



## Kenyan nurses come together

A new association of cancer nurses has been formed in Kenya bringing together nurses from across the country. One of the main objectives of the newly-formed group is to work collaboratively with other stakeholders including the Nursing Council and the Ministry of Health towards the improvement of cancer education and care in Kenya.

The group, as yet unnamed, began as an interest group for nurses involved in, or interested in, oncology. It was brought together by three nurses; chair David Makumi, who works with cancer patients in an inpatient unit; John Njiru, a hospice nurse, and Roselyn Opindi who works in a radiation oncology unit. Membership has grown steadily to 55.

The group is planning a short course for nurses which will include palliative care. It is also intending to develop patient and family education materials as well as starting support groups in the next six to eight months.

The group has already held a series of continuing nursing education forums focusing on various aspects of cancer care which were attended by an average of 50 nurses from different hospitals.

Kenya is a developing sub-Saharan coun-

try with a population of 31 million. It currently has two healthcare delivery systems, a public system funded by tax payers, which caters for the majority of the population, and private healthcare for those who can either afford to pay or have insurance cover.

Data from the Kenya Medical and Research Foundation (KEMRI) indicates that the most common adult malignancies are cancer of the cervix, breast, prostate, and gastro-intestinal tract. Retinoblastoma,



Members of the fledgling nurses' association attending a continuing education session

Burkitts lymphoma and leukaemia are common in children. Also there has been a sharp increase in Kaposi sarcoma due to the high incidence of HIV/AIDS.

Cancer care initiatives in Kenya face the challenges of inadequate infrastructure, poor health care administrative systems and lack of funding. The extreme poverty of many patients, restricted opioid prescribing and minimal educational opportunities for health care staff also cause difficulties.

The few oncology specialists and specialised treatment facilities are only available in the capital, Nairobi, although the majority of the population live in rural areas. Patients generally present late for treatment mainly due to financial constraints, and long distances from hospitals. Pain and related distressing symptoms are commonly reported.

The vision of the newly-formed association is to provide leadership in transforming the delivery of care to cancer patients in Kenya. The association wants to:

- provide resources for oncology nursing education, research and leadership,
- identify and disseminate information on key trends affecting and pertinent to cancer nursing,
- serve as an advocate for the public

and develop solid public cancer prevention education campaigns,

- be a forum for communication and information sharing for nurses involved in cancer care,
- provide support to nurses working in rural areas by providing them with regular updates on trends in cancer nursing,
- work with families and individuals in developing patient support groups and patient education materials,
- be a link between nurses in Kenya and international organisations involved in cancer care.

The association is working towards affiliation with the International Society of Nurses in Cancer Care and is looking forward to working with ISNCC in improving cancer care in Kenya.

### Don't miss out

The 14<sup>th</sup> International Conference on Cancer Nursing is to be held in Toronto, Canada from 27<sup>th</sup> September to the 1<sup>st</sup> October 2006. Don't miss the chance to present at the largest international meeting of cancer nurses. The deadline for abstracts is 31<sup>st</sup> January 2006. Go online at [www.isncc.org](http://www.isncc.org) to submit an abstract.

This issue of International Cancer Nursing News is  
sponsored by Bristol-Myers Squibb Oncology

Bristol-Myers Squibb  
ONCOLOGY

## We want to hear from you!

At a recent meeting of the Board of Directors of the International Society of Nurses in Cancer Care (ISNCC), we affirmed our mission and strategic directions as an organisation. I thought you would be interested in learning about these ideas and invite you to communicate with us about our plans. Tell us what you think about the ideas and how they could work best from your perspective.

The ISNCC was first established in 1984. It was created to foster communication and learning among nurses who care for cancer patients and their families. It was established to promote the special practice of cancer nurses in the international arena and help nurses around the world to be prepared to give the best care possible in their own countries.

Today, with its full, associate, and individual memberships, the International Society of Nurses in Cancer Care is connected to more than 80,000 cancer nurses around the globe. Through this membership the ISNCC works to achieve its mission and goals.

*The ISNCC mission is:* the protection and preservation of health and the relief of cancer-related sickness, and the promotion and co-ordination of the activities of cancer nursing through the advancement and improvement of

- the delivery of nursing care to people with cancer,
- education of cancer nurses, and
- nursing research.

*The ISNCC vision is:* to be recognised as the voice of cancer nursing in the international arena.

To achieve this vision, and to be an effective voice for international cancer nursing, the ISNCC has three critical requirements:

- a stable financial base,
- effective working relationships,

- acknowledgement as an international organisational leader in cancer nursing.
- To realise these three requirements we must take action in five strategic directions:
- become efficient in our business,
  - enhance our revenue base,
  - enhance our visibility,
  - strengthen links with members,
  - increase the availability of education and research opportunities for cancer nurses.

The last two directions have particular relevance for individual members as there have been new developments. There is now a category of membership that is for individuals which means you can join directly giving you the opportunity to be more involved at an international level.

There is also the opportunity, for those of you who can, to support the individual membership of a nurse in a low resource country. And there are ways that your unit or hospital, or your oncology chapter, can support the membership of cancer nurse societies who are new and need some assistance to join.

Our worldwide conference, which occurs every two years, will be in Toronto in September, 2006. Educational opportunities are also being added at a regional level in the form of Leadership Institutes for Cancer Nursing. We have a small budget research grant programme and are looking for ways to augment the funding available for cancer nursing research.

I look forward to hearing from you about the ideas I have presented here. What do you think of them? How do you think they can be carried out for your country or in conjunction with your oncology nursing group?

In the meantime, check our website [www.isncc.org](http://www.isncc.org) for additional details and other programme opportunities.

Margaret Fitch  
President ISNCC

## Fake drugs campaign

The International Council of Nurses (ICN) and the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) have joined together in the fight against counterfeit medicines. Counterfeit medicines represent a major and growing health risk, and it is poor people in developing countries who are most threatened by it.

In developing countries the proportion of fake medicines on the market may be as high as 50%. A WHO survey found that that 51% of counterfeit medicines contained no active ingredient.

Nurses are a key element in the struggle against counterfeit medicines. The pharmaceutical industry worldwide must provide nurses with the support they need to determine rapidly if a medicine is genuine or not, according to the IFPMA.

## Obesity raises risk

Obesity increases the risk of several cancers, according to new research on 145,000 people in Austria over ten years. A higher body mass was found to be associated with a greater risk of colon, rectal, and pancreatic cancer in men and of endometrial and non-Hodgkin's lymphomas in women.

*British Journal of Cancer* 2005;93:1062-7.

## Equal benefits

The fall in mortality from breast cancer is due in almost equal parts to screening and adjuvant therapy. Seven independent statistical models were used to analyse death rates from breast cancer in the United States in 1975-2000. Mammography and the use of adjuvant treatment were found to have contributed almost equally.

Researchers say the mortality rate in this period has fallen by 21% but without these two factors it would have increased by 30%.  
*New England Journal of Medicine* 2005;353:1784-92

### EDITORIAL BOARD

#### President, International Society of Nurses in Cancer Care

Margaret Fitch  
tel: +1 416 480 5891  
fax: +1 416 217 1321  
email: marg.fitch@tsncc.on.ca

#### Central and South America

Stella Aguinaga Bialous  
tel: +1 415 476 8276  
fax: +1 415 476 0705  
email: AQUINAGA@CARDIO.UCSF.EDU

#### North America

Margaret Fitch  
tel: +1 416 480 5891  
fax: +1 416 217 1321  
email: marg.fitch@sw.ca

#### Far East and Australasia

Kazuko Ishihara  
tel: +81 958 83 4994  
fax: +81 958 49 7944  
email: kazuko@net.nagasaki-u.ac.jp

#### Europe

Candy Cooley  
tel: +44 (0)1905 733173  
email: Candy.Cooley@sworcs-pct.nhs.uk

#### Africa and the Middle East

Sarah Ben-Ami  
tel: +972 3 558 0666  
fax: +972 3 558 0777  
email: sbenami1@netvision.net.il

#### ISNCC Secretariat

email: secretariat@isncc.org  
tel +44 (0) 1625 669588  
fax +44 (0) 1625 610152

#### Editor

Kathryn Godfrey  
11 Chesholm Road,  
London N16 0DP, United Kingdom  
email: kathryngodfrey@blueyonder.co.uk  
All correspondence should be addressed to the editor.

<http://www.isncc.org>

#### Published on behalf of the International Society of Nurses in Cancer Care by:

Mediate Health Consulting Ltd,  
108 Chestergate, Macclesfield,  
Cheshire SK11 6DU, United Kingdom.  
email: christine@mediate-health.co.uk

ISSN 09565175



# Care of the adolescent with cancer and their family

**Understanding the complexity of the world of the adolescent and how this affects their experience of having cancer is essential to providing for the unique needs of this age group. Diana Gunn explores the impact of a cancer diagnosis on both the teenager and on their family and wider relationships**

Adolescence is unique in the life span. It is the transition from childhood to adulthood. The need for independence; establishing an identity; adjusting to sexual maturity, which includes physical and emotional changes, all add to the complexity of becoming an autonomous individual.

During my practice as an acute oncology nurse I developed a particular interest in nursing the adolescent with a malignancy. This involved caring for an adolescent who was coping with a life-threatening illness, listening to their turmoil of being an adolescent, and witnessing the dynamics of parental love and protection.

I realised that I had to try and understand the complexity of their world and how this impacted on their illness experience. I have been able to do this by being involved in CanTeen, a New Zealand support organisation, and by working with teenagers with cancer and their siblings. I also explored the maternal experience of caring for a dying adolescent as the topic for my Masters thesis.

## Incidence

The number of adolescents dying in road deaths and committing suicide is greater than the number dying of cancer. In the United States, statistics show that as well as accidental injuries and suicide, homicide is another leading cause of death.

Cancer then, is the leading cause of non-accidental death in the 15-19 year old age group (Jemal et al, 2002). This figure is small in comparison to the overall population dying of malignancies, but the number of adolescents dying of cancer remains constant.

The pattern of carcinomas seen in teenagers and young adults is very different to that seen in older age groups.

Within the age range of adolescence there are differing incidences of diagnosis. The most common cause of death in the 10-14 age group is leukaemia, brain and central nervous system tumours, bone and joint tumours and Non-Hodgkin's lymphomas (Albritton & Bleyer 2003).

The most common cancer-related deaths in the 15-19 age group are from brain and central nervous system tumours,

leukaemia, bone and joint tumours, sarcomas, Non-Hodgkin's lymphomas, thyroid cancer and malignant melanoma (Albritton and Bleyer 2003).

## Survival

Over the last 30 years there have been some remarkable improvements in survival rates in malignancies of childhood. Levi et al (2003) looked at trends in death rates from all cancers and seven selected cancer sites in the population aged 15-24 years in Europe, and for comparative purposes, in the USA and Japan over a period of just over 30 years.

The researchers concluded that overall there was a decrease in total cancer mortality of approximately 40% for both sexes. They attributed this to better treatments and inclusion in multi-centre clinical trials. In eastern European countries there was less improvement which reflected delays in the application of effective treatments and limited involvement in clinical trials.

## Older adolescence

For some cancer types, osteosarcoma, Ewings sarcoma, acute lymphocytic leukaemia and acute myeloid leukaemia, survival rates for adolescents were found to be less than 60%.

This reflects the different cancer types that affect adolescents of different ages. Older adolescents and young adults are unique in the types and biologies of cancer, and in medical and psychological needs. Unfortunately they have had less improvement in treatment outcomes than younger or older patients. For the older adolescent, there is less likelihood that they will be involved in a clinical trial and where they are treated may also have an impact.

## Late effects

There is emerging evidence of major physical and psychological late effects that can range in severity. Late effects are dependent on the specific cancer, the types of treatment received, and the age of the child or adolescent during treatment.

Cognitive function may be affected resulting in declined intellectual or academic ability. Endocrine complications of

treatment may include ovarian and testicular damage resulting in infertility, impaired growth and other dysfunction.

Fear of recurrence appears to be a chronic stressor for individuals and their families (Mellon S, 2002). It is estimated that up to 30% of adolescents with cancer suffer from post traumatic stress syndrome.

In addition, survivors of adolescent cancer have also been shown to be at risk of unemployment (Mostow et al, 1991) and discrimination based on their medical history (Li et al, 1984, Yebby et al, 1989).

## Family and friends

When adolescents are diagnosed with cancer, the quest for autonomy from parents and the development of social relationships among friends are affected.

A cancer diagnosis is a shock for anyone. All the mothers I interviewed described feelings of anger, shock, and confusion at the time of diagnosis. The overwhelming need to protect their child commenced at this time and was apparent throughout their journey. The discovery that their child's life was jeopardised raised deep feelings of love, survival, maternal protection and nurturing.

The hub of a teenagers' life revolves around peer relationships. However, for the teenager, coping with the rigors of treatment — feeling nauseated, fatigued, and generally unwell — changes the importance of what is meaningful at that time.

## Specialist centres

Adolescents are treated in a range of settings. Whelan (2003) identifies that there are 22 recognised paediatric oncology centres in the UK and Eire with six to eight dedicated Teenage Cancer Centres in the UK.

In the United States the majority of adolescents under 15 years are treated at National Cancer Institute affiliated centres. The majority of these adolescents are enrolled in clinical trials. However only 20% of adolescents 15-19 years of age are treated in such centres and only about 10% are enrolled in clinical trials. (Smith, Gurney and Reis, 1999).

There is evidence in the literature that adolescents receiving care under the

umbrella of the paediatric oncologists are doing better and this is partly explained by the enrolment on clinical trials.

But taking the step of recommending that adolescents or young adults be treated by paediatric oncologists can have practical restraints including the fact that many paediatric oncologists are uncomfortable treating older adolescents.

On the other hand adult oncologists are often unfamiliar with detailed paediatric protocols and older patients cannot be registered on paediatric trials.

It is important that these two groups increase their collaboration and communication to help improve adolescent cancer care. Professional rivalries can influence treatment decision-making and no one group has all the knowledge and expertise. However, we do need to be proactive in the way treatment and services are organised for both the teenager and their family.

### Training

Many health professionals receive little training in adolescent health issues, adolescent cancer care, and care of the dying adolescent. As a result, many are not comfortable with any of these areas.

There have been some proactive developments in the last 5-10 years that have

encouraged health professionals to focus on the care of the adolescent. There is worldwide recognition of the importance of youth health and wellbeing. The rate of youth suicide and the incidence of anorexia and bulimia has raised the profile of adolescent health issues.

Obviously, the support and expertise of the interdisciplinary team should be well recognised. For the myriad of health professionals that potentially could be involved in caring for an adolescent with cancer, there needs to be opportunity for professional development that provides education on the uniqueness of the cancer experience in this population.

### The future

The way forward in working with adolescents with cancer is to:

- acknowledge the needs and issues that relate to the adolescent with cancer and their families — it is important that we give the best possible support, tailored to individual needs, so that whatever the outcome we will not have made the situation worse by inappropriate care,
- ensure that teenagers with cancer are enrolled in clinical trials as we know outcomes, including rates of cure, for those involved in clinical trials tend to

be better,

- have a health professional workforce that is interdisciplinary and understands the challenges of adolescence as well as having cancer knowledge and expertise. Caring for teenagers with cancer is stressful and staff support is essential,
- communicate openly and honestly with the teenager and their family. This can be complex and hard to do especially when parents are feeling desperate about their child whilst trying to maintain some resemblance of family life. The teenager may want to protect a parent but to their dismay they become dependent once again and need the nurturing and love their parents provide them with.

*Diana Gunn, Director of Nursing, Burwood Hospital, Christchurch, New Zealand*

### References

- Jemal A, Thomas A, Murray T and Thun M (2002) Cancer Statistics, 2002. *CA: A Cancer Journal for Clinicians*, 2002,52, 23-47
- Albritton K and Bleyer WA (2003) The management of cancer in the older adolescent. *European Journal of Cancer*, Vol 39, No 18
- Levi F, Lucchini E, Negri C and La Vecchia C (2003) Trends in Cancer mortality at age 15-24 years in Europe. *European Journal of Cancer*, Vol 39, No 18
- Mellon S (2002) Comparisons between cancer survivors and family members on meaning of the illness and family quality of life. *Oncology Nursing forum*, Vol 29, No 7
- Mostow EN, Byrne J, Connelly RR, and Mulvihill JJ, (1991) Quality of life in long-term survivors of CNS tumors of childhood and adolescence. *Journal of Clinical Oncology* 9(4): 592-9
- Li FP, Winston KR and Gimber K (1984) Follow-up of children with brain tumours. *Cancer* 54: 135-8
- Yebby CK, Bromberg C, Piedmonte M (1989) Long-term vocational adjustment of cancer patients diagnosed during adolescence. *Cancer* 63: 213-18
- Whelan J (2003) Where should teenagers with cancers be treated? *European Journal of Cancer*, Vol 39, No 18
- Smith MA, Gurney JG and Reis LAG (1999), Cancer among adolescents 15-19 years old. Cancer incidence and survival among children and adolescents: United States SEER program 1975-1995. Bethesda, MD: National Cancer Institute, SEER Program. NIH Pub. No 99-4649

### Teens advice to all:

- Please ask **me** how I'm feeling — not my parents. I know.
- When I'm in the hospital, ask me personal questions in **private**.
- Parents should all relax more because **everything is going to be OK**.
- Please pay attention to my feelings when I need help. **Be there for me** and I'll understand.
- **Knock** before you enter my room, whether it's at the hospital or at home.
- Let me be **me**!

From the Memorial Sloan-Kettering Cancer Centre website [www.mskcc.org](http://www.mskcc.org)

## Stoma care in China

It is estimated that there are about one million people living with a stoma in China. Having a stoma brings discomfort, both mental and physical, to these patients. Doctors and nurses can provide care and support for the patients during their time in hospital but they also need professional guidance and support at home.

Before 2001, there were no enterostomal therapists in China. In February 2001, Zhongshan University in Guangzhou created the first enterostomal therapy school and trained the first 12 enterostomal therapists. In 2004, Peking University followed

its example. As a result there are now 52 enterostomal therapists in China. The training programme has helped to improve the quality of care for these patients by providing a better foundation for specialty nurse training.

### Patient support network

A patient support network has also been created. Tinajin cancer hospital, a large oncology hospital, created the first Stoma Support Association in China in 2001. The association has developed numerous branches.

The association provides financial support, a free advice service for the members, an outpatient service and specialised lectures. It also produces a series of publications including a self-education manual and information about new stoma care products. The association is also carrying out some research in the area of stoma care and association staff make home visits for patients who cannot get out. The association encourages members to meet and holds an annual social meeting. The work of the association has helped patients to be independent and self-caring.

# Contribute to Toronto success!

Preparations for the International Conference on Cancer Nursing in Toronto next year continue. Don't forget that your contributions are invaluable to the depth and variety of the poster and concurrent sessions offered.

Don't be nervous about presenting for the first time. Undertaking a presentation can be scary even for "old-hands" but be reassured that everyone will be working together to support each other. First time presenters will be given all the support they need.

The abstract deadline is just around the corner, on the 31st January 2006. Please send in abstracts about your area of practice and expertise. There will be concurrent sessions that focus on the themes of: prevention and screening, supportive care, palliative care, treatment developments, genetics, models of care delivery, cultural and spiritual care, care of the elderly, care of children, expanded and advanced nursing, ethics, informed consent and clinical trials, politics, policy makers and econom-

ics and patient safety.

The poster display this year will be bigger than ever with prizes in each of the categories of education, research and clinical practice. There will be identified times for poster presenters to be available to discuss their work with interested participants. This provides a great opportunity to be able to discuss your work with nurses from many different countries. Details of how to submit abstracts and attendance applications can be found at the ISNCC website at [www.isncc.org](http://www.isncc.org)

Meantime the Scientific Programme Planning Committee has confirmed a number of excellent speakers on topics related to cancer through the ages; palliative care; evidence-based symptom management; patient safety; cancer genetics and healthy workplace environments.

We have good news in that we have confirmed the opening keynote speaker as Dr Simon Sutcliffe, chief executive officer of the British Columbia Cancer Agency and

chair of Canadian Strategy for Cancer Control. He will speak about the relevance of cancer control planning and the role that nurses must play.

Dr Sutcliffe recently chaired the first International Cancer Control Congress held in Vancouver, Canada where policy makers, administrators, planners, oncologists, nurses and others considered how we could achieve cancer control. Many countries such as Australia, Canada and the United Kingdom have established strategic plans for cancer control, whereas many others have not begun that process. What can we learn from their experiences? How can we maximise the nursing role in cancer control? It will be an interesting speech.

That's all the conference news for now. There will be more news about speakers in the next newsletter and also more about the benefits that Toronto offers as a conference destination.

*Esther Green and Candy Cooley,  
Co-chairs, Scientific Committee*

## VIRTUAL CANCER CARE

### Prostate cancer

There are few more misunderstood and difficult to approach cancers than the one that affects the male prostate gland. Men in western societies are traditionally bad at looking after their overall health and few visit their family doctor as often as needed for regular health checks. Prostate-related problems are affecting an increasingly higher proportion of men over 50.

Despite increasing awareness, the very idea that a doctor will use his finger in the rectum to aid in detection is a cultural abhorrence to most men and can be one more factor against making contact with the medical profession. On the other hand, men are often very computer literate and in the privacy of their homes or office will search the internet for information on just about any subject imaginable. What better way then for health professionals to get vital messages about the detection, diagnosis and treatment of prostate cancer across to men than via the internet.

#### The prostate cancer foundation

<http://www.prostatecancerfoundation.org/>

This large and very professional American site has a lot to offer. There is a wealth of useful information that is well laid out in clear text with a light background and no complex graphics to slow things down. Patients and families will particularly like the personal stories and there are clear explanations of all currently available treatments.

#### The prostate cancer charity

<http://www.prostate-cancer.org.uk/>

This UK based site has a simple, but effective format with some clear colour diagrams and easy to navigate pages. Professionals will find the information well researched and for patients there is even a freely downloadable *Prostate Gland Owners Manual* (perhaps all men should download this). For those whose anatomy is rusty, the 3D prostate finder will amuse and inform. Overall a carefully put together site which is unpretentious and informative.

#### The virtual prostate

<http://www.virtualprostate.com/>

This fascinating site provides health professionals with a range of education resources that are either freely viewable from the site or downloadable as Microsoft PowerPoint presentations. If you find it difficult to get up to date on this subject, can't get to a study day, or are just bored with reading plain text, then this site is for you. The presentations are beautifully put together with superb illustrations and relevant audio commentary. This is just what the internet is best at and this site is a must for your favourites list.

#### Prostate cancer foundation of Australia

<http://www.prostate.org.au/>

This site has a heavy bias towards patient information and is good for that reason.

Everything is simply laid out and accessible via a menu to the left of the home page. It even has a uniquely Australian game called "peeball" which is designed to test the strength and performance of a man's urine flow. Humorous indeed, but with a serious message.

#### Worth a look Prostate.com

<http://www.prostate.com/>

A simple and unpretentious site with much useful and easily digested information aimed at both patient and professionals.

#### Prostate info.com

<http://www.prostateinfo.com/>

This site is designed and sponsored by Astra Zeneca so has a clear bias towards its products, but nevertheless contains a wealth of high quality information for all professions.

#### Cancer bacup

<http://www.cancerbacup.org.uk/>

[Cancertype/Prostate](#)

The most definitive information source for any cancer available today for patients and professionals. The prostate cancer page of this huge, award-winning site does not disappoint.

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

### Engagement and learning in the workplace

One of the challenges for educators in cancer nursing is finding the way or ways of engaging clinical nurses in continuing education. The idea of engagement is generally a positive one. However, in the workplace, where work is central and learning is peripheral, engaging staff in learning becomes an important challenge. Compounding this, imperatives of quality, economy, and safety are constant influences on nursing practice; the tensions between each are continually negotiated using best available evidence.

#### Collaboration

Engagement is defined as “to involve a person (or his attention) intensely” (Wilkes and Krebs 1982). This can be in a collaborative context, where engagement implies co-operation with the same goal in mind. Alternatively, engagement can underpin actions against an enemy — it is associated with conflict. Both forms of engagement exist in modern workplaces.

Skills to support collaborative engagement are essential for educators and clinicians alike when practice change, based upon new evidence, is required. It has been suggested that people are more likely to engage with others if they can see a strong need for it, their environment supports, rather than hinders it, and they have people who will facilitate that engagement (Walsh et al 2005). Wenger’s social theory of learning, *Communities of Practice* (1998), provides a framework for understanding the complex relationships between practice, engagement, meaning, and learning that emerge in the workplace.

#### Participation

In this model, the focus is on learning as social participation. Knowledge is a matter of competence with respect to valued enterprises — such as rapid assessment of the person who is critically ill, compassionate listening to the person’s experience of illness, and unblocking an infusible port. Knowing is a matter of participation in the pursuit of such enterprises, active engagement in the work of the organisation. And finally, meaning — the ability to experience nursing work and our engagement with it as meaningful — is ultimately what learning aims to produce.

In a social theory of learning, the components necessary to characterise social participation as a process of learning and knowing include four concepts: meaning, practice, community, and identity. For individuals, learning is an issue of engaging in, and contributing to the practices of their

communities. For nursing educators the following challenges are important:

- develop inventive ways of engaging staff in meaningful practices, of providing resources that can enhance participation,
- provide communication frameworks and skill development that enhance participation,
- open horizons for work teams so they can put themselves on learning trajectories that they can identify with,
- involve the work team in actions, discussions and reflections that make a difference to the communities that they value.

#### Develop ways of engaging staff in meaningful practices

The nurse educator begins engaging staff through discussion about practices. Which practices are most important to the group? Why these and not others? What does prioritising of these practices reveal about what is important or valued by the work group? How are these values consistent with those of the organisation? The patients and their families? Other work groups?

Responses to these questions reveal the meanings that individuals and the group create from their practice experiences. Examination of these practices, in light of the expectations of others, provides opportunity to see other possible ways of thinking about, and doing, practice. The question that guides such examination is: how are these practices reflective of what is important to us as a group? How could they be different?

#### Communication theory and skills

Listening is a fundamental skill for working in teams. It allows individuals to develop understanding and find meaning in interactions with others (Miller and Babcock 1996). Listening involves hearing the message, providing feedback to clarify the meaning of the message, and then evaluating the message. Nurse educators can develop and facilitate workshops where nurses practice clarifying meaning. Clarifying questions may look like these:

- “What do you mean when you say that we are overstaffed?”
- “What is the patient doing that makes him look worse to you?”
- “When you say we need to make the ‘right’ decision, how will we know it is ‘right’?”

#### Open horizon or broaden perspectives

Many individuals develop habits that hinder thinking, such as resistance to change, conformity, and stereotyping. Nurse educators can alert staff to these bad habits by facilitating an examination of initial feelings about problems and issues, especially strong feelings that prompt an immediate stand, one taken without examining the evidence or weighing competing arguments.

Learning tasks that assist in opening horizons include acknowledging the influences that have shaped one’s thinking, examine personal ideas and attitudes in light of evidence rather than their compatibility with other ideas, and resisting the pressure of habit. The educator is a guide rather than a teacher in this learning work.

#### Involve the work team

Facilitation of discussion is the most powerful tool in nursing education. Providing a forum for discussion of valued practices, in light of organisational goals and best available evidence, requires bringing the group together and monitoring discussion.

The educator uses communication skills, particularly clarification questions, to clarify the meaning of individual views. Responses to the views are solicited, and these too are clarified.

Care is taken to ensure that individual views are respected, but at the same time evidence is required to support ideas, and competing arguments are clearly articulated and evaluated over time.

In conclusion, engagement in work is essential to learning. Multiple forms of engagement exist and through skilled facilitation, nurse educators can promote learning in the workplace. Wenger’s (1998) theoretical model for *Communities of Practice* provides a guide for nurse educators to support workers as learners.

Laurie Grealish

Senior Lecturer in Nursing  
University of Canberra, Australia

#### References

- Wilkes GA and Krebs WA, (Ed) (1982) *Collins Concise Dictionary of the English Language*, Australian Edition. Sydney: Collins
- Walsh K, Lawless J, Moss C and Albo C. (2005) The development of an engagement tool for practice development. *Practice Development in Health Care* 4(3): 124-130
- Wenger E (1998) *Communities of Practice: Learning, Meaning and Identity*. Cambridge: Cambridge University Press.
- Miller M and Babcock D (1996) *Critical Thinking Applied to Nursing*. St Louis: Mosby

## Impact of care by a symptom management nurse consultant

There is research evidence that advanced oncology nursing practice in the form of programmes of education and support and home care have been effective in providing positive health outcomes for cancer patients and family caregivers. A nurse coordinator role has been advocated as essential to quality care for patients and families with chronic disease (Schroeder et al, 2000) and a similar role has been created in Quebec known as the “infirmière pivot” or “pivot nurse” as part of the provincial “Fight against cancer” program in Quebec (Gouvernement du Québec, DeSerres & Beauchesne, 2000).

The purpose of this paper is to report the preliminary results from a chart review sub-study of 15 participants assigned to the Symptom Management Nurse Consultant (SMNC) (n=93) in a larger study.

The purpose of the larger study was to assess the effect of continuity of nursing care delivered by a SMNC on improving symptom relief and patient outcomes. The Symptom Management Model (SMM) was used as the theoretical framework (Larson et al, 1994). The research question asked in this sub-study was: “What is the practice pattern of the SMNC with a lung or breast cancer outpatient population?”

### Methods:

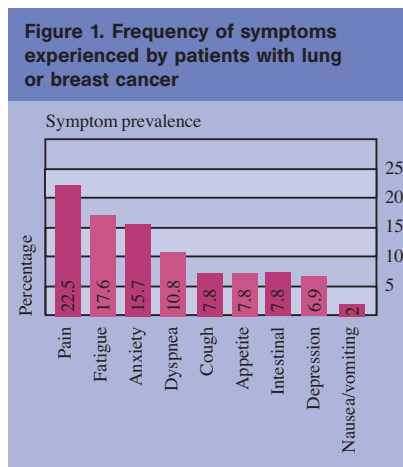
The design of the larger study was a prospective randomised controlled trial with monthly repeated measures over a six-month period. One hundred and ninety patients with lung or breast cancer were recruited in an ambulatory setting. For those patients who were assigned to receive care from a SMNC, a needs-based nursing approach was used in the provision of nursing care, including education about side-effects of treatment, availability of resources, and symptom management. The SMNC met patients in the clinic or contacted them by telephone. All information on activities, assessments, and interventions was recorded in the chart.

As part of the larger study, participants assigned to both arms of the study were asked by a research assistant to complete a set of questionnaires with established reliability and validity. All nurse-patient encounters with the SMNC were coded using the Omaha Intervention Classification Scheme (Martin and Scheet, 1992).

### Results

Figure 1 represents the frequency of symptoms reported by the participants using an 11-point Likert scale (0 = absent and 10 = most frequent). The most dominant symptoms (rated as 5 or above) were pain, fatigue, and

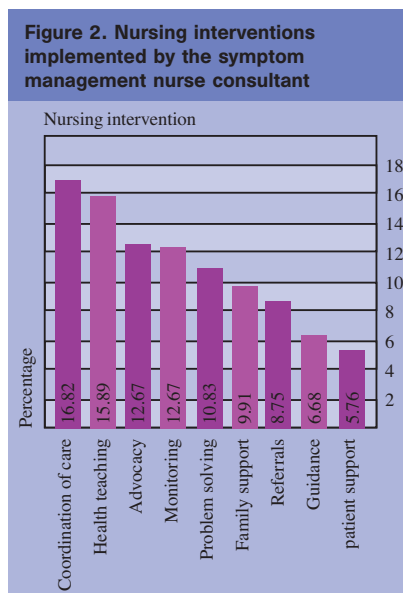
anxiety. Results of the study are consistent with previous study findings that pain and fatigue are the most common symptoms experienced by patients with cancer (Dodd, Miaskowski, and Paul, 2001).



Symptoms that were less frequently reported by the participants (rated as less than 5) were nausea and vomiting, and depression.

The nursing interventions reported in the chart reviews are shown in Figure 2. The three most frequently used nursing interventions were co-ordination of care and advocacy, health teaching, and monitoring of symptoms. Using the Omaha Intervention Classification Scheme, the three interventions were categorised into case management (co-ordination of care and advocacy), health teaching, and surveillance (monitoring of symptoms).

Results of the study suggested that these three interventions were important components of the SMNC’s role in providing symptom management and continuity of care.



### Conclusion

Data collection was completed in July 2005. This preliminary review has shown that the practice pattern of the SMNC addressed advocacy, symptom management, and continuity of care. Further analysis is underway to compare the intervention and control groups on the outcomes of symptom distress, quality of life, and health care use. Results will offer more information on the impact of providing a different nursing care model on patient outcomes. Findings also will help to determine which model of nursing care can better meet the needs of patients with cancer.

The challenge for nurses is to determine which nursing delivery system better manages distressing symptoms. As health care shifts to ambulatory and community-based care, it is apparent that effective symptom control and retention of maximal physical functioning are important across the cancer trajectory.

Oncology nurses who specialise in symptom management find themselves in key positions to further develop their practice. Examination of patterns of symptom distress might also add insight into symptom clusters, and their impact on patient outcomes. Such new knowledge may direct future interventions for the prevention and management of symptoms (Bender et al, 2005).

*Myriam Skrutkowski, Marika Swidzinski, Margaret Eades, clinical nurse specialists in oncology, Andreanne Saucier, Associate Director of Nursing in Oncology, Respiratory and Palliative Care Services, Judith Ritchie, Associate Director of Nursing, Research, Dr Linda Ofiara and Dr Vera Hirsh, respiratory oncology physicians. McGill University Health Centre, Montreal, Canada.*

### References:

Schroeder CA, Trehearne B and Ward D (2000) Expanded role of nursing in managed care. Part II: Impact on outcomes of costs, quality, provider and patient satisfaction. *Nursing Economic*, 18 (2), 71-78

Gouvernement du Québec, Conseil québécois de lutte contre le cancer, (2000). L’intervenant pivot en oncologie, un rôle d’évaluation, d’information et de soutien pour le mieux-être des personnes atteintes de cancer. Document de réflexion rédigé par Marie De Serres et Nicole Beauchesne

Larson PJ, Carrieri-Kohlman V, Dodd MJ, Douglas M, Faucett J, Froelicher E et al (1994) A model for symptom management: The University of California, San Francisco School of Nursing Symptom Management Faculty Group. *IMAGE: Journal of Nursing Scholarship*, 26(4), 272-276

Martin KS, and Scheet NJ (1992) *The Omaha System: Applications for community health nursing*. Philadelphia: WB Saunders

Dodd MJ, Miaskowski C and Paul SM (2001) Symptom clusters and their effect on the functional status of patients with cancer. *ONF*, 28(3), 465-470

Bender CM, Fisun Suenunzun E, Rosenzweig MQ, Cohen SM and Sereika A (2005) Symptom clusters in breast cancer across 3 phases of the disease. *Cancer Nursing*, 28(3), 219