

COVID-19 and cancer nursing: Challenges and opportunities

The year 2020, designated by the World Health Organization as the Year of the Nurse and the Midwife, has presented us with challenges that few have encountered in their lifetime thus far. As I write this commentary, we are now in month seven of the pandemic in Canada, with the first presumptive, and later, lab-confirmed, case of coronavirus disease 2019 (COVID-19) in our country being reported on January 25, 2020 (The Canadian Press, 2020). Since then, life has changed for all of us in ways that may have previously been unimaginable for many. School closures, shuttering of businesses for months, and the historic closure of the US-Canada border all exemplify the seriousness of this pandemic.

In healthcare, the changes have been similarly profound: donning and doffing of personal protective equipment (PPE) have become a routine part of practice for many healthcare providers where before, PPE had been reserved for particular circumstances. Shifting the provision of care away from facilities and into patients' homes and the community while, arguably, something that many in healthcare have advocated for years, happened with such rapidity that the requisite supports and infrastructure failed to keep pace. The perpetual anxiety and worry that accompany putting oneself at risk of exposure has permeated the healthcare workforce. This feeling is magnified beyond words when considering that one's family and loved ones may also be at risk simply because of our chosen professions. For me, unequivocally, the most challenging and devastating aspect of this pandemic has been that people have died alone of COVID-19 and other causes, without family members and loved ones with them in their final moments.

PROTECTING OUR PATIENTS AND THEIR LOVED ONES

Although Canada has managed to avoid overwhelming our healthcare system and resources thus far, Canada has fared poorly in protecting our vulnerable. As of May 25, 2020, more than 80% of all deaths due to COVID-19 occurred in people who resided in long-term care (LTC) facilities, earning Canada the inglorious indictment of reporting the highest percentage of deaths in LTC facilities among countries belonging to the Organization for Economic Cooperation and Development (OECD), the average of which was only 42% (Canadian Institutes for Health Information [CIHI], 2020). COVID-19 has revealed pervasive structural deficiencies in LTC facilities, ranging from how such facilities are staffed to how they are funded (public, private, or mixed) (CIHI, 2020; Detsky & Bogoch, 2020).

While it may be true that SarsCov2 knows no boundaries and affects people of all ages, all races, and all ethnicities, it is not the great equalizer that some have suggested but, rather,

the great emphasize of disparity in our society. Unequivocally, this pandemic has laid bare the shortcomings and deficiencies in our healthcare system. Physical distancing itself is a privilege available to those who can afford to do it, as is taking time off work when one is ill. Access to testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) may be feasible if one has the means to get to a testing centre or a phone for public health to get in touch with them regarding their results; these are all assumptions that belie reality for many.

Equally disturbing, we are seeing disproportionate rates of COVID-19 infection, complications, and mortality in ethnic minorities, people who are incarcerated, people who are homeless, new immigrants, and refugees (Public Health Ontario, 2020). The convergence of social and economic factors has been shown to influence outcomes of COVID-19. Places of employment that make physical distancing difficult if not impossible, such as meat packing plants and work camps, have also placed people at higher risk of contracting COVID-19. In this pandemic, we have witnessed how the Social Determinants of Health have become the Social Determinants of Illness and, ultimately, the Social Determinants of Death (Weil, 2020).

COVID-19 AND CANCER

While research on the impact of COVID-19 on people with cancer is as yet nascent, preliminary research has revealed that people with history of cancer and with active cancer may be at higher risk of adverse outcomes of COVID-19 such as complications and death (Richards et al., 2020). Furthermore, the pandemic has led to changes in resource allocation, as well as attempts to minimize or reduce exposures for people with cancer. The potential implications of doing so may mean that people with cancer might experience delays in diagnosis, alterations in their treatment plans, and lack of access to clinical trials, all of which may, ultimately, impact outcomes in terms of disease activity and survival (Maringe et al., 2020; Sharpless, 2020). In terms of diagnostic delays, Kaufman et al. (2020) examined changes in the number of newly diagnosed patients with cancer before and during the COVID-19 pandemic. Their study involved 278,778 patients and found that, indeed, there was a significant decline in the number of newly diagnosed patients with six common types of cancer (Kaufman et al., 2020).

Innovative approaches to care delivery that sought to reduce in-person visits for people with cancer, such as the use of tele- or video-health 'virtual' appointments, may have been effective for some patients and even welcomed. Some of the benefits cited included that patients did not have to attend in-person visits, had reduced potential exposures to infection, and did

not have to pay for parking (Jiang et al., 2020). However, virtual visits may not be a good fit for all. In particular, virtual visits may miss the nuanced experience of in-person visits, particularly where non-verbal cues may alert clinicians to patients' concerns. In addition, virtual visits may not be as good at detecting changes in health status (Richards et al., 2020). Further, virtual visits may be difficult for those who have poor digital literacy, those with conditions or disabilities that influence the ability to participate in virtual care, or those who do not have access to the technology required for such visits (Richards et al., 2020).

Visitor restrictions, while necessary, have changed how people have been dying, whether from COVID-19 or other causes. In palliative care, we always endeavour to support the person by having whomever they would like present during their final moments. While visitor restrictions were meant to protect patients and staff, such restrictions forced family members to confront seemingly impossible decisions such as having to choose which one or two loved ones would be there for their dying family member. How do you choose between your spouse, your children, or other loved ones? In their article in the Summer issue of the *Canadian Oncology Nursing Journal*, Stilos and Moore (2020) eloquently describe how COVID-19 has changed the experience of dying for patients and their loved ones. There is no way to predict the precise impact of these experiences aside from the knowledge that such collateral damage will inevitably affect many and likely for years to come.

Throughout this pandemic, oncology nurses have remained committed to the provision of high-quality cancer care, education, and research. Oncology nurses have demonstrated incredible leadership and unwavering dedication. As but one example, Robin Morash, the 2018 CANO/ACIO Nurse of the Year, came out of retirement to assist at a COVID-19 screening centre (Payne, 2020), epitomizing the fortitude and humanity that exist within our profession. The 2020 CANO/ACIO conference theme, 'Now and Forever Oncology Nursing', reflects our enduring pledge to endeavour to provide comprehensive care to people affected by cancer. While this pandemic has presented us with an array of challenges in cancer care, we will embrace these challenges with innovation, collaboration, and determination.

PROTECTING EACH OTHER

Recently, I met with a patient, her husband, and her daughter, to assess her eligibility for medical assistance in dying (MAiD). Having been treated for several years for progressive metastatic cancer and with no further disease-directed treatment options available, she easily met the criteria for MAiD. The conversation we had, as intimate as it was, felt inadequate in many ways. Attired in full-body PPE as I was, the interaction felt lacking on so many levels. My gloved hand held hers, but I was unable to feel the warmth of her skin. Though our eyes met easily, mine veiled by a face shield, the connection between us felt muted. She deserved more. Her family deserved more. And we, as nurses, deserve more. I hope she could see the smile in my eyes as she talked about her life, her

family, her wishes. I hope her family could feel my compassion even in the absence of a comforting embrace. While PPE may protect us from a silent enemy, it does not render us impervious to the emotional and psychological impacts inflicted upon us, as we find ourselves in situations that require such drastic changes in practice. During these challenging times, are we doing enough to support each other? How can we remain socially connected while physically distant? Are our employers and places of work doing enough to support nurses during these extraordinary times? CANO/ACIO is committed to supporting oncology nurses and offers opportunities to connect with one another online, engage in Special Interest Groups, and network with one another. We will host our first-ever virtual conference in November 2020.

GOING FORWARD

Nurses are in an ideal position to amplify the voices that have been muted in this pandemic and, in some cases, long before. Nurses like Dr. Kelli Stajduhar and Tanya Sanders have called for healthcare reform, to increase funding and support for home care, as a potential option to address the challenges of institutional care (Stajduhar & Sanders, 2020). Similarly, this pandemic has emphasized the absolute necessity of palliative care. In their article on COVID-19, palliative care, and public health, Rodin et al. (2020) state, "The severe symptom burden, social isolation and solitary deaths of those with severe COVID-19 infections have been a dramatic reminder of [palliative care's] importance and that of human connection in the context of advanced disease" (p. 96). In 2015, the Canadian Nurses Association issued a joint position statement with the Canadian Hospice Palliative Care Association Nurses Group stating that "All nurses have a fundamental role in a palliative approach to care". Ensuring that palliative care content is embedded in nursing school curricula would mean that nurses, irrespective of their practice setting, could provide primary palliative care.

Dr. Sally Thorne (2020) has advocated for nurses to use their voice to speak up for those at risk of being marginalized, to pay heed to the needs of individuals within society, and "be a nuisance within their workplaces, speaking up for the voices that are silenced, figuring out workarounds on procedures where they believe their patients would be disserved, and ensuring that the human rights and dignity of all persons remain part of the equation" (p. 1).

Thorne also suggests that nurses ought to assist the general public navigate and decode the barrage of information bombarding them (Thorne, 2020). As was demonstrated with the confusion around hydroxychloroquine, we have learned that there is a place for all types of trials in healthcare. We need efficacy trials to prove that a treatment or intervention is both safe and that it works before we are prepared to administer it to our patients. Likewise, we need effectiveness trials to demonstrate that treatments will work in real-world settings (Gyawali et al., 2017). Similarly, the fervent push for a vaccine, while understandable, must be tempered with caution and a commitment to safety. Nurses can and should play a pivotal role in helping the public understand the information available to them.

As Barr stated, “...our enamor—as a scientific community—at the speed of innovation we are witnessing, should not cloud our ability to appropriately communicate with the public” (2020, p. 1).

Never before has it been so abundantly clear that we are connected: locally, provincially, nationally, and globally. As Dr. Jane Philpott said in 2010, “...ill health anywhere is a threat to wellness everywhere. We are indeed connected (p. 232)”. We have a responsibility, a moral obligation, to make sure that everyone has access to comprehensive healthcare, from birth to death. To that end, CANO/ACIO recognizes this challenge and is committed to creating a strategy to support oncology nurses to help those affected by cancer within our borders, as well as beyond our borders.

CONCLUSION

There are profound lessons to be learned from this pandemic. We would be foolish if we did not pay attention and act on them. Future generations can look back on us with

gratitude or look back on us in disdain or not look back on us at all, because if we are not smart about this, there will be no future. Indeed, we should not aspire to go ‘back to normal’ but rather, go forward to a better normal.

For all of those who slipped quietly from their lives, alone, in solitude, in silence... the only sound, the constant metro-nomic humming of a ventilator or beeping of an IV pump, we need to be their voice. We need to be the voice for those who are vulnerable, those subjected to structural violence, and those who experience inequity in access to and delivery of care. Now is the time to reimagine how we can best serve those who need care. Now is the time to use our collective voice to demand change. Now is the time to speak for those who cannot speak for themselves. Now is the time. #NursingNow

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