

## Silent voices, hidden practices

Some aspects of nursing practice are never discussed by nurses. This was the theme of the Robert Tiffany lecture presented at the Royal Marsden's National Cancer Nursing Conference in London by Sanchia Aranda, ISNCC board member

In the opening part of her speech entitled *Silent voices, hidden practices* Ms Aranda, Associate Professor of palliative care nursing, University of Melbourne, Australia, told the audience: 'I am arguing that many aspects of nursing and our interactions with, and ministrations to, those who are ill are silent or tacit because we lack the language to describe what we do, along with its impact on the patients, their families and ourselves.'

'This sort of silence stems from the taken-for-granted nature of much of our work and it hides the skill of nursing — a skill it is becoming increasingly important to articulate in these days of economic rationalism.'

Ms Aranda expressed concern that nurses' inability to describe and make sense of these dimensions of their work will have implications for the future of nursing. She said: 'These areas of practice are too easily bundled under the overarching heading of "caring" — a term that has become so nebulous as to be of little use in understanding the complexity of nursing practice.'

Ms Aranda explored the nurse-patient relationship as an illustration of 'silenced' practice. The idea of a relationship between nurse and patient only became possible in the 1960s. Prior to this nursing was limited to ministrations to the physical body of the patient. The nurse is now called on to develop intimate, empathetic and reciprocal relationships with patients. However the nurse is now being pulled by separate forces which encourage closeness but at the same time criticise over-involvement.

Ms Aranda carried out a study of these ideas prompted by having herself developed a close relationship with two particu-

lar patients. Twelve nurses participated in a series of interviews aimed at eliciting the story of their involvement with a patient. Group discussions followed that sought to consider the meaning of these relationships to them and to nursing.

For all the participants this was the first time they had considered these relationships as anything other than something they should hide. Most had learned from experience that talking about an affective response to a particular patient brought sanctions against them.

The findings offer some insights into the hidden nature of the skilled nursing that can arise within close relationships. The findings also illustrate the hidden damage that nurses may confront when these relationships go underground.

Nurse-patient relationships are often referred to as a bad thing. Critics cite the possibility of the nurse abusing her relationship with the patient to meet her own needs and the effect on distributive justice and the even spread of nursing care across all patients. It is suggested that the nurse will be so blinded by her emotions objective decision making will be impossible.

But from the interviews it emerged that the relationship had made a difference to the lives of the patient. Ms Aranda said: 'The reality that as a profession we frown on any single nurse standing out from the crowd means we fail to acknowledge their individual contribution, to single it out for praise and we silence this as a skilled aspect of what nurses can bring to the lives of patients.'

While they sought to provide holistic and person-centred care, most nurses in the

study had concerns about being seen to be involved and this modified their behaviour and made them reluctant to share their experiences of making a difference and being close to patients with other nurses.

'Making these silenced aspects of practice visible helps us to use them in skilled rather than taken-for-granted ways to the benefit of patients and families', said Ms Aranda. 'What this study of close nurse/patient relationships suggests is that the closer we are to patients as people, the more likely we are to understand their feelings and responses to their experiences, and to be responsive to their needs.'

However, in drawing her lecture to a close Ms Aranda did acknowledge that these relationships are not without difficulties and challenges, particularly for the nurse, and that they should not be reified.

But she concluded that: 'While it is true that the demands of care-giving can overwhelm us, it is important that we look to the brighter side — what good are we achieving as nurses in our caring relationships with patients? Somewhere between the extremes of distance and unreflective intimacy lies what many nurses 'know' but which remains largely undescribed.'

Ms Aranda called for nurses to break the silence and to acknowledge and discuss the intimacy of nursing practice. She said: 'This world of the human-to-human encounters between cancer nurses and those who face life-threatening and terminal illness has been silent and hidden for too long. Help to break this silence.'

*A fuller version of this lecture can be found in the International Journal of Palliative Nursing (2001) 7;4: 178-185.*



# Celebrate and campaign

I write this at the beginning of National Nurses Week, May 6-12, in the USA. 'Nurses are the True Spirit of Caring' is the theme for this week. The International Council of Nurses has proclaimed the theme for International Nurses Day 2001 on May 12 as 'Nurses, Always There for You: Unite Against Violence'. Many hospitals and organisations around the world will have a week of ceremonies and events recognising the many contributions of nurses to patient care.

But some say that we have little to celebrate considering the turmoil in the health care system and the nursing shortage, and the problems facing us today. Indeed, we do face a worldwide crisis in nursing. Nurses around the world are leaving their jobs because they are underpaid. Many schools of nursing have declining numbers of applications. Inadequate numbers of nurses leads to overwork, declining quality of patient care, and hazardous working conditions.

The nursing shortage is a global problem

(WHO December 20, 2000). In Poland, ten years ago, over 10,000 new nurses graduated annually. Today that figure has dropped to 3,000. Out of 18,000 nurses in Chile less than half, only 8,000, are actively working as nurses. Shortages are occurring in other countries including Australia, the Philippines, and Western Europe. In Canada, the United Kingdom, and the United States, the average age of nurses is between 43 and 45, indicating a decline in the number of young women entering this profession. When these nurses retire, who will replace them?

How, then, does one celebrate? Nurses Week is not just a time to celebrate our profession and recognise our accomplishments, it is also a time to reflect on our goals and plans for action: an opportunity to address the crisis we are facing. The International Council of Nurses has developed an International Nurses Day kit for nurses to use in their local environments. Many national organisations have developed press releases and suggestions for

nurses to use in their community.

In the USA, there will be a three part series on CNN regarding the nursing shortage during Nurses Week. It is a good time to reach the public and government officials with the message of what we do and what we are concerned about. And what we suggest should be done to solve the problems nurses and their patients face. We do care about our patients and should advocate for them even in turbulent times.

When you receive this newsletter, the formal celebrations of Nurses Day and Nurses Week will be long past. Reflect for a moment on what you did to solve the problems we face. Did you merely complain pointlessly to each other? Or, did you complain constructively to officials and others who have the power to do something about our problems. Did you respectfully suggest positive policies for the future? If you made a positive contribution, hold your head high and feel the pride of being a nurse.

*Connie Henke Yarbrow*  
President, ISNCC

# Biotherapy network update

The World Biotherapy Network, a special interest group of the International Society of Nurses in Cancer Care, held its second meeting at the Oslo conference.

Twenty-two nurses representing all continents were present and participated actively on issues of concern to biotherapy nurses. Immunotherapy and gene therapy were defined as the current primary areas of interest for this group.

A brochure for patients who receive Interleukin-2 has been developed by the network and has received endorsement from the board of the ISNCC. In time it

will be translated from English to several other languages and made available around the world. This brochure has been evaluated by several nurses from different countries around the world for culturally sensitive issues.

The website for the network is in its grass-roots phase. Several members are working on defining issues of interest for our group for the website and possible structures.

Ongoing projects include the development of a teaching aid for nurses who assist patients in learning to live with Interferon, a checklist for nurses who prepare for gene

therapy and a directory of membership.

Planned future projects include a module and syllabus for immunotherapy and a patient brochure for immunotherapy.

If you have not received post recently or you want to become a member of the group, please contact the following address:

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# Help in preparing an abstract

Oncology nurses around the world are continuously developing new innovations and practices. To provide an international knowledge base for cancer nursing it is essential that nurses share their work with colleagues at international meetings. The 12th International Conference of Cancer Nursing (ICCN), to be held in London, UK in 2002 provides such an opportunity.

As oncology nurses who participated in national and international conferences, we would like to share our experience to assist others who are preparing their first abstract.

Abstracts for the 12th ICCN can be submitted for a poster presentation or an oral presentation. The space for poster presentations is specified on the abstract form so that authors are aware of what is involved. Most first time presenters prefer to submit their work for a poster presentation as it involves one-to-one discussion with other nurses who are interested in their work. Poster authors are expected to be present at their posters during meeting breaks.

Other authors prefer to present their work orally, in a concurrent session with several other speakers who then discuss similar topics with the audience. Presenters have a limited time to talk (15 to 20 minutes) which can be difficult for inexperienced speakers. Those authors who choose oral presentation should consider preparing some type of visual material — power point, slides, or overheads — as this increases understanding of the topic for a multilingual audience.

In order to get your paper accepted, the first step is to write an abstract. An abstract is a brief paragraph summarising the paper, article or scientific research. The abstract is judged by the scientific committee which determines whether or not the work will be

included in the scientific programme.

The abstract should be between 150 and 250 words. Keeping it concise and yet informative is the main challenge of abstract writing. Abraham Lincoln said that it took him days to write a two-minute speech, but he could give a two-hour speech off the top of his head.

The abstract is a microcosm of the article. It must include the important elements, following the logic of the scientific paper, in an organised, accurate and readable form. It must be comprehensive and be presented concisely, thoroughly, engagingly and professionally. Plan to write several drafts — it is an important piece of work. The abstract structure elements are :

### Title

The title of the abstract should clearly describe what the paper is about. Sometimes, authors develop creative titles for their work. Creative titles have the benefit of drawing interest to the paper and provide a sense of challenge to traditional thinking. Authors can choose the style for the title.

### Statement

Statement of the problem or purpose of study/research. This is an introductory sentence which should contain the problem or purpose of the work. Some authors state the conclusion of the work in the first few sentences. This is also acceptable. Unlike a novel, don't save the conclusion to the very end — it should not be a surprise.

### Description

Description of the process. How was the work done? What methods did you use to arrive at your conclusion/findings? It may have been a review of the literature, a sur-

vey of colleagues, a pre and post measurement for an intervention. Again, short and clear statements of the process are required. The reviewers will be looking for a method that is consistent with the problem or purpose of the research.

### Sources

Identification of major primary and secondary sources. Include in the abstract the main idea/element from the bibliography which you have found to be empowering and which clarifies the thesis.

### Findings

Summarise the results/data/findings of the work. Include two to four sentences that summarise what you found. Be specific — reviewers are looking for original or meaningful work. Specific descriptions will ensure that reviewers are clear about what you have achieved.

### Conclusions

State conclusions/applications. It is important to show how your work contributes to the body of knowledge known as 'cancer nursing'. What has changed (or could change) because of your work? How might your work assist nurses working in other regions of the world?

### Checking

Authors who are preparing abstracts are encouraged to have their abstract proof-read by a colleague or mentor before submission. Ask this person to tell you what she or he thinks the paper is about after reading it. If the colleague is correct, you have met the criteria for adequate information.

Ask your colleague whether the language is clear. Is the English grammatically correct? Is the spelling correct? Are there some sentences that could be reworded to increase clarity of meaning?

Finally, remember Abraham Lincoln. There will be many drafts and revisions before the final abstract is forwarded to the Scientific Committee. The time and effort will be duly rewarded when you arrive in London in 2002 and meet with nurses from around the world to share experiences and to learn about nursing in other regions.

*Sarah Ben Ami, ISNCC board member, President of the Israeli Oncology Nurses Society and co-ordinator of oncology nursing in CLALIT Health services and Laurie Grealish, ISNCC board member, Executive Officer of the Nurses Board of the Australian Capital Territory*

## Tips for preparing an abstract

- Follow directions provided in the 'Call for Abstracts' issued by the conference organisers.
- The abstract title should be brief and reflect the content of the work. Create an attractive, catchy title that captures the essence of the study.
- Add names of the author(s), address, institutional affiliation, phone numbers, e-mail address, fax number.
- Indicate whether the paper is for oral presentation or poster. If more than one author is listed, indicate which one is the contact person and who is going to present the paper.
- The abstract must fit within the designated area written with requested font and size by the committee.
- The abstract should contain no illustration, but one table may be included. Remember that the table may detract from space available for other aspects of the abstract information.
- Edit the revision. Be sure that the abstract is complete and accurate. Double check that the abstract is written in the same voice as is the paper.

# UICC nursing courses travel

Two oncology nursing courses have been hosted by countries on the opposite sides of the world. The Cancer Education for Nurses Project of the International Union Against Cancer (UICC) sponsored a three-day course in Abu Dhabi, United Arab Emirates (UAE) followed by a three-week course in Panama.

Typically of nations in the developing world, both countries have seen a rise in cancer rates as the acute, infectious diseases are better controlled and populations adopt Western lifestyles.

The course in Abu Dhabi was hosted by the Ministry of Health. One day of lectures and discussions was devoted to each main

topic of interest for the region: breast cancer, haematological cancers, and palliative care. The situation in UAE is unique in that 75% of the countries inhabitants are expatriates from a wide variety of countries in Europe, the Middle East, and Asia. This cultural profile is reflected among the health care professionals and the health care population. The challenges of delivering appropriate and culture-sensitive care are considerable.

The course in Panama was the longest nursing course ever sponsored by UICC. This course was held under the auspices of the University of Panama. The university has just approved a graduate tract in the

study of oncology nursing. The UICC course was an integral part of the plan to launch the new academic specialisation. Attendees included university faculty, graduate students interested in the new tract, and nurses from a number of provinces in Panama.

*UICC Nursing Education courses are funded by the Oncology Nursing Society of the United States and the Norwegian Cancer Society. Further information can be obtained at the UICC website at [www.uicc.org](http://www.uicc.org) or by writing to the Education Program, UICC, 3 rue du Conseil-General, 1205 Geneva, Switzerland.*

## EDUCATION COLUMN

### Applying the Wenger theory to cancer nursing education

It is increasingly clear to the nurse education community that becoming a specialist in cancer nursing is a more complex process than learning pieces of information. Packaging units of information, like chapters of a book, is not enough.

This is particularly salient in a contemporary learning community becoming more focused on the delivery of 'information' in electronic format. Learning is a social activity, and becoming a 'cancer nurse' occurs when students are engaged in meaningful practices, challenged to think beyond the present, and involved in actions, discussions, and reflections that make a difference to the communities they value.

In a text entitled, *Communities of Practice*, Etienne Wenger (1999) proposes a theory of learning based on the following four premises:

- we are social beings;
- knowledge is a matter of competence with respect to valued enterprises;
- knowing is a matter of active engagement with the world;
- meaning — our ability to experience the world and our engagement with it as meaningful — is ultimately what learning is to produce.

The primary focus of the theory is learning as social participation. In learning to become a cancer nurse, the student engages in activities with certain people (patients, families, nurses, doctors, teachers, peers), is an active participant in the practices of social communities (peer group, classroom, health setting), and constructs identities in relation to these communities.

Rather than act as a recipe, Wenger's theory offers nurse educators a guide to think about their teaching in a new way.

Wenger suggests that if the teacher believes that knowledge consists of pieces of information, stored explicitly in the brain, then it makes sense to package this information in well-designed units, to deliver the information in a succinct and articulate way, such as lecturing in a classroom. But, if the teacher believes that information stored in explicit ways is only one part of knowing, and that knowing involves participation in social communities, then the traditional classroom format does not look so productive (p10).

Nursing, and cancer nursing in particular, is a social process. Cancer nurses engage with patients, families, colleagues, doctors, and other health related personnel. As each experience progresses, meaning is created. For example, think about an experience, such as beginning a new job. As each event occurs, you create (and change) the meaning of persons and situations.

On meeting a colleague for the first time, you note that she is abrupt and does not make eye contact — you form an impression about what this colleague is like. As the day progresses, you discover that this nurse was caring for a patient who had been nursed in the ward for months and is now approaching death. The meaning of the previous interaction is changed with this new information. As social beings, we are constantly creating meaning from situations, sometimes unconsciously.

'Because learning transforms who we are and what we can do, it is an experience of identity' (p235). How the student develops an identity of 'cancer nurse' is negotiated through participation in various communities. The experience of identity is a lived experience and 'lies in the way we

live day to day, not just in what we think or say about ourselves, though that is of course part (but only part) of the way we live' (p151). The development of identity is a complex weaving of experience and projections about who we are.

The challenge for cancer nurse educators is to identify ways to support and facilitate opportunities for students to learn. Wenger suggests that learning communities can become places of identity to the extent that they offer a past and a future that can be experienced by the student as a personal trajectory.

A learning community can strengthen the participation of its members by incorporating the students' past into its history — that is by letting what the students have been, what they have done, and what they know contribute to the constitution of (the community's) practice and opening, for each student, trajectories of participation that place engagement in the community's practice in the context of a valued future (p215).

As nurse educators, we are also learning in our communities of practice. It is essential that we think deeply about who we are, how we learn in our daily experience, and what we value in our work. Sharing the ideas introduced by Wenger's work in the community of cancer nurse educators opens a trajectory of participation in cancer education in the context of what we value, proficient cancer nurses for the many communities to which we belong.

*Laurie Grealish, ISNCC board member, Executive Officer of the Nurses Board of the Australian Capital Territory*

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# Cancer care in Europe

Agnes Glaus argues that although Europe does not have a homogeneous population there are benefits in European nurses forming a united force

Europe has many faces. Even though many countries are united in a European Union, its diversity is impressive. It is composed of many cultures, languages, habits, health care systems and many types of nursing.

The incidence of cancer varies greatly from country to country. The age-standardised incidence per 100,000 males in 15 EU countries and Switzerland shows that males from France, Switzerland, Holland, Austria and Belgium have the highest incidence of cancer (table 1). Comparing males with the females, women from Denmark are most prone to develop cancer (table 2).

For both males and females Spain, Portugal and Greece have the lowest overall incidence in cancer (Black et al 1997). It has been proposed that at least for some specific cancer types, the Mediterranean diet could account for part of this advantage. In the European Against Cancer programme a prospective 10-year longitudinal study has been implemented to investigate these influences. Breast, colon and lung cancer are the most frequent cancers among European women with lung, colon and prostate cancer the most common cancers among European males (IARC, 1995). While it is undisputed that preventive strategies are relevant, controversy has been stirred up this year about the benefits of breast screening with mammography.

More women die from breast cancer in Eastern Ireland, South and South-east England. Denmark and Switzerland have above average mortality rates. This distribution is food for thought in itself but most causal influences are unknown. Primary prevention remains a subject for research and secondary prevention can at least detect the disease early.

## Screening

Mammography screening has been established in many countries in the last decade. But a report in the *Lancet* in January 2000 (Gotzsche & Olsen 2000) from the Cochrane Centre in Copenhagen has stirred up controversy. Two statisticians re-analysed data from previously published trials about breast screening by mammography and concluded 'there is no reliable evidence that screening decreases breast cancer mortality and therefore is not justifiable'. Several of the trials they re-analysed were said to have inadequate randomisation or were otherwise biased.

This report has already influenced mammography screening in some countries. Screening programmes which were about to be implemented in Denmark or Switzerland have been stopped. However, the American Cancer Society noted that death rates have been falling steadily for the past 10 years mainly due to mammography. This controversy around mammography provoked worries in high risk women. It also underlines the need for more up-to-date research on this difficult and sensitive subject.

From a nursing perspective, it is interesting to observe the reactions of some physicians' associations who concluded that the money should be shifted from screening to extra research into treatment. It could be interpreted that the *Lancet* article was used to justify financial investment into intensive, curative medicine. We need to realise that in most countries very little money from the overall health care budget is invested into prevention. In Switzerland it is around 1 percent.

Even though the evidence of the *Lancet* report can not be dismissed and must influ-

ence further research, there is no doubt that screening strategies must be developed further. Nurses know best; they care for thousands of women with breast cancer all over the world. How could we think about dropping the screening strategy? The breast cancer epidemic in Europe deserves more attention and nurse researchers, educators and clinicians need to find a major role in prevention. After all, most of us are females and the discussion about mammography screening is led by a male dominated field of medical science and statistics.

## Research

Analysis of money allocated for research also shows evidence of health care politics. In 1997, the European Commission published information about the research programme implementation. In cancer care 66 projects were funded in 1997 with 9m European Currency Units [ECU] (European Commission 1998). The same amount of money was invested for AIDS and about half as much for health promotion generally and for projects dealing with drug abuse.

However, it is not known to what extent nurses are involved in these projects or in the prevention of cancer generally. Looking at the European Union's cancer programmes and the amount of money committed to the different activities reveals that most of the resources go into gathering data and research. The role and place of nursing in these programmes needs to be explored and defined and nurses need to learn how to get more involved.

## Political force

There is no doubt that nurses can represent a political force. The total number of regis-

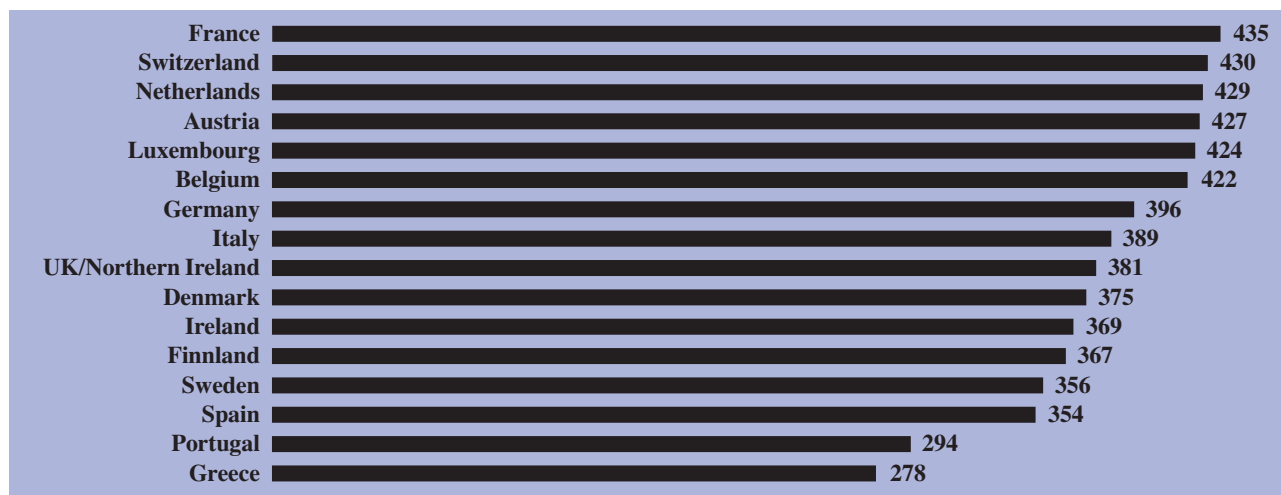


Table 1: Age-standardised incidence of cancer per 100,000 men in EU countries

tered nurses in the European Union is estimated at around 1.7m (Hospital Committee of the European Community, 1992). This shows the potential for professional power. However, across Europe, there is growing acknowledgement of the need for role-clarity in order to maximise the contribution to cancer care.

The economic situation, local possibilities and limits differ greatly between countries. The age of entry into nursing school varies between 14 and 18 years, the length of training from 2 to 4 years. This explains the diversity of interests and the difference in roles, status and, last but not least, salary, which is somewhere between 5 ECU and 4000 ECU per month.

The number of professional nurses available per 10,000 population in different countries was studied in 1987 (Reid & Melaugh 1987). For Wales the number was 23.1, for England 26.9, for France 28.7, for Northern Ireland 47.7, for Scotland 57.8, for Switzerland 63.1 and Sweden 67.2.

Such profound differences are likely to impact on the status of the profession including the type of nursing activities, the power to influence and development. But questions need to be asked on whether the quality of care is better in countries with higher staff levels or whether staff resources are less efficiently used.

It becomes obvious that a documentation system is needed to show what nurses do. This may prove to be complicated because there is no universal nursing language and classification. If nurses show what they do, they need to show why they do it and whether it is effective.

This requires an accepted underlying nursing theory, a way of diagnosing and assessing needs, a clear language to document activities and a link to outcome. For this we need nursing theorists, economists, managers and clinicians who work together. Although some would argue that this process creates too much paper work and even reduces time to be with patients, if

nurses want to become visible and show their effectiveness, if they want to assure and justify adequate staffing levels, this inevitably has to be one of our future roles.

### Nurse education

The increasing number of countries where nursing education is offered at academic levels brings hope because academically trained nurses should be able to develop evidence-based nursing practice.

Academically trained nurses need to take the lead in education, practice, management and research in order to move the nursing profession forward and represent it in the political arena and in the multidisciplinary team.

However, pursuing an elitist nursing agenda is dangerous because the majority of nurses will never be academically trained. Our aim must be to support nurses at the bedside, to help them understand and implement evidence based practice, to help them to become and remain skilled. We can do this by providing education, by supporting their working conditions, by acknowledging their work.

Experience shows that specialisation in oncology nursing is extremely important because the field is so challenging. This type of higher education for diploma nurses can make a real difference — for the nurses and the patients.

In the Europe Against Cancer Programme, in 1987 the European Commission proposed that every member state should recognise the specialist nature of oncology and take action to train health workers in cancer treatment (European Commission 1988).

In response to this the European Oncology Nursing Society (EONS) prepared a Core Curriculum for a post-basic course in cancer nursing. In 1999, EONS has launched the revised Core Curriculum in Cancer Nursing. This document, available in nine languages, outlines the core content and structure of such programmes and can help nurse educa-

tors build up or revise postgraduate education in cancer care.

The political background of this document, as an outcome of the Europe Against Cancer Programme, can underline the importance of this education when local politicians have to be convinced to allocate the money. EONS meanwhile also has established an Accreditation Council where the courses can be submitted for accreditation, which again might be politically important for many countries.

### The future

It has been estimated that there will be another 20 million new cancer patients world-wide in 2020. Cancer nursing has its future in prevention, screening, treatment and care for the dying. However, in many countries there is a serious nursing shortage and some experts even believe that the species 'nurse' will die out. I do not believe that this is true for oncology nurses, I think we are a committed, tough population with creativity and strength. We will have to adapt to changes and developments. We can make a difference to the world.

*Agnes Glaus, Centre for Tumour Detection and Prevention, St. Gallen, Switzerland*

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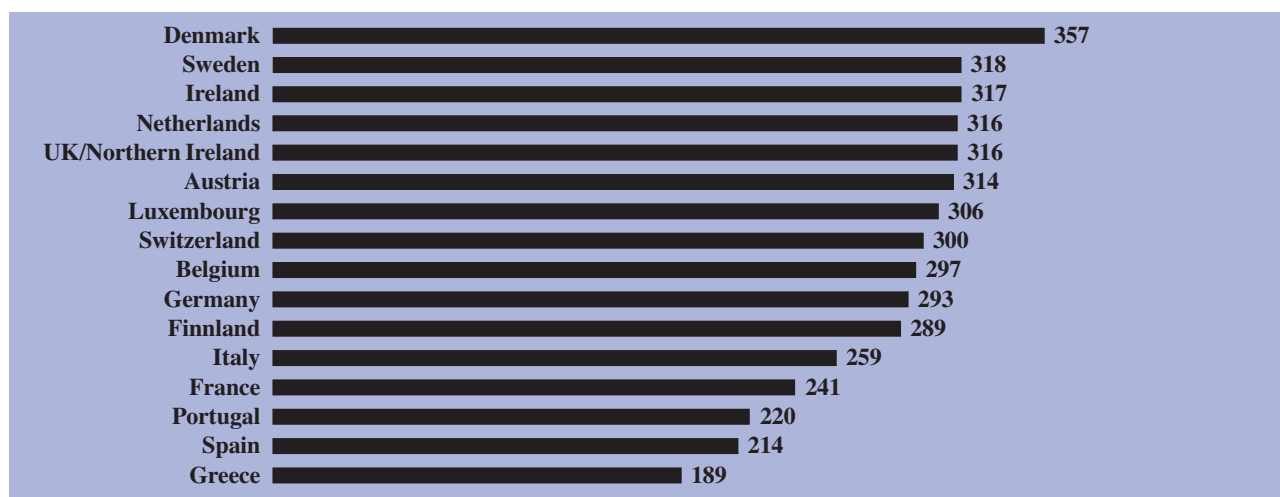


Table 2: Age-standardised incidence of cancer per 100,000 women in EU countries

### Should we evaluate qualitative studies – if so, how?

At the ISNCC conference in Oslo, the Research Committee held an advanced session on issues and challenges in qualitative and quantitative research. Three issues related to qualitative approaches were presented. First, if and how we should evaluate qualitative studies. Second whether computer technology should be used to assist with qualitative data analysis, and third whether qualitative and quantitative studies should be triangulated (ie used in the same study). The first issue is highlighted here: the others in future columns.

How can we distinguish the excellent from the mediocre in qualitative research? The debate around the methodological rigor of qualitative research is confounded by its diversity and lack of consensus about rules to which it ought to conform and whether it is comparable to quantitative research.

Should qualitative studies be judged by the same criteria as quantitative studies, such as validity, reliability and generalizability? Those who support this view believe there is nothing special about qualitative research that demands special criteria (Cavanagh, 1997; Jasper, 1994; Appleton, 1995).

Others say there can be no criteria for judging qualitative research and the very idea of assessing qualitative research is antithetical to the nature of this research (McKenna, 1997; Altheide & Johnson, 1994).

Most others would say, and I am one of them, that qualitative studies should be evaluated using criteria developed for the qualitative paradigm. Evaluative criteria have been developed by authors such as Burns & Grove (2001), Guba & Lincoln (1981), and Thorne (1997). Burns and Grove refer to standards of descriptive vividness, methodological congruence, analytical preciseness, theoretical connectedness, and heuristic relevance. Thorne discusses the criteria of epistemological integrity, representative credibility, analytic logic, and interpretative authority.

Criteria for rigor developed by Guba and Lincoln and later interpreted by Sandelowski (1986) focus on truth value/credibility, auditability, fittingness, and neutrality/confirmability. Most of these authors also identify strategies on how to address the criteria.

Using a member check strategy is one way of supporting credibility. This involves going back to some or all of the participants to determine their agreement with the findings, however this can be problematic. What happens if one participant does not agree? Is the conceptualisation invalid? This is not to say we should not invite participant input, but what is done with that in terms of validity check is questionable. The participants may have changed their minds. The interview process may have made an impact on their original assessment, or new experiences may have intervened.

A study is auditable or consistent when another researcher can clearly follow the 'decision trail' used by the investigator. Another researcher would arrive at comparable but not contradictory conclusions given the data, perspective and situation. The researcher needs to describe the data analysis process clearly, although succinctly, rather than just saying that the findings emerged from the data. The neglect or inability of the investigators to make the cognitive struggles explicit has led to the belief that qualitative research is easy and that it is subjective and unscientific.

A study meets the criterion of fittingness or applicability when the findings 'fit' into contexts outside the study situation and when others view the findings as meaningful and applicable to their own experiences. The findings should be well grounded in the life experiences studied and reflect their typical and atypical elements. The investigator must reflect the position of the participants in relation to those being studied and the meaning of each story or slice of life to the whole.

Many would say that findings generated

from qualitative research are inherently ungeneralizable because the sample is often not representative of the population, however, each participant is selected purposefully for the contribution they can make toward the emerging theory. It is this selecting that ensures that the theory is comprehensive, complete, saturated, and accounts for negative cases.

Neutrality or confirmability refers to freedom from bias in the research process and product. The neutrality of the findings is the focus, not the subjective or objective stance of the investigator. Subjectivity and involvement in the search for truth are valued rather than objectivity and detachment, however the complexities of involvement need to be recognised. Confirmability is said to be met when support for auditability, truth value and fittingness are established.

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## CALENDAR OF EVENTS

**The European Cancer Conference** will take place in Lisbon, Portugal, 21-25 October 2001. *For information contact:* ECCO 11, FECS Conference Unit, Avenue E Mounier 83, B-1200 Brussels, Belgium. fax 32 2 775 0200; email: EBCC-2@fecss.be

**The 16th Asia-Pacific Cancer Conference** will take place in Manila,

Philippines, 18-21 November 2001. *For information contact:* Congress Secretariat, 16th APCC, Phillipine Cancer Society, Manila, Philippines. fax 63 2 734 21 28; email: pcsi@uplink.com.ph

**The 18th UICC Cancer Congress** will take place in Oslo, Norway, 30 June-5 July 2002. *For information contact:* email: congrex@congrex.ch.

**The 12th International Conference on Cancer Nursing** will take place in London, UK, 28th August-1st September 2002. *For information contact:* Emap Healthcare Events, Greater London House, London NW1 7EJ, UK. email: conference.healthcare@emap.com