**Perceptions of the Need for** **Oncology Clinical Nurse** **Specialists in Israel:**

**An Exploratory Qualitative Study**

**Background**

Israel has about 200,000 cancer patients, with about 29,000 new cases annually (Israel National Cancer Registry, 2021). The oncology field involves complex clinical treatments as well as addressing complicated psychosocial aspects pertaining to the patients and their family members (Dopelt et al., 2022). Around the world, medical support positions, such as clinical nurse specialists, have been developed as a strategy to address the healthcare system’s challenges in recent decades. Studies show that, in the situations defined for the position, clinical nurse specialists can provide the necessary medical care in a way that offers the best response to patients’ needs (Alessy et al., 2021; Balsdon & Wilkinson, 2014; Birrell & Leung, 2019). In the USA, there are about 300,000 clinical nurse specialists, and in the UK about 3,300, whereas in Israel, there are only 358 clinical nurse specialists, who work in the fields of supportive care (102), geriatrics (80), diabetes (32), surgery (30), premature infants (28), pain (8), rehabilitation (4) and policy and administration (74) (Khaklai, 2021).

There are barriers and disagreements in the definition, authority, and recognition of this role in the healthcare system in Israel, which make it difficult to expand it to other clinical areas (Aaron & Andrews, 2016). Oncology nursing is a challenging and evolving profession that requires regular updating, both in the medical aspects of the disease and in the mental and social factors related to its diagnosis and treatment (Kadmon et al., 2015). The oncology clinical nurse specialist (OCNS) can improve patients’ health outcomes and quality of life indicators (Challinor et al., 2020), and thus increase patients’ satisfaction with the treatment and involvement in disease management (Andregárd & Jangland, 2015; Kilpatrick et al., 2010; Sheer & Wong, 2008; Wall & Rawson, 2016). Moreover, integrating clinical nurse specialists leads to better patient satisfaction and decreased rates of hospitalization, mortality, and complications (Newhouse et al., 2011).

A recent study in Israel examined the experiences of 39 clinical nurse specialists in supportive care. The nurses reported dissatisfaction with the work environment and with how the hospitals’ physicians and managers implemented and recognized their role. In addition, the limited authority they were granted did not correspond to the definition of the role (Haron, Romen & Greenberger, 2019). These findings are consistent with the results of a previous study conducted in Canada, which presented barriers to the implementation and assimilation of clinical nurse specialists including: lack of a model to guide implementation of the role, lack of an agreed-upon description of the role and its responsibilities, and lack of ongoing support and mentorship (Sangster-Gormley et al., 2011).

Despite the positive evidence regarding the inherent benefits of OCNS, there is disagreement concerning the necessity of the role and its definition. A study that examined the perceptions of this role in the field of oncology found that definitions of the position were unclear. While physicians and managers perceived the role of an OCNS as “helping” medical practitioners in managing their workloads, the OCNS themselves perceived their role as promoting holistic, patient-centered care and proactively meeting the unique needs of oncology patients (Wall & Rawson, 2016). Conflicts concerning the boundaries of the role, lack of resources and organizational and systemic support, and fear that clinical nurse specialists will replace the physicians’ work, limit the potential of the role and reduce its essential contribution to quality care in oncology (Wall & Rawson, 2016).

The growing number of cancer patients and their multiple needs, the shortage of oncologists, and the rapid changes in the clinical, organizational, and technological environment in the field of oncology highlight the need to update the clinical and managerial skills of oncology nurses. The literature shows that OCNS offer many advantages. However, in contrast to many countries around the world (USA, Canada, Great Britain, Japan, Brazil, etc.), in Israel the position of an OCNS has not yet been established. The purpose of the present study is to examine the need and the potential contribution of OCNS according to the perception of medical and nursing professionals.

**Results**

**Themes**

Table 2 presents the main themes, with explanations and quotes that illustrate each.

Table 2: Themes and Quotes

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| **Theme** | **Explanation** | **Quotes** |
| Additional responsibilities and authority for OCNS | **Nurses** suggested expanding the responsibilities of OCNS to include:   * administering pain-relieving medications * giving referrals for tests (i.e., blood tests, imaging) * interpreting test results for patients * giving referrals to other professionals (nutritionists, pharmacists, etc.) * participating in making therapeutic decisions * managing the treatment according to structured protocols * assisting the patient during the transition back into the community * calling the family with updates   **Physicians** suggested that the position of OCNS should include:   * providing a holistic response to patients, especially in terms of follow-up and transition back into the community * providing long-term follow-up for patients after the intensive treatment; this would be a unique added value of the position * administering pain-relieving medications | “The difference between a nurse in an oncology ward and a clinical nurse specialist is their authority and in-depth learning. [They can do] things that an ordinary nurse has no authority to do: prescribe medications, give referrals for tests, make decisions regarding treatment. At the same time, they have excellent psychosocial skills. [They know] how to communicate with families and people in complicated situations, [to deal] with ethical dilemmas, to support a person at the end of life, to manage a decision-making process in cooperation with the patient and the family.” (N8)  “The added value is that she can provide a sense of balance to patients. She will prescribe treatment. Today, she receives instructions from a physician. But if she has the whole world of knowledge about the treatments, the indicators, she will have room to take independent action. If we have a clinical nurse specialist in oncology, she will need, for example, to have the ability to respond and make a medical decision about starting a new medication.” (P1) |
| Contribution to the healthcare system | **Nurses and physicians** described multiple benefits of OCNS to the healthcare system:   1. Reducing and alleviating the burden on physicians 2. Improving service and treatment for patients 3. Reducing hospitalization 4. Creating a professional role at an intermediate level who can help patients 5. Providing a perspective that advances the profession of nursing   However, some physicians argued that the solution to the workforce problem is to add physicians and not to transfer responsibilities to nurses. | “Knowing how to get a person settled back at home, for example, can reduce hospitalizations. When a patient goes home with instructions and is in contact with a clinical nurse specialist, this will reduce visits to the emergency room, hospitalizations and contributes to the wellbeing of the patient and the family.” (N16)  “If there are nurses who know how to respond and do physical examinations and observe the patients’ problems before the physician arrives, that would help. Many times, a physician just goes over the tests and does not have time to physically see the patients and talk to them.” (N4)  “We have a clinical nurse specialist in surgery for the emergency room. She does more than half of the work, so the doctor is freed up to do surgery. She makes diagnoses. She sends for imaging. The patient is not delayed and doesn’t have to wait for the physician to come from the operating room.” (N14)  “This could certainly provide a solution to the distress and pressure we live with. I don’t think there is competition here. There is enough load on the system.” (P4)  “You need a clinical specialist nurse in practically every field. Certainly, in oncology, the patient needs the emotional support aspect. Being with them, the support, is very, very important. Also, a nurse who knows the patient well can give personalized care, tailored to the patient.” (N10)  “Nurses provide a complementary aspect to physicians’ work. And I emphasize - a complementary aspect, not a replacement aspect. They do not need to replace a physician’s work - they need to complement a physician’s work. The medical profession must be maintained. I come from within the system and understand the constraints of the system. Therefore, I allow myself to say that I do not agree with the [response to the] constraints of the system, that if there is a shortage of physicians, nurses are brought in.” (P6)  “The goal of the nursing administration is to promote the nursing profession, not the system. Despite our evidence, as physicians, that she improves patient care.” (P2) |
| Contribution to the patient | A response that is holistic, available, reduces bureaucracy and waiting time. It is particularly important to integrate the role of clinical nurse specialist into community healthcare settings, to improve services and support for convalescents. The nurse will maintain continuity in the transition between the hospital and the community. This can reduce the need for hospitalization to receive further treatment and alleviate the burden on physicians, so that the majority of treatment for convalescents will take place in community settings. | “Today, oncology is looking towards the community. People live with a metastatic disease for many years and they live in their community. A person can chemotherapy or biological therapy with pills, in the community, without going to an inpatient department at a hospital or a radiation institute. Also, the population is older, people live longer, they have underlying diseases as well as cancer. That’s why the treatments are more and more often given in the community. And this will continue.” (N8)  “You can reduce referrals to the emergency room. All patients run to the emergency room, but the emergency room is a very difficult experience for the patient. It exposes them to infections and they wait for many hours. If there is someone in the community who will go to the patient and take care of things that a nurse can do at home, it will be great for everyone.” (N3)  “There is no one who sees the patient as a whole, all the various aspects related to dealing with his medical condition. And I think that nursing, in specific, is a field that really keeps an overall view of the patient.” (N5)  “Many patients in the community fall through the cracks, they are neither here nor there. There are oncology patients in advanced stages, but not yet in hospice, not yet terminal. They need follow-up. A clinical nurse specialist in oncology can provide the solution.” (N3)  “The nurse frees me from the secondary things. This does not free me from seeing the patient, from providing treatment and instructions. But it improves service to the patient.” (P5) |
| Drawing professional boundaries | **Clinical nurse specialists** in various fields expressed concern about the possibility that a change would be made to add this role to the healthcare system, and the Ministry of Health’s unwillingness to grant real responsibility to clinical nurse specialists. They also described dilemmas regarding nurses’ willingness to take on the responsibility of managing treatments or administering medications.  According to the **physicians’** perception:   1. In practice, nurses know how to recommend the proper pain relief medications, but do not have the authority to prescribe them. A physician must make referrals for tests and approve administration of any medications, because ultimately, the physician is responsible for the patient. 2. Creating a role for clinical nurse specialists unnecessarily “wastes” the nursing workforce. A nurse does not need to be a physician’s assistant. For this purpose, paramedics can be trained, for example. 3. Politically, the process of creating a new role with expanded responsibilities must be coordinated with the physicians’ unions so that it will have their support and recognition and not be perceived as “eroding” the physicians’ role. There is a fear that physicians’ status will change as a result, or that there will be discomfort regarding the quality of nursing personnel in the healthcare system. 4. ) In terms of administrative hierarchy, there is a question regarding whether clinical nurse specialists will be subordinate to the director of the nursing department or to the head physician of the relevant department, since the clinical nurse specialist has authority similar to that of a physician. | “What will this contribute to oncology? They [CNS] will learn how to alleviate pain and symptoms. What can a nurse contribute more than a clinical nurse specialist in palliative care does? Beyond that, someone could only prescribe chemotherapy, and I don’t think anyone [a nurse] would want to take that on herself.” (N9)  “Specifically for oncology? I think there is such a shortage of nurses, that this seems to me like a luxury. As it is, there are not enough nurses, in my opinion.” (N16)  “It will hurt the quality of treatment. It bites into the professional authority that until now was given to physicians. It also hurts the physician’s status and standing. The physicians feel that their authority is being undermined. Instead of making the effort to find enough physicians and train enough physicians and employ enough physicians, they bring in personnel of lower quality to do things that are proper medical functions. The result of all this diminishes the quality of medical services. Maybe it’s in exchange for increased availability, because there are more nurses. But it’s definitely a reduction of quality.” (P6)  “The medical profession has only two unique aspects: making a diagnosis and providing treatment. Only a physician can do those things. Whether there is a need for a mid-level practitioner in oncology is a question you should ask oncologists. I think there is. Should that mid-level practitioner be a nurse? In my opinion, no. They should talk to us, the physicians, about this, and it should be done in a way that is cooperative and not adversarial... In many professions, this is not a real need in the system. If there is a real need in the system and we need personnel who are not physicians, we need to create assistant physicians, then we will have an additional profession and will not take the best nursing minds away from nursing and towards medicine, when we already have a shortage in nursing.” (P2)  “There can’t be any confusion between professions. Nurses have enough to do. I am not sure that they should also be given options that require a broad understanding of the patient. In this case, liberalism is based on a misrepresentation of the problem of standards. The problem of standards is that an informed decision is made by the people who control the flow of money. You don’t have to abolish the professional criteria in order to cover the money that is going to other places.” (P1) |
| Preparedness of the field for a new position of OCNS | **Oncology nurses** raised concerns about how OCNS would be accepted by physicians.  **Clinical nurse specialists** in other fields mentioned the gaps between the job definition compared to their actual responsibilities and the current situation in the field. The main gap pertained to prescriptions for medications given by nurse specialists, which are not recognized by the Pharmacists Ordinance. So, despite their professional knowledge and experience in giving referrals, in practice their authority is not recognized. Another issue that came up is that the nurses’ responsibilities are not being implemented, which makes it difficult to grant them more extensive responsibilities.  **Clinical nurse specialists** described the challenges in the implementation process and gaining recognition of their role by the physicians.  **Nurses** all mentioned the importance of recognition of this role by physicians.  **Physicians** referred to the importance of implementing and defining the role in order to promote cooperation in the workplace and so that more physicians will recognize clinical specialists as having the knowledge and authority to give advice and as people who can offer teaching and training. | “I don’t know if the field is ready. How many of the other teams, such as physicians or paramedical teams understand what this role is, what it includes, how to cooperate with that role? Here, I think it might be a little more problematic.” (N2).  “I think that even now there is not full implementation of the responsibilities that already exist. There is a lot of complexity around it. I don’t know if I would be involved in expanding the list of responsibilities, but I would be involved in seeing that what is already on the list is carried out.” (N16)  “There are physicians who accept it, and there are physicians who have a hard time with it -- mostly physicians in the community. Physicians in the hospital love the [clinical nurse] specialists because, for them, this is another significant help in treating the patient.” (N18)  “I think physicians also understand that this is important. The future is going in that direction. If the United States already had this thirty years ago, accepting nurse specialists [working] independently is very common there, so there is no reason why it couldn’t happen in Israel. In my case, there were those who raised their eyebrows and said ‘Who are you, as a nurse, to tell me what to do?’” (N10)  “Only if you are weak, then you are afraid of the rise of the nurse. The nurse will not take my place. But she is my right hand.” (P5) |

**Discussion**

The purpose of the current study was to examine the attitudes of nursing and medical teams regarding the necessity of developing a new role in the Israeli healthcare system: OCNS. Unlike many countries in the world, in Israel, such a role has not yet been developed and defined.

The findings reveal a complex picture regarding the necessity of the role and the need to expand the nurses’ authority. The delegation of authority from physicians to nurses represents one of the most important elements in the professionalization process of nursing (Henderson, 2006). The expansion of nurses’ authority is a significant contributor to professional autonomy (Jones, 2009). Various studies describe positive attitudes physicians and nurses hold regarding expanding nurses’ authority in several areas, based on the belief that it will improve the quality of care (De Baetselier et al., 2021; Ling et al., 2021; Pursio et al., 2021).

The oncology nurses, some of the clinical nurse specialists, the nurses from the Ministry of Health nursing management, and the oncology physicians were unanimous as to the necessity of the role and the ability of the nurses to serve as case managers. Nurses said they see the development of an OCNS as an opportunity for professional development, especially in community healthcare settings. From the point of view of the oncologists, this is a reliable, professional workforce that can relieve their burden and improve the quality of service to the patient.

Like our findings, various studies conducted around the world have indicated the importance of the OCNS from several aspects: improving cancer diagnosis and treatment services (National Cancer Action Team, 2010), preventing the need for hospitalization and emergency services (Corner, 2003; National Cancer Action Team, 2010), reducing in hospitalizations (Baxter, 2011), issuing faster and more accurate therapeutic prescriptions (Tod, 2015), providing a reliable, accessible, and available source of information (Borland, 2014) and providing psychosocial support for patients and their family members (Kerr, 2021; Morgan, 2016).

According to the interviewees, this role can offer the added value of holistic treatment because currently no role serves the function of providing overall management of the treatment. Similarly, Griffiths (2013) reported that the OCNS sees the treatment of cancer patients from a holistic perspective. Brooten (2004) finds an economic rationale for expanding the authority of OCNS, because they provide high-quality care while potentially reducing high costs of healthcare, since they have significantly lower wages than physicians.

In the UK, clinical nurse specialists provide care that was previously performed by physicians (prescribing medications, making diagnoses), which reduces the burden on physicians (Ream, 2009), shortens waiting times for receiving oncology services, and makes treatment accessible to patients in peripheral areas (Farrell, 2011). Since 2010, the Australian government has been operating rural oncology clinics under the management of clinical oncology experts to bridge gaps in access to oncology services between big cities and remote areas (Challinor, 2020; Crawford-Williams, 2018). Therefore, a training and implementation model for clinical nurse specialists in oncology will empower nurses, benefit patients, reduce healthcare costs, and relieve the burden on oncology physicians, especially in peripheral areas where there is a lack of physicians.

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Despite all the inherent advantages and potential of the OCNS, some of the clinical specialist nurses and physicians from professional organizations said that such a position is not necessary, and even if extra assistance is needed it can be provided by physician assistants (for example, paramedics who will undergo appropriate training) and not necessarily by a clinical nurse specialist nurse. Reasons for this included: erosion of physicians’ status; physicians not recognizing the role and broad responsibilities of clinical nurse specialists; compromising on less professional personnel rather than increasing the number of physicians; ambiguity regarding the role and the need for a clear and precise definition its responsibilities. The scientific literature frequently mentions topics such as tension with other professionals, intruding on the responsibilities of other professionals in a way that harms teamwork, and ambiguity of the role of clinical specialists working in a multidisciplinary team (Cook, 2019). Other studies role found that the main challenges in implementing this role are poor understanding of it among decision makers, lack of clarity of the role, lack of support from management, and misunderstanding of it among the medical staff (Bryant-Lukosius, 2007; Delamaire, 2010; DiCenso, 2010). Also, previous studies documented condemnations of the role and criticisms of inappropriate and wasteful use of nursing personnel (Kerr, 2021). All these reasons, mentioned in the interviews in the current study and in previous studies, indicate that interviewees and researchers in the field agree it is necessary to define clear responsibilities for the clinical nurse specialists and the maximum limits of its authority (Droog, 2014; Kerr, 2021).

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Given the global shortage of medical and nursing staff, the World Health Organization (WHO) stated in the Munich Declaration (2000) that healthcare systems must develop new roles for nurses working in hospitals and in the community. The interviewees in the current study said they think that the new role is crucial for community healthcare. Many cancer patients are treated in community healthcare settings, and cancer survivors need treatment and follow-up care in the community. Continuity between treatment in hospitals and community healthcare clinics has an extensive effect on oncology patients. Studies show that such continuity is linked to high patient satisfaction, improved quality of life and mental health indicators (Aubin et al., 2012; Hudson et al., 2009), improved responsiveness to treatment, and better therapist-patient communication (Chen et al., 2019). In contrast, lack of treatment continuity was found to be related to increased use of unnecessary medical services (Skolarus et al., 2012), hospitalizations, and visits to emergency medical facilities (Chen et al., 2019).

Cancer requires complex treatment, use of different sections of the healthcare system, and multiple caregivers. Patients and their families frequently report a lack of information concerning treatments, professionals, ways to communicate with healthcare providers, and above all, how to navigate the healthcare system (Monas et al., 2017). OCNS can fill this vacuum and play a key role in facilitating cancer patients’ encounters with the system. Support for this role was found both in research in the field of oncology and in studies that examined managing chronic care by nurses (Heitner-Albers et al., 2008; Horlait et al., 2022; McHugh et al., 2009; Ness, 2020)

**Study Limitations**

The sample is limited and not representative, but is considered reasonable for exploratory studies using qualitative research methodology. We made efforts to include a wide range of all the stakeholders related to the research topic from various settings and regions in Israel in order to learn from the experience of all the participants.

**Conclusions**

Multidisciplinary, coordinated, and holistic treatment may provide a response to the psychosocial and clinical issues that characterize the oncology field. The findings of this study provide data regarding the need to develop a new role of an OCNS in Israel due to its potential benefits to nurses, physicians, patients, family members, and the healthcare system as a whole. At the same time, the picture that emerges from the research is complex. An in-depth thinking process about the boundaries of the role and its implementation in full cooperation with the oncologists and relevant professional unions in the Israeli Medical Association is needed, in order to avoid unnecessary conflicts in the oncology field. The Israeli Ministry of Health must create a platform for dialogue between management of the nursing and medical departments in order to put aside professional egos and keep patients’ benefits at the forefront for all parties. The role of OCNS can potentially impact the quality of care, prevent unnecessary hospitalizations, alleviate the pressure and burden on physicians, and reduce costs for the healthcare system. As interviewee N15 concluded: “In every field of the healthcare system, if there are nurse specialists, a significant difference will be made.” Based on these findings, we recommend that further research be conducted to examine the cancer patients’ attitudes toward this suggested new role in oncology nursing in Israel.

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