in a different way.

Risk taking isn't always trying something necessarily new. It can mean just

Continued on page 4

Symposium: Humor is an Important Part of a Creative Strategy

Continued from page 3

acting on what we can do with the knowledge and resources we have and not waiting for a better or the best solution.

Humor

Humor is definitely a creative strategy. Who amongst your colleagues makes you laugh or knows how to make their patients laugh? I know of several but I have a couple of stories I'll tell you now and I expect that your own examples are just as amusing. As health care and the world around us changes it sometimes seems it would be easier to resist change and continue on with the way it has always worked. No doubt all of us have been through many cycles of change in our profession and personal life. The pace with which we are confronted with new information can be so overwhelming. But we are nurses, we cope, for the most part. Well, once upon a time there was a physician who thought he could resist change and pull us back from the evil direction we were headed! As the electronic medical record moved forward this particular physician resisted by complaining to no avail. This physician was very unhappy about looking for current patient data in the computer. One day he decided he'd had enough, so he wrote a physician order, and his order declared that all nursing documentation for his patient was to be done on the "blue bordered" progress notes page. So, how was the nursing staff going to respond to that order? Kay decided the only solution was a humorous one, prior to the physicians next visit to the nursing unit, she proceeded to outline one of the computers with blue tape. Voila, the documentation was now within the blue border!

Meeting pt needs outside the "lines"

How many of you colored outside the lines when you were young? Now do you?

Let me share some examples from you of oncology nurses who looked beyond the rules and colored outside of the lines!

Leslie and the Wife

Recently a nurse described for me a memorable patient and wife she cared for in the hospital. This cancer patient had an ileostomy and now a profusely draining fistula that also needed to be bagged. The

wife was the patient's caregiver at home and was at the bedside when Leslie was first changing the patient's ileostomy bag and managing fistula care. Leslie noted that the patient's skin was in near-perfect condition. She commented on this to the patient's wife and began to discuss with her how she had done his ileostomy care. The wife jumped forward to assist Leslie explaining her rule that every last minutia

of adhesive must be off the skin before applying the new appliance; as she talked she began, ungloved, to demonstrate how she accomplished this with her fingernails! As nurse and wife talked and provided the patient care together, they learned from each other.

Leslie was able to assess the wife's abilities and technique as well as teach about

Continued on page 10

Symposium Participant's Nursing Tips or 'Fortunes'

Take time to mentor someone. Never compromise excellence. Tell stories.

- Martha Purrier

It only takes a moment to make a patient feel positive about themselves, i.e., a smile, a warm comment- "you're doing good". Offering to help them with personal care.

- Pat Callow Borgeson

Drink lots of water

Sing

Have fun

Play lotto

Use humor with our patients when appropriate- we have a doctor who loves to tell jokes & will often write in his orders to the nurse to tell the patient a joke a day.

Take time out to take care of yourself (movies, travel)

Don't be afraid to learn from a student or a new nurse.

Touch your patients, sit down on their level.

Don't let your own discomfort in dealing with a situation keep you from doing what needs to be done.

- Kathleen Tilton

Don't be afraid to follow your heart.

Write patients Nickname and spouse's name on ghost charts.

Celebrate each patients' completion of their course of chemotherapy whether it be with a certificate, flowers, balloons or 'poppers'.

- Terry Perkins

The patient often is the teacher- take the time to listen.

Do whatever it takes to communicate with your patients, even if it is charades.

Make them laugh, again whatever it takes. For new RNs: Do a pain assessment of yourself; when you have cramps, headache, disappointment or sad event. Helps people realize value of pain assessment.

When beginning my care for a patient, I ask them what is concerning them the most and I work at trying to get that solved in whatever way I can- whether it be a general question or a care need.

I use humor and laughter not only with my patients and families but with staff and faculty. I am often "looking foolish" but the feedback is "we all love it & don't change"

- Ian Anderson

I am very enthusiastic by nature & enjoy urging other nurses to share their expertise & stretch into new roles. Sometimes when I am in this mode, people can feel too pushed. I have learned to be sure people have an out by saying to them "It's okay to say no right now, I'll ask you again later to help with something else."

- Cathy Goetsch

Ask patients to rate their nausea 1-10 the same way we ask them about their pain. This helps to gauge efficacy of nausea meds.

Share one personal fear with a patient that you know.

No matter how busy you are, treat each patient as if he or she is the only patient you have and no matter how little time you have with them at one time, give them your full attention, your respect, your love, and your compassion.

Instead of leaving nursing because of frustration, I have been researching how I could integrate a personal

Thank you all for sharing your great tips!

- Judy

HIPAA Privacy: Let's Get Practical

Ken Kwon

*Project Manager and the Seattle Cancer Care Alliance HIPAA Privacy Team
Seattle Cancer Care Alliance*

Are your eyes glazed over from reading your new privacy policies? Before disclosing patient health information, do you find yourself scrutinizing the situation a bit longer than before? If so, you are just like many other healthcare workers across the country who are feeling the effects of the new HIPAA (Health Insurance Portability and Accountability Act) privacy regulations that went into effect on April 14, 2003.

The purpose of this article is to help re-focus on some more practical items when it comes to HIPAA privacy compliance. However, we won't re-hash all the privacy rules and regulations you have already received through your HIPAA training.

Did you know?

The original intent of HIPAA was to streamline key electronic billing transactions between providers and payers to increase efficiency and decrease cost. Remember, the "I" in HIPAA stands for "Insurance". Once these Transaction regulations were established, the lawmakers realized that there is a lot of patient health information being passed back and forth, so regulations protecting the privacy and security of that information were introduced. Therefore, when it comes to HIPAA, you typically hear about the big three: transactions, privacy and security. Your organization will probably have dedicated teams working on each group as appropriate.

Regulations	Staff Most Affected
Transactions	Staff who maintain the billing system
Privacy	Staff who handle patient health information
Security	Information Technology staff

Where is the biggest impact?

Although the original intent was to streamline billing, the HIPAA Privacy regulations have the most impact on healthcare organizations. It's no coinci-



dence that the Privacy regulations are also generating the most interest from the general public. In today's society, issues such as identity theft and fraud weigh heavily on the public consciousness. Therefore any topic on privacy is sure to catch people's attention.

What are patients hearing?

As healthcare professionals, we've been reading, preparing, training and gearing up for the new Privacy regulations for some time now. The general public is just now becoming aware of them.

Introductory articles have been written in many mainstream newspapers and provide cursory information on the new privacy regulations, but they don't provide enough details to truly inform the public of their rights. Without more detailed, accurate information and dialogue, it will be easy for people to misinterpret these rights and create inaccurate expectations.

As the privacy regulations become

more widely known, it will be important for you to keep your ears open for the types of questions patients are asking and to make sure to clarify any false expectations.

Most organizations have a process for capturing and logging privacy related questions from patients. Check to see if your organization has one.

Where will patients receive accurate information?

Patients will receive the best information from your Notice of Privacy Practices (NPP). The NPP provides detailed information to patients about their rights and responsibilities of healthcare organizations in regards to privacy. It is also the item that will be most visible to patients when it comes to HIPAA. They won't see all your policies and the training you completed, but they will read a NPP and ask questions about it. The NPP is a very important piece of HIPAA privacy compliance.

Each healthcare organization is required to:

- ✓ Produce a NPP and present it to the patient within 24 hours of their first episode of care.
- ✓ Obtain a written acknowledgement from the patient that they have received the NPP.
- ✓ Post the NPP in a prominent location in the facility and on their web site if they maintain one.

Familiarize yourself with your organization's NPP. It's being distributed to your patients, so they could very easily ask you a question about it.

What should you be aware of?

It will take time to absorb all the Privacy regulations, their nuances and how they relate to your day-to-day activities. But you can ask yourself these questions to create an approach to determining what you should pay more attention to:

- Do you know and understand the

Continued on page 7

Micro Array Technology

Deciphering the Genetics of Cancer

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American Society of Clinical Oncology

Adapted with permission from: Rieger, P.T. (2002). The Impact of Genetic Information in the Management of Cancer. In J. Jenkins, A. Masny, & A. Strauss-Trantin (Eds.). Recommendations for Cancer Genetics Nursing Practice and Education. Pittsburgh, PA: Oncology Nursing Press, Inc.

The explosion, in the past two decades, of knowledge about the molecular basis of cancer is now changing the basic management of the disease. The hope is that these advances will ultimately translate into improved patient survival or even the prevention of cancer. The discovery of genes, or classes of genes, that are altered during carcinogenesis provides new insights into how to determine an individual's cancer risk, provides prognostic indicators for those who develop cancer, and generates new modalities for cancer treatment. In the coming years, these discoveries and new technologies will require that oncology nurses keep abreast of these changes and will also open new roles for those providing care for patients with cancer.

Much of the knowledge gained in this regard has resulted from work related to the Human Genome Project, which was initiated in 1990 and completed in the spring of 2003. The next challenge will encompass decades to come as scientists work to determine the function of all 3 billion DNA letters, and work to understand how those letters direct the growth, life, reproduction, disease and death of human beings.

Cancer as a Genetic Disease

Within the nucleus of each of our body cells is a complete set of genetic instructions, known as the human genome. The genome consists of 23 pairs of chromosomes that are the blueprint for who and what we are. Chromosomes are composed of a tightly coiled material known

as deoxyribonucleic acid (DNA). DNA exists as two long paired strands that spiral into a double helix formation, often visualized as a twisted ladder. Chemical bases (adenine, guanine, thymine, and cytosine) form the "rungs" of the ladder. Each chromosome carries thousands of genes that can be conceptually envisioned like beads on a necklace. The DNA sequence is the particular side-by-side arrangement of bases along the DNA strand (e.g., ATCCTCTAA). Each gene consists of short stretches of DNA that provide the instructions for making a particular protein. The instructions are coded by the order in which the chemical bases are arranged. Some proteins serve a structural function, whereas others have a role in telling cells how to behave.

Cancer refers to a group of diseases in which there is a transformation of normal body cells into malignant cells. During the transformation, cells acquire abnormal characteristics that affect their appearance, the expression of proteins on the cell surface, cell growth, cell reproduction, and cell death. In the process, cells lose their normal characteristics. Over the past several decades, research has begun to uncover the molecular basis of cancer. Scientific evidence has accumulated that suggests cancer is a genetic disease, meaning that it is caused by changes in one's genes. The genetic information (DNA) in the cell is damaged regularly either by environmental agents or by errors made as cells undergo division during cell reproduction. Normal cells have mechanisms to repair this damage. Essentially, cancer occurs when such mechanisms are absent or otherwise fail to protect against the further development and accumulation of genetic errors. This means that the development of cancer is the end result of a series of inherited or acquired mutations, accumulated over 10 to 30 years, that cause a remarkable change in the behavior of a single cell and its offspring (See Table 1).

Risk Management and Cancer Prevention

Identification of Individuals at Increased Risk

Of all cancers, 5%–10% occur in recognizable familial clusterings. Hereditary mutations, in conjunction with acquired mutations, play a fundamental role in the development of these cancers. The inherited mutations place individuals at a heightened risk for the development of cancer and have important implications for the prevention and detection of cancer. More than 50 types of cancer demonstrate a familial clustering that is indicative of inherited predisposition; such cancers include colorectal cancer, breast and ovarian cancer, melanoma, and medullary thyroid cancer. Inherited cancers have several characteristics that differentiate them from sporadic cancers. Within a family, these characteristics are exhibited as: the presence of multiple cases of cancer, especially cancers of the same type within a family; cancer diagnosed at an earlier age than expected for the general population; the presence of multiple cancers in one person; the presence of rare tumors, such as sarcomas or brain tumors; and cancer in paired organs (i.e., both breasts or both kidneys). Cancer predisposition genetic testing is now available for numerous hereditary cancers, yet is associated with numerous potential benefits and risks.

Chemoprevention

One new strategy is the use of pharmacologic agents that arrest or reverse the multistage process of cancer development—that is, chemoprevention. Chemoprevention agents may be classified into two basic categories: agents that prevent initiation of the carcinogenic process (blocking agents) and those that prevent further promotion or progression of lesions that have already been established (suppressing agents). In reality, the distinction between these categories is often artificial (See table 1).

Randomized trials have evaluated the use of chemopreventive agents in the following areas: risk reduction for solid tumors, such as breast, prostate, lung, and colorectal cancers in those at increased risk; reversal of premalignant conditions, such as cervical dysplasia, premalignant

Continued on next page

Major types of agents used in the chemoprevention of cancer include:

- Retinoids (natural and synthetic analogs of vitamin A)
- Estrogen response modifiers (e.g., tamoxifen and raloxifene)
- Deltanoids (natural and synthetic analogs of vitamin D)
- Androgen analogs (e.g., finasteride)
- Agents that alter ovulation (e.g., oral contraceptives)
- Agents that suppress cell proliferation (e.g., difluoromethylornithine [DFMO])
- Nonsteroidal anti-inflammatory drugs (NSAIDs, e.g., aspirin, ibuprofen, sulindac)
- Agents that protect cells from oxidative stress (e.g., vitamin E)
- Agents that block carcinogens from binding to DNA (e.g., oltipraz and acetylcysteine)

Table 1.

skin lesions, and oral premalignancies; and risk reduction of second primary cancers in patients who have had head or neck, lung, or bladder cancers. In September 1998, tamoxifen citrate received regulatory approval for use in decreasing the incidence of breast cancer in high-risk women. In December of 1999 regulatory approval was given for the use of Celecoxib (Celebrex[®]), a COX-2 selective non-steroidal anti-inflammatory drug as treatment for reducing the numbers of colorectal polyps in patients with FAP. It should be used only as an adjunct to usual

care in managing FAP, which typically involves surgical removal of much or all of the lower intestine (colon and rectum) by early adulthood, with careful monitoring of any remaining lower intestinal tissue. The use of the retinoids as chemoprevention in upper aerodigestive diseases (e.g., oral leukoplakia) remains an active area of study.

Diagnosis and Prognosis

An accurate, specific, and sufficiently comprehensive diagnosis helps a clinician develop an optimal plan of treatment and, when possible, estimate prognosis. Recent advances in understanding the molecular basis of cancer, and associated technologies, are affecting the way cancer is diagnosed. Micro array technology is a new way of studying how large numbers of genes interact with each other and how a cell's regulatory networks control vast batteries of genes simultaneously. The method uses a robot to precisely apply tiny droplets containing functional DNA to glass slides. Researchers then attach fluorescent labels to DNA from the cell they are studying. The labeled probes are allowed to bind to complementary DNA strands on the slides. The slides are put into a scanning microscope that can measure the brightness of each fluorescent dot; brightness reveals how much of a specific DNA fragment is present, an indi-

cator of how active it is. DNA microarray technology represents an important new tool to analyze cells and human tissues, and allows measurement of the expression several thousands of mRNA species in a biological specimen.

Treatment

Current modalities of cancer treatment include surgery, radiation, chemotherapy, and biologic therapy. Surgery is often curative when tumors are detected early, and radiation and chemotherapy are effective therapies for some types of tumors. However, the cure of many common tumors, especially when diagnosed at an advanced stage, remains elusive. New insights into the biology of cancer will affect traditional therapies and propel the development of new molecular therapies.

The traditional cancer-treatment modalities—surgery, radiotherapy, and chemotherapy—are based on a nonselective “killing paradigm,” in which the goal is complete elimination of cancer cells, albeit along with many normal cells. New approaches in the management of cancer are based on a new paradigm, a highly selective “control paradigm,” which recognizes aberrancy in tumor cells and attempts to reassert normal regulation. These new approaches may include gene-

Continued on page 14

HIPAA Privacy: Get to Know the Rules and Communicate Them to Others

Continued from page 5

- patient rights listed on the NPP and your organizational response to each?
- For example, if a patient requests an “accounting of disclosures”, will you know who to call or what to do? What about a “request for restriction” of their information?
- Do you know who you could call if a patient has a privacy related question you cannot answer?
 - Do you know who your organization's Privacy Officer is?
 - Every healthcare organization is required to have one.
 - Do you know where your particular high-risk areas are in regards to privacy?
 - For example, are your operations more reliant on phone and fax communication? If so, then you should pay more attention to your policies surrounding messages left

on answering machines and use of fax cover sheets.

- Of your new privacy policies, which ones are truly new and which ones are simply revisions of already existing policies? You should probably take time to really get to know the new ones. They will have a higher learning curve.

The HIPAA Privacy regulations are here to stay. In fact, the journey is just beginning. There is a lot of information to absorb, and it's not realistic to think you will be able to become an expert in it all at once. The sequence of what you learn will really depend on your role, your organization and your risk areas. As you start on your path towards continuous compliance, remember the following key points:

- Pay attention to what patients are asking and what they are perceiving

in regards to privacy - help separate fact from fiction

- Special efforts are made to give them your Notice of Privacy Practices - Get to know it.
- Know your organizational privacy resources - Where are the policies located? Where can you go with privacy related questions? Where can a patient go with privacy related questions? Who's your Privacy Officer?
- Communicate what you've learned with your colleagues - They might face the exact same scenario tomorrow.

And last but not least, when in doubt, trust your professional judgment and experience and treat information as if it were your own. Good faith efforts and intent will just about always lead to the right decision and course of action.

The New PhRMA Code and Its Practical Application

*Linda Hobengarten, RN, BSN, MBA
2003 PSONS President*

Over the past decade, the issue of pharmaceutical industry relationships with physicians, healthcare organizations, and professional societies has grown in both complexity and concern. Especially in times of tight economical constraint, the financial impact of these relationships upon all parties is great. The potential for conflict of interest with inherent ethical risks has been recently called out in a proactive way at the national level. The purpose of this article is to share a

newly developed set of guidelines designed to establish clear motives for these relationships, to reference the newly revised ONS Position Paper on the topic, and to provide some practical 'do's and don'ts' in their application.

In 2001 and 2002, three organizations reached consensus on a set of industry guidelines called the PhRMA Code of Interactions with Healthcare Professionals. These associations were the AMA (American Medical Association), the ACCME (Accreditation Council for Continuing Education), and the PhRMA (Pharmaceutical Research and Manufacturers of America). This

marketing code, while voluntary, has a clear goal of governing the pharmaceutical industry's relationships with physicians and other healthcare organizations. Its overriding theme is, "Relationships are intended to benefit patients and enhance the practice of medicine".

While the code was effective on July 1, 2002, its integration nationwide has been scattered. Pharmaceutical companies are responsible for training their respective representatives so timelines have varied. ONS only recently created a more formal presented of the guidelines and presented to the incoming chapter presidents in March, 2003. The guidelines were influential in a recent ONS position paper revision. I would encourage you to read it in its entirety on the ONS website. Clearly, ONS chapters and their patients will be able to benefit from promotion-free, high quality educational opportunities. This is a major and greatly welcomed shift.

Within the realm of third party education
Continued on next page



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tion and professional meetings, several items are worth noting:

- Sponsorship dollars should be given to and controlled by meeting organizers
- Meeting organizers control selection of content, faculty, materials, and venues
- Meals must be modest by local standards – no guests (e.g. spouses), no “takeout” (e.g. grab and go without educational content).
- No financial support for travel, lodging, time, etc. for individual attendees of CME (Continuing Medical Education).

With regard to scholarships and educational funds, two major criteria must be met. First, selection of scholarship recipients must be made by academic or training institutions/organizations. Any monies must therefore be given to the selecting organization and they then become responsible for the dissemination of the monies to the receiving individual. The second calls for educational conferences to have content dealing

New PhRMA Code Guidelines

Acceptable Gifts

Acceptable educational and practice-related items given as gifts must meet several standards:

- They must be given to a group which, in turn, disseminates them as they see fit. In other words, no direct gifts to an individual.
- Gifts that benefit the patients.
- Gifts of modest value (less than \$100).
- Items offered only on an occasional basis.

- Items of minimal value that are associated with a healthcare professional's practice (e.g. pens, notepads, etc. with a product logo).

Unacceptable Gifts

Unacceptable gifts would include:

- Gifts of cash or cash equivalents (i.e. gift certificates)
- Items intended for personal benefit (e.g. flowers, tickets to special events, etc.).

with major scientific events. No more ‘conference-light’.

The basic practical tenet for all these guidelines clearly becomes, “Nothing should be offered or provided in a manner or on conditions that would interfere with the independence of a healthcare professional's prescribing practices.” This is clearly a shift of funds

from promotion to CME. This will ultimately result in more educational opportunities and better patient care.

I wish to thank Michelle McCorkle and Heather Inch-Desuta from the ONS National Headquarters in Pittsburgh, PA, for assistance with the article content.



WELCOME NEW MEMBERS

Dawn Case

Swedish Medical Center

Lisa Davis

Western Washington Oncology

Susan Delmonte

St. James Medical Center

Lesley Florer

Virginia Mason Medical Center

Kristen Geraghty

Virginia Mason Medical Center

Jacquie Kisling-Ferrier

Wenatchee Valley Clinic

Jane Rosenberg

Seattle Cancer Care Alliance

Kathleen Tilton

Seattle Cancer Care Alliance

April Torrey

Evergreen Hospital

Judy Watson

Wenatchee Valley Clinic

Melissa Yanachik

Assistant Manager – Med/Onc (2) Evening, Night

Clinical Nurse Specialist Med/Onc, Rad/Onc Day

Evergreen Hospital Medical Center, located in Kirkland, WA, is experiencing lots of positive growth and change. More acute care beds, a new high tech computer system, financial health, a progressive CEO, many new expanded and remodeled units, and that's just the beginning! If you'd like to join an organization that is incredibly vibrant and active, please give us a call or apply to:

Evergreen Healthcare, HR

12040 NE 128th St. , Kirkland, WA. 98034
Phone: (425) 899-2511 Fax: (425) 899-2510
Email: jobs@evergreenhealthcare.org

Symposium: Examples of Nurses Who Looked Beyond the Rules

Continued from page 4

asepsis, and learn from her what worked best for his skin and ostomy care, which was different from what Leslie had planned. She also learned that the wife really wanted to do this care herself, to be allowed to participate in her husband's care, his healing. This was incorporated into the care plan, and the patient, wife, and nursing staff all benefited from Leslie's willingness to involve the patient's spouse. I don't think this is a unique occurrence in care of cancer patients but it points out again how important it is to listen carefully and be open to trying things a little different. Leslie cheerfully and pridefully described this creativity as "containment of secretions that provided comfort and healing"!

Sue and the Mother's Day Party

Sue describes a family anxious to celebrate a last Mother's day for their mother dying of cancer. They wanted for their matriarch a special day, but she was unable to leave the hospital. A hospital room though, is not a great party room for a family, so the nursing staff arranged for a room normally reserved for hospital meetings to be made available for the Sunday gathering. The room was decorated and the day was very special for this patient and her family. How different the memory of that Mother's Day might have been if the staff had not challenged the "meeting room rules". They heard that families need and responded.

Kay and the Cat

Kay cared for a cancer patient in the hospital whose cat clearly missed it's owner and would not eat. Discharge date was not near, and Kay's patient suffered over the thought of her cat's refusal to eat because she was not there. Kay encouraged the patient's friend to bring the cat to the hospital. Cat and patient were united for a short but much-needed visit in the patient's hospital room; the cat sat purring on the patient's chest; the patient napped too, almost purring herself. The cat was taken home and promptly ate a good dinner to her human friend's relief. Kay stretched the rules, caused no harm, and supported this patient's healing.

Liz and the Priest

Liz's example is another that shows how looking beyond the obvious physical needs of a patient and acting on our caring instincts can make all the difference. Liz was the visiting nurse for a man I'll call Jim, dying of lung cancer. He lived alone in a small cluttered apartment and

that's where he wanted to die. Despite his goal to die at home alone, he eventually did ask his son to return from out of the country to be with him. As Jim got closer to death, as expected, he became weaker, dehydrated, barely able to talk; but generally physically comfortable. The end could not be far, yet Jim's condition had changed little in several days. For some reason he hung onto life. Liz searched for what else she could do to help him. She recalled that he had been raised in the Catholic faith, although he had not been a practicing Catholic for many, many years. Something told Liz he needed to see a priest. She located a priest in Jim's neighborhood who agreed to see him later that day. Liz had seen the patient earlier that day and found him unable to talk to her, and she wondered if the priest visit would be of any help to Jim. The priest arrived and administered last rites. The priest and Jim talked at length, the visit a clear benefit to the patient. He died soon after the priest's visit.

I am guessing you are thinking of your own examples of how you colored outside of the lines to meet the needs of your patients. Have you shared those stories with others?

Sharing our creativity in nursing education in big ways

So let's talk now about nursing education and creativity. Time to think outside the box! Creativity in nursing education can happen in big ways or little ways. Let me share what I call a big example first. Vicki Whipple's leadership stirred the collective creativity of our oncology nursing community that initiated the work of what became the Puget Sound Oncology Nursing Education Consortium and the successful development of a 4 day course, "Fundamentals of Oncology". I distinctly remember the phone call I received from Vicki in the fall of 1998 describing her ideas to get a group of Puget Sound oncology clinical nurse specialist's and nurse educators together to brainstorm if and how we might share the challenge of the ongoing need to provide oncology education to nurses. The community responded yes let's do it; the work was begun. Boundaries were crossed and resources shared within a competitive health care market. The curriculum for the 4 day educational program was developed and the first successful course was offered in the fall of

1999.

Vicki provided the leadership for this group for over 2 years as the cooperative group grew. Currently the consortium has completed 8 classes with an average of 100 attendees per class. The number of institutions has expanded to 22. I hope you have had an opportunity to benefit from the ongoing collective creativity of this group that continues on, now chaired by Martha Purrier.

What have you individually or with others within your work environment done that you could share beyond your immediate institution walls? How might you do that? Perhaps an article in the newsletter, or other publication? A presentation at a PSONS education meeting? Again, I encourage you to share your creativity.

Creativity in nursing education in small ways

This symposium is another example of an annual meeting that we reserve for learning and reconnecting with our peers. These examples are the exception or should be to the frequent learning that is required as new oncology information and health related information surfaces daily. More often than long seminars or conferences, we attend shorter presentations, maybe an hour or 50 minute lecture. Sometimes though this lecture format just doesn't do the trick. The content you need to convey just doesn't fit that format. Or maybe the lecture format will work but lack of time to plan or attend prevents using the classroom format.

Time to get creative! This next example comes from my own experience again. Many moons ago, in the early 1990's when I was an OCNS at NWH, the nursing management team was making plans to do some hospital wide nursing education to raise awareness of our nursing standards. JCAHO requires that nursing competency be maintained through a combination of competence assessment and educational activities, but enticing nursing staff to participate in review of material that is viewed as less than exciting can be a challenge. To meet this challenge we developed a poster explaining our standards model; this poster, with examples, was placed on each nursing unit for "Standards Awareness Month". During one week of that month we dis-

Continued on next page

Snapshots from the Symposium



Pictured left to right: Martha Purrier, Shirley Wagner, Pat Callow Borgeson, and Cherie Toftbagen.



Judy Peterson's words of wisdom - fortune cookies!



Julie Dezso visits with vendors.



Eileen Hansen and Mona Stage.

tributed 1200 fortune cookies containing 30 different questions. The questions were designed to encourage the nurses to use the standards manual to find the answers. To motivate the nurse beyond his or her own desire to learn about our wonderful standards program, we had a contest. If you answered the question on your fortune cookies correctly on the contest entry blank you were eligible to win a prize. We successfully repeated this fun fortune cookie contest to promote standards awareness 3 successive years. Knowledge can be gained while still having fun! Other fun approaches to learning can include a nursing skills fair, where review of psychomotor skills through demonstration, practice, and mock scenarios, allows multisensory learning; there is nothing like getting your hands on those tubes, pumps, ostomy equipment, and code equipment. The Jeopardy game was a favorite of a rehab clinical nurse specialist I worked with. Games and activities allow us to learn experientially- we learn

from what we do rather than what we are told.

Making time for reflection

When do these good ideas come to us? On our way home from work, as we drive home, or in my case on good weather days my walk or bike home. Maybe for you it is in the shower. Getting ideas in the shower or while you are driving has almost become a cliché, but it is true. It is a time when you are free to think. I can think of many a staff nurse I know who when they sat down to chart at the end of a very busy shift, suddenly had time to "think" and had all kinds thoughts, and questions about their patients, "Freed from the busyness of the day, creative energy emerges." (Kalischuk and Thorpe, 2002)

My own creative ideas often surfaces when I am at conferences like this one, learning new things, networking with others and thinking about how to apply new knowledge and ideas to my own

nursing practice. Do you plan reflective time? Perhaps we all should.

In this busy world we live in it is important to give yourself time to unwind and let your subconscious mind do its work and support your creative side.

Nursing is a science and an art. Art requires creativity. I would ask you to consider some different ways of looking at yourselves and your practice as nurses.

When we dare to be creative, we enrich our practice, profession and selves. And it makes us feel good! Dare to depart from the ordinary!

Summary

I would like to close by sharing with you some small bits of advice. You will find this in the fortune cookies that are on your table, in the little white boxes, but before you leave, you have to share with me. I would like you to write down something that you think is important to share with your oncology nursing colleagues, whether it is a nursing tip you have found especially successful or your own brand of creativity that others would benefit from. As you take a cookie, please give back advice, wisdom, a nursing tip that you would like to share.

As I said when I started, I don't consider myself especially creative, I view myself as a practical person who is not afraid to try a new idea and apply it to old problems. I have learned well the adage, nothing risked, nothing gained. And I believe what we gain is worth sharing with each other. I believe nursing will only grow through our collective efforts; as individuals we can contribute to that by sharing our successes with each other. Whether you agree that the stories I've shared here today are examples of creativity or just what we do, I hope that I have given you a chance to reflect on your nursing practice, and think about what you can share with other oncology nurses.

Many thanks to all of you who have inspired me and keep me impassioned about oncology nursing. I tend to be one whose cup is always at least half full and my wish is that someday we won't need oncology nurses to care for patients with cancer, but instead our jobs will focus mainly on prevention. At that point, if I'm not too old, I plan to switch my specialty to occupational health on the nearest space station. ■

PSONS PROFILE

Susanne Murray, RN, OCN

*Susan Hogeland-Drummond
RN, MN, AOCN
Highline Community Hospital*

Warm. Caring. Knowledgeable. Skillful. A great teacher. These are words that nurses, doctors, and patients use to describe Susanne Murray. It's these qualities that help Susanne calm the fears of patients who are having their first chemotherapy treatments at the Cancer Care Clinic at Highline Hospital. It's these qualities that help Susanne in her role as charge nurse in a busy clinic. It's these qualities that bring smiles to patients and families who are coping with treatment and problems associated with their disease.

Susanne is charge nurse at Highline Community Hospital's Cancer Care Clinic. Her role varies from administering chemotherapy, teaching patients, orienting new nurses, managing scheduling problems, and checking on reimbursement with insurance companies, to assuring that requirements are met for a particular research study. "I love my job," says Susanne. "I like the fact that it's a high-tech, high-touch field. I like the advancements of technologies, delivery systems, and therapies. And I like being able to help people during really difficult times." It's easy to feel the compassion that Susanne communicates when talking about her patients. It's easy to understand why her co-workers say that she has a gift for calming even the most anxious patients.

The special relationship that Susanne cultivates with patients and family members comes from her philosophy about being patient - centered. As she explains, "It's very challenging to deliver this high-tech care in an environment where you're not focused on the technology, you're focused on the person - the patient. I feel that I deliver very competent care while staying patient centered." Susanne recognizes the importance of addressing the needs of the whole person: physical, emotional, social and spiritual. She especially

enjoys the relationships that she develops with patients, their families, and their friends. "Oncology nursing gives me the opportunity to provide emotional support and spiritual support as well. Sometimes you need to facilitate the patient plugging into their own strengths."

Susanne has been a registered nurse for over 20 years, receiving her Associate Degree in Nursing in 1978 from Tacoma Community College. Her broad background includes acute care, home care, infectious disease, research nurse, manager, and IV therapy. She has been in oncology for 6 years, and made the change to oncology because she felt drawn to the specialty. As an experienced nurse, Susanne greets the changes she's seen in oncology nursing. "I've known nurses who are afraid of new things, but I think, 'Yeah!'...I enjoy delivering new therapies the best, and sorting out the wrinkles, so that others can deliver the same care more easily in the future. It's very challenging."

In 1999, Susanne achieved the credential of Oncology Certified Nurse. She continues to grow as an oncology nurse and credits the Puget Sound Oncology Nursing Society (PSONS) and the Oncology Nursing Society for helping her in that process. She has served on the PSONS symposium committee in the past, volunteered at the Fall Institute last November, and is an avid educational forum attendee. Susanne says, "I believe that you should belong to your professional organization, no matter what your specialty. That's where you get your resources, your networking, your education, and where you share with others. I promote PSONS with new nurses. I don't know how any of us would do this without PSONS. I get more information in the mail than I could ever keep up with - It's like the floodgates open when you join. It's a privilege to belong to such an active organization."



Susanne Murray

Like all oncology nurses, Susanne copes with the emotional aspects of caring for oncology patients and families. "It's hardest for me when I see cancer recur, to share the sorrow and move forward with them in hope." Her faith is very important to her as she deals with patients and families. Susanne says, "The grace of the Lord Jesus Christ enables me to maintain hope and a healing attitude in the worst of circumstances." She adds, "Of course there are good outcomes along the way that are a source of great encouragement." Susanne describes the need to have a full personal life outside of work. She is active in her church and in an international bible study. She likes to garden, fish, do Karaoke, and pal around with her husband on his Harley. "My husband and I share our home with two dogs, a cockatoo, two parakeets, and two fish" says Susanne. "I guess it's obvious that I'm an animal lover!"

Why does Susanne choose to stay in oncology? "My work is meaningful and adds so much to the character and richness of my life," says Susanne. "I like the technology, but I like the feeling part too...I feel like I'm exactly where I'm supposed to be in my life - spiritually and professionally. This is what I want to do - take care of patients." Patients and staff that you work with totally agree, Susanne - we think that you are exactly where you should be!

AROUND THE PUGET SOUND

Enhancing Connections

Jennifer Wulff RN, OCN
University of Washington
School of Nursing

In 2003, an estimated 211,300 women will be newly diagnosed with breast cancer in the United States (American Cancer Society, 2003) and an estimated 15-20% of these women will be of child-bearing and child-rearing years. For the last 20 years, the Family Functioning Research program at the University of Washington School of Nursing, led by Frances Marcus Lewis, Ph.D., RN, FAAN, has been studying the impact of breast cancer on all members of the family, not just the diagnosed patient. The study team's past research has shown that during the acute phase of breast cancer mothers prioritize survival over parenting even as their children struggle to make sense out of and cope with what is happening (Lewis, Hammond, Woods, 1993). In prior research, virtually every child exhibited distress during this acute period of time. Because of this research, the team has put together a study to evaluate counseling interventions with the goal of enhancing the connection between the mother with breast cancer and her child (ren).

The Enhancing Connections program is a 2-group randomized study to evaluate a multi-component educational counseling intervention for mothers with school-aged children. The main goals of the intervention are to enhance the mother's parenting skills, to improve the quality of the mother-child relationship, to add to the mother's self-confidence in parenting the child about cancer, and to positively enhance the child's behavioral-emotional functioning.

The study is a multi-site, multi-state nursing study funded by the National Cancer

Institute. The program is being conducted in Washington, Arizona, California, Indiana, Minnesota, and Pennsylvania. The team is still looking for participants newly diagnosed within the last six months with stage 0, I, II, or III breast cancer. Participants need to be married or in a stable, partnered relationship, and have an 8-12 year old child who is aware of the diagnosis. They are looking for participants that speak English and live in the Puget Sound area.

The team also has a pilot study, the Helping Her Heal Program, for spouses of women with breast cancer. The study evaluates the impact of an educational program for spouses/partners of women with breast cancer. The overall goal of this program is to assist the spouse/partner to enhance the quality of his relationship with his wife/partner and to add to his confidence in supporting her during the acute phase of diagnosis and treatment. Eligible participants include men who are married or in a committed, partnered relationship with a woman who was diagnosed in the last six months with stage 0, I, II, or III breast cancer and live in the Puget sound area. If you have further questions or you have someone you would like to refer to either of the two studies, please contact the Family Functioning Research staff at (206) 685-0837.

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Where Are They Now?

The Quarterly is planning an upcoming 25th Anniversary edition of the Regional Oncology Nurses Newsletter (RONS) and would love to hear from all nurses involved with its inception, publication, and membership. Please submit pictures, memories and/or a current profile. Please include what you have done both personally and professionally over the last 25 years. Contact your colleagues who may no longer receive the PSONS Quarterly and ask them to contribute. Please help us make this edition a fond memory for all.

Respond by email to newsdesk@psons.org
Respond by mail to: PSONS, Dexter Building
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Please respond
by July 20, 2003



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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.

Genetics of Cancer: Control Paradigm Replacing Cell Death Paradigm

Continued from page 7

directed therapies, control of cellular proliferation, exploitation of cell death, inhibition of metastasis, inhibition of neovascularization, and reversal of multidrug resistance.

Gene-Directed Therapies

Gene-directed therapies affect protein production at the level of the gene. Thus, gene-directed therapies affect the overproduction, underproduction, or production of mutated or altered forms of proteins crucial for normal cell function. Gene therapy involves the insertion of genetic material into a patient's cells. Thus far, only somatic-cell gene therapy is approved for use in humans. Another use of gene therapy, however, is to label cells, such as bone marrow cells. Such labeling has been used in an attempt to identify whether residual tumor cells within transplanted marrow contribute to relapse. Gene therapy also may be used to insert a:

- Functioning gene into a patient's cells (such as wild-type p53), to correct an error.
- Gene for a biologic protein (such as tumor necrosis factor or interleukin-2), to achieve a sustained release of a therapeutic molecule close to the tumor site (that is, to achieve an effective local drug concentration).
- Gene such as the MDR gene into normal cells, such as bone marrow stem cells, as protection against the effects of chemotherapy and radiotherapy.

Researchers in clinical trials are evaluating gene therapies in patients with a variety of solid tumors. Over the last decade, more than 400 phase I and phase II gene-based clinical trials have been conducted worldwide for the treatment of cancer and monogenic disorders and over 3000 patients have been treated. There are many barriers to effective gene therapy that must still be overcome before the hoped for success in this approach might be fully achieved.

Control of Cellular Proliferation

One strategy for affecting cellular proliferation is to interfere with growth-regulation signals from the cell surface to the nucleus. Such signals regulate cell-cycle progression and proliferation. One potential target for this strategy is the RAS oncoprotein. When mutated, the RAS protein becomes "locked" in its active state, con-

Genetic Changes Seen in the Development of Cancer

Type of Genetic Change	Normal Function of Gene	Result of Mutations
Activation of proto-oncogenes into oncogenes	Promotes cell growth when turned on (similar to an accelerator)	Gives cells an abnormal growth advantage
Inactivation of tumor suppressor genes	Normally slows or stops cell growth (similar to a brake)	Cells continue to grow and replicate
Inactivation of apoptosis genes	Initiates programmed cell death	Cells with genetic damage do not die
Inactivation genes controlling cell senescence	Regulates aging in the cell	Cells do not die when they normally should
Mutation of 'mismatch repair genes'	Responsible for correction of errors during DNA replication ("spell checker genes")	Genetic damage tends to accumulate at a greater rate within the cell

From "Emerging Strategies in the Management of Cancer" by P.T. Rieger, 1997a., *Oncology Nursing Forum*, 24, 728-737. Reprinted with permission by the Oncology Nursing Society.

Table 2.

tinually signaling the nucleus for growth. Ras mutations are particularly prevalent in gastrointestinal malignancies, such as colorectal and pancreatic cancers. Novel anticancer compounds are being designed to inhibit the function of the mutated RAS protein by interfering at different stages of the cell signaling process. Researchers are also studying other molecules important in the process of signal transduction, with the goal of designing compounds to inhibit the activity of the molecules. Potential targets include inhibitors of tyrosine kinases and protein kinase C. Small molecular inhibitors of the epidermal growth factor receptor, platelet-derived growth factor receptor, fibroblast growth factor receptor, and Src family of tyrosine kinases are under development. In May of 2001, imatinib mesylate (Gleevec™), was approved for the treatment of CML. A specific genetic abnormality, a translocation between chromosome 9 and 22, is the cause of CML. The white blood cells that are the hallmark of the disease are made to grow by an abnormal protein, called the Bcr-Abl tyrosine kinase. Most chemotherapies act by killing all fast-growing cells—both abnormal and normal. Gleevec™ works by specifically blocking this abnormal protein, thereby preventing the growth and reducing the number of abnormal white blood cells.

Many molecular approaches to controlling cellular proliferation involve p53 function. Potential therapeutic strategies

include development of drugs that mimic the inhibitory effects of p53 protein on cell division; insertion, through gene therapy, of a functional, normal p53 gene into cells; or use of antisense oligomers to block expression of mutated p53.

Exploitation of Cell Death

At least two potential therapeutic approaches capitalize on natural mechanisms of cell death. The first involves restoring or stimulating apoptosis, by, for example, blocking bcl-2 expression. The second involves administering molecules that inhibit the effectiveness of telomerase. Normal human cells undergo a finite number of cell divisions and ultimately enter a nondividing state called replicative senescence. The proposed mechanism of this "molecular clock" that triggers senescence is telomere shortening. The enzyme telomerase, present in cancer cells and reproductive cells, retains the lengths of telomeres; thus, cells are able to replicate without limit. The development of antitelomerase therapies is an active area of investigation.

Inhibition of Metastasis

An important window for intervention in the treatment of cancer may be the period from a cell's hyperproliferative state to the point where the cell acquires the ability to invade and metastasize. Potential therapeutic approaches to inhibiting metastasis are many; the approaches fall into two major cate-

Continued on next page

gories. The first involves cell-surface proteins and secreted proteins—such as adhesion receptors, degradative enzymes, and their inhibitors—and motility-stimulating cytokines. The second involves regulatory proteins and pathways inside the cell, such as the calcium-mediated signaling pathway. Examination of the structure and function of molecules involved at these regulatory “checkpoints” could lead to the development of agents that can block tumor invasion or growth.

Inhibition of Neovascularization

A very active area of investigation is the inhibition of neovascularization. The goal of this work is to deprive tumors of their blood supply. The breakdown of basement membrane and tissue matrix are processes integral to neovascularization, tumor invasion, and metastasis. Therefore, agents that inhibit neovascularization also may inhibit tumor invasion and metastasis, and vice versa. Investigators are now evaluating several antineovascularization agents.

Conclusions

Although more than one million people are diagnosed with cancer every year and more than 500,000 die of the disease, the future is bright for cancer management. Indeed, more than 60% of all cancer patients currently survive their disease. The war on cancer has never been more exciting nor has it moved at such a rapid pace. Oncology nurses, now more than ever, will be needed to educate patients. They will have to explain the complexities of new management strategies, design effective interventions for new, and as yet unknown, side effects that may be associated with emerging therapies; and assume new roles in the ever-expanding arena of cancer care. It is a challenge that initially feels overwhelming, especially to a nurse who currently lacks fundamental knowledge about cell biology, cancer biology, and genetics. However, the nursing profession must begin educating nurses now, so the wealth of knowledge and skills they currently possess can be applied to the future of cancer care.

Activation of proto-oncogenes into oncogenes Promotes cell growth when turned on (similar to an accelerator) Gives cells an abnormal growth advantage Inactivation of tumor suppressor genes Normally slows or stops cell growth (similar to a brake) Cells continue to grow and

TREASURER'S REPORT

for First Quarter 2003, ending March 31st.

Uncleared checks Q4	3,117.65
A. BEGINNING BALANCE	
(Ending Balance Last Report)	\$70,288.20
REVENUES	
Dues (Amount per person \$25-30)	6,085.00
Program Participation Fees	24,035.00
Interest (Checking/Savings/Certificate)	15.35
Donations	10,250.00
Exhibit Fees	13,700.00
Fundraising	0.00
Miscellaneous Other (Specify)	
Advertising	1,480.00
Gain (loss) IDS	422.47
B. TOTAL REVENUES	\$55,987.82
EXPENSES:	
Printing (Typing, xeroxing, etc.)	2,047.04
Postage	407.39
Supplies	336.27
Meetings (Place, refreshments, etc.)	18,443.66
Travel (Airfare, hotels)	0.00
Bank Service Charges	0.00
PO Box Rental	0.00
Honorariums and Speakers	4,875.00
Grants/Scholarships/Awards	1,000.00
Fundraising	0.00
Miscellaneous	3,533.92
C. TOTAL EXPENSES	\$30,643.28
D. ENDING BALANCE THIS PERIOD	70,228.20
E. Outstanding Checks	15,723.10
F. TOTAL (Balance + Outstanding Checks)	\$86,011.30
Balance Checking	52,074.69
Balance Savings	1,171.23
Balance Investment Savings Account	32,765.38
TOTAL ASSET BALANCE	\$86,011.30

replicate Inactivation of apoptosis genes Initiates programmed cell death Cells with genetic damage do not die Inactivation of genes controlling cell senescence Regulates aging in the cell Cells do not die when they normally should Mutation of “mismatch repair genes” Responsible for correction of errors during DNA replication (“spell checker genes”) Genetic damage tends to accumulate at a greater rate within the cell.

From “Emerging Strategies in the Management of cancer” by P.T. Rieger, 1997a., *Oncology Nursing Forum*, 24, 728-737. Reprinted with permission by the Oncology Nursing Society.

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Year 2002
**PSONS QUARTERLY
WRITING AWARDS**

The winners of the PSONS Writing Awards for the publication year 2002 are:

RABIYA MUHAMMEDI

PSONS member

For her article on the
**“Overview of Head and Neck
Cancer”** in the summer issue

and

JUDY OZUNA

non-PSONS member

For her article on **“It’s All in
Your Head: Assessing Brain
Function”** in the summer issue

and

SUSAN HOGELAND DRUMMOND

Readers Choice Award

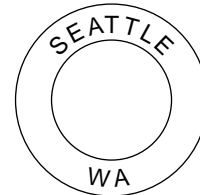
For her article on **“Leadership
Lessons from Linda”**
in the winter issue

Articles were judged for clarity of writing, timeliness of topic, usefulness to practice and the ability to stimulate interest by the editorial board of the Quarterly. *Congratulations Rabiya, Judy, and Susan!*

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