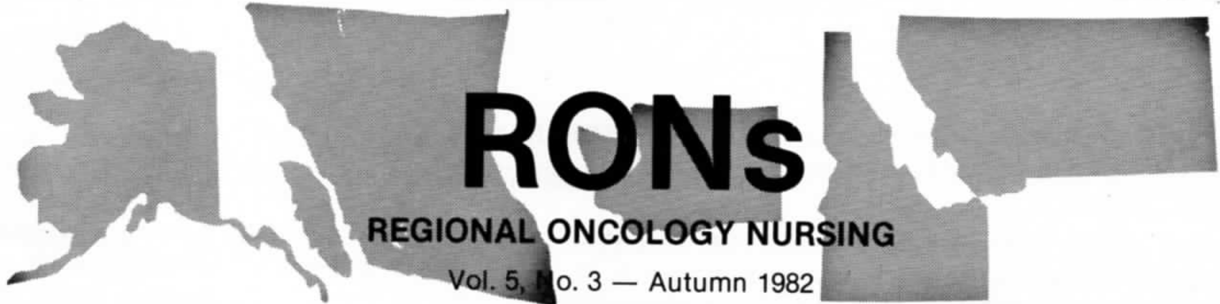

PRESIDENT'S REPORT

Judy Kornell

The planning committee for the annual nursing symposium and RONs meeting has been getting up for 7:30 AM meetings most of the summer. Much work has been done by Lynne Talley, Teresa Coluccio, Ann Reiner, Ryan Iwamoto, Janet Schwarz, Rosemary Ford, Patty Mulhern, Liz White, Ann McElroy, Karen Landenburger, and Judy Kornell. See article this page for further information.

Issues that are facing us as an organization include a decision we need to make regarding becoming a local chapter of the Oncology Nursing Society. Our membership has considered this in the past, and has voted against it. This was because of philosophical and political differences over the Equal Rights Amendment and location of ONS Congresses.

However, since our resolution was passed at the last ONS Congress, that issue is now moot. We will again discuss chapter status at our Fall quarterly meeting, and will plan to vote again on the issue at our Winter annual meeting in January. Please attend the Fall meeting if you have questions or opinions about this question.

RONs QUARTERLY MEETING

DATE: OCTOBER 22, 1982

PLACE: VIRGINIA MASON HOSPITAL
AUDITORIUM
9th AND SENACA
SEATTLE

TIME: 7 pm to 9 pm

TOPIC: "Talking with Kids Whose Parents have Cancer"

SPEAKERS: JOANNA BECKLEY, MSW
CYNTHIA LEE, MSW, MPH
Tumor Institute
Swedish Hospital and MC

PLEASE JOIN US

ANNUAL NURSING SYMPOSIUM

"Humanistic Dimensions of Cancer Nursing: a Cultural and Spiritual Perspective" will be the title of a two-day symposium sponsored by the Regional Oncology Nurses' (RONs).

The purpose of this conference will be to stimulate reflection on the interaction between values, religion and culture in cancer nursing care.

The symposium, as usual,will be held in conjunction with RONs annual meeting. The dates are January 21 and 22, 1983.

Leah Curtin, director of the National Center for Nursing Ethics will be the keynote speaker. She will address the existential concerns of patients with cancer, integrating how a patient's values affect his or her decision-making.

Johnny Cox, director of Health and Human Values at Providence Medical Center in Seattle, will also speak. His perspective will be from the spiritual dimension.

Two associate professors from Seattle University complete the speakers list. Jane LaFarge, RN, Ph.D. and Rose DeGracia, RN, MS will speak to the cultural issues affecting cancer patients' needs.

In addition, the ever-popular roundtables will be scheduled as usual into the symposium time.

Registration for the symposium is $50.00, which includes lunch, continental breakfast, educational handouts and published proceedings.

To register, and for additional information, contact Teresa Coluccio 206-326-5937 or Ann Powers Oakley 206-292-2766.

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EDITORIAL:

Nurses and Social Workers

The hospital where I work is thinking of adding a social worker to our hematology-oncology out-patient department. The nurses who work here are pleased with the thought of their patients receiving more comprehensive care, but they also are feeling somewhat threatened and uneasy. It seems to me that the setting is this:

1. We want to help our patients, but we also want our patients to know that it is we who have helped them. In fact, nurses, ~~physicians and social workers~~ sometimes seem to be competing for (grateful) recognition from their patients.

2. A nurse's psychosocial interventions are frequently the most rewarding and satisfying of all patient care activities. Nurses do not want to lose that part of their job.

Two articles in Social Work and Health Care address this potentially difficult situation. One (1) is a report on a survey of RNs and social workers in 4 Seattle area hospitals. The second (2) is a discussion of a particular social worker-RN conflict.

The survey of 237 RNs and 60 social workers showed that hospital-based social workers in general are older and better educated than the hospital-based RNs. Only 14% of the RNs had master's degrees; 85% of the social workers did. Perhaps this discrepancy makes RNs fearful that they will be forced "back" into task-oriented medical assistance activities because the social worker is more explicitly and extensively trained to provide psychosocial care. The addition of a social worker to a team may imply a step down in status and function for the RN.

A social worker friend of mine points out that social workers have their own fears of status-demotion. Social workers may become competitive and defensive if their psychosocial skills are overshadowed by the team's defining them predominantly as "the one who deals with welfare, transportation or meal tickets."

The second paper reported that when a social worker was added to a renal dialysis team "a sense of territoriality, resistance to sharing information and a defensiveness regarding assessment and intervention developed" between the social worker and the RN.

I have seen these behaviors in action; they create a devastatingly uncomfortable (not to mention unproductive) work environment. For instance, information and knowledge about a patient can be used as a weapon to be withheld or strategically divulged in a power struggle among health care providers. Both patient and provider suffer.

A number of factors create this problem; a variety of solutions can be suggested. Teamwork, it appears, is here to stay. Caregivers will continue to have to work together. Given that, how can we overcome our mistrust and our competitiveness? How can we best maintain our job satisfaction and our sense of professional identity and ability?

I think the best bet is with open and direct communication, particularly on the topic of role expectations. Problems of ego and status should be expected. The problems of overlap of function, and of differences in skill and preparation (as well as inclination) will never be completely settled. They will come up periodically in every team and can never be permanently set aside.

The best defense against the problems of RN-social worker teamwork is a good offense. Meet the questions of job satisfaction, job description, leadership and decision-making head on within your team. Don't wait for them to come to you.

Kit Bakke RN

(1) Williams, C., et al., "Social Work and Nursing in Hospital Settings," Social Work in Health Care, 3(3):311-322, Spring 1978.
(2) Lowe, J. and M. Herranen, "Conflict in Teamwork: Understanding Roles and Relationships," ibid., pp. 323-330.

Cancer Treatment Update

Three new cancer therapies were presented at the July RONs quarterly meeting. The following is a short description of each, including addresses for obtaining further information.--Ed. note.

HYPERTHERMIA: Heating of tumors to cause cell death is currently being tested in Phase I, II and III studies. Heat is conveyed to solid tumors via implanted needles; the tumor is heated for at least an hour (during which the patient must lie completely still in an isolation room). This treatment is repeated at 72-hour (or longer) intervals. Much of the nursing care with this therapy has involved helping the patient cope with the stress and anxiety of that hour of immobility and isolation. In addition, prolonged hyperthermia of deep tumors can cause the "heat stroke" phenomenon in a patient as the entire body does absorb some heat.

For further information, contact the Tumor Institute of Swedish Hospital Medical Center, 1221 Madison, Seattle WA 98103.

MONOCLONAL ANTIBODIES: These hybrid cells (hybridomas) have been studied intensively since the mid-1970's. They are immune cells developed to attack antigens of particular tumor cells. They are injected into a person with cancer and theoretically they attack only the cancer cells in the person. Monoclonals can be combined with chemotherapy agents so that the toxic drugs are carried directly to the tumor cells by the antibodies.

Monoclonal ("single-clone") antibodies are produced by injecting tumor cells from a person with cancer into a mouse. The mouse then produces antibodies against the human cells. These antibodies are removed from the mouse spleen and fused with cancer cells from a second mouse with myeloma. These fused antibody-myeloma cells with multiply endlessly.

The hybrid cells which contain antibodies against the original human cancer are then selected out and cloned separately. Each cloned cell will produce antibodies against the original human cancer indefinitely.

Currently, monoclonal antibodies are being tested diagnostically to identify populations at high risk for acute lymphocytic leukemia, melanoma and some non-Hodgkin's lymphomas. Therapeutically, they are being used in Phase I testing against colon cancer, melanoma some leukemias and graft-versus-host disease.

Potential side effects of this treatment include all possible effects associated with introducing a non-human protein into a human bloodstream.

For further information, contact the Fred Hutchinson Cancer Research Center, 1124 Columbia, Seattle WA 98104.

NEUTRON BEAM RADIOTHERAPY: This is a particular frequency of radiotherapy which can produce intense irradiation of a very discrete field. It is being tested especially in cases of head and neck cancer, brain tumors and bladder cancer. It can be used alone or in conjunction with more conventional radiation.

Usually it is not applied more than three times a week. Although it may be more effective than conventional radiation in some cases, it also causes necrosis of normal tissues. In early tests of neutron beams in glioblastomas, the patients died of necrosis of the brain due to the therapy at the same rate as others died of their untreated tumors.

However, adjustment of timing and dosages has led to an increase in median survival of persons with glioblastoma from death in less than 6 months to death in 12-13 months. For further information, contact the University of Washington Hospital, Department of Radiology, 1959 Pacific, Seattle WA 98105.

Virginia Shubert, RN

RONs NEWSLETTER

Published Quarterly by Regional Oncology Nurses

Edited by Kit Bakke and Judy Moore

Letters and articles are requested from all RONs members and other readers.

Submit material for publication to Kit Bakke, RN, Children's Orthopedic Hospital and Medical Center, H-517, 4800 Sandpoint Way NE, Seattle WA 98105.

CASE PRESENTATION: Home Care for a Woman with an Epidural Catheter

Marian is a 69 year old woman who has been bedridden with pain for over a year. She lives at home with her husband. She was diagnosed with breast cancer 20 years ago and her disease has had many ups and downs throughout its course. The development of painful bony metastases to her pelvis proved to be a unique challange in pain management.

As Marian's bone pain increased, both IM morphine and oral methadone became inadequate comfort measures. After the persistent efforts of her home care nurse, she was accepted by the Pain Clinic at the University of Washington for the placement of an indwelling epidural catheter.

Epidural catheters have been used extensively in the past for the introduction of anesthetic agents for surgery and childbirth. The catheter, in these cases, is left in only a few hours. Until recently, there has been much controversy regarding the placement of epidural catheters for long-term use because of the risk of infection. So far, (about 2 months) this has not been a problem for Marian.

In July, the catheter was introduced into the epidural space percutaneously at the level between L3 and L4, and taped in place. The distal end, approximately 14 inches from the point of entry, is closed with a needle adapter and injection cap, then coiled and taped to Marian's abdomen. The length of the catheter allows for easy manipulation for both patient and caregiver.

Initially, b.i.d. injections of 3mg morphine diluted in 5cc normal saline was effective pain management. This has had to be increased several times, and is now 9mg morphine in 5cc normal saline every 6 hours.

Although aseptic technique is used in the preparation of the medication, the injection site on the catheter is not cleansed. Introduction of alcohol or betadine into the catheter caused the patient much discomfort, as well as breakdown of the cap. The injection cap is changed every three days.

The procedure for injection is as follows: 1) aspiration of the catheter to check for placement; 2) injection of the medication slowly; and 3) injection of 0.3 cc air to clear the catheter of the medication.

As the medication enters the epidural space, it diffuses across the membrane into the central spinal canal below the level of entry. The morphine does not flow upward into the brain. Anesthesia of the spinal nerves a distal to the catheter site is felt within 3-5 minutes.

As Marian's bone tumors have grown, both the dose and frequency of her injections have been adjusted to keep her comfortable. She now gets 0.05 cc epinephrine with each dose of morphine to decrease the amount of morphine absorbed by the blood vessels. This addition has resulted in a longer duration of pain relief.

Marian's care has presented quite a challenge to her home care nurses. The necessity for close monitoring requires 2-4 nurse visits a day. Marian is also able to self-administer her medication. This is an important source of self-confidence for her. An extra prefilled syringe is always at her bedside should she require it between nurse visits.

The frequent visits have required the services of two home care agencies and multiple nurses. This number of different nurses has proven stressful to Marian and her husband.

However, the efforts of these caregivers have been fruitful. During the last couple of weeks, Marian has frequently recorded "zero's" on her daily pain scale. At the time of this writing, she is able to enjoy restful sleep freed from the fear that the pain will return.

The use of indwelling epidural catheters, as illustrated by this case, is a new technique for providing continuous comfort for cancer patients. The main complication appears to be the need for frequent nurse contact. The payoff of comfort within the home setting seems to justify the necessity of this extensive caregiver commitment.

Cathy Nunneley, RN

REFERENCES

Schwarz, T. "Prolonged Regional Analgesia with Morphine--Epidurally," RN, May 1982, pp. 33-5.

Howard, RP, "Epidural Morphine in Terminal Care," Anaesthesia, Vol. 36, pp. 51-3, 1981.

QUARTERLY MEETING MINUTES

The following is an abbreviated version of the secretary's minutes of the meeting held July 24, 1982, in Seattle. A quorum was not present (12 members).

President's report by Judy Kornell, stated that Dr. Day, of FHCRC, has agreed to finance the next two issues of the newsletter, and also assist with the cost of the RONs Annual Symposium. Other sources of support will also be explored for the future.

Treasurer's report, given by Ann Reiner, included a $150 contribution for the UICC Social Gathering for International Nurses.

UICC and Program Committee reports, by Ryan Iwamoto, asked for additional volunteers to assist with the buffet dinner for UICC nurses, and also with meeting logistics. Changing quarterly meeting days to mid-week was discussed, but weekend meeting days were retained to encourage out-of-town member attendance.

Kit Bakke, co-editor of the newsletter, encouraged the membership to submit articles, case studies, upcoming events, etc. These should be submitted approx. six weeks prior to scheduled quarterly meetings.

Karen Landenburger, reporting on Nurse-to-Nurse, stated that the Nurse-to-Nurse Network will be integrated into the Cancer Information Service (FHCRC/CIS: 1-800-552-7212). Names and numbers of oncology clinical specialist resource persons in the area will be available at this number. The number of calls per month is presently 20, which is down from 100 previously. It was suggested to make the service more widely known via the WSNA journal.

Ann Oakley and Judy Kornell reported on the Annual Symposium planning committee, which continues to meet regularly. This year's symposium is to be Jan. 20-21, 1983.

Ad Hoc Committee - oncology clinical specialists in the area were brought together in May to share the purpose and goals of RONs and create a forum to discuss common concerns. The two identified areas of interest were standardizing Hickman Catheter care, and discharge planning.

A proposal for Hickman care has been developed, and a first draft was distributed at the meeting.

Judy Kornell and Ruth McCorkle of the nominating committee, reported that two offices will be vacated this year: vice-president and treasurer.

Bylaws - the question of becoming a local chapter of ONS will likely be raised again this year.

Karen Landenberger proposed a formal recognitions of Gail Hongladarom as a strong supporter of RONs. This will be done at the annual meeting.

Ann McElroy announced that ONS is changing the policy of the national nominating committee to 'self nomination'. More information and applications are available in the Summer 1982 issue of <u>Oncology Nursing Forum</u>.

Ryan Iwamoto, RN

CLINICAL NURSE SPECIALISTS

The Clinical Nurse Specialists of Puget Sound held their second meeting on August 24, 1982, at Northwest Hospital, with approximately thirty nurses in attendance. A unanimous decision was made to define Clinical Nurse Specialists as: "those nurses who, through concentrated study and supervised advanced practice at the graduate level (Master's or Doctoral), have concentrated on a defined area of knowledge and practice in a selected clinical area of nursing." (ANA Social Policy Statement.)

The group discussed its potential relationship with the ANA Council of Clinical Nurse Specialists as well as the KCNA and WSNA. Options for affiliation will be explored.

Members agreed that future areas for exploration include clarifying the CNS's position within the nursing community, examining research opportunities and looking at peformance evaluations. Future meetings are scheduled for the fourth Tuesday of every month.

October's meeting will be held at Fairfax Hospital at 2 PM. Interested people should contact Laura Heard (624-1144) or Karen Bonnell (821-2000).

- Marshall Clarke, RN,MSN

RESEARCH HIGHLIGHTS:

Place of Death For Home-Hospice Clients

The purpose of this study was to describe differences between a group of persons who died at home and a group who died in a hospital within three days of admission.

Major objectives were 1) to identify home care stresses which might lead to a hospitalization not desired by the dying person; and 2) to identify nursing actions which might help a family to cope with those stresses associated with an imminent death at home.

A sample of 46 adults who died of cancer while receiving home-hospice care was studied. Half died at home and half in a hospital. Methadology was a retrospective examination of home-hospice records and a statistical group comparison via chi-square and other tests.

Results indicated that the two groups did not differ significantly for any variables in these categories: home-hospice length of stay; diagnosis by location of primary neoplasm, sites of metasteses; length of illness; chronic other conditions; symptom manifestations; or personal and social characteristics of the primary caregiver (the relative who provided most of the home care)--the PCG.

The groups did differ significantly for seven of twenty-two nursing action variables. For the home death group, nurses assessed more frequently that the ill person expressed awareness of the terminal prognosis, that the ill person and/or the PCG held a specific wish for the place of death, and, at an appropriate time, that the death was imminent.

For this group, nurses intervened more frequently to facilitate open negotiation between the ill person and the PCG about wishes for the place of death. The nurse discussed more frequently with the PCG what needed, or need not, be done if the ill person were to die at home.

Approaching significance (with p=.05) was the intervention of teaching the symptoms which indicate imminent or occurred death.

Overall findings suggest that the major home care stress influencing determination of the place of death was the stress of openly negotiating wishes for the place of death. When nurses intervened to facilitate such discussions, the client and PCG were more likely to reach a collaborative decision, and the ill person was very likely to die in the desired place. However, nurses did not consistently facilitate this negotiation.

An unexpected finding was that the sex of the PCG appeared to be associated with the expression of wishes of the ill person. Persons with male caregivers were less likely to have a documented wish for the place of their death than were persons with female caregivers. If they did express a wish, the wish was as likely to be for death in a hospital as it was for a death in the home.

Persons with a female caregiver were likely to express only a wish for a death at home. In addition, ill women were less likely to express any wish than were ill men.

If it were expressed, both ill men and ill women were likely to express a wish for death at home. Ill women, however, expressed more reservations about a home death, and voiced many concerns for caregiver welfare, than did men.

These findings suggest that ill women, and ill persons of both sexes with male caregivers may need more intensive hospice support in negotiating wishes about dying than do ill men with female caregivers.

(Abstracted from Shubert, Virginia, "Variables Influencing Selection of Place of Death of Persons Dying of Cancer While Receiving Home-Hospice Nursing Care," Master of Nursing thesis, University of Washington, 1982.)

NOTE: For a copy of the study instrument, send a stamped self-addressed envelope (double postage--40¢) to: Virginia Shubert, RN
%Community Hospice
200 West Thomas
Seattle WA 98119

DON'T FORGET TO ATTEND

AUTUMN RONs MEETING

OCTOBER 22, 1982 7 pm

ANA ETHICS OFFERINGS

The American Nurses' Association is offering two aids to nurses interested in improving their ethical literacy.

The ANA's committee on ethics has just issued a 40-page publication on Ethics References for Nurses. This pamphlet is available from the ANA Publication Orders, 2420 Pershing Road, Kansas City, Missouri 64108. Cost is $4. Ask for Publication # G-137.

In addition, the committee is planing conference for the summer of 1983 on ethics in nursing and teaching ethics in nursing curricula.

RN HOSPICE TRAVEL MONEY

RN's employed full time in an American hospice program are eligible for the Winston Churchill Traveling Fellowships for 1984.

The fellowships provide grants varying from $2000 to $4000 to travel and observe work in their field in British Commonwealth nations. Grantees must spend at least 6 weeks abroad

Applications may be obtained from The English Speaking Union, Education Department, 16 East 69th St, New York 10021, Deadline Dec. 31.

SPECIAL INTEREST COMMITTEE: HICKMAN CATHETER PROTOCOLS

Following it s inception in May, the RONs ad hoc committee comprised of oncology clinical specialists from throughout the area, has been meeting almost weekly.

To date, the procedures for drawing blood from adults and children have been finalized; and procedures for flushing and heparin locks are in progress.

The intent of this committee is to share information/expertise and develop procedures that allow for a more consistent approach between institutions and providers. This committee will continue to meet weekly and participation/information welcome. Contact person: Peggy Hutchinson, FHCRC, 292-2931.

BEREAVEMENT SUPPORT GROUP

This spring, a group of interested professionals and volunteers from various agencies throughout Seattle gathered to discuss what types and amounts of services are available to survivors. A second meeting was held in September, sharing inovations in bereavement program planning, and lending peer support.

A third meeting will be held in early December. For further information contact Hospice of Seattle, the agency facilitating these meetings: 784-9222.

JOIN THE REGIONAL ONCOLOGY NURSES!

Just fill out this information and we will send you a membership application:

NAME ______________________________

ADDRESS ______________________________

CITY ____________ STATE ________ ZIP ____

Represent yourself in RONs. Help RONs represent you. Join us now.

Send to: Regional Oncology Nurses
% Judy Kornell
4545 Somerset Dr. SE
Bellevue, WA 98006

UPCOMING EVENTS

"Living Through Death"
Unity Church, Seattle
October 16, 1982 8AM-5PM
Fee: $25
More Information: 624-5799

"Grief - A Part of Living"
Northwest Hospital, Seattle
October 19, 1982 9AM-5PM
Fee: $30
More Information: Education/Training Dept., NW Hosp., 364-0555

"A Bereavement Intensive"
by: Community Home Health Care
Red Lion Inn, Sea-Tac, Seattle
October 21-22, 1982
Fee: $80
More Information: CHHC, 285-7030

"Hypnotic Techniques for Family Therapists"
Michele Ritterman, faculty
NW Family Training Institute, Seattle
October 23-24, 1982 9AM-4:30PM
Fee: $130
More Information: Marianne Guss, 838-3689

"Human Values and Cancer: Dilemmas in Cancer Care"
American Cancer Society
Hilton Hotel, Portland
October 29-30, 1982
Fee: $65
More Information: Darlene Corkrum, 283-1152 (Washington)

"Brief Therapy With Individuals/Families"
John Weakland, faculty
NW Family Training Institute, Seattle
November 5-6, 1982 9AM-5PM
Fee: $120
More Information: Marianne Guss, 838-3689

"Breast Cancer Conference for Nurses"
Bethesda Hospital, Cincinnati, Ohio
November 5-6, 1982
Fee: $70
More Information: Virginia Blocker, 513-559-6323

"Interpersonal Communications and Territoriality: How to Be Courteously Assertive and Aggressive
Seattle Pacific University
Nov. 5 & 12, 1982 8AM-12:30PM
Fee: $58
More Information: Pat Jennings, 281-2233

"The Cancer Program in Your Community Hospital"
by: American Cancer Society
Washington Athletic Club, Seattle
November 19, 1982 8AM-5PM
Fee: $30 (includes lunches)
More Information: Terri Arnett, 283-1152

Oregon Comprehensive Cancer Program of Portland, Oregon
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