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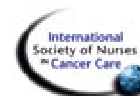

Tiffany lectureship awarded

A nurse whose work is focused on sexual rehabilitation after treatment for cancer has been awarded the Robert Tiffany lectureship.

Isabel White, Remedi/Macmillan Clinical Research Fellow in Cancer Rehabilitation at the Florence Nightingale School of Nursing & Midwifery at King's College, London said she was thrilled and surprised to receive the award.

She said: "I feel really honoured to be awarded such a prestigious lectureship by my peers and especially at an international level. I am incredibly grateful that people I respect in cancer nursing value the academic and clinical work that I have been doing."

Psychosexual care

Isabel first became interested in the subject of psychosexual care during her time as a junior sister at the Royal Marsden Hospital, London when she became aware that treatment had affected the sexual lives of patients and also that care of this treatment consequence could be much improved.

"At that time, in the 1980s, the issue of the impact of cancer treatment on sexual health was discussed with young men treated for testicular cancer but not addressed well for the majority of people whose sexual lives had been affected by cancer or it's treatment.

"Since that time there has been some progress in this aspect of care but it has mainly been in the management of male sexual difficulties with the advent of Viagra. However, for women there has still not been much progress in the past 10–15 years."

Isabel has recently completed a doctorate funded by Cancer Research UK which examined why patients and health professionals do not discuss the sexual consequences of cancer treatment. This work began to identify the topics that need to be included in the development of a clinical assessment instrument for treatment-induced female sexual difficulties after pelvic radiotherapy.

As part of her current role, Isabel is building on this work in a post-doctoral fellowship to design and validate a clinical assessment system for female sexual rehabilitation after pelvic radiotherapy for cervical and endometrial cancer. The aim is to design a patient questionnaire which can be used by women with their clinicians to discuss sexual recovery after cancer and to support clinicians in this with management guidelines and referral pathways.

Isabel White, who is to give the Robert Tiffany lecture at the 16th ICCN

Therapist role

To consolidate her skills, Isabel has trained as a psychosexual therapist and works one day a week in this role. Her expertise means that she is able to ask what could be seen as intrusive and private questions in a way that are received simply as part of routine care. It is this approach that she would like cancer clinicians to be confident in, through using a comprehensive clinical assessment system.

In addition, Isabel is establishing a service specialising in the care of those whose sexual lives have been adversely affected by cancer at one of London's cancer centres. This will be one of only a few sexual counselling or rehabilitation services in the UK specifically designed for those treated for cancer.

To inform this process, Isabel recently visited cancer survivorship services at two world renowned cancer centres in the US to see how they approached the issue of sexual rehabilitation.

As well as her research and clinical work, Isabel has significant experience in nurse education during her career as a nurse teacher and also as a lecturer/practitioner.

Robert Tiffany lecture

Isabel will be focusing her lecture at the 16th ICCN in Atlanta on the management of treatment-induced sexual difficulties in oncology within the context of care after cancer treatment.

The lecture will have two key themes. The first will be living with and beyond cancer and how nurses can contribute to helping people reach their recovery and rehabilitation potential. The second will consider more specifically the assessment and management of the many couples whose sexual lives have been adversely affected by cancer treatment.

She said: "My challenge in this lecture is to inspire nurses to consider patients' lives after treatment finishes. We need nurses to be committed to caring for problems created by illness or treatment and to contribute to the process of rebuilding the psychological and social dimensions of people's lives as well as the physical aspects of their recovery after cancer."

- *The Robert Tiffany lecture will be given at 11am on Tuesday the 9th March at the 16th ICNN in Atlanta. Highlights of the lecture will be reported in a later issue of the newsletter.*

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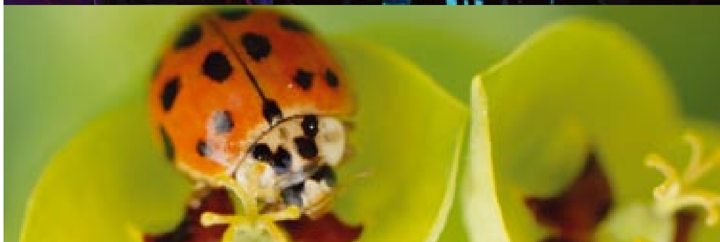
The International Society for Nurses in Cancer Care sincerely thank Emory Healthcare, Atlanta, Georgia, USA, for their support of the 16th ICCN by being the sponsoring agency for the Georgia Nurses Association Continuing Nursing Education application. EMORY HEALTHCARE is an approved provider of continuing nursing education by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. CNE credits pending.



Keeping travel scholarships alive

As nurses gather in Atlanta from around the world it is time to reflect on what has happened since we met last in Singapore. The global financial crisis (GFC) has affected many of us and while the big economies are slowly recovering, confidence will take some time to return.

This crisis has also affected ISNCC with reductions in overall registrations for the conference but more critically a reduction in the number of travel scholarships we have been able to provide for nurses from low resource countries. The number of nurses seeking this funding far outstrips our ability to support them and the ISNCC Awards Committee always feels very torn as every application is deserving of support to be able to join us at ICCN.

I would like to personally thank the five organisations that provided travel scholarship funding for the 16th ICCN — including Cancer Care Ontario, Canadian Association of Nurses in Oncology (CANO/ACIO), Princess Margaret Hospital, Peter MacCallum Cancer Centre, and the Royal Marsden Hospital. These organisations have truly kept the travel scholarship programme alive.

As I have discussed before, ISNCC is committed to the UICC-led World Cancer Declaration and its goal to focus on improving cancer outcomes globally and not just in high resource countries. To this end, ISNCC has partnered with UICC to further the work towards the Declaration and we will be discussing this important activity during the Member Council meeting in Atlanta. However, one of our most important potential points of influence is to foster the development of our nursing colleagues through travel scholarships to attend ICCN.

At this meeting we will launch a Scholarship Fund for this purpose and ask that you all visit the registration booth and make a donation for travel scholarships at the next ICCN and also consider how you might get your colleagues at home involved in raising funds for this worthy cause. Your small contribution will join with the contribution of other nurses to make a difference.

Sanchia Aranda,
ISNCC president

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Outstanding contribution award for ISNCC Secretary/Treasurer

Professor Patsy Yates, Secretary/Treasurer of ISNCC, has been awarded the Tom Reeve Oration for Outstanding Contributions to Cancer Care by the Clinical Oncological Society of Australia.

She is the first nurse to receive the award which formally recognises a national leader in Australia who has made a significant contribution over a relatively long period towards cancer care through research, clinical leadership and/or community service.

Professor Yates is the Director of the Centre for Palliative Care Research and Education, Queensland Health and Professor, School of Nursing, Queensland University of Technology, Australia and has had a distinguished career as a cancer nurse both nationally and internationally.

She has attracted in excess of $15 million in competitive research funding, has 70 publications in refereed scientific journals and published 10 book chapters. She has been invited to present 30 international and 31 national conference papers.

Professor Patsy Yates accepting the award from Professor Tom Reeve

Her contributions to ISNCC since 2004 have been as the Far East and Australasia Representative to the Board from 2004 to 2008, the Chairperson of the Scientific Planning Committee, 13th International Conference on Cancer Nursing in 2004, and the Co-Chairperson of the Scientific Planning Committee for the 15th International Conference on Cancer Nursing in 2008. Since 2006 she has been a member of Research Committee, a Director of International Society of Nurses in Cancer Care Limited (Education and Business Arm of ISNCC) and since 2008 has held the position of Secretary/Treasurer.

In accepting the award Professor Yates acknowledged the collaborative contributions of nursing, medical and allied health colleagues in supporting her career.

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Effect of one-time stop smoking intervention before surgery

This qualitative study explored how newly diagnosed breast cancer patients experienced preoperative smoking cessation counselling

Introduction

There is growing evidence for the beneficial effect of intensive preoperative smoking cessation interventions lasting 4–8 weeks on postoperative recovery and long-term smoking cessation in patients undergoing elective, non-malignant surgery (Thomsen et al. 2009a).

The incentive to advise cancer patients to stop smoking in relation to cancer surgery is therefore strong. The question is: how do patients, who are newly diagnosed with cancer and scheduled for cancer surgery, experience preoperative counselling to stop smoking?

We explored this in a qualitative study of eleven Danish women smokers, diagnosed with breast cancer, and scheduled for mastectomy or breast conserving surgery (Thomsen et al, 2009b).

Method

The women were between 40 and 72 years of age (median age 50); all had participated in a one-time preoperative smoking cessation intervention of 45–90 minutes duration 3–7 days before surgery. The principles of motivational interviewing inspired the intervention, which was provided by nurses trained as smoking cessation counsellors (Miller & Rollnick, 2002). A personalised nicotine replacement schedule was also offered.

We collected data through individual semi-structured interviews. All interviews began with the following question: Please tell me how you experienced counselling to stop smoking in relation to surgery?

Interview data was analysed using Ricoeur's theory of interpretation (Lindseth & Norberg, 2004).

Findings

Four main themes emerged:

1) Reflecting upon smoking and health

Breast cancer diagnosis and the need for surgery invoked an acute sense of physical vulnerability in the women, and being offered smoking cessation counselling in the context of this vulnerability triggered reflection upon the health risks of smoking and the benefits of smoking cessation. The women were certain that they would not have contemplated smoking cessation had they not been offered counselling to do so preoperatively.

2) Escaping the social stigma of being a smoker

The women experienced smoking as increasingly awkward due to restrictive smoking policies. They felt under constant pressure to stop smoking from family and looked down upon by society as smokers. Therefore, they perceived the offer of smoking cessation counselling before breast cancer surgery as an opportune way of escaping the social stigma of being a smoker.

3) Heightened awareness of being addicted to smoking

Smoking cessation in the context of breast cancer diagnosis was difficult for those who habitually smoked to cope with anxiety and stressful emotions. Nevertheless they experienced an increased awareness of their addiction to smoking.

For example, they "thought twice" and tried to recapture their motivation for wanting to quit when the urge to smoke arose. They described themselves as more "responsible smokers" because they smoked less or switched to what they considered "less toxic cigarettes".

4) Enacting a duty of responsibility

The women experienced quitting as an enactment of a duty of responsibility towards themselves and those nearest to them. Quitting was associated with a sense of personal achievement and endorsed by family and friends. Those who were able to quit were furthermore surprised by how easy it was to stop smoking. They also experienced improved well-being, less coughing and less shortness of breath within days of stopping.

Discussion

Cancer diagnosis is widely portrayed as a "teachable moment." Teachable moments are naturally occurring life transitions or health events thought to motivate individuals to spontaneously adopt risk-reducing health behaviours (McBride et al. 2003). Three key components allegedly underlie the concept and are believed to influence whether an event constitutes a teachable moment; these are the degree to which an event affects:

- perceptions of personal risk,
- emotions such as worry,
- the individual's self-concept (McBride et al, 2003).

All key components were affected in the women in this study, and offering patients smoking cessation counselling in this specific context appeared to facilitate the women's negotiation of the prospect of quitting.

Nevertheless it is important to note the finding that the women would not have contemplated smoking cessation had they not preoperatively been offered smoking cessation counselling. In other words, although breast cancer diagnosis constitutes a teachable moment, patients do not necessarily spontaneously stop smoking.

Indeed, there are indications that the impact of cancer diagnosis on life-style is modest and transient, and proactive interventions may be needed to motivate and sustain healthy life-style changes (McBride et al, 2008; Stull et al, 2007). Nurses and physicians should therefore acknowledge the key role they have in motivating newly diagnosed cancer patients to stop smoking.

Surveys of the patient education practices of oncology nurses and of non-vascular surgeons, however, suggest that a minority motivate and support patients to stop smoking (Lally et al, 2008; Owen et al, 2007). One reason for this is that they believe patients are not motivated to quit smoking (Sarna et al, 2001).

Motivational potential

Our study indicates a motivational potential of offering smoking cessation counselling in the context of breast cancer diagnosis and surgery. A precondition for realising this potential, however, is proactive support and assistance to help patients stop smoking (Browning & Wewers, 2003).

Nurses and physicians are also fearful of stressing patients or making patients feel guilty (Sarna et al, 2001). In our study, the women did not express feelings of guilt or increased stress. Among those who were unable to quit, some wished for prolonged support to become smoke-free.

Despite an increased awareness of being addicted to tobacco smoking, the anxiety and uncertainty of being diagnosed with breast cancer and undergoing surgery caused relapse to smoking. Smoking to alleviate distress is a commonly documented feature of women's smoking (Gillies, 1999; Schnoll et al, 2007).

Women may also be more prone to perceive themselves as being addicted to

cigarette smoking (Gillies, 1999). Compared with men, women report lower levels of confidence in achieving cessation and greater perceived difficulty with cessation (Schnoll et al. 2007).

Nicotine withdrawal

Women also experience more severe nicotine withdrawal symptoms, show lower compliance with nicotine replacement therapy, and have significantly higher rates of nicotine metabolism than men (Schnoll et al, 2007). Future research into these factors would be relevant for tailoring smoking cessation interventions to women with cancer.

To conclude, in our study, preoperative smoking cessation counselling motivated attempts to stop smoking. The one-time counselling session was sufficient to support smoking cessation in some women. Cancer anxiety was, however, associated with relapse to smoking for the majority of the women, indicating the importance of persistent intervention to support smoking cessation in women with breast cancer.

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VIRTUAL CANCER CARE

Cancer and complementary therapies

Increasing numbers of people are now routinely accessing a variety of complementary therapies alongside conventional cancer treatments and are finding them very helpful with regard to alleviating some of the worst side effects.

Equally there is an increasing body of evidence for their efficacy in improving overall quality of life.

In developing countries, where access to mainstream cancer treatments is severely limited, the use of herbal and natural medicines remains an integrated and acceptable part of care.

How then do we advise our patients of what is available to them and more importantly what is safe, affordable and suitable for their needs?

This is where the internet can really help and give health professionals a base line starting point of some well balanced and informative web sites.

Cancer Help UK

http://www.cancerhelp.org.uk/about-cancer/treatment/complementary-alternative/index.htm

This highly professional UK web site has some excellent material in this area and is a superb starting point for both the health professional and patient alike. It is well laid out, easily navigated around and written in clear language.

As well as expected material on research, organisations and reading lists, there is some very useful advice about what questions to ask therapists or doctors, and a huge list explaining what different therapies are.

Complementary Cancer Therapies

http://www.complementarycancertherapies.co.uk/index.html

I liked this site very much despite its UK-centric information regarding finding a therapist. It's good mainly because it's written and maintained by working therapists who have a detailed understanding of their role and know how to put it across. They have created a colourful and simple web site which is easy on the eye, accurate and realistic in its information and many patients will find it helpful.

Macmillan Cancer Support

http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Complementarytherapies/Complementarytherapies.aspx

This large UK-based cancer charity has a hugely expanded and highly professional website that is regularly updated so the quality of its information is usually exemplary.

There are six areas relevant to complementary therapies all accessible from a menu on the left of this page, the most interesting of which is the one related to feelings, personality and cancer.

Worth a look

Cancer Treatment Centres of America

http://www.cancercenter.com/complementary-alternative-medicine.cfm

If you ignore the promotional parts of this site there is some good information here including some short videos from a range of therapists and experts. For those who are more visually oriented, and like to hear people talking rather than reading lots of material, this site may be worth a visit.

Quackwatch

http://www.quackwatch.org/00AboutQuackwatch/altseek.html

This website is for those nurses who have ever been asked by a patient about strange and obscure therapies that purport to help cancer sufferers and I am sure that will include most of us. What it does is list a wide range of dubious and downright dangerous therapies, their origin and why they are not endorsed.

The site is brutally honest and for that reason I recommend that it is used by health professionals only as a reference point and not recommended to patients. It could, however, be a very useful resource and safeguard to help protect the more vulnerable and desperate of our patients.

Robert Becker, Macmillan Senior Lecturer in Palliative Care, Staffordshire University Faculty of Health and Sciences and Severn Hospice, UK

Collaborative cancer nursing symposium held in Tanzania

A collaborative symposium on cancer nursing was held as part of the 7th International Conference of the African Organization for Research and Training in Cancer (AORTIC) in Tanzania in November 2009

This symposium was a joint effort by the ISNCC and nurse leaders within AORTIC. The joint symposium with ISNCC was a first for the African nurses attending the conference for three reasons:

- the joint symposium was offered as part of the formal conference programme,
- it had international collaboration,
- it had simultaneous translation into French.

These aspects reflected the commitment AORTIC has to cancer nursing training and preparation.

The impetus for the collaborative symposium came from Petra Fordelmann. Petra is a member of the board of ISNCC as well as the council of AORTIC. Ms Fordelmann and her Tanzanian colleagues from the Ocean Road Cancer Institute, Mary Haule and Pendo Bukori, worked with Margaret Fitch (Odette Cancer Centre, Toronto) and Barbara Fitzgerald (Princess Margaret Hospital, Toronto) to plan and offer the symposium.

Organisers of the collaborative symposium: from left to right (back) Barbara Fitzgerald, Margaret Fitch, Petra Fordelmann, (front) Mary Haule, and Pendo Bukori

Leadership

The collaborative symposium was designed with the ultimate aim of fostering nursing leadership. The specific goal focused on how to enact leadership within clinical practice situations. The key message during the symposium was that nurses can be leaders regardless of the role or position they hold. With the appropriate knowledge and skills, every nurse has the potential to be an effective leader.

The symposium began with a lecture on nurses as leaders in all aspects of cancer control. There are many opportunities to engage in activities related to prevention, early detection, care of patients receiving treatment, education, and palliative care.

With the predicted increase in cancer incidence, nurses need to be preparing to face the escalating cancer burden. Cancer incidence is predicted to double (increase by 50%) by the year 2020; and 70% of that increase will be in the countries of middle to low resource.

A second focus for the symposium was an exploration of how nurses could enact roles in symptom management and psychosocial care of individuals with cancer. Lectures were presented outlining the Framework for Symptom Management (Dodd) and Supportive Care in Cancer (Fitch) and how these could be used in practice to guide cancer nurses in assessment and intervention with patients.

Case study

Participants had the opportunity to apply this learning during small group discussions about a specific case study. The ensuing discussions and plenary feedback allowed the nurse participants to engage in meaningful dialogue about approaches to patient care in Africa.

Nurse leaders brought teams together to discuss patient/family situations as a multidisciplinary group. Nurses at the symposium then reflected on a possible "change in care" for their settings where they could get staff physicians to participate in case reviews when they do their rounds and ensure that care embraces the full range of issues/challenges patients face.

Finally, the development of cancer nursing in Tanzania was presented with illustrations about nursing care at the Ocean Road Cancer Institute in Dar es Salaam. In many parts of Africa, cancer centres are being planned and built in major cities. The countries are working to meet the growing demand for cancer care. Yet, for many areas of the continent, the obstacles to cancer care are seemingly insurmountable. Resources are limited and access to education for specialty nursing practice is challenging. Many individuals are diagnosed with cancer when the disease is advanced and palliation is the most appropriate treatment. However, access to appropriate care and medications remains widely variable.

Nurses are the "backbone" or mainstay of the health care delivery in many African communities. These nurses must be armed with current knowledge about cancer and up-to-date skills for cancer patient care. Public education about cancer prevention is a critical aspect of cancer control in middle and low resource countries, in particular, lowering levels of tobacco use and reducing infections.

Solutions to care delivery need to be contextualised and adapted to the local jurisdiction. One wonderful example of nurses who were engaged in innovative solutions was shared at the conference. The nurses in a village setting would perform visual cervical examination. If they observed a suspicious lesion they would use a digital camera to take a picture, then upload the picture and send it by cell phone to the physician who was more than 1000 kilometres away. The physician would respond with instructions about necessary interventions as soon as the picture was received. The nurse could then intervene with the woman who was still in the clinic — and in many instances still in the examination room.

EDUCATION COLUMN

Using online education for nurses working in community settings

Introduction

Good quality care in complex nursing specialties like oncology requires nurses to have access to graduate and continuing education programmes. For nurses working in more isolated locations in developing countries this is a particular problem, since they have only limited access to these programmes.

However, in these situations even small oncology nursing associations can expand nurses' educational opportunities at different levels (local, regional, national). They can facilitate the updating and improvement of nurses' knowledge which in turn will improve the care of cancer patients and their families.

Some developing countries have successfully increased and improved their communication networks to make educational material available. However, nurses in Latin America have great difficulties accessing available resources due to:

- the fact that most of the published scientific articles and online courses are available only in English or French,
- the high costs of subscription fees compared to nurses' salaries.

The AEOC

The Colombian Oncology Nursing Association (AEOC) has been in existence for 18 years. During that time its main purpose has been the development and academic excellence of oncology nursing in the country. For this reason it has focused its efforts on developing courses and scientific activities related to cancer nursing care.

These activities have been aimed at groups of registered nurses and nurse assistants in small cities and towns in Colombia who work in institutions that treat cancer patients. These cities and towns often do not have specific institutions that teach oncology nursing.

In order to do this, AEOC has had teams of experts share their knowledge and experience with these nurses. Since unfortunately government institutions do not support these activities, it has established a relationship with the pharmaceutical industry* for financial support.

Evaluation and feedback from attendees at these courses and activities has always been positive. AEOC's purpose has been to increase its educational range and offer them to a larger number of nurses. Realising that the emergence of distance learning has made education more available, accessible, and convenient (Mancuso-Murphy, 2007), AEOC started a new initiative with the support of the pharmaceutical industry.

This initiative involved creating a website with the aim of sharing current information, translated into Spanish, with oncology nurses. In addition, the information is adapted to better suit the needs of Colombian cancer patients and the realities of the health system that they are served by.

Users of previous courses were asked to fill in questionnaires regarding what topics they felt would be most relevant to their needs. An online course curriculum was developed based on these questionnaires, and for each topic, oncology nursing specialists were selected to write and review manuscripts and to select high-yield bibliographic references.

A physician with experience in the development of this type of courses helped with the technical issues of the course development, but not its content.

The first online course

In 2008 AEOC offered their first online course on the management of symptoms and the side-effects of treatment in cancer patients. Topics covered included;

- nausea and vomiting,
- pain,
- mucositis and oral complications,
- cachexia,
- sleep alterations,
- lymphedema,
- fatigue
- skin lesions.

The resources available for each topic included a PowerPoint presentation, online forums for discussion of different aspects and experiences, teacher counselling by an expert and specific evaluations.

The second online course

In August 2009 a second course was offered entitled *Nurses in the management of side effects of the combined treatment of breast cancer*. This focused on the principles of the therapeutic combination in oncology and the nursing care of the main problems derived from the combined treatment of breast cancer. The course included the following topics:

- the multidisciplinary team in oncology,
- the main side effects of the combined treatment,
- chemotherapy and radiation therapy protocols,
- the basic principles of surgical treatment.

Nurses using these courses rated them highly for their general quality and the opportunity they provided for online learning in Spanish. Participating in these virtual update activities has allowed nurses to improve their fund of knowledge. The availability of this continuous education tool has become an integral part of their care of cancer patients.

However, although the objectives of providing continuing education in oncology nursing were achieved, around 37% of the attendees did not complete the courses or did not meet the minimum score needed. The cause of this has not been well established, but some reasons behind this could be:

- the lack of protected time from work for nurses to dedicate to these courses,
- the fact that some nurses who took the courses were newly qualified, and therefore relatively new to the subject of oncology,
- the fact that the courses were funded by a third party rather than the attendees themselves, which may make some participants lack motivation in completing the course.

In the future the AEOC will be looking at the development of new strategies of motivation and commitment to improve cost-benefit and decrease the high drop-out rate.

Conclusion

With the success of distance learning in nursing education (Mancuso-Murphy, 2007; Udod & Care 2002) this method seems to offer promising opportunities for nurses from developing countries who are practicing in the community. Distance education allows nurses to update their knowledge and provides access to expert teacher advice,

However, there are a number of possible areas of improvement in terms of time and financial support in order that attendees are more likely to reach the academic goals of the courses that they follow.

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* AEOC´s academic activities have been funded partially by: Bristol-Myers Squibb Colombia.

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RESEARCH COLUMN

Palliative and hospice care in Botswana with a focus on pain relief

Limited resources in community-based programmes and hospital settings and a lack of end-of-life social policy hamper hospice and palliative care in Gaborone, Botswana.

Gaborone was founded in 1967 as the capital city of Botswana and has over 200,000 inhabitants, making it the country's largest city. The only other city in Botswana is Francistown, in the north.

The HIV/AIDS pandemic has dramatically increased the need for hospice and palliative care, not just in Gaborone but in all of Botswana. Government data from a systematic sample of Botswana households in 2004 revealed that nearly 10% of women and almost 4% of men aged 15 to 19 were HIV positive.

Approximately 44% of women and 36% of men aged 30 to 35 were estimated to be HIV-positive (The Joint United Nations Programme on HIV/AIDS, 2006).

Community-based programmes

Two community-based programmes in Gaborone provide hospice and palliative care: one is supported by the government; the other is funded by a charitable organisation.

The Ministry of Health's home-based nursing programme operates out of each of the 15 primary health care clinics located throughout the city. One nurse per clinic visits individuals living in the clinic's service area who have been recently discharged from the hospital or are at the end of life.

The demand for home-based nursing outstrips the number of visiting nurses, limiting the number of visits home-based nurses can make. Moreover, legal restrictions limit home-based nurses' role in managing pain: by law, opioids can only be dispensed in hospital settings, thus home-based nurses cannot administer opioid analgesics at home.

The other community-based programme is Holy Cross Hospice (HCH), a non-governmental organisation located in a low-income neighbourhood. The hospice provides respite day care for about 20 adults with HIV/AIDS four days a week. There is no inpatient hospice at the present time.

Hospital

Princess Marina Hospital (PMH), a 550-bed referral hospital, is one of two acute-care hospitals in the city. The other is a private hospital that serves only those who have private medical insurance. According to the director of nursing, PMH runs at 200% capacity and most of the overflow is from individuals at the end of life whose loved ones have rushed them to hospital.

However, the limited resources and systems at PMH restrict cancer nurses' abilities to manage end-of-life symptoms. Nurses on the oncology ward reported inadequate equipment. For example, the ward did not have automated intravenous (IV) machines or patient-controlled analgesia machines.

Gaining access to supplies of oral or IV morphine required sending a ward staff member to other units of the hospital in search of the one nurse who kept the key to the morphine medicine cabinet for the entire hospital.

Optimal palliative care cannot be achieved without pain control. However, hospital systems and lack of resources hinder the ability of health care providers to achieve good pain control outcomes.

I conducted a study on the PMH oncology ward to examine the effectiveness of pain control. Twenty patients were interviewed on July 19 and 20, 2007. The mean age of the participants was 40 years. The majority were diagnosed with Kaposi's sarcoma (n = 12). Others had lung cancer (n = 3) and colorectal cancer (n = 2); the remaining had breast, supraglottal, or gastric cancer.

One patient was administered IV morphine on a manual drip, and the others were treated with oral codeine. The average pain score on the numeric rating scale was 7.5 out of 10. Only the patient treated with IV morphine reported an acceptable level of pain.

Social policy

Gaborone's social services department attempts to alleviate the burden on the city's health care resources through the policy of repatriation. The policy dictates that the city's residents who are at the end of life and have no extended family in the city are to be repatriated to their original home villages to be cared for there by their extended family.

The policy stipulates that before repatriation a social-work evaluation must determine that the home village has adequate resources. Despite this attempt at a safeguard, two problems plague this policy.

First, unless the people in Gaborone to be repatriated are originally from Francistown, they face fewer resources in their home village. While every village with a population of at least 500 villagers has a health-care post staffed by a registered nurse, often the nearest primary hospital is as far away as an hour's drive. Most villagers do not have cars.

Primary hospitals, with the exception of PMH in Gaborone and the referral hospital in Francistown, do not have specialty care such as oncology. Furthermore, the same restriction on administration of opioid medications by home-based nurses exists in villages as in Gaborone, and hospitals may be too far to go to for pain management.

One family of a man who was dying of renal failure reported not wanting to be repatriated to their home village because of inadequate access to health care.

Second, the policy does not account for the modern realities faced by those individuals who do have extended family residing in Gaborone and thus are not subject to repatriation. Gaborone is an urban centre to which families migrate for education and employment.

Often adult children of those at the end of life have the responsibilities of work or care for their own young families.

Therefore, while the intent of the social policy of repatriation is to alleviate burden on health-care resources in Gaborone, it actually does little to provide resources to people who have been repatriated or to those who are not subject to repatriation.

Summary

Inadequate staffing, equipment, processes, and access to opioid analgesics impede nurses' ability to provide quality hospice and palliative care at home and in the hospital setting in Gaborone. In a selected group of patients with advanced cancer in Gaborone, inadequate pain relief was reported. The social policy of repatriation likewise hinders quality end-of-life care for the city's residents.

Further study is needed to determine where residents of Gaborone prefer to die (at home in Gaborone, in their villages of origin, or in a health-care facility).

Findings of such a study would have the potential to yield important information health care administrators could use for the optimal allocation of health care resources. In addition, the finding could direct policy makers in reformulating health care and social policy to meet the needs of people at the end of life.

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