



Tiffany lectureship awarded

The Robert Tiffany Lectureship has been awarded to Ursula Courtney, an oncology nurse whose work focuses on psycho-social cancer care.

Ursula Courtney, who is the Director of Services at ARC Cancer Support Centre in Dublin, Ireland said she was delighted to win this award. She said: "I am absolutely thrilled. To me it is the peak of what can be achieved. I love what I do and to receive an award as well is very exciting."

Extending the nursing role

Ms Courtney has worked in oncology nursing for nearly twenty years. For the past ten years she has been Director of the ARC Cancer Support Centre which is a community-based charitable organisation offering support to people affected by cancer and those who care for them.

Her contribution to promoting the extended role of nursing in relation to psycho-social cancer care in Ireland has been considerable. ARC has now become the accepted blueprint for community-based psycho-social cancer care in Ireland and



Ursula Courtney, 15th ICNN Robert Tiffany lecturer

has been adopted and endorsed by the Irish Department of Health and Children.

Ms Courtney said: "I am very committed to extending cancer care outside of the hospital. More questions arise for the patient when they get home and it feels like a long time before they will be going back to the hospital.

"We provide a safe place where patients can show their feelings and find the information that they need. Nurses working within hospital services often do not have the time to offer the level of support that we do."

The centre has encouraged men, who are traditionally reluctant to seek support, to attend. Indeed over the last ten years the proportion of men has increased from 1% to 25% of the users of the centre.

Research focus

The focus of Ms Courtney's research work has been on the impact of psycho-social care in groups such as men with prostate cancer and women with gynaecological cancers.

In 2006 she was given an award by the Irish Association of Nurses in Oncology for her work with men and prostate cancer which led to a scholarship to the Memorial Sloan Kettering Hospital in New York, US.

Structured programmes

The men with prostate cancer followed a four-week programme which enabled them to meet others with the same condition and to find out more about their condition. The research showed that the experience of the programme enabled the men

to make choices about their treatment.

The centre offers this once-a-week four-week programme for a variety of groups including men whose female partners have breast cancer.

Ms Courtney has developed a profile as a speaker both nationally and internationally. She will be delivering the Tiffany lecture at the Singapore conference. Her lecture will explore the focus of her work and the extension of the boundaries of cancer nursing. The lecture will be covered in detail in a later issue of ICNN.

Singapore delegates

This issue of the newsletter has a special message for delegates at the 15th International Conference on Cancer Nursing. Turn to page seven to find out useful information to help you get the best out of your time at the conference and in Singapore.

**Don't miss our report on the 15th International Conference
on Cancer Nursing in the next issue**

Honouring our colleagues

As I write this message we are in the last stages of preparing for our biennial conference. Around the world nurses have been preparing to travel to Singapore to share their knowledge, meet up with old friends and make some new ones, and most importantly to celebrate cancer nurses and their contribution to cancer care.

Others, particularly those involved in the local organising committee, the scientific committee and other parts of ISNCC have been making last minute changes to the conference arrangements so that we can all benefit from a successful meeting.

All of these nurses and staff are everyday heroes in the tapestry that makes up ISNCC and the 15th ICNN. Each makes a voluntary contribution that is priceless for without this effort we would simply cease to be. The board of directors of ISNCC offers thanks to the many individuals who

have made a contribution to the society. And in particular to those who have given time and effort to the conference through membership on a committee, submitting an abstract, preparing a poster or paper or simply for attending and participating.

The word hero comes from the Greek goddess, Hera, and relates to the words *protector, defender or guardian*. To me cancer nurses are the guardians of cancer nursing, what it has contributed in the past and present but crucially what it will contribute in the future to the lives and well-being of people affected by cancer.

Cancer nurses' work is increasingly recognised as a critical component of cancer control and in the main this work is achieved without accolade or fanfare. However every second year we have a chance to honour our colleagues through various recognition awards: the Robert

Tiffany Lecturership, the Past President's Award, the Distinguished Merit Award and travel scholarships. The Tiffany lecturer for 2008 is Ursula Courtney who is profiled in this issue. Other award recipients will be featured in our conference coverage.

The individuals who have obtained this recognition inspire us all with their words and efforts. They are symbols of what can be achieved and accept these awards not just for themselves but for the many other nurses and individuals who will have helped make their achievements possible.

Please take a moment to get to know these individual nurses a little while you are in Singapore and if not joining us, take a moment to read the pages of this newsletter and the post-conference issue to find out more about cancer nursing heroes.

Sanchia Aranda
ISNCC president

AORTIC 2009

The African Organisation for Research and Training in Cancer (AORTIC) recently held its 6th International Cancer Conference, in Cape Town, South Africa, a highly successful event, attended by over 400 delegates.

AORTIC's 7th International Cancer conference will take place in Tanzania from 11–14th November 2009. Areas of focus will include: Preventable cancers, National Cancer Control Programmes, Management of specific cancers, Chemotherapy, Radiation and Palliative Care.

This forum will bring together leading African health care professionals in cancer care, oncologists, public health educators, advocates, and various international partners to address the dilemma of cancer in Africa. For more details contact: info@aortic2009.org or visit www.aortic.org

Cancer Chronicles

The finalists for the first-ever international documentary film competition on cancer have been announced.

The Reel Lives: The Cancer Chronicles film festival aims to raise awareness of the complex realities of cancer globally, to shatter taboos and myths surrounding the disease, and to challenge stigma. The 30 finalists are from 18 different countries and include 15 public service announcements, 10 short films and 5 feature-length films.

All the finalists have a direct link with cancer, and address the patient experience in some way, which also includes the perspectives of family, caregivers, research, and cancer organisations

The festival will take place 28–30 August in Geneva and is organised by the International Union Against Cancer (UICC). For more information go to www.reellives.org

Advanced practice

The International Council of Nurses (ICN) has produced a publication to support the increasing number of advanced practice nurses, a role which is increasing around the world. *Scope of Practice, Standards and Competencies of the Advanced Practice Nurse* focuses on the scope of practice, standards and competencies of the role of the advanced practice nurse.

This publication will provide guidance and direction to nurses, the nursing profession, educators, regulatory authorities and the consumers of care.

It was developed as a result of the growth of this professional role and a response to multinational changes in the health care systems, such as globalisation, economic constraints, reform, technology and consumer demand. For more information go to www.icn.ch/bookshop.htm

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Valuing family relationships

Patients and their families need to be cared for and supported in a way that values, honours and preserves the dynamics of their family relationships

In my experience as a palliative care nurse specialist the effects of family dynamics and relationships have an impact on the dying process. Lifelong relationship habits such as devotion, synergy, bullying, dominance, submissiveness, being 'a giver' or 'a carer', will have a lot of influence in the journey of dying.

In our role as nurses and in our interaction with patients and families, we need to deal with many uncomfortable situations in a way that supports the patient and the family. It is equally important to honour and preserve these relationships.

Care for the person will inevitably include care of the family. Complex relationship issues, generally of long standing, will often surface during the stressful time of dying.

As a palliative care nurse I have found myself repeatedly considering the effects that the quality and dynamics of family relationships have on the dying process. If we could understand this better, would we be better equipped to care for patient and family, to provide support and not interfere with the relationship? This question has led me to explore the phenomenon of family relationship history, its effect on the dying process and the fragile balance of science and relationships in the emotionally charged specialty of palliative care.

Relationships

I see relationships as common bonds which unfold in unique and mysterious ways. They are experienced as a journey and life experience which affirms the significance and value of being fully human. It is a place for love to be present, a sharing and touching of souls. Hawthorne & Yurkovich (2003) describe relationships as "a fundamental dimension of human experience: it confirms one's existence and is essential to life. It is the means by which humans achieve, not only meaning but also purpose in life".

Relationships are the way in which people connect, and find common ground. They can vary in levels of intimacy and sharing. Enduring relationships are often based on trust but can be based on fear and lack of self esteem and will be influenced by our experiences of relationships in childhood.

Relationships and palliative care

If our objective is to support people and allow them to die how and where they wish, we need to understand the social relationships and social context in which they live. Kristjanson and Ashcroft (1994)

talk about the family not only as the key source of support for the patient but as "the unit that faces the disease". Common sense and experience tell us that it is impossible to separate patients and their families and social systems.

Sholevar and Perkel (1990) explain the dual effect of the family and social network on the illness and the illness on the family and social network. This is because family members give and receive support, and even now in the institutional setting and within intellectual appreciation of palliative care there is still a tendency to overlook them.

Repositioning health professionals understanding so that dying is seen primarily as family-centred means the family experience becomes central. As families observe the patient's distress, it impacts on them psychologically often resulting in guilt. They commonly feel they have not done enough to relieve the suffering. They carry a huge burden if they do not have the resources needed to provide required care. Families can experience problems with physical health and well-being as they care for loved ones, and any chronic illnesses can be exacerbated (Kristjanson & Aoun, 2004; Whyte, 1997).

The role of the nurse includes assessing and understanding just how the patient, his or her disease or symptoms are affecting the family and in turn how the behaviour and the reactions of the family impact or influence the patient's experience. While our involvement in the patient's journey is often a small window within their life, the journey will have been longer for them. They bring with them all their life experiences, good and bad and it is these which has shaped them and created the person they are, including a network of family and friends. It is the purpose of family-centred care to maximise family support (Maher & Heming, 2005) and minimise disruption to family dynamics (New Zealand Ministry of Health, 2003).

Relationships and science

Perhaps at the core of the dilemma often found in palliative care is that of the relative importance of science and relationships. The question is how do we work with the two in a manner which provides optimal family-centred care, without one overshadowing the other? Recognising this balance requires an alertness on the part of the practitioner since every person will be different and every family will require a different balance.

Hawthorne and Yurkovich (2003)

explain that the dynamics of science and relationships are difficult to separate as they are both essential to the quality of life in the practice of palliative care. When the dynamics of science overwhelm relationships, relationships can end up taking a back seat and even being overlooked. This emphasis on science can have serious consequences for human relationships and the patient's quality of life.

Gulino (1982) expresses similar concerns stating that "because the natural science view of reality objectifies the phenomena under study, those aspects of the human experience which lay within subjective experience can be distorted or worse, not perceived at all".

Hawthorne and Yurkovich (2003) discuss the difficulties in palliative care in relating to relationships between patients and health care professionals. They report on studies where patients, families and health professional express discontent and dissatisfaction with their experience of palliative care. But the issue of relationships between the patients and their loved ones remain unexplored.

Changing face of health care

The traditional approach to health care where the health professionals take over and direct care for a person and their family is being replaced by one in which the family and health professional are in partnership. The family becomes actively engaged in caring for their ill relative. Families want to be involved and want to be able to decide what is in their best interest (ICN, 2002). This is about allowing families autonomy.

Kite (2001) explains the literal meaning of autonomy as "self-rule" and how it defines us as individuals. When looking at the discipline of ethics, the ICN (2002) states that to "respect persons as an autonomous individual is to acknowledge their choices which stem from personal values and beliefs". Thus autonomy is aligned to patient choice which has always been a fundamental value of palliative care, in particular allowing patients to choose where to die.

Kite (2001) raises a valid question when asking "how do we distinguish what patients mean and want from choice in end of life care, from what healthcare providers think they mean and want?".

A common dilemma faced by health professionals is to try to determine who knows what is in the best interest of a patient who may be unable to make his or

her choice known. The view of health care professionals may differ from the family who may or may not have had a long-term intimate relationship with the patient.

Farsides (1998) states that an eminent philosopher and legal theorist wrote "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny". It is clear that we cannot determine what the patient may want without involving the family.

The future

Segaric and Hall (2005) highlight the need for research to make a shift from theoretical knowledge to understanding more about the realities of practice and more specifically to understanding the meaning that nurses attribute to family nursing.

Colleen Fischer (2003) explains how family conflict or abuse can impact on the provision of quality of end-of-life care and ultimately on the facilitation of a "good death". She states that "good deaths only happen if the dying person, the family, and the health professionals all agree with what is happening in the time before death".

Researchers have recognised the fractured nature of many families but as Fischer explains this is not taken much beyond challenging nurses to work with different families in a non-judgmental way and being aware that terminal illness and other crisis will result in old family conflict and coping mechanisms coming to the fore.

Behaviours such as poor communication and dominance will stretch the family's ability to cope. Studies have found that in marriages where there is good quality communication, more solid family cohesion and less family conflict, patients are more likely to be alive five months later. This strengthens the evidence of the

impact that relationships have on the dying process and the need to work within a family model of care in palliative care.

When reflecting on my work it is apparent to me that the many nurses I have interacted with have had a different view of family nursing to my own. A focus on research would provide valuable insight to why as Segaric and Hall (2005) state "despite growing recognition of the importance of family in health-care and considerable progress in family theory development, only limited progress in the transfer of family theory to acute practice has occurred".

While there is irrefutable evidence that family relationships do impact on the dying journey for patients, there is a lack of empirical evidence. It is my dream to conduct research which shows that nurses' perceptions of this reality affect the outcome for the person and family.

Conclusion

Caring for families is an integral part of palliative care and is exciting and rewarding. It is crucial to remember that a person's life journey and their story belong to them and their family, and health professionals need to allow them to have their own experience.

Kristjanson and Aoun (2004) talk about the meaning of illness and how the understanding of the illness impacts on families as diagnosis is not an event that is part of the normal expectation of the family life course. It results in family members needing to redirect their time and energy and to re-examine the quality of their relationships and their views of the future. As nurses we are in the privileged position of supporting these families in a way which values, honours and preserves their relationships.

Nurses are ideally positioned in their multi-skilled roles and with their closeness to people. They are the key resource in caring for families in many disciplines including palliative care. This offers the privilege of witnessing human nature and places them in a position to facilitate amazing events and to assist and listen as patients make meaning through their life course. Allowing a wider appreciation of what it means to be human requires a willingness and passion to explore our ways of being. *Sandi Haggart, Palliative Care Nurse Specialist, Waikato Hospital, Hamilton, New Zealand*

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RESEARCH ROUNDUP

HRT fall impacts

A sharp fall in the use of hormone replacement therapy (HRT) has been associated with a decrease in the incidence of breast cancer among older women, an Australian study has shown.

Following negative publicity a 40% decline in the prescribing of HRT between 2001–3 was associated with a 6.7% fall in breast cancer incidence in women over 50. During the same period women under 50 showed no significant change in incidence of breast cancer.

The researchers say that the study indicates that HRT associated increase in breast cancer risk is rapidly reversible after use of the therapy is stopped.

Medical Journal of Australia 2008; 188: 641–4.

Role of PSA test

General screening using the prostate specific antigen (PSA) test may reduce the number of deaths from prostate cancer, research shows. In the US, Canada and five European countries, mortality from prostate cancer is now lower than it was before the PSA test was introduced in the late 1980s.

Researchers analysed WHO mortality data from the International Agency for Research on Cancer for 38 countries for 1975 to 2004. They comment that current clinical trials in the US and Europe which will complete in the next two years will be able to more clearly tell the difference between the effect on mortality of screening and of advances in treatment.

International Journal of Cancer doi: 10.1002/ijc.23591

Nurse programme

A programme to combat depression given by cancer nurses improved quality of life, anxiety and fatigue in one in five patients with severe depression.

The Scottish study offered patients a programme of one-to-one sessions of problem-solving therapy over an average of seven weeks. After a period of three months, 20% fewer patients were suffering clinical depression compared with those receiving standard care.

The benefits of the therapy were found to persist after six and 12 months.

The researchers say that as 10% of cancer patients suffer clinical depression this approach could prove very beneficial.

The Lancet 2008; 372: 40–48

Cancer survivor programmes

Nurses are creating programmes and services for cancer survivors which may present models for integrating cancer survivorship into national and global health strategies.

Nurses at the National Cancer Institute IRCCS Giovanni Paolo II in Bari, Italy are identifying and describing their patient population, now cancer survivors, who could be served by their institution. The nurses' work is part of comprehensive and collaborative efforts to recognise and address the health concerns of cancer survivors in Italy.

A 'work in progress' report on the programme was given recently at a conference held in Bari entitled *Life beyond cancer – Survivor: person, not patient anymore*. The programme was acknowledged by over twenty organisations including the ISNCC, the Oncology Nursing Society and endorsed by the Human Health Foundation Onlus.

The scientific committee charged with



Marisa Longo, Pamela Haylock, Grazia Bradascio, Antonia Di Lella

programme planning, led by Vittorio Mattioli, MD, included US oncology nurse Pamela J Haylock and Susan Leigh, nurse, cancer survivor, and founding member of the National Coalition for Cancer Survivorship. Additional faculty for the event included many of Italy's prominent cancer scientists, care providers and representatives of the health ministry.

The nurses' project, led by Antonia Di

Lella, Marisa Longo, Grazia Bradascio, and Elisabetta Rizzo, is part of the nationwide Italian Project PIO7, directed by Professor Umberto Tirelli. PIO7 is an integrated research programme to design and implement multidisciplinary and evidence-based approaches to people with cancer, and includes six projects in different cancer centres in Italy.

Projects include efforts to define medical and psycho-social assessments and rehabilitative interventions, genetic bases and

prevention of depression and other affective states, assessment and psycho-social rehabilitative pathways specific to women, and nutritional and metabolic rehabilitation among survivors.

The expected outcome is to put forward a proposal for national and regional cancer survivorship plans that includes guidelines for improving the quality of life for people with cancer.

VIRTUAL CANCER CARE

Cancer education for professionals

The potential of the internet to act as a medium for interactive education is enormous, but we are only just beginning to exploit this area within cancer care. Regular readers of this column will know that there are very few websites that offer truly interactive education.

Those that do offer it do so in a variety of formats; some are accredited through universities and have to be paid for whilst others are charitable in origin and free to access. This edition of Virtual Cancer Care will take a look at some of the best around to help you in your professional development.

Cancernursing.org

<http://www.cancernursing.org/index.asp>

This superb UK web site offers free-to-access online courses of good quality on many aspects of both cancer and palliative care. It is a charitable organisation, run on a shoe string by enthusiasts in the field, which has established a well-deserved reputation for excellence over the last 3 years.

You only need to register with the site and you can access any of the 11 courses currently available without any further formality. You can keep your open confidential learning log and download a certificate when your study is complete.

I confess to a slight bias towards this site as I am an author of one of the courses.

However, because of this inside knowledge I can strongly vouch for the rigour that goes into the writing and blind academic review of the material before it goes live to ensure quality.

Marie Curie Cancer Care Learning Zone

<http://learningzone.mariecurie.org.uk/>

This major UK cancer charity is at the forefront of e-learning initiatives. This site offers you a mix of both full online learning and blended learning (some face-to-face).

There are a range of courses available from leadership and management through to MSc studies. Most are university accredited and as a result there will be some cost attached, but the materials are carefully trialled and quality-controlled to ensure a positive experience.

Help the Hospices

<http://www.helpthehospices.org.uk/elearning/>

This UK website offers the CLIP (Current Learning in Palliative Care) e-learning programme. CLIP is designed to be achievable in 15 minutes of study and offers a selection of worksheets. It costs nothing to access and is regularly updated by a professional in the field. A real coffee break study session.

Worth a look Stoppain.org

http://www.stoppain.org/for_professionals/content/education/elearning.asp

This US web site designed by the Beth Israel university offers a small number of sponsored pain-oriented courses for both medical staff and nurses. Some are free and others you have to pay for, but all are accredited in some way.

End of Life Palliative Education Resource Centre

<http://www.eperc.mcw.edu/>

More palliative care than cancer care, but this US site offers a vast resource of educational materials.

Med Ethex on line

<http://webcampus.drexelmed.edu/medethex/intro.html>

This US site offers a series of free-to-access case studies on medical ethics and communication skills that are directly applicable to cancer care. You simply need to click on the 'cases' icon, enable pop-ups on your computer task bar, give your name and email address and away you go.

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

Welcome to Singapore delegates

Welcome to the 15th International Conference on Cancer Nursing. As the conference theme suggests, our meeting in Singapore provides an opportunity for cancer nurses from around the world to “create partnerships, champion progress and celebrate their practice”. We hope that you take the opportunity to learn about developments in cancer nursing, network with colleagues from around the world, and reflect on how we as cancer nurses can continue to improve cancer care

Each day of the conference is themed. We cover a broad range of topics of interest to cancer nurses, and our plenary session speakers are all leaders in their field. Covering such a broad range of topics can appear overwhelming at first, especially when choosing which concurrent session to attend! We encourage you to take some time to familiarise yourself with the range of sessions on offer so that you gain the most from your conference experience.

Don't forget to allocate some time to visit the more than 250 posters that are being displayed at this year's conference. The posters present information about the

latest developments and best practices in cancer nursing that will be of much interest to you. Please review the conference programme to see the times that poster authors will be present at their posters, so that you can engage in discussions about the work that is being displayed.

In addition to the scientific programme, you may also like to take the opportunity to meet with representatives from the ISNCC Board. Board members are keen to hear from you about the challenges and concerns that cancer nursing faces in your country, so that we can ensure the society responds to these challenges effectively. So please attend any regional meetings that are scheduled during the conference.

The local organising committee has prepared some exciting cultural experiences through the conferences. Right from the beginning, you'll be welcomed and entertained with multi-ethnic cultural music performances and dances.

Aside from the conference itself we hope that you will not miss the “Tropical Delights in the Jungle Twilight” which will be held at the Singapore Zoo Night

Safari, the world's first wildlife park built for visits at night. This will take place on Wednesday 20 August 2008, and a limited number of tickets are available at US\$110 per person. Please visit: <http://www.isncc.org/meeting/Tropical-Delights>.

Do explore Singapore and nearby countries with the tours available. Please visit <http://www.isncc.org/meeting/Activities-and-Tours> for details of the tours available.

Members of the local planning committee and the volunteers are looking forward to receiving you. You can identify them by the scarves that they will be wearing. If you need any practical assistance or advice during the conference, please contact the registration desk where staff from the conference secretariat will be happy to assist you.

Please also take some time to visit the conference exhibit hall and talk with representatives about their products and services.

Our sincere thanks goes to all involved in ensuring this conference will be a rewarding experience for all delegates.

*Chua Gek Phin and Patsy Yates,
Co-Chairs,
Scientific Programme Committee*

EDUCATION COLUMN

Healthy lifestyles – nurses can lead the way

Nurses are in a unique position to promote healthy lifestyles — we are in close contact with patients and their relatives and we can begin by being good role-models.

A profound shift in the balance of the major causes of death and disease has occurred in developed countries (high-income countries) and is underway in developing (low-income countries).

Globally the burden of non-communicable diseases has rapidly increased. Since the year 2000 non-communicable diseases have accounted for almost 60% of the 56 million deaths annually and 47% of the global burden of disease.

In 2002 the World Health Organisation produced *Reducing risks, promoting healthy life*, a report describing how, in most countries, a few major risk factors account for much of the morbidity and mortality. For non-communicable diseases the most important risks include high blood pressure, high concentration of blood cholesterol, inadequate intake of fruit and vegetables, being overweight or obese, physical inactivity and tobacco use.

This burden of mortality, morbidity and disability is currently greatest in developing countries where those affected are on average younger than in developed countries and where 66% of deaths occur. Rapid

changes in diet and patterns of physical activity are further causing rates to rise.

The prevalence of overweight and obesity is increasing in developing countries and even in low-income groups in richer countries. Factors which increase the risk of disease include elevated consumption of energy-dense, nutrient-poor foods that are high in fat, sugar and salt, coupled with reduced level of activity. Smoking also increases the risk of these diseases.

Of particular concern are unhealthy diets, inadequate physical activity and energy imbalances in children and adolescents.

Diet and physical activity influence health both together and separately. Although the effects of diet and physical activity on health often interact in relation to obesity, there are additional health benefits to be gained. Physical activity is a fundamental means of improving the physical and mental health of individuals.

Governments have a central role in creating an environment that empowers and encourages behavioural changes by individuals, families and communities. This allows them to make positive life-enhancing decisions on healthy diets and patterns of physical activity.

Education, communication and public awareness are the key issues to underpin a sound basis for action. Consistent, simple and clear messages need to be prepared and conveyed in a culturally acceptable format to all age populations.

The American Cancer Society's guidelines (ACS, 2006) for diet and activity gives useful tips:

- Maintain a healthy weight,
- Adopt a physically active lifestyle,
- Eat a healthy diet,
- Limit alcoholic intake.

In this corner of the world we have made a start. Healthy foods have been introduced into the hospital cafeteria, a gym is opening for staff, a female badminton team has been formed and a no-smoking policy was introduced 12 months ago.

We can and must take up the challenge!
*Professor Virginia Gumley,
Director of Nursing/Nursing Education,
Shaukat Khanum Memorial Cancer
Hospital, Lahore, Pakistan*

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Abnormal breast screening results: the psychological consequences

Breast cancer is a leading health concern in Canada. Screening programmes and better treatments are helping to lower the death rate from cancer (Cancer Care Ontario, 2007). Despite the clinical benefits of screening, health care providers need to acknowledge the anxiety it brings to women.

Social support is a means of addressing anxiety but as yet this has not been formally identified or explored in our patient population. During patient focus groups on breast cancer management, sources of anxiety were identified that included a general frustration with perceived uncertainty of the care plan and unacceptable waits for diagnosis (Durham Regional Cancer Centre, 2005). This article describes a research study that will be undertaken to address issues raised in the patient focus group.

The purpose of the proposed study is to describe anxiety experienced by participants in a breast screening programme who have received an abnormal screening mammography result, and to identify the social support needed between further investigations. Although the clinical benefits have been well documented, the psycho-social consequences of screening must also be given high priority. In a systematic review Brett et al (2005) examined the psychological impact of screening.

Patients who were informed in a timely manner of a benign screen did not experience noteworthy anxiety. However, those who required additional investigations did report significant anxiety during the investigation intervals. There were also reports of significant anxiety that extended beyond these time frames. (Thorne et al, 1999; Meystre-Agustoni et al, 2001; Pineault, 2007).

Social support

It has been reported that social support has a positive impact on anxiety experienced by women undergoing breast screening and further investigations of a breast abnormality (O'Mahony, 2001; Drageset & Lindstrom, 2003). Social support encompasses emotional, informational and tangible attributes (Schaefer, 1981; Langford, 1997).

The support takes the form of:

- Emotional support — a caring and comforting approach given by a significant other, family, friends, and/or health care professionals.
- Informational support — pamphlets, teaching sessions, and websites.
- Tangible support — actions that offer support through practical means such as financial aid, transport and shopping.

This descriptive study will take place at Lakeridge Health in Oshawa, Ontario,

Canada where the Ontario Breast Screening Program (OBSP) was introduced in September 2006. The OBSP is a provincial programme that offers a screening mammogram every two years to women between the ages of 50–79.

Statistics from last year at our facility predict that approximately 10% of women attending breast screening will have an abnormal result and have to return for additional investigations. These investigations may include mammogram, ultrasound, and biopsy. Women with abnormal results receive a call from a clerk with an appointment for the investigations as ordered by the radiologist.

If the radiologist recommends a biopsy procedure, contact will be made with their family physician so he/she can explain to the patient that a biopsy is needed. A nurse navigator from our facility is available to patients at any point in the process from screening through to diagnosis.

Inclusion criteria

During a four-month period, all women attending the OBSP with an abnormal screening mammogram will be contacted to take part in the study. To be in the study, women will:

- be 50–69 years of age,
- have had a screening mammogram in the two months prior to the survey,
- have had an abnormal test result,
- be waiting for or have had additional tests,
- be able to answer the questionnaire in English.

The anxiety of participants will be evaluated using two measurement instruments. Psychological consequences linked with screening mammography will be evaluated with the Psychological Consequences of Screening Mammography (PCQ), developed by Cockburn, De Luise, Hurley, and Clover (Cockburn, 1992).

This instrument assesses the positive and negative effects inherent to the experience of screening. It comprises 22 questions related to three different fields: emotional, social, and physical. The second instrument developed by Meystre-Agustoni, Paccaud, Jeanning, and Dubois-Arber (Meystre-Agustoni et al, 2001) the Breast Cancer Anxiety Indicator (BCAI) is designed to measure anxiety during the pre-diagnostic phase.

Information about social support (emotional, informational, tangible) will be gathered using a 13-item questionnaire that addresses the support needs by the participants, the support they received, women's satisfaction with the support, and the desired improvements to the offered support. This

13-item questionnaire uses items taken from Barrera, Sandler, and Ramsay's Social Support Questionnaire (Barrera, 1981) and different topics inspired by Ong, Austoker, and Brett (Ong, 1997).

Findings from this study will address concerns expressed by former patients at our centre through patient focus groups. The study will yield important information about women's anxiety levels and social support needs during the time immediately following the receipt of an abnormal breast screening result.

The study findings will assist in developing guidelines and informing practice for nurses in advocating for the supportive care elements necessary to provide personalised response to questions, initiation of appropriate referrals, and ensuring continuity of care. *Manon Lemonde, Associate Professor, Faculty of Health Sciences, University of Ontario, Oshawa, Canada, Patti Marchand, Clinical Nurse Specialist, RS McLaughlin Durham Regional Cancer Centre at Lakeridge Health, Oshawa, Canada*

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