EDITORIAL

Transitioning to survivorship: An imperative for cancer nurses

Lately I have been hearing a lot of conversations and presentations at conferences about transitions in cancer care, especially the transition at the end of primary cancer treatment. What happens during the transition from primary cancer treatment to post treatment follow-up care, or survivorship, is seen as critical to the long-term health of survivors. The growing number of cancer survivors has stimulated an emphasis on finding new models of care for some cancer populations whereby the responsibility for survivorship follow-up is transitioned to primary care providers, either completely or as a shared approach. A variety of models and tools have been designed to assist in this transition and cancer nurses are at the forefront in testing some of these approaches.

One of the key tools to successful transition has been heralded as the survivorship care plan. It is seen as a key component of survivorship care and a vehicle for supporting transition. It is meant to help both the individual who is entering follow-up care and the health care provider(s). A survivorship care plan generally contains information about the person’s diagnosis and treatment received, surveillance follow-up regimens, late and long-term side effects to watch for, self-management strategies, lifestyle and coping advice, and community resources that could be of use.

Early work evaluating the effectiveness of survivorship care plans was not entirely promising. However, there were significant challenges with these evaluations: lack of agreement on appropriate outcomes, wide variation in actual models and modes of delivery, and lack of attention to implementation processes. More recent work has taken these shortcomings into consideration and the resulting evaluations are much more promising. One consistent finding from survivors who have received a survivorship care plan has been satisfaction with having relevant information about their own situation ‘at their fingertips’.

Despite this situation, uptake of survivorship care plans and implementation of evidence-based models of survivorship care has been slow, hindered by a range of barriers (e.g., confusion about roles and responsibilities, financial concerns, time constraints, not seeing survivorship are part of the cancer journey). Yet survivors continue to report unmet needs post primary cancer treatment. They have identified the urgent need for improvements in access, availability and coordination of services; currently they experience a fragmented and somewhat chaotic system of care once they complete their primary cancer treatment. They find there is confusion about where to go and whom to see if they have concerns. In particular, survivors have indicated the need to feel better prepared at the end of treatment for what is ahead of them. The transition to follow-up care can be an anxiety-filled proposition for them.

I believe that oncology nurses are in an ideal position to provide leadership surrounding the transition of cancer patients. As nurses anticipate the end of primary cancer treatment for an individual, conversations about transitioning could be taking place and patient concerns identified. Oncology nurses could be the health care professional who organizes and shares a survivorship care plan with the individual patient (and family) and reviews it with them. Or oncology nurses could organize group sessions where transitioning is the main focus of the interactions. It could be conceived as an orientation session for survivorship, similar to the orientation sessions we currently hold prior to beginning cancer treatment.

Here are a few recent articles that might be helpful in undertaking this important aspect of survivorship cancer care:


Margaret Fitch, RN, PhD
Editor in Chief, CONJ