The COVID-19–Cancer Connection

I recently completed work at a large-scale, drive-through COVID-19 vaccination initiative and was immediately struck by its military parallel in mobilizing this emergent medical response. Federal personnel were deployed quickly to assist the local workforce untested in a public health domain. The expansive integration of technology was at a level I had not previously witnessed. Computerized algorithms organized the flow of cars through a huge fairground (think Disneyland Park). Databases were created to register the public, make appointments, and document the specifics of vaccination administration. From day one, the pharmacy tent was in constant overdrive to ensure vaccine supply was in sync with hourly demand. The interface of all these platforms vaccinated 2,300 people per day.

I also witnessed considerable stress in those waiting in line. Ongoing uncertainty, weekly—or at times daily—new information about COVID-19, and rampant hearsay prompted unease. I was repeatedly asked questions such as, "How effective is this vaccination?" and "I hear the Pfizer one works better than the others. Is that true?" The isolation of many older adults was poignantly shared ("I miss my grandchildren so much." "We haven't left our house in over 300 days."), as was their sense of loss ("Both of my neighbors died from [COVID-19]."). I realized many of these comments paralleled those I've heard in oncology practice.

Our work environment as oncology nurses is dominated by the emotional angst our patients and families struggle to contain. Rampant misinformation is the norm. We often lack definitive answers to the pressing questions patients pose. Time spent with those we nurse is brief. Disparity prevails. High-functioning teams are needed rather than solo interventions. Often, psychological first aid and brief damage control is all we can render. We feel pressured to pack a considerable amount of nursing into only minutes of care. In pondering these constraints common to COVID-19 and cancer nursing, I ask, would increasing staff numbers resolve these problems? Or is it more about how we can practice differently?

> "Often, psychological first aid and brief damage control is all we can render."

This massive vaccination initiative was staffed by nearly 200 individuals; I was one of only five RNs employed. In our supervisory role, we acted as mentors and resources in symptom assessment. We responded to questions and offered education at the point of care. We monitored at-risk public for anaphylaxis and counseled the anxious. We taught and supervised nursing students who were there for clinical time because hospital access was not open to them. We role-modeled how to talk to those who felt panicked and de-escalated mounting distress.

We did not vaccinate; paramedics, medical assistants, the National Guard, and the National Disaster Medical System staff administered the vaccine. At first, I was taken aback by this. Shouldn't this be done by a nurse? Is it a problem with supply and demand that others were assuming what nurses traditionally do? Or perhaps I should ask myself, "Why not?" With the impending nursing shortage, future forecasts compel us to anticipate and plan for an altered practice paradigm. What skills will remain unique to nursing?

This question reminded me of a past keynote presentation message addressing nursing's future. Consider what nursing looked like when you started your career and what it looks like now—for me, there has been dramatic change. Therefore, you must anticipate equivalent remodeling in the future. The nursing of tomorrow will not look like it does today. To a great degree, the COVID-19 crisis has prematurely triggered such transformation.

From my ongoing review of the COVID-19 literature, five themes have the potential to endure long-term and have special relevance to oncology nursing (Dzau et al., 2020; Fauteux, 2021; Meti et al., 2020; Muturi et al., 2020; Pham et al., 2020; Shah et al., 2021; Yackzan & Mahon, 2021; Zanville et al., 2021):

- Achieving enhanced understanding of others' roles, learning how to practice together, and engaging in skilled communication
- Reclaiming nursing's public health roots by focusing more on community-based care
- Practicing—not just talking about—diversity and inclusion
- Rapidly adopting telehealth and virtual care
- Acknowledging historic mental health neglect through pervasive prevention and wellness program integration

This year, I celebrate 50 years as a nurse and recognize common ground

between then and now. My oncology nursing career began during a crisis. In 1971, President Nixon signed the National Cancer Act (National Cancer Institute, 2021) in response to cancer's growing prominence. Professional education, resource allocation, and a designated federal structure were needed to leverage specialty practice and research. However, oncology nursing and medical oncology had not been formally established in 1971. At that time, in the absence of clinical evidence-based guidelines, nurses and fellows in the chemotherapy clinic where I practiced had to rely on each other. We truly worked as a team, questioning each other for lessons learned from past experiences, engaging in critical thinking, and employing innovative problem-solving in making care decisions. Five decades later, I again have found myself in new territory that is requiring me to think outside the box as the COVID-19 crisis prevails.

Florence Nightingale said, "Every nurse must grow. No nurse can stand still; she must go forward, or she will go backward, every year" (Nightingale, 1888, p. 864). Perhaps we need to reframe our thinking about the COVID-19 pandemic. Although it has been characterized as the most horrendous global scourge in modern times, it has forced us to think quickly, design solutions with only partial evidence, and do the best we can with limited resources. It has also elevated awareness of a hidden domain of our everyday practice, namely our compromised mental health (Jacobs, 2021). This is a pressing practice affliction we cannot ignore as our future materializes on the horizon.

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REFERENCES

Dzau, V.J., Kirch, D., & Nasca, T. (2020). Preventing a parallel pandemic—A national strategy to protect clinicians' well-being. *New England Journal of Medicine, 383*(6), 513–515. https://doi.org/10.1056/NEJMp2011027

Fauteux, N. (2021). What lies ahead for nursing? *American Journal of Nursing, 121*(4), 57–60. https://doi.org/10.1097/01.NAJ.0000742536.77302.f8

Jacobs, A. (2021, February 4). A parallel pandemic hits health care workers: Trauma and exhaustion. *New York Times*. https://www.nytimes.com/2021/02/04/health/health-care-workers-burned-out-quitting.html

Meti, N., Rossos, P.G., Cheung, M.C., & Singh, S (2020). Virtual cancer care during and beyond the COVID-19 pandemic: We need to get it right. *Journal of Oncology Practice, 16*(9), 527–529. https://doi.org/10.1200/OP.20.00281

Muturi, I., Freeman, S., & Banner, D. (2020). Virtual funerals: A feasible and safer option during the COVID-19 pandemic. *Journal of the American Geriatrics Society, 68*(11), 2472–2473. https://doi.org/10.1111/jgs.16774

National Cancer Institute. (2021). *National Cancer Act of 1971*. https://cancer.gov/about-nci/overview/history/national-cancer-act-1971

Nightingale, F. (1888). Florence Nightingale: The Nightingale School. In L. McDonald (Ed.), *The collected works of Florence Nightingale* (Vol. 12). Wilfrid Laurier University Press.

Pham, Q., Hearn, J., Gao, B., Brown, I., Hamilton, R.J., Berlin, A., . . . Feifer, A. (2020). Virtual care models for cancer survivorship. *Digital Medicine, 3,* 113. https://doi.org/10.1038/s41746-020-00321-3

Shah, M., Roggenkamp, M., Ferrer, L., Burger, V., & Brassil K.J. (2021). Mental health and COVID-19: The psychological implications of a pandemic for nurses. *Clinical Journal of Oncology Nursing, 25*(1), 69–75. https://doi.org/10.1188/21.CJON.69-75

Yackzan, S., & Mahon, S.M. (2021). COVID-19 pandemic 101: An epidemiology and public health primer for oncology nurses. *Clinical Journal of Oncology Nursing, 25*(1), 33–40. https://doi.org/10.1188/21.CJON.33-40

Zanville, N., Cohen, B., Gray, T.F., Phillips, J., Linder, L., Starkweather, A., . . . Cooley, M.E. (2021). The Oncology Nursing Society rapid review and research priorities for cancer care in the context of COVID-19. *Oncology Nursing Forum, 48*(2), 131–145. https://doi.org/10.1188/21.ONF.131-145

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