FEATURE ARTICLE

Treating One of Our Own

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As a group, oncology nurses are aging, mirroring a large portion of the American public. Many practicing nurses are approaching middle age, and with increased age comes an increased risk for cancer. Many oncology nurses are cancer survivors, and the experience of treating a colleague is becoming more common, but few publications have addressed this topic. Pennsylvania Oncology Hematology Associates (POHA), a private medical oncology practice in Philadelphia, has encountered such a situation. This article captures the experience of one oncology nurse who underwent chemotherapy treatment for breast cancer at her place of employment. She discusses her cancer, chemotherapy treatments, and new level of understanding with patients. Her colleagues also share their reactions to witnessing the survivorship process. The nursing team at POHA has been inspired and humbled by the experience, and patient care has been enhanced. The courage of one individual’s journey has demonstrated how a negative situation can be transformed into a positive one.

Oncology nurses, like all nurses in America, are aging along with a large percentage of the American public. Just as the baby-boomer generation reaches middle age, most actively practicing nurses are reaching the same milestone. Increased age also brings an increased risk for cancer (Schmidt-Luggen, 2000; Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000). Many oncology nurses are cancer survivors (Picard, Agretelis, & DeMarco, 2004); therefore, the experience of treating a colleague is becoming more common. This article will describe the experience of members of a chemotherapy unit who administered chemotherapy to a colleague with breast cancer and worked alongside her on the days of her treatment. By relaying the experience, including its challenges and rewards, the authors hope to help other oncology nurses who most certainly will face a similar situation in the future.

Review of the Literature

Scant professional literature addressing the experiences of nurses who are cancer survivors is available; however, the Oncology Nursing Forum published a two-part article regarding professional and personal experiences with cancer. In Part I, DeMarco, Picard, and Agretelis (2004) discussed personal nursing experiences and how profession influenced survivorship. Using an interview process, the phenomenologic study delved into the lives of 25 RNs with cancer. DeMarco et al. concluded that nurses were more aware of the possibility of developing cancer because of their increased knowledge of medicine, but that understanding was not acknowledged in their care. Part II of the article was based on the same patient population as the first, but Picard et al. (2004) emphasized the professional effects of being a patient. The researchers noted that the healthcare community is responsible for investigating and responding to the needs of its colleagues. Several common themes were identified among the nurses: (a) Individualized support from colleagues allowed the nurses to balance work, life, and treatments and (b) healthcare professionals can advance...
their clinical practice by learning from coworkers’ experiences. Picard et al. concluded that nurses became more compassionate, although a sense of role ambiguity existed at times.

Fedora (1985), a survivor of osteogenic sarcoma who eventually became a nurse, discussed her experience with cancer in an attempt to enhance patient care by nurses and other healthcare professionals. She described her emotions, fears, anxieties, and insecurities and explained that patients with cancer need information, acceptance, understanding, peer support, normalcy, and an honest expression of feelings. Because nurses have opportunities to provide physical and emotional support, they are able to touch on much of the patients’ needs. As a cancer survivor, Fedora was more capable of caring for her patients.

Social support is a large part of cancer care. Finfgel-Connett (2005) examined the concept of social support versus the concept of caring. The two concepts can be interchangeable or very different. Social support incorporates emotional and instrumental support into a social support network. Finfgel-Connett showed that nurses need to assess patients’ social support and refer them to the appropriate discipline when necessary. In addition, the difference between social support and caring must be identified clearly, indicating a continued gap in knowledge of the concepts.

Minnaar (2003) conducted a descriptive study in South Africa that evaluated how nurses care for their patients. The article was ambiguous in differentiating between caring among staff versus caring for patients; however, nurses were more caring to their patients when working in a caring environment. According to the nurses in the study, the hospital environment was not particularly caring. Nurse managers were not viewed as being sensitive and respectful to the needs of nurses; therefore, satisfactory caring suffered. Minnaar concluded that a caring environment is imperative to facilitate excellent overall patient care.

In her 1992 article, Susan Leigh, an RN and a cancer survivor, discussed survival and the effect of health care and society on patients. She noted that survival varies based on the person viewing it. For example, a social worker often looks at the psychosocial effect of survival, whereas a physician generally looks at the biomedical side of survival. Leigh also described changes in the concept of survivorship. At one time, “survivor of cancer” referred to a spouse or close relative of a patient who died. Survivorship now is focused on the patient, is considered lifelong, and is not limited to the period when patients undergo cancer treatment.

Leigh (1992) discussed several challenges of recovery and survivorship. An abundance of information may be overwhelming to patients because a large amount of energy is required to organize and understand it. Loss of control also is a challenge of recovery as Leigh related the years she needed to regain emotional and social stability. She described the obstacles that survivors face with long-term and delayed effects of therapy. Survivors often hesitate to complain about the disease and treatment effects for fear that others may criticize them for not being grateful for being alive.

Leigh (1992) referred to her survivorship as being a magical experience. She believed that hope, empowerment, and an illusion of cure lead to her survival. Each survivor has unique challenges to face, and how the challenges are confronted is based on individual coping mechanisms. Empowerment leads to internal strength and the desire to seek external sources of support through family, friends, healthcare providers, and, most importantly, fellow survivors. Leigh alluded to finding meaning in her diagnosis as an important aspect of spiritual healing. She also discussed the challenges that nurses and other healthcare professionals face when caring for patients with cancer and suggested that caregivers listen and respond to the needs of patients. Poor communication, not poor care, causes many patients to complain about their treatments. Patients wish to be treated with sensitivity and respect.

No theoretical and few empirical studies relate to nurses as cancer survivors in the literature; however, treating a colleague is more common than is reported. Therefore, the experiences of nurse cancer survivors needs to be explored and documented. The purpose of this article is to share the experience of one nursing unit in hopes of increasing awareness (see Case Study).

Setting

Pennsylvania Oncology Hematology Associates (POHA) is a private oncology practice affiliated with Pennsylvania Hospital in Philadelphia. Pennsylvania Hospital, the nation’s first, has a long history of diagnosing and treating cancer. As a member of the University of Pennsylvania Health System, the academic urban medical center diagnoses approximately 2,000 new cases of cancer per year. More than 10,000 chemotherapy treatments were given in 2004, with breast cancer being the most frequently reported diagnosis (Joan Karnell Cancer Center at Pennsylvania Hospital, 2005). Seven physicians work in the practice along with more than 70 employees, including 12 staff members in the chemotherapy suite (i.e., a nurse manager, five RNs, three medical technicians, one scheduling coordinator, one pharmacy technician, and one pharmacist).

Implications and Recommendations

Working with a coworker receiving chemotherapy can be a learning experience. Oncology is a very difficult field from which to separate one’s emotions, especially when a coworker is diagnosed with breast cancer. Although the unit in the case study cheered Linda on throughout her treatment, several staff members also needed encouragement. Some felt awkward asking Linda how she was feeling. Perhaps that was because they did not want her to feel sick or did not want to remind her that she was considered a patient with cancer who needed to focus on herself rather than be the one helping others through treatment. The transition from nurse to patient and back again was difficult on her and on staff. As noted by Picard et al. (2004), nurses must ask what kind of support is needed rather than anticipate what might be helpful.

The staff often felt helpless, wanting to protect Linda and ease her workload on days when she was experiencing symptoms. As a result, Linda was encouraged to talk to her doctor about her symptoms to allow more privacy and help her separate her work environment from her treatment environment.

The staff experienced some anxiety related to Linda’s procedures. Some of the nurses felt awkward about starting her IV; therefore, one nurse was appointed as Linda’s primary caregiver. The primary nurse embraced the role and approached Linda’s treatment like any new patient starting treatment. The primary nurse was an essential part of the success of the experience for the staff and Linda. Although the nurse gave Linda information that might have been basic or obvious, providing all information ensured that nothing was overlooked or assumed.
Case Study

Linda D. Piscitelli’s Story

I started a new job working for a large group of hematologists and oncologists with a great deal of enthusiasm. At the end of the first week of work, I had my annual screening mammogram. I had my test and never gave it another thought; I was trying to adjust to my new job. A week later, I received a frantic phone call from my primary physician’s office. I returned the call and found out my test was questionable; I needed an ultrasound immediately. I still did not panic because I have had questionable results in the past. At the ultrasound, the radiologist said, “I believe you have cancer, but it can be removed. You can have chemotherapy, reconstruction, and be just fine. I went through this 20 years ago.” I only remember thinking how this would affect my family—how to tell them!

I met with a surgeon, a plastic surgeon, and an oncologist. I needed several tests and then had to decide whether to have a lumpectomy or mastectomy. After consultations and consideration, I decided to have a mastectomy with reconstruction and chemotherapy. The decision of where to receive treatment was never difficult. I had eight years of oncology nursing experience and full confidence in the group for which I was working. I had worked for other oncologists, but I believed in the group I was working for. However, I was concerned about my new employer. I felt very guilty that they had hired a “sick” new nurse, but the amount of emotional, financial, and social support I received from my new employer and coworkers overwhelmed me.

I was a new employee, so I had no benefits, no sick time, and no vacation time. I needed to take time off for the surgery. My coworkers donated one sick day each so I could take the time I needed. My chemotherapy was delayed because I needed almost eight weeks to recover from surgery; however, I took only two weeks off work. I spent six weeks packing an open wound on my chest four times per day—a complication of the surgery. Recognizing my difficulties, my supervisor changed my hours from 8:30 am–5 pm to 10 am–4 pm during that time, which was more helpful than she realized.

The day finally came to start chemotherapy. I actually was excited to start because it would be over soon. I had no qualms about being treated where I worked. I could only see the benefits! If my coworkers had concerns, I never knew it; they never said a word to me and only continued to support me. I worked for six hours, signed out, had my IV started and my blood drawn, met with the doctor, and received my chemotherapy. I took no other time off with my first treatment, waiting to see how it would affect me and if I got sick. I learned that I needed two days off approximately four days after the treatment because of side effects. Again, my supervisors were very understanding and willing to work with me to give me whatever I needed.

I decided to work as much as possible throughout the chemotherapy to keep myself busy. I did not want to sit home and think about how sick I was. As the treatments progressed, I learned firsthand which medications controlled my side effects and which did not. I had access to a pharmacist for all of my questions and gained new respect for my patients and what they are put through in the name of being “cured.” I was on dose-dense doxorubicin and cyclophosphamide followed by paclitaxel. I experienced a moderate number of side effects with doxorubicin and cyclophosphamide, but I developed neuropathy after my first treatment with paclitaxel, which increased with each successive treatment. After the second treatment, I fell down some stairs because I could not feel anything on the bottom of my feet. After the third treatment, which was dose reduced, I passed out. As a result, I decided to go on short-term disability for the safety of my patients and myself.

I was amazed at the amount of time I needed to recover from the effects of chemotherapy. I did not realize how pale and weak I had become. I could not pick up small things, turn pages in a book, or walk without watching every step. I gave up several of my favorite foods and drinks because I could not stand the way they tasted. The skin on my hands and feet peeled in large chunks no matter how much or which lotion I used. The only side effect that did not bother me was the hair loss; I hated wearing a wig, so I just went bald or wore a hat. Because I was never sick before, it was the hardest thing for me to deal with. I also had difficulty accepting that I had to slow down and take care of myself.

When I treat new patients now, I try to give them as much information as I think they can handle. I tell them all the possible side effects, emphasizing that everyone is different and they will just have to wait and see how they feel. At the same time, I let them know we all are here for them and will support them with whatever they need. I know the whole experience has made me a better nurse. If I think a patient can handle it, I tell them I am a cancer survivor.

One advantage of Pennsylvania Oncology Hematology Associates (POHA) is that it offers many options for patients, including social workers, psychologists, art therapy, music therapy, and shiatsu massage. Many support groups and programs are available for patients as well as family members and caregivers. I found the music and relaxation therapy to be the most beneficial. Being treated where I was the best choice for me. Cancer changed my life forever, but it also changed the way I think and feel about life.

Manager Kim E. Consalvo’s View

Just after Linda started her employment, she met me in the hall first thing in the morning. She was very calm and told me about her abnormal mammogram and breast ultrasound. Linda’s radiologist was confident that the biopsy would prove to be cancerous. I made a feeble attempt to support and reassure her, but I was amazed at Linda’s calm composure. We decided to wait until she received the biopsy results before discussing the next step.

Without thinking of the consequences (i.e., not asking Linda what she wanted to do or how treating her on the unit would affect the staff), I strongly encouraged Linda to seek a consultation with David Mintzer, chief of the Section of Hematology-Medical Oncology. I quickly met with Dr. Mintzer, hoping he could allay my fears. He kindly offered to speak to Linda that day. Linda and I also decided that we would notify the chemotherapy staff at a meeting the following day.
Unfortunately, the biopsy was positive for cancer. Linda was referred to a surgeon at Pennsylvania Hospital who suggested she have neoadjuvant chemotherapy to shrink the tumor and allow for lumpectomy. However, Dr. Minter recommended Linda have a mastectomy and then adjuvant chemotherapy, to which Linda agreed.

Surgery with immediate reconstruction was scheduled, and Linda did not work for approximately two weeks. Her chemotherapy regimen would be doxorubicin, cyclophosphamide, and paclitaxel dose dense every two weeks with pegfilgrastim support for eight cycles.

Starting chemotherapy in February, Linda chose to receive her treatment on Thursdays, work on Fridays, and take Mondays and Tuesdays off. I asked her to let me know how she was feeling and hopefully reassured her. Amazingly, Linda was able to work until late April, when her neuropathy got the best of her. She then decided to go out on disability. I encouraged her to stay on disability during her recuperation.

This was my first experience dealing with a major illness involving one of my staff, and I did not know Linda well because she had only been employed with us for a short time. I was torn between addressing and being compassionate to her needs and supporting my other staff. How would we proceed? What if she was not able to work? Was I doing more for Linda, crossing the line between personal and professional? Was I offering enough time off, advocating for her to Dr. Mintzer, giving enough support, and talking to her as a nurse but at the same time realizing that she was a patient? I really tried to gauge how I attended to Linda by following my own good judgment and intuition.

David M. Mintzer: Physician and Employer View

From the physician’s (and in this case, also the employer’s) viewpoint, a number of details should be considered when deciding whether to treat a nurse or employee on site. Two female employees were diagnosed with breast cancer in 2004. One chose to be treated at POHA and the other was treated elsewhere. Pros and cons exist to both approaches.

First, the patient should receive optimal health care in whatever setting is selected and should be comfortable in making an independent decision. Provided that optimal therapy can be given on site, risks and benefits must be considered. The employee-patient may experience an increased level of comfort, support, and convenience when being treated at a place of employment. A fellow employee has a certain status and undoubtedly will receive special attention. In addition, the employee may receive “professional courtesy” with reductions or waiving or copays or charges.

Employee-patients can experience negative aspects to being treated in the workplace. First, confidentiality is lost because work colleagues are aware of the patient’s medical issues. Second, the employee-patient may feel inhibited in calling for help or asking questions rather than experiencing easier access to physicians and answers to questions. Quick “curbside” consultations in the hallway can lead to inadequate and incomplete medical care and should be avoided. If issues arise, they should be addressed at regular visits in a private examination room with the same full attention every patient deserves.

A number of details should be considered when deciding whether to treat an employee on site. Ultimately, an employee-patient is entitled to the same consideration, treatment, and follow-up as any other patient.

The employee-patient may be uncomfortable when choosing one doctor or nurse caregiver over another for fear of offending a colleague. In addition, the employee-patient may feel intimidated about seeking a second opinion for fear of insulting staff.

Treating a colleague can be compared somewhat to treating a family member, which generally is viewed as inappropriate. Offentimes, such a situation can lead to loss of objectivity, denial, and a strain on relationships. Although colleagues are not strictly family members, some of the same considerations apply.

A practice needs to consider the potential for increased anxiety and stress that caring for a colleague may place on an already stressed oncology staff. The situation may be unobtrusive if all goes well with a straightforward adjuvant therapy case, but if complications arise from treatment or a recurrence of disease, issues may develop rapidly.

A practice also has to consider how its patients will react to being treated by someone who is going through cancer therapy. Increased empathy and sensitivity are potential advantages. Having had the experience of being a patient can make healthcare providers better caregivers. Patients may see a nurse who is going through cancer treatment and continuing to work as an inspiration. However, other patients might be uncomfortable being treated by someone they see as ill and possibly not at full capacity for providing treatment.

An employee-patient’s health care should be the first priority. The pros and cons should be discussed with all staff involved so that everyone is comfortable with the decision. Ultimately, an employee-patient is entitled to the same consideration, treatment, and follow-up as any other patient.

Staff View

When Linda was diagnosed with breast cancer, we (i.e., Lindsay Williamson, Marianne Englander, Kara Lyons, Cynthia Wise, and Tracy Manuella) were shattered with the news. A week later, she asked for our reactions to her request to receive chemotherapy in our unit. She felt that it was the best place for her to receive treatment. We unanimously agreed that if she felt comfortable with us, we had no qualms with her decision.

Giving a colleague chemotherapy treatments can be an excellent learning experience. Linda was able to give us insight into what was beneficial during her experience as well as recommendations regarding how to treat a colleague with cancer. Confidentiality was important for all of us. Linda’s treatment was administered in a private room during the latter part of the day when most of the other patients were finished. In fact, many patients did not know that she had cancer because she continued to work three to four days per week.

Because some staff were uncomfortable treating Linda, she was assigned a primary RN who cared for her throughout her entire regimen, resulting in a level of comfort and consistency. Linda also used the facility’s pharmacist and nutritionist and found music therapy to be beneficial.
Treating a colleague with cancer was a positive experience for the staff; they believed that it made them better nurses and more conscientious of patient symptoms. That validated the findings of Picard et al. (2004), who reported that the compassionate interpersonal connection between nurse-patients and their colleagues was a lifeline that helped nurse-patients get through treatment and apply the experience and knowledge to practice. Nurse-patients invited their colleagues to apply the deepening compassion to their practice. The staff was affected by Linda's symptom experience; watching her manage symptoms seemed to make them more real to staff. Linda worked during her treatment, giving insight into the importance of work for patients with cancer. Working allows patients to continue a normal routine and avoid putting life on hold for cancer treatment. The staff also gained knowledge regarding fatigue and nausea management in a work environment that they can pass on to other patients. Perhaps most importantly, Linda demonstrated the benefit of working through her treatments, not realizing the effect that her example had on her colleagues and their future interactions with patients.

Professional coworkers with cancer should be treated as any other first-time patient. Remember to question and review symptom management. Follow up with quality-of-life issues, especially fatigue and neuropathy. Patients should be encouraged to take full advantage of supportive services, particularly psychological counseling or alternative therapies. Social support can make a difference in patients' illness experience (Picard et al., 2004).

Communication is an essential tool in treating a colleague. Because Linda and the staff were able to talk openly and honestly, although not always comfortably, they were able to work through the challenge as a team and come through the experience as a stronger and more cohesive unit. For an intervention to be successful, the manager in the setting must encourage open communication and protect privacy. The staff had to be open with Linda in expressing their discomfort or anxiety, and Linda, in turn, needed to be open with them in expressing what she needed as a patient. She had to give them permission to treat her as a patient and not a colleague or nurse.

Conclusion

Although the experience of treating a colleague was upsetting and anxiety provoking for the staff, the experience was not negative. Linda became a mentor to the entire staff by teaching them not to give up, no matter what the obstacle. She demonstrated courage, strength, and motivation and taught—without realizing that she was teaching—how to maintain dignity when something as fierce and powerful as cancer occurs. The disease did not tear her down, at least not on the exterior, and she maintained a positive attitude throughout the experience.

The effect on the patients being treated alongside Linda was significant; her determination and courage were contagious. Linda often was seen sitting with a patient, whether during her own infusion or while administering an infusion, sharing her experience. She was able to turn a negative experience into a positive one, and by her example, the staff was able to find the positive in the experience of treating a colleague.

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References


Appendix. Do’s and Don’ts When Treating a Colleague With Cancer

Do’s and Don’ts for the Nurse-Patient
Do give permission to the staff to treat you as a patient, not a nurse.
Do use all available services at your cancer center.
Do be honest with your caregivers regarding side effects and how you are feeling.
Do speak with a pharmacist if one is available.
Don’t confuse the nurse role with the patient role; separate the work environment from the treatment environment.
Don’t push yourself beyond your limits.
Don’t be afraid to ask for help.
Don’t use “curbside” consultations to talk about symptom management with your doctor; make an appointment.

Do’s and Don’ts for the Staff
Do treat the nurse-patient the same as any other first-time patient.
Do follow up with quality-of-life issues with the nurse-patient.
Do follow the manager’s model for appropriate communication.
Do assign a primary staff caregiver to coordinate care.
Do allow the nurse-patient to decide where to be treated without pressure.
Do encourage discussion about all potential issues, possible severe side effects, extravasations, and recurrence.
Don’t assume that the nurse-patient knows everything about treatment and side effects.
Don’t be afraid to talk about the illness, treatment, or side effects; open communication helps everyone involved.

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