

## Tiffany lectureship awarded

Barbara F. Piper, an American oncology nurse with a career-long interest in cancer-related fatigue, has been awarded the Robert Tiffany Lectureship.

Dr Piper, Associate Professor in the College of Nursing at the University of Nebraska, US, said she was both surprised and delighted to receive the award. She told



**Barbara F. Piper, DNSc, RN, AOCN, FAAN, winner of the Robert Tiffany Memorial Lectureship**

ICNN: 'To be nominated by the Oncology Nursing Society was an honour in itself, whether or not you receive the award.

'It is touching to have been chosen. Having met Bob Tiffany 18 months before he died, I thought the world of him and his achievements.'

### Fatigue

Barbara is currently preparing her lecture which she will present to delegates at the 12th International Conference on Cancer Nursing in London. While not sure of the details she is sure that it will focus on the subject of fatigue.

She first became interested in the subject of fatigue when she was working as a staff nurse caring for a woman with leukaemia. In disease remission, the patient needed to have consolidation treatment to guarantee lasting remission but refused.

This decision surprised her. 'She refused because the fatigue she had experienced was so bad that she was not willing to go through that again. This experience raised questions in me. Could the fatigue have been made less overwhelming and chronic?'

### Little research

She became involved in research while still working as a ward nurse and began to learn the research process. A few years later Barbara began to investigate the topic of cancer-related fatigue and found that little research existed.

In 1982 she carried out a research project on diarrhoea and vomiting in ENT patients but found that in fact fatigue was the number one symptom. Since that time her research activities have focused on fatigue and the development of a multi-dimensional subjective fatigue scale

Her work culminated in the Piper Fatigue Scale (PFS) which is used for patients with moderate to severe fatigue. She developed it when she found that fatigue could not be measured clinically. Despite the fact that mentors told her it

would be a lifelong activity, which it has proved to be, she went ahead.

The PFS is the most frequently used scale in the United States and has now been translated into a number of different languages including French, Swedish, Turkish, Chinese, Mandarin, Cantonese and Spanish.

### Patient contact

Barbara still works on the scale continually modifying and improving it. Currently the PFS is composed of 22 measures (scaled 0-10) that quantify four dimensions of subjective fatigue. Five other items on the scale are not used to calculate a score but reveal qualitative data.

As her work became more research focused Barbara continued to have contact with patients. 'I always kept one foot in the ward. You need to be engaged with practice.' She still sees patients either when carrying out data collection or if a patient is referred to her for a consultation on fatigue.

She loves her current teaching job where she primarily teaches undergraduate and graduate students while doing research projects with masters and doctorate students. It also enables her to have the resources to continue with research.

Barbara has published widely on the subject of fatigue and the Piper Fatigue scale. Her interest is currently focused on the question of how other symptoms cluster with fatigue and how these may be related to biologic markers of fatigue and may be affected by fatigue treatments.

- Delegates will hear the Robert Tiffany Lecture on Friday 30th August. Highlights of the lecture will be reported in the next issue of the newsletter.

# Looking back

It has been an honour and privilege to serve for the past six years as President of the International Society of Nurses in Cancer Care (ISNCC). I have pondered long and hard about this, my last President's message. There is so much I could say about this exciting and rewarding experience.

I have met many wonderful nurses from around the world, learned about cancer nursing from a global perspective, increased my understanding of the unique perspectives of international networks, and realised the importance of international collaboration. In the face of the many problems cancer nurses are encountering in their own countries, it has been heartening to see the dedication, concern for quality patient care, and enthusiasm that is pervasive worldwide.

This last message provides me with the opportunity to look back on the events of the society over the past 6 years. In my first message I talked about 'moving forward' and with nurses helping nurses we did move forward.

The ISNCC board members, committee members, and full member societies, with the advice and input of nurses from around the world, have immeasurably advanced cancer nursing. A new constitution has been passed, bylaws developed for the society and policies to guide the structure of ISNCC initiated. We have revolutionised international communication between cancer nurses. Our voices are being much better heard around the world. We have met and overcome many challenges. Let me highlight some of these areas.

## Communication

Questions were raised six years ago about membership. How do we better communicate with nurses and member societies around the world? How do we reach nurses

in countries where a national nursing group has not yet been established and help nurses establish cancer nursing societies in their own countries? What mechanisms can we establish to allow member societies to participate and contribute to ISNCC activities?

First, let us look at the progress in communication. In 1998, International Cancer Nursing News underwent a new design with a new logo. It not only featured news from member societies but began to include a feature article with a research and education column in each issue. Today this newsletter continues to expand its content. With the change in membership categories to include associate nurse members, the newsletter will now reach more nurses worldwide.

The ISNCC web site was launched in September 1999 to inform visitors to the site about the society and provide information on conferences, grants, events and publications. An education programme Fundamentals of Oncology is available for nurses worldwide to download and use in their education endeavours. In 2001, the site was redesigned to expand functionality for future use by committees and the board. The site has seen steady growth in use since its launch with over 300 visitors each week from around the world.

The ISNCC has developed an Adopt-a-Society programme to enable societies from developing countries to be formed with support by well-established societies or institutions so that both sides could learn from each other. To date, Duke University is collaborating with the Zimbabwean Society of Nurses in Cancer and Palliative Care and the Metro Minnesota Chapter of the Oncology Nursing Society, USA has begun communication and collaboration with nurses from Uruguay.

Progress has been made in collaboration



of member societies with ISNCC on a number of projects. The success of conferences in 1998 and 2000 would not have been possible without the support and involvement of the Israel Oncology Nursing Society and the Norwegian Society of Nurses in Cancer Care. The Royal College of Nursing Cancer Nursing Society is providing us with much support and advice for this year's conference.

A unique mechanism of collaboration was the joint sponsorship of ISNCC and the Oncology Nursing Society (ONS) of an Introductory Research Symposium prior to the 11th International Conference on Cancer Nursing, in Oslo Norway in 2000. This was such a great success that another symposium has been scheduled for 28 August 2002, prior to the 12th International Conference on Cancer Nursing in London. The ISNCC Research Committee and ONS are currently working on a proposal for an international education project regarding nursing research.

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# Nurses can help tackle nausea

A third of patients are still suffering from chemotherapy-induced nausea and vomiting (CINV), according to a survey presented to delegates attending the third biannual convention of the European Oncology Nursing Society (EONS).

The results of a pan-European nurse survey showed that nearly two decades after the introduction of highly effective anti-emetic therapies, patients are still needlessly suffering this side-effect from chemotherapy. The survey of 180 nurses in six countries identifies the need for nurse awareness and training initiatives.

The survey highlighted that, after hair loss, nausea and vomiting are the two most common concerns expressed by patients

when told they require chemotherapy.

Nausea and vomiting are two of the most common side effects of chemotherapy, affecting about 70% of patients, and representing a major therapeutic challenge in cancer and post-operative care.

These side effects can be so uncomfortable and devastating to the quality of life that some patients opt to delay or refuse further potentially life-saving treatment.

It is generally accepted that full 24-hour coverage from nausea and vomiting is required from anti-emetic treatment strategies if disruption to a patient's quality of life is to be minimised.

Trained oncology nurses have a significant influence over treatment strategies

with 39% of respondents having a high, and 28% having a moderate involvement in the decision regarding which anti-emetic treatment is used.

Commenting on the results of the survey, Giel Vaessen, President, EONS, said: 'The significant influence nurses have over treatment of CINV coupled with their high level of patient interaction means that nurses are ideally placed to take a lead in reducing the unacceptably high incidence of CINV.'

'Better nurse education, assessment methods, identification of patients who are inadequately controlled and a thorough review of current treatment approaches are urgently needed,' he concluded.

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## Voice of cancer nurses

How can we ensure that the ISNCC is recognised and positioned in the international arena so that the voice of cancer nursing is heard around the world? How can we improve our relationship with international organisations and government agencies? These questions were also raised six years ago.

The Society has represented cancer nursing by participating in meetings involving international organisations. We have been represented at meetings of the World Health Organization (WHO), the International Council of Nurses (ICN), the United Nations, the International Union Against Cancer (UICC), and the Pan American Health Organization (PAHO).

The voice of cancer nursing has been shared at a conference sponsored by ICN dedicated to envisioning the future. Most recently, the ISNCC, a non-governmental organisational (NGO) member of WHO, was invited to participate in the Meeting of Partners on Strategic Directions for Nursing & Midwifery Services. As a partner with WHO and numerous international organisations, the ISNCC will participate and collaborate on future plans of action. Currently, the ISNCC and ICN have developed a project proposal to increase nurses' involvement in the tobacco control movement.

Position statements have been developed on cancer pain, tobacco use and health, cervical screening, and skin cancer in order for the voice of cancer nursing to be influential on important matters and promote the delivery of high quality cancer care. Several position statements have been translated into Portuguese and Spanish and additional language translations are underway. The education committee has developed a paper

on how to use ISNCC positions statements in order to help nurses use these statements for education and health policy.

## Research and education

The specialty of cancer nursing needs to be constantly revitalised by the infusion of new information generated by research. Efforts to meet this goal have included the development of a Directory of Oncology Nurse Researchers, research sessions at each conference, and the development of a small research grant programme. To date, three research grants have been awarded in the amount of \$5000.

The second edition of the Core Curriculum of Palliative Nursing, which has been endorsed by WHO and the ICN and supported by an educational grant from Macmillan Cancer Relief, will be launched at the 12th International Conference in London, August 28-September 1, 2002.

This conference also exemplifies the involvement of cancer nurses worldwide as over 400 abstracts were received for presentation. Nurses will come to London to share their experiences, network, and participate in education sessions. Support from corporations, member societies and individuals have made travel scholarships available for nurses from developing countries who will have the opportunity to meet their colleagues in London.

## Continuing the move forward

The past six years have had ups and downs, as would be expected with any organisation that is in the process of development. The downs have been related to the change in management of the organisation and the subsequent closing of their conference department. However, the ISNCC has survived these hurdles with the help of good

leadership, a strong Secretariat, and board members who have been understanding and supportive through several crisis situations. Members whose papers or requests were lost or misplaced during this time have been understanding.

However, the positives far outweigh the negatives. The progress that has been made has been monumental thanks to the volunteer efforts of many board members, member societies, and committee members. Support from corporate members has been important and we must continue to evaluate how we can work with companies, charities and other international organisations.

Moving forward will only be possible if we continue to cultivate our members and develop a system that allows them to participate in an international organisation. It will take further strategic efforts to determine how we can increase member participation and how activities can be organised regionally and be applied at the international level. On the other hand, we have to evaluate how we can best work with member societies at their level. We need to discover the best way to provide support and collaboration to societies at all stages of development.

The momentum must continue because much still needs to be done. We cannot allow our progress to stagnate. I am convinced that the ISNCC will continue to move forward. The next President and the board leadership will have many challenges but they will also have many opportunities. I have been blessed with the devoted help and support of many talented cancer nurses around the world. I am grateful for this. The new leadership will have my support and blessings as they continue to move ISNCC forward.

*Connie Henke Yarbrow,  
President, ISNCC*

# Pre-conference workshops

Two pre-conference workshops have been organised for the 12th International Conference on Cancer Nursing following the success of those offered at the Oslo conference.

The first is a joint ISNCC and Oncology Nursing Society introductory research symposium called *Moving towards evidence-based practice*. The meeting provides an opportunity for nurses to be introduced to the research process and concepts of evidence-based practice.

The workshop is aimed at cancer nurses with minimal or little research knowledge.

The course will focus on finding relevant research reports and systematic reviews, critically evaluating the evidence with research reports, understanding the research process, identifying subjects for research and will look at how to start a research project.

The second workshop *Nursing strategies in breakthrough cancer pain* is mainly for palliative care nurses but may also be of interest to cancer nurses who need to understand and treat breakthrough pain.

Breakthrough pain has a major impact on treatment compliance and quality of life,

particularly in the last few months of life. Cancer nurses can improve outcomes by developing pain management strategies based on an evaluation of a patient's pain and by using new approaches and treatments.

Barriers to effective pain management will be discussed as well as the key issues of treatment of breakthrough pain. This workshop is supported by a grant from Cephalon Inc.

The cost of each workshop is £60. If you are interested in registering for either workshop, please do so with the conference office early to avoid disappointment.

## EDUCATION COLUMN

### Cancer nursing education in Turkey

Turkey connects the continents of Europe and Asia and that why it is also known as Eurasia. The population of Turkey is about 67 million and has an average life expectancy of 69 years. Cancer is the second leading cause of death in Turkey with an incidence rate of 150-300/100,000 and a mortality rate of around 11%. Breast, lung, and prostate are the most common cancers.

The field of oncology has been growing in Turkey as has oncology nursing. But there are still no formal educational programmes such as certification or continuing education programmes. A specific graduate programme in oncology nursing was started in one of the universities in 1995, but it is not active at the moment. In fact only one nurse has so far graduated from this programme with the title 'oncology nurse'.

The first postgraduate course in oncology nursing was held in the capital Ankara in 1987 with the collaboration of the Ministry of Health, Hacettepe University and the International Union Against Cancer (UICC). Marian L. Frerichs who has attended this course on behalf of UICC invited Leman Birol, Professor in Nursing at Hacettepe University School of Nursing, to the International Cancer Nursing Congress in 1988 which was held in London.

Professor Birol went on to found the Oncology Nursing Association of Turkey. She was the first president of the association and has had major impact on the development of oncology nursing, as well as nursing itself, in Turkey.

The Oncology Nursing Association of Turkey was founded in 1989 with the goal 'to improve and disseminate the understanding and knowledge of oncology nursing'. To meet this goal, the association has focused on the educational needs of its members. It currently has about 330 members from

different areas of oncology nursing.

A total of fifteen educational programmes have been held by the association since its foundation. These include:

- 1991: *Seminars in Oncology Nursing*, in collaboration with Hacettepe University School of Nursing, focused on nursing care and symptom control of cancer patients and the role of nursing in the early diagnosis of cancer.
- 1996: *Protecting Ourselves*, in collaboration with the European School of Oncology (ESO), focused on the importance of cancer prevention and taking preventive measures for handling antineoplastic agents.
- 1998: *Comprehensive Chemotherapy*, in collaboration with the University of Pittsburgh Cancer Institute and Hacettepe University Postgraduate School of Hematology-Oncology.
- 1999: *Symptom Control and Quality of Life in Cancer*, in collaboration with ESO.
- 2000: *Sexuality in Cancer Patients*, in collaboration with the Israel Cancer Association.
- 2001: *Treatment Modalities in Cancer and Ethical Issues in Oncology Nursing*.

Some of the universities and oncology institutes also organise local, 2-3 day long educational courses in oncology nursing mostly for in-service education purposes. However, the impact of these courses on oncology nursing practice is questionable.

A session on oncology nursing was scheduled for the first time in the 13th National Cancer Conference in 1999. The main issue discussed in this conference was the challenges in cancer care in

Turkey. The basic problems and challenges of oncology nursing in Turkey as identified in a national report are summarised below:

- Lack of educational programmes for nurses specialising in oncology
- Inadequate basic knowledge on safe handling of chemotherapy
- Need for job descriptions
- Need for standards of professional practice
- Inadequacy in teamwork concept in oncology

The Oncology Nursing Association recently developed a strategic plan for oncology nursing in Turkey over the next four years. Concluded objectives are as follows:

- Educating nurses in oncology field
- Developing nursing care standards
- Following literature in oncology nursing and developments in oncology
- Educating patients and their families
- Educating public on cancer
- Conducting and supporting research in the field of oncology nursing
- Developing standards in continuous and in-service education programmes
- Implementing standards in nursing practice and evaluating their outcomes

These eight objectives are also in line with the strategic plan objectives of the European Oncology Nursing Association (EONS). The Oncology Nursing Association of Turkey aims to act, with a European dimension, to enhance the health care level and to improve the quality of life of those individuals with oncological problems in Turkey.

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# New roles offer opportunities in the UK

Continuing our series on cancer nursing around the world, a report from the UK looks at service developments which have opened doorways for the cancer nurse

When asked to write an article on cancer nursing in the UK I thought it would pose no difficulties. When you are part of a system and have been a cancer nurse in a country for 17 years you feel that you should have an inherent grasp of the system and its problems and challenges.

To the outsider the UK may seem an homogeneous unit but when you start to unpick the different threads of the four countries which make up the UK — England, Wales, Scotland and Northern Ireland — you find a diversity of cancer nursing which makes explaining it in clear unambiguous terms a challenge in its own right.

Cancer nursing as a specialty in the UK has been around for many years and is an area of continuous development. Recent history has however seen an increase in the recognition of the role of the cancer nurse and a massive increase in role diversity. These changes were triggered by the publication of a Department of Health report called *A Policy Framework for Commissioning Cancer Services* (DoH 1995) England and Wales.

This report focused on the configuration of cancer services and strived to achieve a patient-focused approach to treatment and care. A key component was the role and make up of specialist multi-professional teams within cancer centres and cancer units. It strongly supported the role of the specialist cancer nurse and has led to an increase in many tumour-specific roles as well as supportive care roles such as lymphoedema and palliative care.

This report was closely followed by reviews in Wales (*Cancer Services in Wales 1996*), Scotland (*Commissioning Cancer Services in Scotland 1996*) and Northern Ireland (*Campbell report: Cancer services — investing in the future 1996*). Although there was a degree of local variation a similar model of service delivery was adopted.

Many further documents have since been released which have had an impact on the structure and provision of cancer nursing services. A key area was the development (still in progress) of a series of *Improving Outcomes Guidance* documents which focus on the make up of the multi-disciplinary teams.

In all of the published documents so far the role of the specialist tumour-specific nurse has been defined although the evidence to back this model up is minimal.

The framework of these documents has been mirrored in the publication of the *Cancer Standards* which provide an assessment framework to determine whether cancer centres and units achieve the required level of care.

Hospitals are now assessed on whether they have the required number and level of cancer nurse specialists in post. The *Cancer Standards* also identify the requirement for each hospital to identify a *Cancer Lead Nurse* as part of its leadership team. This model is replicated in the *Cancer Network* which is a virtual organisation that brings together the purchasers and providers of cancer care and the voluntary sector for an average population of 1 million.

The *Cancer Network* is charged with taking forward and implementing the *Department of Health's Cancer Plan*. These developments have highlighted the leadership role of the cancer nurse and ensure that the voice of cancer nursing is heard at the level where strategic changes in service delivery are made.

So where does that leave cancer nursing? We have seen massive changes in our health service with cancer remaining high on the political agenda for many years. Developments are many but there is still a long way to go.

## Clinical role of the cancer nurse

The UK has for many years seen specialist cancer nurses mainly in breast care, generic cancer care and chemotherapy. Since 1995 the workforce now reflects clinical nurse specialist roles in many areas including breast, lung, colorectal, gynaecology, palliative care, urology, lymphoedema and chemotherapy together with function specific roles such as endoscopy. It is expected as further *Improving Outcomes Guidance* documents are published there will be a continual increase in roles.

Unfortunately there has been little consistency in the development of these roles. The *Nursing Contribution to Cancer Care* (DoH 2000) has sought to partly address this and in reflecting the national nursing strategy (*Making a Difference 1999*) proposes a career framework for cancer nursing.

As well as the specialist practitioner role it is imperative that the required expertise at ward and community level is not forgotten particularly in areas not usually designated as cancer wards but where a significant part of the patient population is having investigation or treatment for

cancer (eg surgical wards).

Unfortunately there is no nationally agreed definition of what a cancer nurse is. The *Cancer Standards* attempt to identify some criteria such as academic qualifications for the specialist practitioner roles but not at all levels. A recent piece of work in progress is working towards the development of nationally agreed core competencies for cancer nursing. This is being led by a group of *Cancer Network Lead Nurses* and links in to a *Department of Health Cancer Nursing Advisory Group*, which is currently looking at workforce issues.

## Cancer nursing education

Post graduate cancer nursing education programmes have been around for many years within the UK. Primarily these were accessed by nurses working in non-surgical oncology but the value of these courses is widely recognised in all care sectors now. Cancer nursing education programmes are also widely available at BSC and Masters level with a significant number of cancer nurses pursuing their studies at doctoral level.

The main gap in the cancer nursing education profile is that of pre-registration education. Although every nurse will at some stage care for patients with cancer, the level of education in basic training remains low. Cancer workforce planning is being driven by the *Cancer Networks* working closely with our *Workforce confederations*. It is hoped that this will lead to a more proactive approach in planning the workforce and the required educational programmes that are needed to support this.

## Cancer nursing career pathways

Within the UK the structure of the workforce is changing dramatically, leading to many diverse opportunities for the cancer nurse. Career pathways can now progress in many directions. For nurses wishing to remain clinically focused a vast array of specialist roles are now available.

As well as the traditional clinical nurse specialist role there are now many functionally specific roles such as endoscopy and a new level of nursing has been introduced which enables further clinical progression. The role of the *Nurse Consultant* is a senior registered practitioner with considerable specialist experience and advanced qualifications to combine expert cancer nursing with significant professional leadership,

# Charity makes links

President of ISNCC, Connie Henke Yarbrow, Tore Schjolberg, Board Member for Europe and Vernice Ferguson, past President of ISNCC were among the guests at a reception in April given by the British Ambassador and Lady Meyer in Washington DC.



Connie Henke Yarbrow and Dame Gill Oliver

The occasion was in honour of Macmillan Cancer Relief, one of the UK's two major cancer care charities. Guests included representatives of the American Society of Clinical Oncologists, the National Cancer Institute, the American Cancer Society, and the Oncology Nursing Society.

Friends of Macmillan in Washington had raised money to support Kathryn Nattress and Ashley Adsett, two Macmillan Nurses from the UK, to travel to Washington and take part in the Annual Congress of the American Oncology Nursing Society.

This event provides an opportunity for discussion, debate, learning and sharing with over five and a half thousand delegates; plenary, podium and poster sessions together with a large commercial exhibition. Kathryn and Ashley had ample opportunity for networking, for sharing their own skills and knowledge and for learning from nursing colleagues from the US and around the world.

Macmillan Cancer Relief is a UK Charity committed to a time when every person has equal and ready access to the best information, treatment and care for cancer and where unnecessary levels of fear are set aside. Over £60m of donated

money is used each year to develop services for people affected by cancer and to make the cancer experience easier.

Macmillan is a UK charity and is relatively unknown overseas. However, it is keen to explore opportunities in which collaborative partnerships may be developed to share experiences, to learn from colleagues in other countries and to benefit from innovative projects and developments beyond the UK. Macmillan is best known for the Macmillan nurses who provide care and support for people affected by cancer. There are now over 2,000 such nurses across the UK.

Macmillan also runs Macmillan CancerLine, a telephone service that provides information and advice on cancer related topics.

A new and expanded website is currently being developed, to be launched towards the end of this year. In the meantime visit us on [www.macmillan.org.uk](http://www.macmillan.org.uk).

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consultancy, educational, research and service development functions.

For nurses who wish to pursue a leadership role there are now senior leadership positions with hospitals, primary care and the Cancer Networks. These Lead Cancer Nurses work within a leadership team to influence both organisation and strategic delivery of cancer services. For nurses who wish to follow a research path this can be achieved either through existing clinical roles such as the Clinical Nurse Specialist or Nurse Consultant or through a small but growing number of research roles.

Many nurse researcher roles are closely linked to clinical trials and there are now established cancer research networks, which mirror the population of the Cancer

Networks. There is also a growing body of nursing research posts, which will increase the paucity of cancer nursing research across the UK that currently exists.

The cancer agenda has also seen over the last few years many exciting national projects such as the Cancer Collaborative Project, which is a service redesign project. This has opened the door for many nurses to follow a project worker route and has empowered many nurses to directly influence patient care through changing the patient pathway.

It is an exciting time to be a cancer nurse in the UK. Cancer treatment remains a high priority for the government, which has ensured an increase in resources. The government has produced

## Pain at home

Patients attempting to institute a cancer pain management regimen at home need ongoing assistance with problem-solving. A US study identified seven areas where patients experience problems: obtaining the prescribed medication, accessing information, tailoring prescribed regimens to meet individual needs, managing side-effects, cognitively processing information, managing new or unusual pain, and managing multiple symptoms simultaneously.

Schumacher KL et al Putting cancer pain management regimens into practice at home. *J Pain Symptom Manage* 2002; 23(5): 369-82.

## Laughter

Humour is an important coping factor. A survey of patients found that they believed that humour played a role in their spirituality and their perception of the meaning and purpose of life. Nurses' use of humour was found to be important in building deeper, more trusting relationships with patients.

Johnson P. The use of humour and its influences on spirituality and coping in breast cancer survivors. *Oncol Nurs Forum* 2002; 29(4): 691-5.

## Caregivers

Home care of the patient with advanced cancer depends on the availability of a family care giver. A survey of care givers found that they are significantly involved in symptom management. Their role does have a negative effect on their health, schedule, anxiety and energy. But they find meaning in their role and feel relatively well prepared. The survey suggests the need to move towards development of caregiver-focused nursing interventions.

Aranda SK, Hayman-White K. Home caregivers of the person with advanced cancer: an Australian perspective. *Cancer Nurs* 2001; 24(4): 300-7.

a Cancer Plan (DoH 2001) which is driving forward the cancer agenda and cancer nursing is key to its delivery.

The cancer nurse remains an amorphous creature with many generic and specific roles. The role of the cancer nurse is continually developing and is making strides to continually improve patient care. There is still much work to do to fulfil all the opportunities ahead of us but I believe that the cancer nursing workforce will grasp these opportunities and make a real difference to patient care in the UK.

*Helen Porter*  
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### Should qualitative and quantitative studies be triangulated?

An emerging trend over the last decade has been the increasing blending of qualitative and quantitative data within a study to answer clinical and theoretical questions. This is referred to as triangulation. Combining methods has been viewed as somewhat controversial. In this article, types of triangulation as well as issues and strategies to consider for conducting multi-method studies are described.

Triangulation is a technical term used in surveying and navigation to describe a technique whereby two known or visible points are used to plot the location of a third point. Triangulation in research refers to the combination of two or more theories, data sources, methods, or investigators in one study of a single phenomenon to converge on a single construct. The following list further reflects the types of triangulation.

- Investigator triangulation: research team with shared interest in topic and diverse perspectives and areas of expertise regarding topic.
- Data triangulation: multiple data sources with similar foci to obtain diverse views through a range of data about topic.
- Time: collect data at different points in time.
- Space: collect data at different sites.
- Person: collect data from more than one level of persons: individuals, groups, or collectives.
- Theory triangulation: propositions derived from competing theories — typically occurs at conclusion of study.
- Methods triangulation: more than one research method or data collection technique because each taps different dimension of problem.
- Unit of analysis triangulation: relates to the dimension of analysis (eg individual behaviours and interactions between individuals).
- Analysis triangulation: more than one strategy to analyse the same data set for validation.

Triangulating is used to provide confirmation and completeness. It is not the simple combination of different kinds of data but

the attempt to relate them so as to counteract the threats to validity in each. Using triangulation can capture a more complete, holistic and contextual portrayal and reveal the varied dimensions of the given phenomenon. It should not be expected that each source of data will confirm each another. Rather, each source will contribute an additional piece to the puzzle and in that way complement each other. The researcher's bias can be minimised and the validity of the findings enhanced. Neither qualitative or quantitative methods can fully deliver on the promise to establish the truth, however combined judiciously the combination of methods can provide more complete insight. Using several methods also helps to rule out rival explanations.

Some scholars however argue that quantitative and qualitative approaches should not be triangulated. They believe that using mixed methods is method slurring and consider it to be sloppy research. They believe qualitative and quantitative research is based on totally incompatible paradigms and as such, should not be combined.

Although there is greater recognition of the potential advantages of multi-method research, the researcher needs to carefully consider several important issues before doing such work. Using multiple strategies in a single study requires attendance to the bias-checking procedures for each method. The investigator also needs to think of the unit of analysis selected because a triangulated study requires a common unit of analysis, such as the individual or the family. Because of the added complexity, conducting a triangulated study requires more time, more data collectors, greater data preparation time and consequently greater cost. In addition, the investigator needs a wider repertoire, knowledge level and expertise in each of the methods. When it comes to data analysis, issues need to be addressed about how numerical data and linguistic or contextual data are combined, how divergent results between numerical and linguistic data are interpreted, how will overlapping concepts that emerge that are not clearly differentiated from each other be handled,

whether and how data sources should be weighted, and whether each method should be considered equally valid.

Mitchell (1986) suggests that each type of data should be analysed separately in accordance with sound principles of analysis pertinent to the type of data examined. A decision then needs to be made whether a conceptual or statistical approach will be used to merge the two different types of variables that have theoretical importance in terms of the model. The statistical approach should be used only if the variables can be defined carefully and kept conceptually distinct from one another.

Foster describes a process of conceptual triangulation and clearly outlines five steps in conducting conceptual triangulation: 1) conducting qualitative and quantitative research true to the paradigmatic assumptions of each method, 2) distinguishing pertinent results within each method, 3) examining confidence in the results, 4) developing criteria for inclusion of results in the conceptual model, and 5) constructing one or more conceptual models (1997). These strategies provide direction in doing this work.

Nursing needs methods to enhance our efforts to describe and conceptualise the complexity of the human response to illness and health care situations. A multi-method approach has the potential to strengthen the comprehensiveness and/or reliability and validity of a study. Triangulation can provide a way to overcome deficiencies intrinsic to a single-investigator, single-site, single-theory, single-method, or single-unit of analysis, but the strengths will only be realised when care and attention are paid to addressing underlying issues.

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#### References

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## CALENDAR OF EVENTS

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