Oncology nurses are the backbone of cancer care. Nurses intuitively know how important it is to recognize and acknowledge what makes each patient unique. As we reflect on the numerous contributions of oncology nurses to the care of the whole person, we are reminded that current approaches and interventions follow the principle of placing the patient and family at the centre of the treatment plan along the entire continuum of illness. To do this, nurses need to be ready to identify and address sources of distress, particularly at times known to be most stressful, such as the initial diagnosis or subsequent transitions in care – the end of active cancer treatment, or when a cancer relapses.

Nurses provide emotional support throughout the entire cancer journey, and address multiple aspects of the illness experience that encompass psychosocial, spiritual and physical domains of care. Oncology nurses are also essential members of the palliative care team, ideally suited for this role given their comfort and expertise in symptom assessment and management. Given the intensity of the emotional connections between nurses and patients, and the toll exacted by the constant exposure to patients who suffer, it is important to prepare nurses for practice and maintain their psychological wellbeing.

Patient- and family-centred care begins with the assumption that the individual patient is part of a wider family structure and that providing the best possible medical and psychosocial care for the patient means incorporating, forming partnerships with – and when possible – providing care and support for the significant family members. This model of oncology care is the standard practice with cancers in children while the interdependence of the patient and their family members is more obvious, and can serve as a good working model for innovation in cancer care for adults.

Another important aspect of psychosocial care is the ability and willingness of oncology nurses to identify emotional distress in their patients and refer them to treatment when necessary. Research indicates that cancer patients suffer substantial physical and psychological distress and are at an increased risk for suicide. We also know that healthcare professionals frequently fail to recognize psychological disorders in cancer patients. For example, in one study, healthcare professionals identified only one-third of distressed cancer patients who were suffering from severe mental health distress.

Identifying anxiety and depression
Oncology nurses, who have extensive and ongoing contact with patients and their families, may be in a particularly good position to identify anxiety and depression and make the appropriate referrals when needed. Depressed patients with cancer have worries about their disease, relationships with friends, the well-being of family members, and finances. The picture is even more complicated when we think about the long-term impact of a diagnosis of cancer. A recent meta-analysis has shown that anxiety is the most common mental health issue among long-term cancer survivors, a growing segment of our patient population that deserves our
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As time pressures increase, with greater time spent charting or performing tasks that do not involve direct contact with patients, it is sobering to reflect on the vital aspects of the nurse–patient–family relationship. Sitting with a patient who is receiving an infusion, a nurse may skillfully redirect that patient’s anxieties, coach them to take their anti-emetics or anxiolytics on a regular schedule, and maintain their innate hopefulness in a better future. Experienced nurses can also help patients shore up their social supports, perhaps encouraging them to seek help from members of a religious community or relatives or friends who mean well, but need specific directions in order to be useful. Moreover, nurses can perform a vital role in guiding patients to trusted sources of medical information that are vetted by experts, and also help patients debrief after consultations with their oncologists, where treatment options may have been discussed. Helping patients sort through various treatments by thinking about pros and cons, by helping them sharpen their own questions and discuss their hopes and values, provides an invaluable service that is often not sufficiently attention and expertise.¹²

Leeat Granek
Moments of compassion – a personal perspective by Leeat Granek

My mother was first diagnosed with breast cancer when she was 34 years old. My older brother was 13, I was 9, and my baby brother was less than a month old. Little did we know that this first diagnosis was to be the beginning of a two-decade journey into the world of cancer. She would be treated nearly continually over my entire childhood and into my early adulthood for relapses, and eventually for metastatic disease that would ultimately take her life. Cancer was a chronic and steady presence in our lives and continues to leave a shadow to this day.1

Over the nearly 20 years of her treatment, we had a lot of contact with oncology nurses. There was the primary nurse who always looked slightly harried, but who was kind, available, and seemed to have superpowers to coordinate my mother’s complicated care. There were the ‘chemo nurses’ who, to my mother’s delight, always commented on her cheerful outfits, asked about her children, and sat with her for a few minutes when she was ‘hooked up’ to the slow-drip. There were the ward nurses who allowed our whole family – my dad and three little children and a dog in tow – to eat takeaway Chinese food and light Chanukah candles in the waiting room when she was admitted for long stretches of time. And finally, there were the palliative care nurses, who asked about her pain, but also about the books she was reading and the sweaters she was knitting. These nurses provided efficient and stellar medical care, but it was these little moments of compassion and recognition of my mother’s humanity that mattered the most. My mother felt she was appreciated and seen as a whole person with a full life, not just another cancer patient needing an intravenous line. These acts of kindness were a gift for the entire family and helped us deal with illness and loss, for which I remain grateful to this day.

acknowledged by other members of the professional cancer team.

Finally, oncology nurses who are on the front line of patient care are witnesses to intense suffering and are exposed to repeated losses. As such, they may be at risk of burnout, compassion fatigue, grief and moral distress. On an aeroplane, we are taught to secure our own oxygen masks first before helping the person sitting next to us. This metaphor is apt for oncology nurses and other healthcare professionals working in the intensely interpersonal and high-pressure environment of cancer care. Without our oxygen – whether that be social support, hobbies, taking time off, and taking good physical and emotional care of ourselves – we cannot help others. Some examples of self-care might include debriefing sessions,13,14 day-long retreat workshops,15-17 educational sessions on coping,18,19 and week-long residential programmes.19 Strategies on preventing and reducing burnout might also include forming stronger relationships and connections among the healthcare team, providing psycho-education on how to identify, control, and treat stress, and learning how to regulate one’s emotions.20

We count on oncology nurses to deliver care that is grounded in evidence and generously sprinkled with compassion. The impact of those moments of connection and care leave a lasting impression on patients and their loved ones and help them overcome the suffering and sorrow of illness and loss.

Details of the references cited in this article can be accessed at www.cancernurse.eu/magazine

Lidia Schapira, is based at Massachusetts General Hospital and Harvard Medical School. Leeat Granek is based at the Department of Public Health, Faculty of Health Sciences, Ben–Gurion University of the Negev, Beer Sheva, Israel.

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