Foundations of Practice

A highly disproportionate burden of cancer is manifested in the world's poorest societies (National Cancer Policy Forum, 2017). Since 2016, I have volunteered with the Washington, DC–based organization Health Volunteers Overseas and have provided oncology and palliative nursing education and consultation in Vietnam, Honduras, and Bhutan. In addition, I have volunteered with Living Room International in Kenya, focusing on hospice nursing resource enhancement.

I have traveled more than 50,000 miles to those four resource-impoverished nations and witnessed hardships beyond description. One country had an average daily wage of $1. In another, three patients slept on two cots pushed together. The hospital I most recently visited had no centralized medical record. Instead, patients carried a small notebook where the physicians would write their notes. In all of these facilities, there was one toilet and one sink for each care setting. Patients lined corridors and courtyards and waited hours, sometimes days, to be seen in clinics. There was no dietary service; if the family did not bring the patient food, he or she did not eat.

The cancer care I witnessed was somewhat reminiscent of my earliest nursing days in the 1970s—butterfly needles and no pumps, gloves, or identification bands. To nurse overseas, I had to use my basic skills as I had done 40 years ago. I could not rely on technology to tell me when a patient was in trouble; I had to assess using what I saw, heard, and asked. Grimaces, strained posture, a profound limp, a hand not leaving the lower back, a face turned toward the wall when asked about worry—this was my dataset. I then had to determine what I could do to help patients with so few available resources. What I ultimately discovered was a gift. It was a reawakening of those important lessons learned early on in my nursing career.

In one setting, a middle-aged woman was lying in the corridor with her daughter by her side. The patient had undergone a mastectomy earlier that day. Her affected arm was hanging off the side of the cot in a dependent position, and the drain was on the floor. Through an interpreter, I asked one of the nurses, "Where can I find some pillows?" She replied that there were none. I then asked about blankets, and we were able to find two. With careful folding and the use of the daughter's jacket, we were able to prop up the patient and her arm and affix the drain with a paper clip to keep it from lying on the floor. Both the patient and her daughter tightly grasped my hands in theirs as I was leaving.

> "With careful folding, we were able to prop up the patient and her arm and affix the drain with a paper clip to keep it from lying on the floor."

In a free-standing hospice, I saw a patient holding what looked like a dish towel up to his face. I was told that his mandible was missing. The patient couldn't talk. I asked him if I could help him find a better way to manage the drainage. His eyes widened and he nodded affirmatively. The charge nurse and I brainstormed. We took a surgical mask, opened up bunches of 4 x 4s, stuffed them lightly into the mask, and gently tied it around his ears. Although he could not smile, the elimination of his furrowed brow told me everything I needed to know.

On a home palliative visit, I met a daughter who was caring for her mother with advanced gallbladder cancer. The patient was jaundiced and experienced vomiting when she tried to eat. The palliative care physician changed her medications—stopping, increasing, and adding to the regimen. I said to him, "Those are a lot of adjustments. Do you think the daughter will remember everything?"

"Oh, sure," he said. "Her English is pretty good, and she's been doing a great job with the meds."

Knowing the patient's status was worsening and anxiety was likely accompanying this change, I persisted. "Well, can we ask her if it would help if we wrote all these medication changes down for her?" The physician then hesitantly asked the daughter. She looked at me with tears forming in the corner of her eyes and nodded yes.

My international volunteer experiences have validated key nursing lessons from my formative years. I fear this expertise has lost its value and importance within our contemporary high-tech culture of cancer care. When you, as a nurse, consider what a patient needs, I encourage you to not just think of a medication or a test; rather, ask if it is a pillow, a comforting hand on the shoulder, help getting out of bed to sit in a chair to eat, making eye contact, or advocating on the patient or family's behalf.

Before I volunteered overseas, I thought I would be infinitely limited in what I could achieve when I visited these countries. On the contrary, I was ultimately given the gift

of realizing that my basic nursing foundation was really what mattered most. These skills are the greatest tools nurses possess and the most meaningful to those in receipt of our care. In 1859, Florence Nightingale shared, "You have no idea what the craving of the sick with undiminished power of thinking, but little power in doing, is to hear of good practical action, when they can no longer partake in it" (p. 58). It is indeed time to bring back the basics.

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