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# WHNPs in specialty positions: Cultivating a new role in gynecologic oncology

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Throughout my graduate education in nursing, I had no doubt that I ultimately wanted to focus my practice on women's health. However, I did graduate with a fair amount of trepidation about the possibility that I had limited my options in the advanced practice arena, especially after I had chosen to narrow my focus to oncology. Over the next couple of years, I came to realize not only that my options as a women's health nurse practitioner (WHNP) were more numerous than I had thought, but also that I would be able to help cultivate new roles within the profession as well.

With a background in oncology nursing and a new graduate degree as a WHNP, I had the privilege to combine my two passions: I was able to participate in a highly competitive yearlong postgraduate fellowship for advanced practice providers (APPs) in oncology within my community and university health system. Implemented at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital (the James) in 2013 and accredited by the American Nurses Credentialing Center in 2016, this fellowship provides APPs with first-hand clinical experience paired with core oncology didactic training. The program includes completion of the Oncologic Nursing Society Post-Master's Foundation in Cancer Care course and examination, which served as an excellent complement to my foundational education as a WHNP. The fellowship provided training in a variety of women's health disciplines in the oncology setting, including breast surgical and medical oncology, radiation oncology, endocrinology, and palliative care. I had the opportunity, through inpatient and outpatient clinical rotations, to develop a wide range of skills and ultimately focus my practice in the field of gynecologic oncology.

The gynecologic oncology patient population is diverse, encompassing individuals with ovarian, uterine, cervical, vulvar, or vaginal cancers. Overall, these gynecologic cancers account for 18.6% of those found in women throughout the world.[1] Treatment of these malignancies usually begins with surgery and often includes adjuvant treatment with systemic chemotherapy, radiotherapy, and/or hormone therapy. Patients' experiences with these diseases can vary greatly, depending on the type of disease, the stage at detection, the methods of treatment, and incidence of recurrence. The surgical and medical management provided to patients with gynecologic malignancies makes for a very complex service line, with a growing need for APPs and a particularly great opportunity for WHNPs. Not only do our WHNPs work in conjunction with oncologists to manage and treat gynecologic malignancies and complications that can arise from those malignancies, but they also provide specialized services to patients that are cornerstones of

WHNP education: health promotion and preventive services; resources and education; psychosocial care; and relationship-based, patient-centered care during diagnosis, treatment, and follow-up.

The gynecologic oncology department at my institution is growing rapidly, both in patient volume and staffing needs. In a year's time, the service has grown from three nurse practitioners (NPs) on staff to a total of six NPs, five of whom are WHNPs. Each team has a physician, an NP, and a primary registered nurse. The NP spends 2-3 days a week in the outpatient clinic, seeing patients either with the physician or independently, and has one office day for administrative work. Chemotherapy is administered onsite at the outpatient clinic 5 days a week, and had historically been managed by whichever team was in clinic that day, along with four to five chemo nurses.

As a fellowship-trained WHNP, I was in a unique position to fill and help develop a new WHNP role within the department—one that focuses on the management of onsite chemotherapy, thereby balancing the workflow for those in clinic. In this new "chemo/float" WHNP role, I cover almost every aspect of the gynecologic oncology service and have three major responsibilities: (1) As the dedicated "chemo NP," I address patients' needs *during* their treatment, including management of infusion reactions; (2) As a "float NP," I cover a weekly Friday clinic through which all seven attending physicians rotate, as well as provide clinic coverage for any NP on leave; and (3) I provide cross-coverage in the gynecologic oncology inpatient setting at The James.

In my primary role as a chemotherapy NP, I am still learning to gauge and address the needs of our patients and the chemotherapy nurses providing direct care. Initially, my goal was to help decrease or eliminate interruptions to the primary team during their busy day in clinic. I standardized a process of informal rounding on patients receiving chemo, particularly to address the needs of those patients who had not seen a provider in clinic that day (i.e., those receiving day 8, day 15, or day 22 of that cycle of chemo). In this capacity, I can focus on the symptoms of the patient's disease and/or treatment that may require more scrupulous management, provide emotional support, and respond immediately to hypersensitivity reactions. In addition, I have standardized and disseminated the management and documentation of these infusion reactions to other NPs in our department. I work closely with nursing and our onsite specialty pharmacists to tailor best management and patient care. Because of my experience in the hospital, I understand the most common acute issues that lead our patients to an emergency department visit or hospital admission and can better work with our teams to prevent both.

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Developing a nontraditional WHNP role has provided benefits and challenges alike. The first of these benefits has been the continuity of care I can provide from the clinic to chemo to the hospital. Whereas our other NPs have one or two clinics to which they are dedicated and a group of patients they know very well, I have had the opportunity to get to know patients across all seven clinics—through direct coverage on clinic days, managing their issues in chemotherapy, or overseeing their care while they are in the hospital. Although it took several months to build up this familiarity with so wide an array of patients, the continuity of care has been remarkable and is recognized most prominently by the patients themselves. Given my unique role, there is the real potential that I might see a patient for her first "new patient" visit in clinic, spend weeks with her during daylong treatments in chemotherapy, manage her acute problems in the hospital during an admission, and see her for follow-up in the clinic months later. This continuity provides comfort and peace of mind to patients, elicits confidence in our overall care team, and ensures elevated quality of care for patients throughout their experience.

Another benefit of this unique role has been the development of valuable inter-professional relationships. I was grateful for my fellowship training as I navigated the complexities of oncology and the needs of our patients; I utilized the knowledge and connections both in the outpatient setting and at the hospital to find my niche as a WHNP in our health system. I have continued to foster these relationships over the past year, particularly with multidisciplinary members of each team, including NPs, nurses, case managers, physical therapy, social workers, and each of our seven attending physicians. Perhaps

the most noteworthy inter-professional partnership I have fostered has been with our onsite pharmacists. Our work overlaps so notably in chemotherapy that this relationship has proved invaluable in managing patient care. Working together as an interdisciplinary team has demanded flexibility and creativity on all our parts. This collaboration has led to a more balanced workflow for the patients and the organization, and has provided me with a rich learning environment.

Now, a year later, this WHNP role is still evolving. We have added a similar NP position at our other treatment site, which includes chemo management, clinic coverage, and survivorship care. Both positions are still changing to fit the needs of a rapidly growing service line at The James, and I believe strongly in their potential to improve the lives of our patients. My WHNP education laid the groundwork for my future work in the field of women's health, and my fellowship training refined those skills to a more specific oncology patient population. It has been a privilege to cultivate this unique WHNP role and create a tailored approach to chemo management, clinic visits, and inpatient care. This role elevates continuity of care for our patients and fosters the inter-professional relationships that augment that care. By moving outside the traditional WHNP role, we are finding ways to address and manage patient needs in a revolutionary way.

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### Reference

1. Cook O, McIntyre M, Recoche K. Exploration of the role of specialist nurses in the care of women with gynaecological cancer: a systematic review. *J Clin Nurs.* 2015;24(5-6):683-695.

*(continued from page 34)*

**Berkeley. The author states that she does not have a financial interest in or other relationship with any commercial product named in this article.**

### References

1. Ljubin-Sternak S, Meštrović T. Chlamydia trachomatis and genital *Mycoplasmas*: pathogens with an impact on human reproductive health. *J Pathog.* 2014;2014:183167.
2. CDC. Sexually Transmitted Diseases Treatment Guidelines, 2015. *MMWR Recomm Rep.* 2015;64(3):1-137. cdc.gov/std/tg2015/default.htm
3. Tully JG, Taylor-Robinson D, Cole RM, Rose DL. A newly discovered *Mycoplasma* in the human urogenital tract. *Lancet.* 1981;1(8233):1288-1291.
4. Taylor-Robinson D, Jensen JS. *Mycoplasma genitalium*: from Chrysalis to multicolored butterfly. *Clin Microbiol Rev.* 2011;24(3):498-514.
5. Wikström A, Jensen JS. *Mycoplasma genitalium*: a common cause of persistent urethritis among men treated with doxycycline. *Sex Transm Infect.* 2006;82(4):276-279.
6. Frølund M, Lidbrink P, Wikström A, et al. Urethritis-associated pathogens in urine from men with non-gonococcal urethritis: a case-control study. *Acta Derm Venereol.* 2016;96(5):689-694.
7. Sethi S, Zaman K, Jain N. *Mycoplasma genitalium* infections: current treatment options and resistance issues. *Infect Drug Resist.* 2017;10:283-292.
8. Manhart LE. *Mycoplasma genitalium*: an emergent sexually transmitted disease? *Infect Dis Clin North Am.* 2013;27(4):779-792.
9. Wiesenfeld HC, Manhart LE. *Mycoplasma genitalium* in women: current knowledge and research priorities for this recently emerged pathogen. *J Infect Dis.* 2017:216(suppl 2):S389-S395.
10. Lis R, Rowhani-Rahbar A, Manhart LE. *Mycoplasma genitalium* infection and female reproductive tract disease: a meta-analysis. *Clin Infect Dis.* 2015;61(3):418-426.
11. Couldwell DL, Lewis DA. *Mycoplasma genitalium* infection: current treatment options, therapeutic failure, and resistance-associated mutations. *Infect Drug Resist.* 2015;8:147-161.
12. Bradshaw CS, Jensen JS, Waites KB. New horizons in *Mycoplasma genitalium* treatment. *J Infect Dis.* 2017;216(suppl 2):S412-S419.
13. Manhart LE. *Mycoplasma genitalium* on the loose: time to sound the alarm. *Sex Transm Dis.* 2017;44(8):463-465.
14. Golden MR, Workowski KA, Bolan G. Developing a public health response to *Mycoplasma genitalium*. *J Infect Dis.* 2017;216(suppl 2):S420-S426.
15. Torrone E, Papp J, Weinstock H; CDC. Prevalence of *Chlamydia trachomatis* genital infection among persons aged 14-39 years—United States, 2007-2012. *MMWR Morbid Mortal Wkly Rep.* 2014;63(38