

Yale CANCER
CENTER

answers

WNPR Connecticut Public Radio



Hosts

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Oncology Nurses: Providing the
Support System for Cancer Care

Guest Expert:
Marianne Davies, APRN

Yale Cancer Center Answers

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Welcome to Yale Cancer Center Answers with Dr. Francine Foss and Dr. Lynn Wilson. I am Bruce Barber. Dr. Foss is a Professor of Medical Oncology and Dermatology, specializing in the treatment of lymphomas. Dr. Wilson is a Professor of Therapeutic Radiology and an expert in the use of radiation to treat lung cancers and cutaneous lymphomas. If you would like to join the conversation, you can contact the doctors directly. The address is canceranswers@yale.edu and the phone number is 1888-234-4YCC. This evening Francine and Lynn are pleased to welcome Marianne Davies. Marianne is an oncology nurse at Yale Cancer Center and she joins us for a conversation about supportive care. Here is Francine Foss.

Foss Let us start off by having you tell us a little bit about what your job entails.

Davies Right now I am working as a nurse practitioner in the Cancer Center and I have been doing that for about 10 years; however, I started out about 25 years ago in oncology nursing. From the time I was in college I have always been interested in oncology and started out as an inpatient medical oncology nurse and went to bone marrow transplant for about 10 years then did a short bit as a clinical nurse specialist in education, but always focused on oncology, so now as a nurse practitioner.

Foss Can you tell us what an oncology nurse is?

Davies Specifically oncology nurses that are hired throughout the country have a bachelor's degree in nursing, so it is a professional education and then the advanced degrees can either be done on an institutional level or they can be done on a national level. The Oncology Nursing Society does sponsor several courses and certifications specifically either as an oncology nurse or as an advanced practice nurse, or as a clinical nurse specialist. At Yale we have a very thorough training program for our nursing staff to make sure that they have all the additional education that they might need to take care of the oncology population that they are going to be working with.

Wilson When you started Marianne, did you deal with and help manage all sorts of patients with cancer or did you have a specialized interest? How did it work in the beginning? Talk to us about how that transitioned during your career?

Davies Oncology nursing has become much more specialized, as has all of oncology. In the beginning most of us managed a group of patients with a variety of different diagnosis, and we began to see through the years that each specific diagnosis in itself required specialized training and so now nurses, specifically of Smilow Cancer Center at Yale, are assigned to specific disease populations; therefore, you can get an education in terms of the specialties and subtleties of that specific diagnosis, managing the diagnosis, the symptom clusters that those patients might experience, the specific treatments for age, because the treatments are very specific to the different disease entities.

3:06 into mp3 file <http://yalecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

- Wilson What part of Smilow do you work in? Which teams do you spend most of your time with? Tell us about the multidisciplinary interactions that you have.
- Davies It is really fascinating, now that we are all in one building at Smilow it's quite nice to be able to interact with members of the health care team under one roof. I specifically work in two different units, one is the Breast Cancer Center, which is on the first floor, and then the other unit is the Multidisciplinary Clinic on the fourth floor with the head and neck cancer population, and sarcoma. What we try to do, specifically for the mid-level providers as we call our nurse practitioners and physician assistants, is to assign each of us to a specific disease unit so that we work with one specific physician, medical oncologist, and also members of the extended team. What is nice about having a multidisciplinary clinic is that the patients can come to our center and see not just their nurse and get their infusion, but also see the nurse practitioner, their medical oncologists, radiation oncologist, their pulmonary physician if they require that, a surgeon, and other supportive members of the team.
- Foss Marianne, can you clarify for our listeners the difference in the roles between an APRN, or a mid level practitioner, and an oncology nurse?
- Davies An oncology nurse has a bachelor's degree in nursing and so they might serve some of the roles in the infusion center such as administering chemotherapy, they might be managing patients in the radiation therapy centers such as complications from radiation therapy, assisting in procedures, they may work in the inpatient unit in which they are managing patients that are in an acute care setting requiring hospitalization. Then, what we call a mid-level provider is somebody who is either a nurse practitioner or physician assistant who has a master's degree preparation. They might have been in oncology in the past, but that is not necessary to the role and once you have that mid level certification, the roles are a little bit different. The nursing staff in the other areas is doing a lot of managing of symptoms, physical and psychosocial, and actually delivering therapeutics. Mid-level providers, or nurse practitioners, are actually seeing patients along with their physician collaborator, seeing patients independently, performing physical examinations, diagnosing, ordering tests, very similar and hand and hand with the physician that they are working with. They can write prescriptions and order tests and order the chemotherapy and follow patient's symptoms.
- Foss The nurse practitioner role is one that is not specific to oncology, one can find nurse practitioners in many other areas of the hospital as well correct?
- Davies That is true, it originated I believe as a primary care role to serve underserved populations across the country where there were not enough physicians. That started about 40 to 50 years ago and

6:06 into mp3 file <http://valecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

then it went on to meet the needs of women having children who did not have obstetricians around, so nurse midwives. You can become a nurse anesthetist, that is also a mid-level role but we do have several practitioners at Yale-New Haven Hospital in cardiology, surgery, and pediatrics and I think almost in all of the speciality areas.

- Wilson Obviously your work, Marianne, is extremely challenging and can be complicated. Tell us what you feel is most rewarding about it.
- Davies Probably the most rewarding thing is that the patients are so challenging, they have to overcome so many different obstacles and whether it is making a decision about what treatment to take or whether they should proceed with treatment, how to tell family members of the new diagnosis, or how to get family members involved in care. Helping patients overcome those obstacles is really one of the most rewarding things. It is also very rewarding after they get through treatment and helping them learn how to reintegrate back into their old lives or what their new life might be like now, after they have completed their treatment.
- Wilson When a patient gets a new diagnosis of cancer, obviously this can be very overwhelming. What are some of the greatest challenges that you see these patients facing, and what are some of the techniques and programs that you use to try to help them embark on going through the treatment process?
- Davies I think the most challenging, or difficult part of a patient getting the diagnosis is that it is not a simple blood test like it might be for diagnosing Lyme disease, where you go into a primary care office and do a blood test to get an answer, but with cancer it is not that simple. Sometimes these patients are going through testing, whether it is blood tests or scans or examinations, it could be as long as six weeks before one really knows what the true diagnosis is and that is very stressful. So part of our role is to be there and help support patients through that process and through that unknown, because they are getting a lot of input and a lot of information, whether it is from family, friends, the internet, television, all well meaning people that are trying to feed them information. We try to help them focus on what information they need until they actually have the diagnosis, and that can be very distressing. Their anxiety level tends to escalate during that point in time because they are not doing anything to get well at that point.
- Wilson You brought up the internet, do you think the internet has made your job more challenging or made it easier? Talk to us about the interactions you have with patients based on their internet information because there is a lot of information available, obviously.
- Davies The internet can be very helpful, but it is very challenging for us. There might be thousands of websites perhaps on how to diagnose breast cancer, for example, and patients often times do not

9:05 into mp3 file <http://yalecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

know how to discern which websites are reliable to review, and what to trust, and there is also a lot of false information out there. Patients need to work with their health care providers to help identify which websites are reliable ones so that they are not putting their faith and trust into things that almost anybody could put up on a website about, so that is a real challenge. At the same time, it can be very helpful in explaining to patients perhaps different therapies that might be available if you can help guide them into the reliable sites.

Foss Marianne, can you talk a little bit about the interaction between the nurse practitioner and the treating physician? I know with a number of my patients, they feel more comfortable talking to the nurse practitioner about specific issues, and also most patients don't really want to bother the doctor but they are more willing to sit down and spend time with their nurse practitioner and that certainly plays a major role in the overall care of that patient. Could you tell us a little bit about your interaction with the physician?

Davies That is really good point and that is why we do have such a nice cooperative practice within our multidisciplinary clinic. The patients and family members do tend to bring up different issues with each of their different providers. I think often times patients or family members might feel like they are bothering the physician or they might be fearful perhaps that if they bring up certain symptoms that a physician might not want to continue with certain treatment regimens, this is particularly true when you are dealing with patients that might be on clinical trials, and so they tend to open up more about the symptoms with the nurse practitioner in the room, but then it is our job certainly to make sure that we are collaborating very closely and sharing that information so that we can best care for the patient.

Foss Accessibility?

Davies Physicians, particularly in an academic center, have many other responsibilities besides their clinic responsibilities such as teaching and research, and I think probably the best role that we have in our particular outpatient setting is that the nurse practitioners, or the physician assistants, are there and accessible because we do not have all of those other roles. So if a patient needs to come in on an urgent care basis, if they need to come in on what is considered an off clinic day, we are available to provide those urgent care services for them.

Foss Marianne, are the nurse practitioners also available outside of the academic setting in the community offices?

Davies There are nurse practitioners in some of our community offices with some of the colleagues that we have in the community, but not all of them have nurse practitioners.

11:56 into mp3 file <http://valecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

Wilson We are obviously excited about our move to Smilow Cancer Hospital. Tell us a little bit about what you think the advantage is, from your perspective, for all of us being in one place as opposed to spread out through several buildings, as we were in years past?

Davies It has been really exciting over the past year to be in the same building, it really allows a lot more collaboration. We are able to have many more conferences, tumor boards, research team meetings, disease team meetings, and it makes it much easier to facilitate care of the patient being in one facility. It also is very helpful if we are seeing patients in one clinic, if they have an urgent care issue and we need to collaborate with somebody in a different unit, that we are able to have access to that very quickly instead of having to send somebody to another building.

Wilson In your position you can be involved in an academic setting in both clinical care and research, there are some practitioners who are exclusively clinical, some who are just working on research clinical trials, what is the division?

Davies The nurse practitioners do play a role in assessing patients for clinical trials, assessing for toxicities in clinical trials, but we also have another division of oncology nursing which are research nurses, and they help to do the nitty gritty work of keeping patients safe on a clinical trial and assessing them for toxicities and tolerance to treatment.

Wilson We are going to take a short break for a medical minute. Please stay tuned to learn more information about supportive care for cancer with Marianne Davies.

*Medical
Minute*

There are over 11 million cancer survivors in the US and the numbers keep growing. Completing treatment for cancer is a very exciting milestone, but cancer and its treatment can be a life changing experience. Following treatment, the return to normal activities and relationships may be difficult and cancer survivors may face other longterm side effects of cancer including heart problems, osteoporosis, fertility issues, and an increased risk of second cancers. Resources for cancer survivors are available at federally designated comprehensive cancer centers such as the one at Yale Cancer Center to keep cancer survivors well and focused on healthy living. This has been a medical minute brought to you as a public service by Yale Cancer Center. More information is available at yalecancercenter.org. You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.

Wilson Welcome back to Yale Cancer Center Answers. This is Dr. Lynn Wilson and I am joined by my co-host Dr. Francine Foss. Today we are joined by Marianne Davies and we are discussing supportive care for cancer. Marianne, how has the field of oncology nursing changed since you first started seeing patients? Obviously, you are extremely experienced and have had a lot of

14:50 into mp3 file <http://yalecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

different roles during your career. What do you think are some of the important changes that have taken place?

Davies I think that over the course of the twenty-five years that I have been managing and dealing with cancer patients, initially most of our patients were treated with very aggressive therapies in the hospital. I think we always felt that we needed to have that protected environment in order to administer a certain chemotherapy drug and we also had patients in the hospital for many of our clinical trials. Over the course of the years, many of those very aggressive therapies have moved to the outpatient setting. It used to be that the outpatient setting was for very simple procedures and if you walk through our infusion centers now you will see that there is a high level of skill involved with the nurses managing these patients in the outpatient setting. There are very complex treatment regimens often times over a period of several day time and it may last several hours each day. So, we are managing patients in the outpatient setting more aggressively. We have become very skilled at our supportive care for those patients in terms of managing symptoms and being able to keep patients out of the hospital with complex symptoms or side effects that they might have had from their treatments. We are also working very closely with our community colleagues, whether it is the VNA, CanSupport, or Hospice Home Care Nurses to help us manage the symptoms in the homes so the patients do not need to spend as much time in the hospital for those kinds of things. In addition, we used to deal with the acute reactions in the hospital setting and now in most cases that is reserved for patients that are acutely sick with some complication from their therapy.

Foss Marianne, one of the major changes in oncology has been the availability now of oral chemotherapy drugs and that obviously poses a lot of issues with respect to accessibility, insurance issues, and compliance issues, and how do you monitor those patients? Can you tell us as a practitioner, what the impact of oral chemotherapy has been in your practice?

Davies It is really exciting to know that you can administer chemotherapy in the oral fashion, but I think that a lot of patients in the community and family members can underestimate the impact of these therapies, as they still are chemotherapy, they still must be monitored very closely, and they do still have side effect profiles that need to be managed. In some situations, patients in some of the outlying areas might not be managed as closely and what we like to do is bring the patients back very frequently during the initial onset of using these oral therapies and there has been a lot of research that has shown that close monitoring by the nurse practitioner and nursing staff of these patients, bringing them in weekly, will allow you to assess their compliance, also monitor for the toxicities. Most often the toxicities or side effects from these treatments occur in the first few weeks so it is critically important that the patient understand that they can still have those reactions and the need to have them come in and be monitored. Then as we begin to develop a rapport with

18:01 into mp3 file <http://valecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

the patients we understand their compliance and then we might be able to spread out the visits a little bit more.

Wilson Obviously you are very experienced, but the field of oncology is complicated and evolves and as a physician there are various mechanisms that I use to try to keep up with advances and learn about new things. What sort of resources and opportunities do you have for that?

Davies Probably the largest organization that we use in oncology is our parent organization which is the Oncology Nursing Society which is now international. We do have a congress, or big convention each year in which thousands of nurses come in from around the world and we are offered four to five days of seminars and continuing education. The organization also has several chapters in the state of Connecticut, we actually have four local chapters and they meet on a monthly basis, they provide continuing education seminars and they also provide an opportunity for networking for nurses across the state. They also have a fabulous online education program where nurses can get really specific training in certain areas of their practice and get continuing education credits. We are also very lucky at Smilow Cancer Hospital that they really do value education and we have a great education department, most of the units at Smilow actually have a unit based educator. We have clinical nurse specialists that also help provide additional training for nurses and also several seminars are offered on an ongoing basis throughout the year for new nurses that are coming in and for continuing education to assure that everybody's competencies are up to date, particularly if there are any new changes in the field. We are very lucky that we have that right at our fingertips on an ongoing basis.

Foss In terms of integrating care between the inpatient and outpatient setting, is there frequent interaction between the inpatient teams and the outpatient nurse practitioners?

Davies It is more so now that we are all under the same roof. Because we are in the same facility, the nurse practitioner are often making rounds on the inpatients for people that we do see in the clinics and we are able to have more of a dialogue now with the inpatient staff regarding hospitalization. One of the other things that is really very helpful is the use of an electronic medical record versus a paper record. We can communicate electronically a lot more effectively, we can monitor our patients when they are in the hospital, and the hospital staff can monitor the patients once they have been discharged too because we all share the same records. Similarly, I can see what is happening in radiation therapy and they can see what is happening in medical oncology, so we get to work together and collaborate in that way as well.

Wilson You have mentioned that with advances many patients are able, fortunately, to spend more time at home and less time in the hospital, but that in some cases may create some additional stresses for the family members. Obviously, if the patient is in the hospital the family can visit and the care

21:09 into mp3 file <http://valecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

team is around, but at home patients could get into trouble and do family members have access to you and your services, how do interact with them? How do you handle that sort of situation?

Davies We work very closely with our discharge planning team and working with the patients at home and they do contact us fairly frequently from home whether it is the visiting nurse that calls us on a weekly basis for any updates or changes. They really are our eyes in the community if the patient is linked into a visiting nurse service, but a patient's family does require a lot of support and I think that is underestimated in many situations. Again, we are fortunate that we have additional support services, but they are going through changes as well. There might be a lot of role changes perhaps if a family member was the breadwinner and now the other spouse has to go out and get a job, or maybe both need to leave their jobs, so financial difficulties can really complicate their care and add to additional stressors in the household. It may be a child caring for a parent or a parent now caring for a child, and we help identify what all those stressors are so that we can help put those additional resources into place to help support them so that we can keep patients home and keep them safe, but sometimes that requires a lot of investigating. Often patients or family members do not understand that they can share all of that information with us and it is most helpful if they do because then we can help provide a support structure to keep them home and safe and of the best quality of life they can have when they are there.

Foss One of your roles is the well-being of the whole patient, and so often times you could potentially be meeting with patients and family members in a counseling type of a setting, not really focusing on their medical issues, but on their psychosocial issues as well.

Davies That is correct, and that is just as important in terms of dealing with the patient's quality of life. Often times what we think as a medical provider is that we have to just treat the disease and that is not really what we're all about in oncology. We need to treat the entire person and how they either accept the disease, how they are mentally dealing with the disease, and whether they have anxieties or stressors is critically important to them being able to even tolerate treatment into the future and we know that if we can help support the patient in a psychosocial fashion, then they actually do better through the treatment, there is more compliance, there are better outcomes, so it is really just as helpful to meet patients for those counseling sessions.

Foss One the things that happens for many of our patients in oncology is that at some point they undergo an evolution from being a patient to being a survivor, and I think that is something that we probably do not do as well as we could be doing. Could you talk a little bit about that and how you undergo that evolution with the patient? How you change what you are doing as the patient gets further and further out from cure of their cancer?

Davies In the past we used to have the standard that you had to wait five years before you

24:15 into mp3 file <http://yalecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

could say a patient was in survival mode, and that is just not the case. Often times patients might have four months of treatment and after that they are now into their re-entry into life and into survivorship issues and this is when we need to integrate patients into either survivorship counseling or survivorship clinics where they can begin looking at those re-entry issues. What are some of the side effects or the long-term complications of their treatment, of their diagnosis, and how do we help work with those so that they can have the best quality of life? At the completion of treatment is really when those patients should be focusing on those survivorship issues and we need to certainly increase the resources to be able to help people whether it is physical therapy reconditioning, through nutrition, through continued counseling, or whether it is through screening for other health complications because of their disease. Those are a lot of the issues that should begin immediately upon completion of treatment.

- Wilson What are some of the most exciting things you have seen, not only in your day-to-day work, but in the field in general of oncology?
- Davies What is really exciting now is personalized care for patients. It used to be that everybody with one specific diagnosis got one treatment, but now with the advances in genetic testing and what not it is not just one standard approach, it is really a customized approach to what the patients specific health status is, what their genetic makeup is, what their specific tumor is, and how we can help craft a therapy that is very specific to them and that is what makes this continuing to be an exciting field because we need to keep up-to-date on that as well and work with the patients to be able to identify treatments.
- Wilson I have had times in my practice in a multidisciplinary setting where the patient can actually be sometimes overwhelmed by all these different doctors and practitioners and students and research projects and all sorts of things that they have access to in a clinical visit. What sort of role have you played in trying to explain that to a patient, or help them through that anxiety because it can be a pretty daunting experience obviously?
- Davies What we try to do in our clinic is bring the patients back after just a couple days of those initial multidisciplinary meeting so that we can sit down and they have had a chance to process some of the information. There is a good chance that they have not processed most of it because it so overwhelming and hopefully they have received a lot of written documentation, but after the initial diagnosis and treatment plan is given, it is helpful to bring them back, bring them back with a family member and sit down and review everything that has been done. It reinforces the treatment plan and allows you to again establish more of a relationship and rapport with the patients. That is one of the things I think that is critical to the role of the nurse practitioner in our clinic.

27:05 into mp3 file <http://valecancercenter.org/podcast/oct1010-cancer-answers-davies.mp3>

- Foss Marianne, can you comment on the role of the American Cancer Society and the Leukemia and Lymphoma Society and various advocacy groups that are out there.
- Davies What is really helpful is we have several social workers within our institution that help patients to identify if they need additional resources in the community, and the Leukemia and Lymphoma Society and American Cancer Society have been incredibly generous not only on a national level, but also locally with our patients and helping to provide access to different services, whether it is transportation assistance, payment of certain procedures or medications, or support networks in the community. Helping to link into the local divisions of these societies has been quite helpful for many patients.
- Wilson I am sure that these relationships that are forged with your patients are very close and patients become very dependent on you and your expertise. Just logistically, how do they access you? Say they are at home or they are out of town and there is a problem, is there a call system or do they call you by phone, how does that work?
- Davies Normally they call our call unit, as were now in one main building each of the disease units has a calling number that goes to a team. If a patient needed to reach me and I might not be there for a day, there will be another member of the team that would get back to them and return a phone call and then internally we have a system in which we notify each other and a lot of it is done through the electronic medical record where we, whether it is a medical oncology fellow or physician or other division, all communicate what the patient's concern is so that we can help make sure that we coordinate the care.
- Foss Could you tell us just in closing, what you think might be the future for oncology nurse practitioners? Can you see the role evolving in any specific direction?
- Davies I am seeing in certain areas even outreach programs into the community, so perhaps here in New Haven we might have some satellite offices where we are offering services so that patients do not always have to come so far away from home, so I think we are evolving in that way. Also, we are evolving in maintaining patients in the home, so perhaps in home visits there is a role there for mid-level providers or nurse practitioners and certainly now that we are in one building, there is an opportunity to really advance nursing research in terms of symptom management and collaborating with our medical partners and also the School of Nursing to advance symptom management for patients.

Marianne Davies is an oncology nurse at Yale Cancer Center. If you have questions or would like to share your comments, visit yalecancercenter.org where you can also subscribe to our pod cast and find written transcripts of past programs. I am Bruce Barber and you are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network