

Who

Are we working together or falling apart? **Professor Alison Richardson** addressed the UK Oncology Nursing Society conference in Manchester last month to examine how cancer nursing is responding to the changing face of the NHS

Cancer nurses and cancer nursing face an uncertain future. After three decades of sustained achievement and progress there is increasing concern about possible erosion of gains made to patient-centred care by nurses who are specialists in this field. Lead cancer nurses are in the front line, constantly challenged by this situation.

Do we move forward together reshaping our contribution for the benefit of patients, or let things drift and possibly fall apart? Depending on who you talk to, and what you read, it's possible to be persuaded we face a fairly forlorn prospect.

Because of the institutionalised models of care delivery to which cancer nursing currently adheres, we place the specialism at risk, a potential demise that mirrors the ongoing demise of our hospitals. I strongly believe our demise might either be accelerated or contained by cancer nurses themselves.

There are many factors driving changes in healthcare delivery. We now find ourselves in the early stages of one of the most significant changes in the way health care will be provided since the inception of the NHS. As a consequence, the position and role of hospitals as a significant provider of care is being eroded and cut back.

CHARLES MULLIGAN

will lead the way?

Lack of confidence

Attempts to achieve greater efficiency through economies of scale are leading to fewer, larger general hospitals. Ironically this is happening when public confidence in large general hospitals is waning for a number of reasons: MRSA, mixed-sex wards, poor quality food, insufficient attention from staff and the risk of being a victim of medical error.

According to Nick Black, a professor of health services research at the London School of Hygiene and Tropical Medicine, we have been here before. In his paper (Black 2005) the establishment of hospitals in our cities in the 18th and early 19th century are tracked and Professor Black makes the point that while the affluent provided financial support for such facilities, none would have relished being cared for in such an environment.

The workhouse infirmaries were a refuge of last resort for the poor. While originally they had been symbols of civic pride and sources of hope, pressure resulting from rapid growth in the urban population accompanying industrialisation led to a fall in standards. By the first half of the 19th century, inpatient care in general hospitals had become unpleasant, sometimes dangerous and largely ineffective.

However, starting in about 1860, hospitals began to be transformed. By the turn of the 20th century, inpatient care was no longer to be avoided.

Professor Black argues that nursing reform and improvements in buildings were largely responsible for this dramatic change, rather than medical advances such as the contribution of anaesthesia and antisepsis. He demonstrated that the major changes in medical practice occurred well after major improvements in nursing care and hospital buildings had been well established.

He went on to argue that since then hospitals have become victims of their own success. Developments, most notably in pharmaceutical and more recently information and communication technology now offer alternative ways of delivering care.

Patients have less need to attend hospital, drugs can replace surgery, diagnostic technology can be moved to primary care, surgery can take place in health centres, telemedicine and telecare dispense with the need for patients to travel, improved management of illness in the community limits acute episodes and improved patient knowledge and self care can enhance self-sufficiency.

Shifts in nursing care

Black (2005) describes the particular developments that have led to the shift in care we are now witnessing.

He remarks nursing has fundamentally changed with shifts in our own social expectations and shifts in emphasis in nurse

to reductions in junior doctor hours and medical staff shortages.

Over the last ten years, I do not think I exaggerate in saying specialist nurses have increased exponentially, mainly in hospital-based cancer care services. Many services have large numbers of nurses who can be roughly classified as specialists. Several domains of practice have evolved and been variously documented.

The degree to which nurses accomplish these roles depends on the knowledge and experience of individuals and the context of where they work.

A specialist is someone who focuses their knowledge and skill on the specific medical and nursing needs of a particular group of patients (Casteldine 2003). In medical

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training – from experience and competence to a knowledge-based education. While change is essential to our development, key elements of nursing, such as a holistic approach and focus on the essentials of care, have perhaps been undermined.

The way in which hospital services are managed have experienced several changes. The management of activities essential to function such as nursing, cleaning, portering, supplies, catering, and maintenance have been separated. We have lost the integration by which nurses manage all these functions at the level of the patient and the ward. Such integration helps achieve good quality care.

Rapid growth in cancer nursing

A second generation of nurse specialists evolved in the 1990s. Many in response to the Calman-Hine report (Expert Advisory Group on Cancer 1995) and later the improving outcomes guidance, and more generally driven by the UKCC'S Scope of Professional Practice (1992) and others in response

specialisation, emphasis is on technical expertise and the knowledge gained from working with a particular medical condition or body part. On the contrary in nursing, although there is emphasis on the nurse developing specialist knowledge and skills in a particular field, they bring not only their generalist nursing background, but also develop the discipline of nursing in the specialist field of work.

Is there an argument to be advanced that in cancer nursing we have, in some cases, pursued a medicalised specialist role for nurses? Many specialist nurse roles are centred around medical diagnosis, treatment or patient monitoring functions. We now face a certain danger in the fact that many nurse specialists have followed this path and failed to define not only specialist nursing but also essential nursing practice. National Institute of Health and Clinical Excellence (NICE) site specific improving outcomes guidance [for an example see NICE 2003] portrays a rigid blueprint for the role and we have perhaps

allowed ourselves too readily to become seduced and orientated around a site-specific model of care delivery

Most role developments in cancer nursing embrace both expansion and extension. The consequence is that its boundaries are shifted and the fundamental nature of nursing is changed. I would argue strongly that the cancer nursing profession does not exist solely to take on delegated tasks of other professions.

A unique contribution

There is research to clarify what it is about specialist nursing roles that makes them unique and of value (McIntosh 2003). I would like to think that specialist nurses have developed because they contribute in unique and important ways to helping patients manage the problems they face. However, lack of clarity and co-ordination has allowed things to get out of control, with a potential loss of key nursing competencies.

So where do our opportunities lie? I recognise it is singularly unsexy and politically incorrect to focus on hospitals in many circles at the moment. But while not underestimating the scope for cancer nurses to contribute to cancer care in the community, I make no apology for this. Hospitals will always be needed for patients with cancer who are severely ill and require complex treatments.

The 19th century taught us that nurses were central to the running of hospitals. This requires strong leadership – leadership you all can provide – together we are responsible for taking cancer nursing care forward. But I also want to stress that this is not work to be undertaken in isolation.

We might, as Casteldine (2003) suggests, need to redraw the boundaries between the work that generalists and specialists who work with cancer patients undertake. We must recognise the levels and types of nursing care and skill that need to be differentiated, valued and supported. There is no doubt that nurses who call themselves generalists today are proud of their broad range of competencies and skills. Good partnerships between specialists and generalists will bring about a system of health and nursing care that puts patients first and emphasises continuity and co-ordination. We should re-examine the key differences between specialist nurses and

generalists in the field of cancer care and health care more broadly. Such an exercise might liberate us from our entrenched positions.

The way in which cancer nursing practice is developed now for the future must have the interests and needs of patients, carers and wider communities at its core.



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We need to seriously re-examine the needs of future patients and with this rethink what cancer nursing needs to look like.

In turn this will:

- Redefine the relationship between patients and those providing care
- Create opportunity for new partnerships
- Inform the planning and design of services.

Finding the right balance

On the one hand, cancer nurses need to value the uniqueness and range of their own skills and resist adopting models from other professions. But on the other, rigid categorisation may serve to encourage independent working rather than team working, and it is important that knowledge and skills are shared. Cancer nurses must be proactive in negotiating the boundaries of the service they provide. This leads me to one major question: 'What should our response be to overcome our current challenges so that cancer nursing can continue making its full and very necessary contribution to patient care?'

The burden of change falls on everyone, but is at the moment most evident among nurses, perhaps because of their greater numbers, but also because of their capacity to embrace new skills within a holistic healthcare model.

There is a fundamental philosophy associated with nursing which is discrete as a discipline but which complements and facilitates the skills of other healthcare professionals and patients themselves. The cancer nurse of the future has to continue to reflect this philosophy, while retaining capacity for flexibility.

We need to think outside our normal parameters to find new solutions to the changing needs of people affected by cancer and the changing context of care delivery. But this will require some thought. We need to rapidly develop a collective vision, developing a coherent evidence-based argument for what the contribution of nurses in cancer care might be.

We are living through a challenging era that necessitates constant changes in direction. Maintaining the status quo is not an option

open to us; cancer nurses can lead much of the change necessary and have a key role to play in working with others to ensure that new and sustainable models of cancer care are designed around the needs of future patients **cnp**

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