



quarterly newsletter of  
the international society  
of nurses in cancer care

VOLUME 14 NO 1 2002

# Collaboration provides the key

Collaboration in the global fight against cancer is becoming more and more important. Opportunities for organisations such as ISNCC and the International Union Against Cancer (UICC) to work together are on the increase.

Since 1938 the UICC has been working from a small secretariat in Geneva. It is an independent, international, non-governmental association of more than 290 member cancer-fighting organisations from 86 countries. The Cancer Education for Nurses Project within the UICC seeks to increase the knowledge and professional potential of cancer nurses.

Many countries lack the resources for providing professional nurses with even basic education about cancer nursing. In many countries specialty cancer nursing is not established. There are no specialty professional organisations nor are there cancer nursing courses in universities at undergraduate or graduate level. Continuing education is rare and is often conducted by local physicians rather than by nurse educators.

Since 1983 the Nursing Project has held 28 basic cancer nursing education courses in 25 countries in Asia, Africa, Europe,

North and South America. Courses are designed in co-operation with local hosts. International nursing faculties conduct the courses with local physicians and nurses. ISNCC board members have served on the faculty of a number of courses.

Since 1992 UICC and the Nursing Project have awarded 83 fellowships to nurses from 38 countries to support one-month observerships at renowned cancer institutions in Europe, Australia and the United States.

The Trish Greene UICC International Oncology Nursing Fellowships (IONF) are awarded on a competitive basis to nurses from developing countries who have submitted applications describing viable projects. Through all these efforts the Nursing Project is changing the lives of cancer patients and the nurses who care for them.

Language divides the nurses of the world. Because of the profession's low status, language education is usually not available to nurses of developing countries. These problems can be overcome with translators during the nursing courses. But nurses in developing countries are usually without written professional material on the latest in medical therapeutics and nursing practice.

Plans for the on-line nursing manual include the translation of all materials into the major languages. In 2002 the UICC will open for the first time the IONF observerships to nurses without a working knowledge of English.

A variety of opportunities for collaboration exist for professional organisations in the areas of education, professional development, and health policy. The most basic opportunity is for the sharing of information and information resources.

The Nursing Project and the ISNCC board are working on a pamphlet describing basic elements in establishing a specialty nursing organisation. There are mutual links at both UICC and ISNCC web sites. Additional opportunities exist in the sharing of nursing expertise in the formation of joint committees dealing with such issues as tobacco control, prevention and detection activities, and professional education.

The Nursing Project continues to invite ISNCC and EONS members to serve on faculty for nursing courses, and as speakers at regional and international conferences.

Collaboration on health policy issues on the international stage is a more complex endeavour, complicated by a variety of governmental and health care infrastructures, differing levels of economic development, and a wide disparity of professional education and standards.

Nonetheless opportunities exist, especially in collaboration with agencies such as WHO and organisations such as ISNCC and the International Council of Nurses (ICN). UICC also works to collaborate directly with Ministries of Health to develop national cancer control programmes. The Nursing Project is committed to being a participant in all of these efforts.

*Dennis W. Pyritz, RN, OCN, Chairperson, Cancer Education for Nurses Project*



The international and national faculty of the UICC course in Guatemala. ISNCC board member Myrna McLaughlin Anderson is on the far left

Sponsored by Bristol-Myers Squibb Oncology



# Unsung heroes

These days *Making a Difference* seems to be a popular theme of conferences, articles and editorials. This is heartening as all would agree that nurses and health care professionals make a difference in the care provided to our patients and family members.

At the centre of the disaster response to the September 11th attack was a nurse, Lynn Slepski, MSN, RN, CS, Commander, US Public Health Service who coordinated and directed disaster medical care. She deployed forensic dentists, industrial hygienists to conduct environmental surveillance, and

data entry personnel. She was also the officer in charge of the anthrax contamination at the US Capitol. Indeed, many nurses were behind the scene of this horrendous attack; they were making a difference and often referred to as the 'unsung heroes'.

At the International Conference in London, cancer nurses from around the world will meet to discuss how they are making a difference in their own unique settings. For example, a nurse from China will tell us how Chinese classical music helps the anxiety of patients undergoing

gastric cancer surgery. A nurse from Uganda will present the challenges of palliative care and training in her country.

Nurses from the United States, United Kingdom, and Canada will discuss new therapies, research advances, and the challenges of high-tech care. A nurse from Israel will discuss educational interventions in a rural Arab school for rehabilitation of paediatric cancer patients. Symptom management, long-term care and palliative care are topics that will be presented by nurses from Japan, Australia, Turkey, Brazil, Southern India, Ireland, Norway, Sweden, and Thailand.

Many interesting topics will be discussed in the abstract sessions including the nursing shortage, fatigue, pain management, breast cancer and cancer prevention.

These are topics of great interest and one thing that is so prominent is that cancer nurses from around the world are indeed making a difference. We are unsung heroes to many patients and family members.

Join us in London to celebrate how we are making a difference. Let us all congratulate those nurses, tell them thank you, and let them know they are heroes making a difference.

*Connie Henke Yarbro*  
President, ISNCC

## EONS award



Former ISNCC board member Kathy Redmond received the European Oncology Nursing Society (EONS) Distinguished Merit Award at the ECCO 11 conference in Lisbon.

The title of her award lecture was *Facilitating patient choice: an imperative for cancer nurses*. She told the conference that nurses have a key role in facilitating patients involvement in decision making and in ensuring that patient choice is

respected. Nurses need to challenge paternalistic attitudes towards patient involvement in decision making and to ensure that they have access to understandable and unbiased information.

She also warned of the pitfalls, that health professionals need to be aware that there is often a major disconnect between the attitude they hold towards the value of cancer treatments and that held by their patients. If no attempt is made to determine a patient's attitude toward treatment, there is a danger that decisions will be made based on the preferences of the health professionals involved.

Kathy Redmond has extensive experience in cancer nursing from a clinical and academic perspective. She currently runs her own health care consultancy in Milan, Italy and was previously a lecturer in cancer nursing at the School of Nursing and Midwifery, University College, Dublin. She has been President of the European Oncology Nursing Society (EONS). Ms Redmond's interests include symptom management, clinical decision making and patient participation in care.

## Help needed

Do readers know of any breast cancer information that has been translated into Russian or Ukrainian? If you do please contact Ms Beverley Nicholson at [bevnick@cwnet.com](mailto:bevnick@cwnet.com) who would very much like to use the material with Russian and Ukrainian immigrants.

## EDITORIAL BOARD

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

Connie Henke Yarbro  
tel: (00) 1 573 446 5159  
fax: (00) 1 573 446 4459  
e-mail: [Yarbroch@aol.com](mailto:Yarbroch@aol.com)

### Central and South America

Stella Aguinaga Bialous  
tel: (00) 1 415 476 8276  
fax: (00) 1 415 476 0705  
e-mail: [AQUINAGA@CARDIO.UCSFEDU](mailto:AQUINAGA@CARDIO.UCSFEDU)

### North America

Margaret Fitch  
tel: (00) 1 416 480 5891  
fax: (00) 1 416 480 6002  
e-mail: [marg.fitch@tsrcc.on.ca](mailto:marg.fitch@tsrcc.on.ca)

### Far East and Australasia

Kazuko Ishihara  
tel: (00) 81 958 83 4994  
fax: (00) 81 958 49 7944  
e-mail: [kazuko@net.nagasaki-u.ac.jp](mailto:kazuko@net.nagasaki-u.ac.jp)

### Europe

Helen Porter  
tel: (00) 44 151 604 7489  
e-mail: [helenp@ccotrust.co.uk](mailto:helenp@ccotrust.co.uk)

### Africa and the Middle East

Sarah Ben-Ami  
tel: (00) 972 3 558 0666  
fax: (00) 972 3 558 0777  
e-mail: [sbenami1@netvision.net.il](mailto:sbenami1@netvision.net.il)

### Editor

Kathryn Godfrey  
11 Chesholm Road,  
London N16 0DP, United Kingdom  
e-mail: [kathryn@vangod.u-net.com](mailto:kathryn@vangod.u-net.com)  
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, P.O. Box 297  
Macclesfield, Cheshire SK11 7FZ,  
United Kingdom.



# Come to London this summer

The 12th International Conference on Cancer Nursing will be held in London, August 28th to September 1st 2002. The conference is held every second year and offers a wonderful opportunity for networking and professional development.

The theme for the 12th conference is *Making a Difference*. This theme was developed to reflect an international trend towards evidence-based healthcare and the need to more fully examine and celebrate the contribution of nurses to patient and family outcomes. While this means that the conference has a strong research flavour, the emphasis is on clinical practice development with many of the latest trends in cancer nursing being presented.

Over the four days of the conference many internationally recognised nurses will present in featured plenary sessions covering topics as diverse as genetics, symptom management, treatment trends and tobacco control.

The speakers include Paula Rieger, current ONS President, Professor Alison Kitson of the RCN Institute, Dr Christine Miaskowski from the University of San Francisco, Dr Naeema Al-Gasseer, of the WHO, Maria Hlnopthia from South Africa, Keiko Tamura from Japan, Dr Marli Villela Mamede from Brazil and Dr Elinor Wilson

of the Heart & Stroke Foundation of Canada.

Plenary sessions are also used to honour the contribution of our heroes in cancer care through presentation of the Distinguished Merit Award, the Tiffany Lecture and the Past President's Award. There will also be a touch of British tradition in the form of a debate and a special final surprise celebrating our conference theme, where we will end with a relaxed social event.

The conference programme committee received over 400 abstracts from nurses in all parts of the world. These abstracts were ranked through a blind review process involving about 20 nurse researchers, educators and clinicians from different countries. The decisions were difficult but limited space allowed for just over 100 of these to be presented in concurrent sessions.

Conference attendees can select concurrent sessions that reflect their clinical, education or research interests or try something new such as learning about technological advances or exploring the impact of the worldwide nursing shortage.

Many more abstracts feature as poster presentations, which over the last two conferences have become an increasingly important part of the programme.

In addition to the main conference programme several satellite sessions have

been organised including a research course and breast care 'train the trainer' programme taking place before congress.

There will also be opportunities to meet with nurses with similar interests in special interest sessions. The conference will also be supported by our colleagues in industry through a trade exhibition that will provide additional opportunities to gain up-to-date information on new cancer treatments and support products direct from the suppliers.

Perhaps the most remembered aspects of these International Conferences are the friendships made or renewed every two years. This networking helps to place your work in an international context but also helps stimulate new ideas and often lasting collaborations.

The organisers have included a range of social events that facilitate this networking and with London as our host venue these events are supplemented by a wide range of social opportunities that only this wonderful city can provide.

Please join us for a celebration of cancer nursing at this central event in the cancer nursing calendar.

*Sanchia Aranda, chair of the scientific committee and Associate Professor of Palliative Care Nursing, University of Melbourne, Australia*

## New improved ISNCC website

The ISNCC website ([www.isncc.org](http://www.isncc.org)), originally launched in September 1999, has been redesigned making it more informative and easier to use. Since its launch the content on the site has expanded significantly and outlived the original design. The new site was launched at the beginning of this year. It brands ISNCC as a global organisation and highlights critical time-sensitive information for the user. For example, all of the information for the upcoming conference is now only one click away on the redesigned home page. The site also incorporates some new programming languages, while retaining its readability in all browsers and many languages.

### Core areas

After the redesign of the site was complete, the content on the site was reorganised into the following areas:

#### About us

In the section of the site you will find the mission statement, information about joining ISNCC, the board of directors and governing structure, a brief history of ISNCC and messages from the current president.

#### Grants and awards

The ISNCC has a growing number of grant and award programmes. The applications and guidelines for applying for them are available. Most grant applications are due in October. Members can also nominate for the Tiffany lecture and apply for the Past Presidents Award here.

#### News

This section of the site houses late breaking news about ISNCC, global cancer news and highlights from International Cancer Nursing News.

#### Publications

One of the main reasons for the redesign of the site was to expand and improve this area of the site. The society offers a variety of position statements, many available in languages other than English. They are indexed by subject and reformatted for easy downloading. Another highlight is the research directory.

#### Conference 2002

The complete conference brochure and information is now available for this year's conference. Hotel reservations can be made

online via the website of our travel partner.

The ISNCC website site has experienced continued growth since its launch in 1999. On average the site receives 56 unique visits per day and the average visitor stays on the site for about 8 minutes. The bulk of the users are making their first visit to the site, and about one third are repeat visitors.

ISNCC website visitors come from around the globe. USA, United Kingdom, Korea, Netherlands and Columbia are the geographic locations with the most use. Conference and grant information appear to be the most popular items of interest for the user base.

Site visitor numbers are rapidly increasing with 879 visitors in 1999, 4,503 in 2000 and numbers more than doubling in 2001 to 10,245. So far this year there have been 5,234 visits.

Stop by our site. The editorial board has many exciting developments planned for this year, so visit us frequently. Member comments are always welcome and can be sent to [webmaster@isncc.org](mailto:webmaster@isncc.org).

*Elizabeth G. Gomez RN, MSN, AOCN, Webmaster*

# Nurses take the lead in openness

Our series of features on cancer nursing around the world continues with a report from Panama which highlights the many challenges facing cancer nurses

Panama is the youngest republic in Central America having obtained its independence in 1903. Panama is internationally known for its 8th wonder of the world, the Panama Canal which connects the Pacific and Atlantic oceans through a sophisticated system of lake fed locks that are still a marvel nearly one hundred years after they were built.

Panama has a population of 2.8 million. Fifty one percent of the population is under age 50. The life expectancy for men and women is 76 and 78 years respectively.

Panama is a melting pot of cultures and races. One of the groups that make up our society are the Native Indians who live in extreme poverty and, to a certain extent, are isolated from the rest of the population. There are roughly seven different Aborigine groups each with its own dialect and customs.

American culture is very prevalent in our society. We have a strong concentration of citizens with European, Chinese and Japanese heritage. There is a high level of immigration from countries to the south of us, Colombia, Peru, Ecuador and also from the Dominican Republic and Haiti. Many new immigrants live in very bad conditions where poverty is endemic.

Panama has a democratic system of government and currently has its first female president in its history, Mireya Moscoso Gruber, who was elected in popular elections. There are three branches of government, executive, legislative and judicial.

Under law, the government has the responsibility to ensure that each citizen receives a basic level of health care. One important element in this mission is the Social Security Administration whose responsibility it is to provide health insurance and medical care to all workers and their families including children until age 25. The Ministry of Health Services oversees the Social Security Administration and has established the framework for health care legislation.

Cancer is the number one cause of mortality in our country. Among women, the leader is cervical cancer followed by breast cancer. A recent study found that the human papilloma virus has spread widely in the interior of the country. Among men the leading causes are lung cancer, colorectal and prostate cancer.

There is one government funded public cancer facility. The National Oncology Institute is a 120-bed facility which provides cancer care for those citizens unable

to access private care. On a monthly basis the unit receives and responds to about 59,000 inquiries.

The private care facilities are plentiful and provide a much higher technologically-based level of care to their patients. There are several organisations that are actively lobbying on behalf of better care and facilities for cancer patients. Among them, Asomapac, Funda Cancer, Hospes and Help.

Citizens receive care that is comparable to citizens in developed countries. Nonetheless oncology nursing has lagged behind in terms of the academic preparation of nurses.

## Nursing history

The first nursing school was founded in the Santo Thomas Hospital in 1908 with the Public Health School for Nurses established in 1935. In 1969 the National University established a nursing curriculum. In 1984 the nursing school was established and designated as a nursing faculty that allowed the students to graduate with a baccalaureate degree in Nursing Science. Ninety per cent of nurses in Panama now have a baccalaureate degree in Nursing Science.

The masters degree was instituted in 1990. In 1998 we started work on a curriculum for a post-graduate degree programme in cancer care. In the year 2000 we began planning for the first International Course for Nurses in Cancer Care with the support of the UICC, the University of Panama and the endorsement of the ISNCC. The first international symposium for nurses working in cancer took place in March last year.

Last year the University announced approval of the proposal to establish the

post-graduate programme for oncology nursing which started with a registration of 22 nurses. The university recently established a Nurse Aide Certificate programme.

## Reality

Panama currently has 3900 nurses and about 2500 nurses aides. Patient care in Panama is provided by nurses with the help and involvement of nurses aides for routine functions.

Public health agencies are not sufficiently proactive in their approach to cancer prevention. For example, there's no clear leadership or direction on the issue of nutrition and its potential effects. There are some private volunteer organisations that have tried to take on this issue but they are faced with a daunting task. The National Cancer Society has established a smoking cessation programme which has had very modest success.

The National Registry Office was established in 1999 and along with the National Oncology Institute is waging a campaign to raise the excise taxes on cigarettes and direct the revenue towards the oncology institute to add resources and improve the level of care provided to the patients.

Historically nurses involved in the care of patients with cancer have developed a high level of sensitivity to their patient's suffering and have forced a rather revolutionary shift by forcing doctors to share more information with them in order to provide a better quality of care to their patients.

*Myrna McLaughlin Anderson,*  
*Assistant Professor,*

*Marbella Edificio Royal Centre, Panama*



Native Indians often live in extreme poverty

# Identifying context of care

To cope with the challenges in cancer care that face us we need to deal with them in their appropriate context, argues Suzanne Steginga in an abridged version of a presentation given at the International Conference in Oslo

The challenges facing cancer care include global, cultural and patient specific issues. Global challenges include changes in economic systems, cultural issues include changes in family structure, work practices, and social values. Patient specific issues will include both medical and demographic characteristics.

A current cultural issue impacting on how we deliver care in Australia is the changes occurring in communication. We live in the information age. The accelerating rate of change in itself presents unique challenges, both for us as a community and as individuals.

In parallel with the increase in information and access has been a rise in consumerism where many people and in particular some specific patient groups are seeking and demanding information that once was restricted to the domain of the health professional. For example, prostate cancer self help groups are emerging that seek to assist men in the search for information about prostate cancer treatment. These groups are typically oriented around information seeking and will connect with groups in other countries via the Internet.

## Decision making

Increasingly, physicians in Australia report that patients are accessing Internet information to assist with decision making about treatment. Thus, we are seeing a clear effect from these changes in communication in how many of our patients learn about their cancer and its treatment, and how they make decisions about treatment.

There are both positive and negative implications from the changes. On the positive side, information about treatment can provide people with the information necessary to participate in treatment decision making, to carry out self care activities, to prepare for the consequences of treatment and to comply with prescribed treatments. On the negative side, information overload can bewilder the lay person and itself contribute to feelings of confusion and uncertainty.

A key challenge then for people with cancer will be negotiating large amounts of information from a range of sources that includes not only the traditional health care team, but also the Internet, consumer groups and the media. How can we as health care providers respond to this and

provide supportive care for our patients in this environment? Work we have undertaken in Australia with men with prostate cancer was initiated by this dilemma.

There is a current clinical imperative for men with prostate cancer to be actively involved in treatment decision making. For example, after the diagnosis of localised prostate cancer a man may be asked to choose one of three possible treatments: watchful waiting, radical radiation therapy, or radical prostatectomy.

This treatment choice is offered on the basis that if a man has a grade 1 or 2 prostate cancer his chance of being alive in ten years with aggressive treatment is close to a man who chooses conservative management (Chodak, Thisted, G.S., & al., 1994). By contrast to watchful waiting, side effects from both radiation therapy and radical prostatectomy include impotence, bowel injury and urinary incontinence (Altwein et al, 1997; Herr, 1997; Lim et al, 1995). Thus men are asked to balance the chance for cure with quality of life considerations.

In the case of men with advanced prostate cancer, men will need to be involved in decision making about the type of hormone treatment utilised as well as the timing of such treatments (Reese, 2000). Thus, in the clinical context of prostate cancer informational support is especially critical.

## Isolated group

However, men are a hard to reach population group. Compared to women, men visit their general physician less often (Briscoe, 1987), are less likely to seek information about their health (Rakowski et al, 1990) and are less likely to seek emotional or psychological support (Bland, Newman, & Orn, 1990).

Rather than replicating existing models of support we elected to follow a three-phase project to identify and develop supportive care services that would be most acceptable to men and most responsive to their needs, and sensitive to the contextual issues.

For phase one we undertook to investigate men's preferences for information and support for cancer by surveying a community sample of 1464 Queensland men (Dunn, Steginga, Occhipinti, McCaffrey, & Collins, 1999).

Social Support Network which included family and doctor was most preferred, followed by External Emotional, including peer support and counselling and then External Informational Support which included the Internet. The low preference for telephone support and the Internet in particular may seem surprising. However, in times of rapid change and situations of high threat or stress, sources of information that are seen as credible and personally connected, (ie the physician), may be most useful and most preferred.

In the second phase we consulted with health professionals and men with prostate cancer about the most effective way to provide information support. We identified a preference for self materials such as videos and booklets that can be provided to the patient by the physician and then used in the home environment with the support of family.

## Unmet need

Consultation with health care professionals identified a need for resources to be designed to separately target men with localised prostate cancer and men with advanced disease. As our previous research suggested, men prefer to receive information and support for their cancer from their doctor so a clinician was chosen to present the medical content in the videos to enhance acceptability.

The videos include interviews with men previously treated for localised prostate cancer thereby adding peer-led coping information. In this way the videos aim to reduce men's anxiety through the consumer presentations and so facilitate better understanding of the medical content.

The third phase included a survey of men's unmet supportive care needs to identify priority need areas for our next phase of programme development (Steginga et al, 2000). To this end we have surveyed 206 men with prostate cancer who were members of prostate cancer self help groups in Queensland using the Supportive Care Needs Survey (SCNS) (Bonevski et al, 2000).

Priority areas identified included assistance with sexuality and masculine self image concerns, coping with fears about cancer recurrence and informational support in areas specific to each man's individual medical care (Steginga et al, 2000).

Next, we intend to seek further advice from men with prostate cancer about the best ways to assist them with these priority need areas. In conclusion, this project is still evolving, developing in close reference to the contextual issues relevant to the patient group, men with prostate cancer. The uptake of programmes developed thus far has been high, extending nationally.

The success of this project we believe relates to using a process that ensures contextual issues are responded to. First, it is important to have a clearly defined patient or client target group and to identify the contextual factors relevant to that group. Second, needs assessment should be action oriented and responsive to contextual issues. To do this multiple consultation processes involving all key stakeholders are essential.

*Suzanne Steginga, RN, BA, BBehSci (hons), Manager, Community Services, Queensland Cancer Fund*  
For the full version please contact [ssteginga@qldcancer.com.au](mailto:sssteginga@qldcancer.com.au).

## References

- Altwein, J., Ekman, P., Barry, M., et al (1997). How is Quality of Life in Prostate Cancer Patients Influenced by Modern Treatment? The Wallenberg Symposium. *Journal of Urology*, 49 (Supplement 4A), 66-76.
- Bland, R. C., Newman, S. C., & Orn, H. (1990). Health Care Utilization for Emotional Problems: Results from a Community Survey. *Canadian Journal of Psychiatry*, 35(5), 397-400.
- Bonevski, B., Sanson-Fisher, R., Girgis, A., Burton, L., Cook, P., Boyes, A., & The Supportive Care Review Group. (2000). Evaluation of an Instrument to Assess the Needs of Patients with Cancer. *Cancer*, 88, 217-225.
- Briscoe, M. E. (1987). Why do People go to the Doctor? Sex Differences in the Correlates of GP Consultation. *Social Science of Medicine*, 25(5), 507-513.
- Chodak, G. W., Thisted, R. A., et al (1994). Results of conservative management of clinically localised prostate cancer. *New England Journal of Medicine*, 330, 242-248.
- Dunn, J., Steginga, S. K., Occhipinti, S., et al (1999a). Men's preferences for sources of information about and support for cancer. *Journal of Cancer Education*, 14, 238-242.
- Herr, H. W. (1997). Quality of life in prostate cancer patients. *CA - A Cancer Journal for Clinicians*, 47, 207-217.
- Lim, A. J., Brandon, A. H., Fiedler, J., et al (1995). Quality of Life: Radical Prostatectomy Versus Radiation Therapy for Prostate Cancer. *Journal of Urology*, 154, 1420-1425.
- Rakowski, W., Assaf, A. R., Lefebvre, et al (1990). Information-Seeking about Health in a Community Sample of Adults: Correlates and Associations with Other Health-Related Practices. *Health Education Quarterly*, 17(4), 379-393.
- Reese, D. M. (2000). Choice of hormonal therapy for prostate cancer. *The Lancet*, 355, 1474-1475.
- Steginga, S. K., Occhipinti, S., Dunn, J., Gardiner, R. A., Heathcote, P., & Yaxley, J. (2000). Supportive care needs of men with prostate cancer. Under Review.

## EDUCATION COLUMN

### Strategies to improve pain and palliative care in Brazil

Brazil is the largest country in South America (8,547,463km<sup>2</sup>), with a population of approximately 174 million, 85% of whom live in urban areas. There are enormous regional differences in educational and economic aspects. The population is young (30% are aged less than 15 years, 65% are aged 16 to 64) and life expectancy is 69 years.

Cancer is the third leading cause of death in Brazil. The estimated incidence of neoplasm for 2001 was 305,330 and the estimated mortality was 117,550. Skin (non melanoma) cancer, breast, stomach, lung, prostate and cervix are the most frequent cancers.

The adequate control of pain and other symptoms is a challenge for Brazilian nurses. Health professionals have been organising different strategies to improve these aspects of care and nurses are involved in two of these initiatives, described below.

#### League Against Pain

Disciplines focusing on pain concepts and pain therapy are not traditional in medical and nursing undergraduate programmes in Brazil. In 1995 faculty members of the Nursing School and the Medical School of University of Sao Paulo organised the League Against Pain at an university hospital.

The League Against Pain is an extracurricular training programme about pain for nursing and medical students. All activities are voluntary and developed after the regular classes. The student training consists of

an initial 15-hour course. During the following 10 months, for 3 hours a week, students are trained in the care of patients with chronic pain and other symptoms. The physical, behavioural, social and clinical findings of patients and the most appropriate therapies for each situation are emphasised. The League Against Pain is recognised as a good model to introduce the pain topic to undergraduate students and this initiative has been replicated by other universities.

#### Continued educational programme in pain and palliative care

This programme was organised six years ago, by a group of professionals and scientific societies. The objectives of the programme are: to improve health professionals' knowledge about pain control and palliative care; to develop centres for training in pain and palliative; to educate the general public; and, to help patients and families to organise into associations that would help them get cheaper medication and to solve other difficulties. A non-governmental organisation collects donations to support the projects of the programme.

Many things have been accomplished to meet the programme objectives and other are still being done.

- Proposal of a core curriculum about pain and palliative care for nurses, physicians, dentists, psychologists and social workers. This curriculum was published in a scientific journal.

- Development and free distribution of a booklet about pain control for the general public.
- Intensive work with the media, after which some newspapers and television channels organised specific features about chronic pain and palliative care and continued to disseminate issues related to these topics.
- Another initiative was the creation of the Pain Caravan. The caravan will visit 50 cities in Brazil to disseminate information about pain and palliative care for the professionals, general public, politicians and policy makers.

Last January the programme achieved an important step. The Health Ministry created the National Programme for Assistance to Patients with Chronic Pain and Palliative Care. A group of professionals representing different associations, including the Brazilian Nursing Association, were nominated to be part of this technical committee.

This committee will establish care and education standards and guidelines. Initiatives like this will really make difference in patients' care and quality of life.

*Cibele Andruccioli de Mattos Pimenta, PhD, RN, Associate Professor, University of Sao Paulo, Nursing School, Board Member of the ISNCC*  
*Dr Joao Augusto Bertuol Figueiro, Director of the Continued Educational Programme in Pain and Palliative Care*

### Identifying patient outcomes from nursing interventions

How do we know and how can we show that nursing care makes a difference? This column focuses on ways to identify appropriate outcomes and their indicators to measure the effectiveness of nursing interventions.

Patient outcomes refer to changes in patient states and behaviours, including patient perceptions following intervention. Outcomes include changes in skills, knowledge, attitudes, values, status, condition, and behaviours.

Nursing sensitive patient outcomes do not refer to what the nurse does, but to the changes that resulted from the nursing interventions. For example, nurses teach patients but it is what the patient learns and does in terms of attitudes, skills, knowledge and changes in behaviour that are the outcomes.

#### Patient outcomes

Identifying and measuring patient outcomes from nurses' work is not easy, particularly when outcomes are often influenced by more than one discipline. How do we go about identifying patient outcomes and specifically those outcomes that are sensitive to nursing intervention? To facilitate the process, it is helpful to think about the patient population and the likely care trajectory for that patient group, including the expected progression of a condition or disease.

By identifying the potential patient problems/nursing diagnoses and the goals for those situations, we are making an effort to predict care needs. In that way, we are better able to clarify the interventions we need to use and to predict the outcomes that are reasonable, attainable and likely to be important. We need to identify the interventions we use in order to reach those goals and objectives.

#### Selecting outcomes

When thinking of outcomes, think of the longer term outcomes as well as those that are more immediate and those that are intermediate term. We might not always be

able to see achievement of the longer term outcomes, but by showing the degree that the initial and intermediate outcomes are realised provides support to argue that the longer term outcomes are more likely to occur.

The choice of which outcome measures to use depends on the purpose of the outcome assessment, the type of patient groups involved, and the nursing interventions of interest. Outcomes should be selected that are easily identifiable, measurable, and directed toward meeting the goals of the assessment being done.

Regardless of the type of outcome measures chosen, the goal should be to obtain a valid, reliable, and thorough assessment. Some outcome measures are more sensitive than others in reflecting changes due to nursing intervention. For example, morbidity and mortality are gross indicators that are primarily influenced by medical care.

#### Classification

We also need to think of when to measure outcomes. Preferably a baseline assessment has been done that can be used as a point of comparison. The timing of when additional assessments are done depends on the situation. Some outcomes result more quickly from our interventions than others.

Frameworks that classify outcomes can assist us in identifying outcomes and their indicators. Nelson et al (1996) describe four types of outcomes: 1) functional status, risk status, and patient well-being; 2) costs associated with care; 3) satisfaction with health care and perceived benefits, and; 4) clinical outcomes.

The Nursing Outcomes Classification (NOC) (Johnson, Maas & Moorhead, 2000) is another classification system that provides a standardised language to measure the effects of nursing practice on patient outcomes. The outcomes and their indicators were developed using a very methodical and research-based approach.

No classification system should be a

recipe book, but the availability of such outcome classification systems can greatly facilitate the work of making the impact of nursing care visible.

#### Evaluation

Depending on the interventions that need to be evaluated, it may be desirable to identify other instruments or data collection methods. Several sources that might be useful have been identified by Kleinpell-Newell & Weiner (1999). Furthermore, in some situations, it may be necessary to develop an outcome measure. You might want to refer to a paper I did with some colleagues that describes how we developed and tested instruments to measure client outcomes at the Comox Valley Nursing Center (Hilton, Budgen, Molzahn & Attridge, 2001).

Whatever methods we use, we need to evaluate the care we give. I hope that some of the strategies described here might be helpful to you in your work. As noted by Marek (1997), we must identify what nurses do (nursing interventions) in response to what sort of patient conditions (nursing diagnoses) with what effect (nursing outcomes) and we must do so quickly. Let's meet the challenge!

*Ann Hilton, ISNCC board member, RN PhD, School of Nursing, University of British Columbia, Canada*

#### References

Hilton, B.A., Budgen, C., Molzahn, A.E., & Attridge, C.B. (2001). Developing and testing instruments to measure client outcomes at the Comox Valley Nursing Center. *Public Health Nursing*, 18(5):327-339.

Johnson, M., & Maas, M. & Moorhead, S. (2000). (Eds.). *Nursing Outcomes Classification (NOC)*. (2nd ed.). St. Louis: Mosby.

Kleinpell-Nowell, R., & Weiner, T. (1999). Measuring advanced practice nursing outcomes. *AACN Clinical Issues*, 10(3):356-368.

Marek, K.D. (1997). Measuring the effectiveness of nursing care. *Outcomes Management for Nursing Practice*, 1(1):8-12.

Nelson, E.C. et al (1996). Improving healthcare, Part I: The Clinical Value Compass. *Joint Commission Journal on Quality Improvement*. 4 (April 22):243-258.

## CALENDAR OF EVENTS

**The 27th Annual Congress of the Oncology Nursing Society** will take place in Washington DC, USA, 18-21 April 2002. For information contact: ONS, 501 Holiday Drive, Pittsburgh, PA 15220 USA; tel: 412 921 7373

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

**The 12th International Conference on Cancer Nursing** will take place in London, UK, 28 August-1 September 2002. For information contact: Liz Peim, 12th ICCN, PO BOX 6626, Leicester, LE2 1YU; tel: 44 (0)116 270 3309; fax: 44 (0)116 270 3673; email: [conference@isncc.org](mailto:conference@isncc.org)

**The 12th European Cancer Conference** will take place in Copenhagen, Denmark, 21-25 September 2003. For information contact: ECCO 12, FECS Conference Unit, Avenue E Mounier 83, B-1200 Brussels, Belgium; fax: 32 2 775 0200; e-mail: [info@fecsc.be](mailto:info@fecsc.be)