CHAPTER 1

Introduction

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No man can know where he is going unless he knows exactly where he has been and exactly how he arrived at this present place.

—Maya Angelou

Courage is the first of human qualities because it is the quality which guarantees the others.

—Aristotle

Oncology nursing emulates the best of nursing today. Where else do nurses provide such benevolent care for the soul of a human being, the soul of their patients? We thoughtfully assess and evaluate our patients, select and implement interventions based on evidence when possible, use our presence to provide thoughtful care throughout the cancer experience—from diagnosis to treatment, remission, recurrence, cure, and survival. Cancer care is complex and requires an understanding of multiple physiologic and psychological responses to the disease process and numerous treatment modalities. In addition, numerous factors, such as age, gender, socioeconomic status, ethnicity, and race, can influence incidence rates of cancer, response to treatment, and survival outcomes. Oncology nurses scientifically and intuitively know that sometimes process is as important as outcome.

Historical Perspectives

History can be defined as a study of events from our past leading up to the present time. However, the study of history focuses on not just the chronology of events but also the impact and influence those events continue to have throughout time (Egenes, 2009). Over time, healthcare events occur and trends emerge. These historical trends, in turn, can influence or sway the fortune of individuals and groups (Egenes, 2009). The development and evolution of the nursing profession is intricately and powerfully connected to historical influences over the years.

Nursing has often been called the oldest of arts and the youngest of professions (Donahue, 2010). Although the origins of nursing predate the mid-19th century, the history of professional nursing traditionally begins with Florence Nightingale. However, the hospital schools established in the United States differed from the Night-
In many schools in Europe in one very important respect: they were not endowed as they were in Nightingale’s era and thus had no independent financial backing (Ashley, 1976). As a way to resolve this economic challenge, the hospital-based schools agreed to provide nursing service in exchange for the hospitals offering clinical experience. This type of apprenticeship arrangement was primarily an economical relationship prompting hospitals to establish schools on their own initiative; thus, the hospital was in charge and the student nurse was the apprentice who provided free labor to the hospital in return for informal training (Ashley, 1976).

The first permanent school of nursing in the United States is reported to be the nurse training school of the Women’s Hospital of Philadelphia, which was established in 1872 (Egenes, 2009). Following the Nightingale model, the school had a set curriculum, paid instructors, equipment for the development of skills, provisions for experiences in other hospitals, and a nurses’ library. In spite of resistance from early physicians, in 1873, three notable nurse training schools were established: the Bellevue Hospital Training School of New York, the Connecticut Training School in New Haven, and the Boston Training School in Massachusetts General Hospital (Egenes, 2009). Notwithstanding an intriguing history of obstacles and resistance from the medical community, nursing as a profession has made significant progress. Over past decades, standardization and accreditation of nursing schools has expanded, and as the body of knowledge and science has increased, so has the complexity of patient care.

In nursing, like other healthcare disciplines, much of patient care has evolved to be specialty based. In some areas of health care, specialization in nursing practice began as early as the 1940s; however, it was not until the 1970s and 1980s that specialization of nursing practice flourished and specialty certifications became common. The most notable exception was in pediatric oncology nursing, which became a subspecialty in the early 1940s. These nurses initially worked with tumor specialists and became self-taught in cancer nursing practices. During the early years, pediatric oncology nurses primarily worked to ensure patients were comfortable. By the 1960s, pediatric oncology nurses were practicing advanced clinical skills, and pediatric nursing was the first specialty to develop standards for cancer care.

In adult oncology practices before the 1960s, cancer treatment primarily involved surgery. In 1971, the National Cancer Act was adopted to reduce the incidence of cancer and cancer deaths. Cancer care became more comprehensive, and nurses assumed broader roles in the specialty care of patients. Recognizing the need to provide better care to patients with cancer and to foster professional development of nurses taking care of patients with cancer, a group of pioneer oncology nurses got together and developed a charter for the first oncology nursing professional organization. The Oncology Nursing Society (ONS) was founded in 1975, and in 1979, ONS released its standards for nursing practice. ONS administered its first certification examination in 1988. These historical events were the foundation of oncology nursing practice as we know it today.

The history of nursing demonstrates a pattern of recurrent issues that the profession has been prodded to address over time. Some of these issues include professional standards, autonomy of practice, scope of practice, and control of professional practice. Through the years, the profession has dealt with nursing shortages, new categories of healthcare providers, ethical issues, and changes in healthcare delivery systems. In retrospect, history has shown that not all the concerns facing nursing have been successfully resolved in a clear and proactive manner. However, past decades have brought new insights into the way our profession can better meet these
challenges. Only by understanding the challenges of the past will we be able to find solutions for today.

The history of nursing has distinctly been linked to a tradition of caring (Reverby, 1987). Traditionally, nurses have felt a responsibility to reach out to those in need and to advocate on their behalf. However, Reverby (1987) also contended that nursing’s core value of caring may contribute to the dilemma of nursing in the United States, in part because nurses have often equated the “mandate to care” with properly fulfilling the role of a professional nurse. In this context, nurses continue to deal with the dilemma of altruism versus autonomy in their practice. Accordingly, nurses face challenges to fulfill this mandate in a society that has typically refused to value caring (Reverby, 1987). Therefore, it is our responsibility to create a political awareness for the basis of caring and to find new ways to gain the authority to implement an acceptance of caring and, in the process, gain an understanding of how to practice altruism with autonomy (Reverby, 1987). By doing what we do best, we need to focus on providing “care” while continuing our expert surveillance of patients, advances in technology and scientific discovery, and changes in societal norms, healthcare policy, and delivery systems.

An Institute of Medicine (IOM, 2011) report provided several recommendations that have the potential to transform the nursing profession. Briefly, the report’s four primary recommendations were that nurses should (a) practice to the full extent of their education and training, (b) achieve higher levels of education and training through an improved education system, (c) be full partners with physicians and other healthcare professionals, and (d) develop effective workforce planning through better data collection. The report also recommended to increase the number of baccalaureate-prepared nurses from 50% to 80% and to double the number of nurses with a doctorate by 2020. It is critical to note that the report is not just about nursing per se but also is about an enhanced capacity of nurses to deliver high-quality, patient-centered care (Mason, 2011), and marks a difference in what nursing used to be and what it is going to be (Lavizzo-Mourey, 2011). However, it is important to remember that a key operative is “potential.” Although nursing was clearly instrumental in creating the recommendations put forth within this monumental report, we must continue our vigilant efforts to push forward and engage in discussions with lawmakers, healthcare policy reformers, and the medical community to sustain and maintain a presence in the implementation of these provoking recommendations.

Future Expectations and Actions

Although the issues addressed in the following chapters are challenging areas that we need to continue exploring with ongoing and thoughtful discussions, the list is not inclusive. Healthcare policy is often in a state of flux as we try to balance the social and economic needs of society and the healthcare priorities we face over time. The U.S. population is aging, and with this comes an increase in age-related diseases and related syndromes. Comorbidities are common in the aging society and especially so in the oncology patient population. The number of individuals with chronic diseases such as diabetes, heart disease, hypertension, pulmonary disease, dementia, and cancer is increasing at an alarming rate. Our shift in health care needs to focus on prevention, early detection, and living with chronicity.
Healthcare providers will need to be educated in both aging concepts and chronic diseases.

According to Ashley (1976) and Donahue (2010), nursing is healthcare. Today the United States has the opportunity to transform its healthcare system. RNs can and should play a fundamental role in this transformation. However, professional organizations, the insurance industry, government, and healthcare organizations all must play a role to improve the current regulatory, business, and organizational conditions (IOM, 2011). Perhaps it is not surprising to some that more than 35 years ago, Ashley (1976) wrote, “Given recent and current criticisms of poor quality in health care, the public would do well to turn more of its attention to the developments in nursing and to the problems with which this group has to contend” (p. 132), and “It is time nursing emerged to provide the care it can provide. Society can scarcely afford the waste by ineffective utilization of the talents and abilities of professionally and technically prepared nurses” (p. 134). We are at another crossroads in our history and in our professional development. It would be wise for nurses to thoughtfully consider optimal responses to the opportunities presented in the IOM (2011) report. Indeed, no one is more qualified to chart our future direction, nursing’s future, than we are. We are responsible for the direction we take and must assume the leadership and courage necessary to achieve the goals outlined in the IOM report.

References


