

Making a difference in London

Countries can learn much about the causes of cancer from each other according to keynote speaker, Dr Paul Kleihues, Director of the International Agency for Research on Cancer, France.

During a stimulating presentation to open the 12th International Conference on Cancer Nursing, Dr Kleihues analysed incidence of cancer and mortality rates across different countries and regions.

First he looked at cancer caused by infection. In developed countries, the cancers associated with, and caused by chronic infections constitute 8% of all malignancies. But in developing countries, up to 25% of malignancies are caused by infectious agents, including hepatitis B and C, human papilloma viruses and helicobacter pylori.

Vaccination against hepatitis B has been very successful. Dr Kleihues told delegates: 'We instigated a study in the Gambia and found that in a country that previously had a prevalence of more than 30%, and had adolescents developing hepatic cancer, that a vaccination programme given after birth prevented carrier status in more than 97%.

'And the vaccination sells in Africa for 60 or 70 cents. Unfortunately many countries are unable to maintain a high standard of vaccination year on year.'

In developed countries successful screening programmes have reduced the mortality of cervical cancer. 'In countries with a sophisticated health service the mortality has decreased dramatically, largely due to early detection. But the very sad fact is that 85% of women who die from cervical cancer are living in developing countries.

'It is not just the number of smears you perform,' he pointed out. Good follow-up is crucial. 'In Brazil the health minister promised and indeed delivered seven million cervical smears in a year but 30% of cases were lost in follow-up.' A research

project has started in India where women are seen only once, diagnosis and therapy are offered on the same day.

Aside from cancers caused by infection, lesser developed countries have a lower incidence of cancer. In developed countries, the overall cancer mortality is more than twice as high as in developing countries. The main reasons for the greater cancer burden in affluent societies are the earlier onset of the tobacco epidemic, the earlier exposure to occupational carcinogens, and the Western diet and lifestyle.

Approximately 30% of malignant tumours are now thought to be due to diet and lifestyle, characterised by a high caloric diet, rich in animal fat combined with low physical activity.

Tumours associated with the Western lifestyle include cancer of the breast, prostate, colon and rectum, and endometrium. Dr Kleihues told delegates that given the increasing prevalence of obesity in many countries it is unlikely that the incidence of these tumours will decrease in the foreseeable future. A reduction in mortality will largely depend on progress in early detection and treatment.

Tobacco consumption remains the most important avoidable cancer risk. Approximately 100 million people died in the 20th century from tobacco-associated diseases.

Recent epidemiological studies indicate that the adverse health effects are greater than previously estimated. Half of regular smokers are killed by the habit. One quarter of smokers will die prematurely during middle age (35 to 69 years).

It has been long recognised that in addition to lung cancer, tobacco smoking causes tumours of the oral cavity, pharynx, larynx, oesophagus, pancreas and bladder.

In a recent consensus conference at the



Dr Paul Kleihues opening the London conference with a keynote presentation

International Agency for Research on Cancer (World Health Organisation), this list was extended to include several organs with a two- to three-fold elevated risk in smokers versus non-smokers: tumours of the kidney, stomach, uterus, cervix, liver, nasal cavities, and myeloid leukaemia. However, there was no evidence of a causation by smoking of endometrial, breast and prostate cancer.

The Working Group also unanimously concluded that frequent exposure to passive smoking is associated with a 20% increase in lung cancer.

Dr Kleihues emphasised the need for prevention as lung cancer survival rates continue to be poor. 'Recent research shows that stopping smoking is a very good idea at almost any age. If you quit at the age of 50, which is pretty late, you are reducing your risk by 50 per cent and if you stop at age 30 you are reducing it by 80 per cent.

'So we should not only concentrate on preventing smoking in the first place but also give the message that stopping smoking is a very good idea and extremely effective.'

Help others build a society

Connie Henke Yarbro, President of the ISNCC, celebrated the importance of the role of the cancer nurse in her presidential address. She told delegates that 'it is the nurse, not the doctor, who will be fighting on the front line in our battle against disease'.

She called for nurses to help each other: 'We have come a long way in the development of independent national cancer nursing societies but we still have a long way to go. I call upon every well-established national society to identify a country where their sisters need help and give that help freely.'

Ms Henke Yarbro expressed concern about the global nursing shortage. She gave many examples including the Netherlands where it is has been predicted that there will be a shortage of 7000 nurses this year. Ten years ago, over 10,000 new nurses graduated annually in Poland; that figure has fallen to 3000. Chile has 18,000 nurses of whom only 8000 practice their profession.

She said: 'Studies clearly show that reducing the hours of nursing care provided by registered nurses each day is associated with lower quality of care for hospitalised patients. The problems of the nursing shortage are long-standing and cyclic, but if we

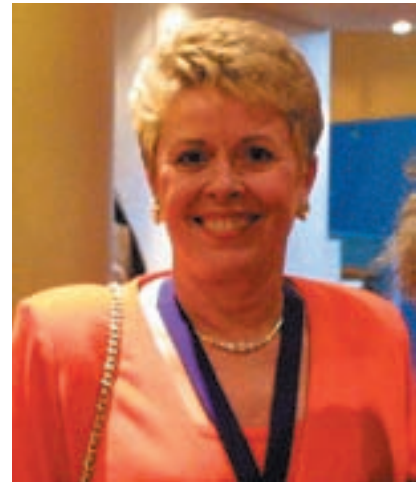
don't overcome the current shortage the quality of care will be affected.

'Many countries are addressing this issue and we must speak out and participate to ensure better pay, better conditions, more students entering our profession, and encouraging nurses to pursue faculty education. It is of the utmost importance to let our patients, the public, and the media know what we do and how we make a difference.

'More than 11 million nurses provide care in hospitals and rural health centres, schools, workplaces, prisons, war zones, refugee camps. We are the key to effective delivery of health care.'

She pointed out that ISNCC is uniquely positioned and qualified to meet this challenge. 'The recruitment, training, and practice of cancer nurses follows a pattern as health care systems evolve. Countries in which nurses have blazed the trail through this challenging wilderness have much to contribute to those just beginning that long trail of development. ISNCC can facilitate that sharing. That is central to our mission.'

She echoed the title of the conference, *Making a Difference*. 'We do make a difference. Cancer nurses are working across the



globe making a difference in their own unique way from Kenya, China, Russia, Spain, and Senegal.'

During her address Ms Henke Yarbro thanked the Scientific Planning Committee, The Royal College of Nursing, The Royal Marsden Hospital and Macmillan Cancer Relief, for their part in developing a conference which offered 115 oral presentations and 250 poster presentations of excellent quality.

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Genetics are the way forward

Chemotherapy is a 'shotgun, untargeted, approach' and will ultimately be replaced as the frontline treatment for cancer, delegates were told.

Paula Reiger, director of international affairs at the American Society of Clinical Oncology, made the claim in a presentation on the impact of genetics on cancer management.

'Cancer has many faces under the microscope. Advances in genetics are leading to molecular profiling — the ability to analyse the 'signature' of each individual tumour,' she said. 'It transcends the 'histological' typing of today. At the moment we treat people very much the same.'

Dr Reiger said that scientific discoveries had revealed how genes become altered or mutated in cancer patients. These advances not only provided new clues on how to spot those at most risk of developing cancer, but also helped give individual patients a more exact prognosis.

'For example, you may have a breast cancer patient who doesn't need drug treatment because we know she will not proceed to have a more aggressive cancer. Chemotherapy is a shotgun, untargeted approach. We need to think of a time when it is no longer the frontline treatment,' she said.

Pointing to the improvements made in risk assessments over the last few years, Dr Reiger said: 'One in eight women will get cancer in the US but we can't point a figure on which person that will be. But we are getting better at levelling risk.'

'Cancer is a puzzle and we are now beginning to understand the biology. The challenge is to interpret a meaningful pattern from the 'noise'. It is like a 'magic eye' picture.'

She acknowledged that gene therapy — trying to correct mutated genes — had so far had little success, but added that there were

exciting times ahead.

She told nurses that they must begin to acquire a solid foundation in cell biology, genetics and the molecular basis of cancer so they could understand and participate in new ways of managing the disease.

'Genetics will impact on all of us in cancer nursing. Nurses are the eyes and ears of families. When we evaluate patients we are looking for strong family histories, ie, through the maternal or paternal line, not across the entire family tree. We are looking for clusters of like cancers, such as breast, which occur earlier than they should, in a person's thirties, forties rather in their seventies. These are 'flags' for families who may bear further investigation.

'A lot of people feel powerless about cancer. They feel they can do nothing about it. But they are so wrong. There is a lot they can do to protect themselves. Nurses have a very powerful role in educating people to reduce risk and intervene before something happens,' she said.

Testing people for genetic susceptibility to cancer raised many difficult issues, not least the huge psycho-social impact on the individual, she said.

It was doubly important, then, that nurses were clued up enough about the subject to make sure these patients received qualified counselling, she said.

Dr Reiger acknowledged that the subject of cancer genetics could be 'overwhelming', but said delegates must adapt to the changes that were happening in their chosen field of nursing.

'We will never be extinct but we will be doing different things from what we envisaged ten years ago. The subject is overwhelming and we will learn this information at different degrees, but if even one nurse grasps it, it will help patients. If we feel overwhelmed, what do the patients feel?'



Paula Reiger

ICCN 2004

The 13th International Conference on Cancer Nursing will be held in partnership between ISNCC and the Cancer Nursing Society of Australia (CNSA).

The conference will be held at the Sydney Convention & Exhibition Centre, Sydney, Australia from August 8-12th 2004.

For further details on the conference, travel and holiday options, please contact the conference office:

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Nurses who smoke must quit now

Deaths linked to smoking could rise to 10 million a year in just a few decades unless radical action is taken, an expert in tobacco control warned.

Each year, over four million people die worldwide from tobacco-related diseases such as lung cancer and heart disease. The World Health Organisation estimates that this means that there is one tobacco-related death every eight seconds.

The WHO further estimates that if nothing is done to curb tobacco use worldwide, tobacco-related mortality is likely to increase to 10 million people annually by the year 2030.

Support needed

Elinor Wilson, chief science officer at the Heart and Stroke Foundation of Canada, urged nurses to do all they could to stop people from smoking, including quitting themselves.

‘Nurses are role models. They are well placed to screen people and discuss smoking-related risk factors. But nurses who smoke are less likely to bring up the subject of their patients’ smoking habits,’ she said.

Ms Wilson, an ex-smoker herself, said she appreciated the reasons why nurses smoked, and called on employers to provide more support. ‘I started smoking when I worked in intensive care because of the stress.

‘Hospital policies should promote and encourage nurses to give up smoking. If a hospital goes smoke-free they should provide smoking cessation programmes for staff,’ she said.

The problem is concentrated in low-to-

middle income countries, where 80% of the world’s 1.2 billion smokers lived.

‘If this was an ordinary kind of epidemic, everyone would be scrambling to intervene. But only 15% of doctors are even asking patients about whether they smoke when they come to see them,’ she said.

Epidemic

Ms Wilson added that every research study should have tobacco use as a variable ‘because there is a significant corollary between tobacco use and whatever you are studying’.

She said that tobacco smoking goes through epidemic-like stages around the world. Sub-Saharan Africa was going through the first stage, with plenty of scope to intervene now.

China, Japan and Latin America were at Stage II, with male smoking beginning to peak but with more women taking up the habit. Russia had more female smokers than anywhere else in the world.

European countries were in the third stage, with male smoking on the decline. The US, the UK and Canada were at the fourth and final stage: smoking rates had stabilised but the health effects on women who started smoking 20 years ago were beginning to show.

She added that in America tobacco dependence was seen as sharing many features with a chronic disease. ‘You go through a relapse, remission, request ongoing care, rather than acute services. Nicotine is more addictive than cocaine and heroin and we should treat those

addicted to it no less seriously,’ she told conference delegates.

Cessation

Ms Wilson said that Nicotine Replacement Therapy was a ‘big boon’. ‘It more than doubles the smoking cessation rate. There is evidence that NRT plus one other intervention is the most effective way for people to give up smoking.’

But she added that cessation programmes were often poorly funded, attacking those governments which did not give part of the taxes raised from tobacco to healthcare, as happens in the US and Thailand.

‘NRT isn’t available to three-quarters of the people in Latin America. Where it is, it costs more than a packet of cigarettes.’

Germany was also attacked for being particularly poor at tackling smoking rates.

‘The vector is the tobacco industry with a multi-national interest in maximising their profits. This is an industry which promotes a product that kills if it is used in exactly the way it is intended,’ she said.

Ms Wilson emphasised the role of the nurse in smoking cessation. Evidence suggests that smoking cessation interventions delivered by a single or number of clinicians will increase abstinence rates. Nurses as researchers and policy developers are also roles that are important to the global reduction of tobacco use.

She concluded: ‘There are so many things that nurses can do to make a difference. You must do whatever you can do to reduce smoking — quit smoking, get the hospital to change its policies.’

Scholarships spread the word

Travel scholarships made it possible for eight nurses to fly to London for the conference.

One of the recipients was Nita Pokharel, professor of nursing at the Biseswar Prasad Koirala Institute of Health Science, Dharan, Nepal.

The trip had so far cost £1,200 and would have been unthinkable on her current salary of £80 a month, she said.

Mrs Pokharel, a cancer survivor herself, said she would take the lessons learnt at the conference back to her own country, where specialist training has a low priority.

‘You really have to go abroad for training. In fact, I have asked people I have met here to come to Nepal and share their knowledge,’ she said.

The other winners were Mary Haule from

Tanzania, Shereen February and Alison Boshov from South Africa, Fatma Ozgul from Turkey, Shi-Xia Li from China, Adella Hibbert from Jamaica, Larissa Sams from India and Rehana Elahi from Pakistan.

Adella Hibbert, a specialist nurse at the Hope Institute Hospital, Kingston, Jamaica, said: ‘It’s been so important to me — not many of us work in cancer care in my country. I really want to do a course in chemotherapy administration, and the nearest place to do it is the US. I have been able to network with American colleagues here and have found out more information.’

Travel scholarships were provided by Clinical Insights Inc, SuperGen Inc, Oncology Nursing Society (ONS), Royal Marsden Hospital, and Professor Kazuko Ishihara, Japan.



Travel scholarship winner Larissa Sams

Remote rural care needs improving

Patients requiring cancer treatment in remote parts of Australia are likely to have a poorer outcome compared to patients in major cities.

Key problems for nurses in rural areas are a lack of experience in the safe administration of chemotherapy, problems accessing specialist education and short staffing, according to a nurse-led study from the University of Southern Australia Toowoomba, Queensland.

Metropolitan-based health departments and specialist cancer centres that referred patients to rural areas also failed to appreciate just how basic the conditions could be.

Associate professor Patsy Yates, who presented the study on behalf of colleague Alexandra McCarthy, said that 67 nurses were surveyed from rural health facilities.

She said that patients requiring specialist cancer care would not qualify for state assistance to travel distances of over 1000km to the nearest treatment centres.

'It also means that the patient is taken away from their support network at a time when they most need it,' she said. But being treated nearer home had its own

problems, the study found.

'In Australia it is difficult to attract nurses to work in remote areas and some nurses might find themselves having to deal with chemotherapy for the first time since training. In many remote areas there aren't policies to deal with specific problems such as chemotherapy.'

Participants reported that equipment such as infusion pumps may not be available, and that they often had difficulties obtaining chemotherapy drugs at right time and temperature.

Sixty one per cent of the nurses surveyed said they were unable to obtain relief staff to cover for extra training sessions.

There were problems in finding a suitable place to treat cancer patients, for example, there were examples of chemotherapy being given on maternity wards.

The study recommended that the profile of cancer nursing should be increased in remote and rural areas, including increased access to education. The occupational health and safety of nurses administering chemotherapy also required improvement.



Robbing Peter to pay Paul

Extensive and 'predatory' recruitment by western countries has led to a global shortage of nurses that has affected even the Philippines, which has traditionally had a surplus, a US academic warned.

Brenda Nevidjon, of the Duke University School of Nursing in North Carolina, said that 25% of hospital nurses had left the Philippines on working visas after 'heavy recruitment' from their ranks by the US and other western nations.

'The Wall Street Journal has identified

that the Philippines is beginning to see the same deficits now,' she told the conference.

Ms Nevidjon was also critical of the US National Council of State Boards of Nursing for allowing its license examination to be sat abroad to cut the costs of migration to the US.

'This is a global issue,' she said. 'We have to be careful of the migration: are we robbing Peter to pay Paul?' She spoke of a hospital in Zambia that needed 1,500 nurses, but only had 500.

As an alternative strategy, she favoured strengthening ward management grades, targeting recruitment at ethnic minority groups, introducing family-friendly working policies and giving nurses greater input in decision-making.

Ms Nevidjon also advised nurses to make sure that colleagues from overseas were treated fairly. 'You can advocate that these nurses get equal conditions of employment and benefits. We should be concerned, regardless of their country of origin.'

Growing need for cancer nurses

A chronic lack of oncology nurses in Africa has left the vast majority of patients without specialist care, an academic from the continent has warned.

South Africa, which is the best served country on the continent, has only 240 trained oncology nurses, or one for every 45,200 people who will develop cancer in their lifetime, said Petra Fordelmann of the National Accelerator Centre in Cape Town.

'In the rest of Africa it is even worse,' she said. 'Uganda has only four cancer

nurses and Namibia has fewer than ten.

'Zimbabwe has introduced a palliative care module to its nurse education programme and plans to introduce an oncology module next year,' she added.

At least one in four Africans will develop cancer during their lifetime, making it the second biggest killer disease after AIDS, but the lack of nurses is seriously hampering its diagnosis and treatment, Ms Fordelmann told the conference.

The biggest killers are all 'preventable'

cancers, such as cervical and lung.

But getting the right training is a struggle; because of general staff shortages, nurses are not allowed to pursue further study during working time and have to study on their days off. In addition, oncology journals are 'almost non-existent' in Africa.

Ms Fordelmann said that rural nurses are isolated from the main treatment centres, and limited access to computers ruled out distance learning, except by older postal methods.

Does age matter in cancer care?

Delegates at the London conference met up to take part in a lively debate on the motion that 'There is no ageism in cancer care'. Both sides argued strongly before delegates voted for whoever had convinced them of the validity of their view

Ageism is prevalent in cancer care, according to a lively conference debate that heard examples of older people being withheld necessary treatment because of their age.

Up to 85% of cancers are in people aged over 65, delegates heard, but surgery is performed less often and radiotherapy is used less often in older people with cancer.

Dr Alexander Molassiotis, senior lecturer in cancer and palliative care, University of Nottingham, UK, who defended the motion that 'There is no ageism in cancer care' tackled this apparent discrimination.

'There are many factors, such as a poor prognosis for making a good recovery, the level of frailty and the threat of higher toxicity if there is impaired liver/renal function,' he said.

The doctor accepted that women over 65 were not called up for mammography every five years, but pointed out that those under 50 weren't either. 'Women over 65 are encouraged to self-refer. It is more an issue of education than ageism,' he said. He claimed there was 'no compelling evidence showing systematic age discrimination'.

Shelley Dolan, nurse consultant at the Royal Marsden Hospital, UK also defended the motion arguing that age is an indication of frailty.

But, speaking against the motion, Marvella Brown, Macmillan senior lecturer in haematology, Hammersmith Hospital and Thames Valley University, UK, said: 'Where are older people in clinical trials?

'84% of 6,000 elderly people surveyed didn't understand what clinical trials were or didn't think it was an issue for them. As many as 49% of women with breast cancer are over 55 but only 9% are entered into

clinical trials. One in four older cancer patients receive no or inadequate relief for cancer pain.'

She added that unless elderly people were included in trials it was impossible to test the efficacy of cancer treatments in that age group.

Dr Molassiotis acknowledged that elderly people were excluded from clinical trials but claimed that wasn't because of ageism. Instead testing for the efficacy of treatments became problematic when there were other factors influencing a patient's morbidity.

He added: 'Doctors are concerned about older patients being harmed during trials and litigation. You also need to follow up studies for a long time but if a patient is aged 90, can you be sure of following them

in the next 10 years?'

Maggie Crowe, nurse consultant, cancer services, lead cancer nurse at Royal United Hospital NHS Trust, Bath, UK, seconded Ms Brown's objections. She said that she had been a cancer nurse of 16 years and had witnessed first hand explicit ageism on the wards.

'I have seen older people with lymphoma be given reduced doses of chemotherapy,' she claimed.

Dr Molassiotis urged delegates to remember that older patients were more frequent users of the health service than younger patients and 'that may increase the probability that they will have a negative experience'.

However, his argument failed and the motion was overwhelmingly defeated.



Delegates at the London conference enjoy networking with colleagues from around the world

Religious differences overcome

A palliative care service run by Jewish and Arab staff in Israel has been a success despite the religious hostilities endemic to the region.

Mali Szlaifer, of the Home Hospice in the Valleys in Nazareth, the largest hospice in Israel, said families were grateful to have an alternative to hospital care.

'Palliative care is not part of routine medical care, these necessary services are occasionally provided by charities but 80% of deaths are still in hospital where patients

do not receive the care they choose. They are often far away from their home and loved ones.'

The hospice, which was set up in collaboration with clinicians in Detroit, USA, now takes about 40 patients a month and has a strong philosophy of respecting cultural and religious differences.

'The area is well known for its hostilities and lack of understanding between people but care is provided by multi-religious staff, including Arabic-speaking Jewish

nurses,' said Ms Szlaifer.

'Patients and families said they appreciated and accepted our help. It shows the feasibility of multi-religious collaboration in palliative care.'

The nurse said she wanted to see high quality palliative care standardised throughout Israel. 'You have to take your vision and translate it into a systematic vision. You have to be stubborn but you also have to be flexible. Sometimes it turns out better than you think!' she said.

Past Presidents' Award

The Past Presidents' Award was presented at the London conference to Sulochana Retnamony, a clinical instructor from India.

The award is awarded to a nurse who has made a significant difference to cancer care in a developing country. The nurse has to have initiated and sustained a programme of cancer care in his or her country for three or more years.

Ms Retnamony (right) was instrumental in setting up a palliative care clinic and starting a palliative care course at Tata Memorial Hospital in Maharashtra state where she has worked for the past 23 years.

Following a 10-week palliative care training course in the UK in 1993 she began to introduce palliative care services back in India.

As nurse co-ordinator she set up a palliative care clinic with an anaesthetist and a medical social worker. The number of patients attending this clinic has risen from 500 to 3000 in the year 2000. A palliative care clinic and home care services are now available at the hospital throughout the working week.

Ms Retnamony was aware of the need for staff education. She initiated awareness programmes such as workshops, seminars and in-service education for nurses.

She identified a need for training programmes for rural hospital doctors and nurses. A syllabus was formulated and initially training was offered for three weeks and then extended to a month. The training is broken down into three parts.



As a result staff trained in palliative care are available even in remote rural areas of Maharashtra for when patients are discharged home

Ms Retnamony was a founding trustee of Oncology Nurses Association of India and is currently secretary of the organisation.

Nurses offer mastectomy follow-up

A non-medical service invented by nurses in Brazil to help women with breast cancer and their families has been successful beyond all expectation, delegates heard.

The nursing model of care was based on 'Acolhimento', which in Latin America means to embrace somebody with great warmth, according to a paper by Marli Villela Mamede, vice dean of the University of Sao Paulo at Ribeirao Preto. (The paper was read out in her absence).

The service for women who have had

mastectomies, which is based in the university's school of nursing, is free of charge and anyone who attends will be treated. After the first visit there is no scheduled follow-up, women are invited to come when they can.

'We wanted to move away from a rigid medical model and take into account that women have responsibilities for children and elderly parents. We wanted to base the service on the life experience of women in Brazil,' according to Dr Mamede.

'When we first set it up people said "nobody will ever come back" but in the 13 years we have been operating there has never been less than 25-30 women in the clinic'.

Women with lymphodema issues are encouraged to come back to clinic more frequently during the first few weeks after a mastectomy and are told this will improve their outcome.

As well as support groups, the service also runs social activities and retreats to emphasise the importance of well-being.

Voices from the conference

Some comments from delegates at the London conference

Dame Gill Oliver,
director of service development,
Macmillan Cancer Relief UK

'It's an unique opportunity for cancer nurses around the world to meet together. You can communicate by email but it's not the same as sharing experiences face to face. It's amazing how far we have come since the first conference — now there is an emphasis on evidence-based work and we ask ourselves is this what patients really want?'

Grace Cheang, staff nurse, National University Hospital, Singapore

'I enjoyed the workshop on palliative care and to hear the different views of nurses from around the world on this subject. Its importance has not been recognised in some countries. I've also learnt a lot from

my colleagues in the UK and the USA.'

Adella Hibbert,
specialist nurse/in-service trainer,
Hope Institute Hospital,
Kingston, Jamaica

'The workshop on wound care was very helpful as was the session on fatigue. We don't have oncology training in our country, so it's very important for me to return to my colleagues and impart the evidence-based research I have picked up here. I only wish that more nurses like myself had the opportunity to attend.'

Dr Linda Krebs, assistant professor of nursing, University of Colorado

'This is my third conference and I love the networking, seeing people from other countries, it's always so exciting. I loved

the talk on song and dance in South Africa and the speaker from Israel was very interesting. There is so much strife in her country.'

Pauline Rose, clinical nurse, Royal Brisbane Hospital, Australia

'It's been a very stimulating conference. I thought the session on palliative care in south India was wonderful. You get so focused on what you are doing that you can forget what is going on out in the wider world. The lecture on chemotherapy-induced peripheral neuropathy was also excellent — a little bit different.'

Lotta Norlander,
registered nurse, Sweden

'There are so many nurses from different countries, and not just from the West.'

Merit Award shared



The conference saw two nurses honoured with the society's Distinguished Merit Award.

Christine Miaskowski, professor of nursing, University of California, USA, and president of the American Pain Association (right); and Brian Lake, former professional development manager at the Royal Marsden NHS Trust, London,

UK, received their medals from ISNCC President Connie Henke Yarbro.

The award is given every two years in recognition of an outstanding contribution to cancer nursing.

The committee appointed to judge the nominations decided to jointly award the Distinguished Merit Award to these two excellent candidates.

Screening

Middle class men with health insurance were the primary users of a free prostate cancer screening service in the US.

Presenting the results of her study, Marva Mizell Price, from Duke University School of Nursing, South Carolina, said more innovative strategies were needed to encourage men who were less well educated to seek screening.

Prostate cancer is the fourth most commonly diagnosed cancer worldwide. It is also the second most common cause of death amongst African American men — 50% higher than for white men, for reasons not fully understood. The 5-year survival rate for African American men is 81%, compared to 95% in white men.

Ms Mizell Price surveyed men who attended a free prostate cancer screening service over two years — 1,000 men in total — and found that most were employed or retired. More than half (51%) had a college education and/or a professional job.

She said that the screening service was publicised via a postcard sent to men's home. Their names were taken from a mailing list, which may go some way to explain why some less well educated men were excluded.

Inadequate pain control in children

Children with cancer in some developing countries are suffering unnecessarily because of poor pain assessment and management.

A nurse-led study at two paediatric hospitals in Morocco, found that staff often felt 'powerless' to help patients in pain. There was also a widespread belief that pain was inevitable and some suffering had to be endured, especially by male patients.

Patricia McCarthy, clinical nurse specialist, at the Children's Hospital of Eastern Ontario, Canada, who presented the qualitative study of hospitals in Casablanca and Rabat, said: 'It did not seem that pain was much of a priority in the hospital setting. Staff were feeling overwhelmed by the issue of pain assessment and management.'

'There was a disparity between the understanding of the roles of the various health-care professionals, a lack of policies and procedure, and basic knowledge, a lack of resources and a shortage of medical and nursing staff,' she said.

Ms McCarthy found that the myth that morphine should only be used in the terminal stage of cancer persisted in the hospitals. Access to opioids was also limited by

government restrictions, complex policies and sometimes the cost.

The study involved five focus groups, including 14 nurses, who discussed a list of ten questions about pain management. They were asked to document current practices in pain assessment in Morocco and any culture issues that influenced practice. The study found that children's cancer pain was a concern for both nurses and doctors.

Another nurse said: 'The families are always asking us to do something to help the pain, but we try our best but unfortunately it's often not enough.'

Researchers also found a lack of training and resources about cancer pain assessment and management. One nurse said: 'We rarely evaluate pain. The children are the ones who alert us by crying. Sometimes they hit their heads, when we see that we tell ourselves we have to do something.'

The study uncovered no consistent cultural beliefs that acted as a barrier to effective pain relief, in fact some were helpful, said Ms McCarthy.

'Saying prayers and reading the Koran helps patients. Some mothers used a mix-

ture of honey and saffron to treat mucositis pain and nurses told us they felt this was more beneficial than the standard mouth rinses available.'

However, one doctor in the focus groups said: 'Illness-related pain has to be endured, especially by boys otherwise they don't measure up.'

It is hoped that the study results will improve understanding of the issues related to children's cancer pain in Morocco and inspire further collaboration.

Ms McCarthy concluded that there was a need for a comprehensive approach for pain relief in Morocco.

'Pain management needs to become a priority. They should promote more hopefulness among staff. Staff need to work as a team and use comprehensive strategies to assess and treat pain. Education has to be a priority.'

She finished with a quote from the World Health Organization: 'Nothing would have greater impact on the quality of life of children with cancer than the dissemination and implementation of the current principles of palliative care including pain relief and symptom management.'

Support cuts worry

Women with gynaecological cancers are not getting all the information they need to help reduce their anxiety.

In a survey of 70 women, Jo O'Neill, of the Carole Farrell University of Manchester, UK, found that support from a clinical nurse specialist could make a significant difference to a patient's psychological recovery from cancer.

The women, who were from the North-west of England and had cancer of the cervix, uterus, ovary, vagina or vulva, were questioned at the time of their diagnosis and then six months afterwards.

Although there was a strong link with the hospital initially, six months later the women were more likely to depend on TV, radio and magazines for information.

The 16 women who had no access to a CNS at all after six months were judged to be more likely to be anxious and depressed. The most popular type of information requested was the possibility of a cure and about the stages of the disease.

'The study suggests that women are not getting the information they want and have a number of needs and worries,' said Ms O'Neill.



The presidency of the ISNCC was taken over at the London conference by Margaret Fitch, Head of Oncology Nursing and Supportive Care at Toronto Sunnybrook Regional Cancer Centre Canada. She succeeds Connie Henke Yarbro who held the presidency for eight years. Ms Fitch is pictured here at the London conference with Ms Henke Yarbro (left). A profile of Ms Fitch will be included in the next issue of the newsletter along with a tribute looking back at Connie Henke Yarbro's presidency.

Conference highlights

A travel scholarship winner shares her experiences of the conference

Cancer nurses aim to provide advanced and quality care to patients with cancer. To accomplish this aim they need to learn from each other about the worldwide resources that are used to treat cancer. The 12th International Conference on Cancer Nursing has been one of the important events of this year which helped nurses to fulfil their aim.

The theme of the plenary sessions on the opening day was 'Making a Difference'. Maria Hlnopthia, South Africa, shared with us that African communities are participating in cancer prevention and care by using the natural art of singing and dancing in order to promote a healthy life style.

The following day the plenary sessions focused on evidence-based practice. Innovative approaches to manage physiological responses to cancer and its treatment, fatigue, pain and mucositis, were presented.

Diagnostic criteria for Cancer Related Fatigued (CRF) and the role of patient education, counselling, pharmacological and non-pharmacological interventions in managing CRF were established.

Analysis of the literature focused on how the management of cancer pain can be

effected through patient education. An evidence base summarised the systematic approach for prevention and management of mucositis.

Plenary sessions on targeted therapies in cancer care were held on the third day. Debra Wujcik, USA explained the role of biotherapy in the treatment of cancer with a special emphasis on source of origin, mechanism of action and toxicity of Monoclonal Antibodies (MoAbs).

Helen Convery, UK, discussed the exciting advancement of technology in reducing the geometric error in delivering radiotherapy to patients. She detailed that patient immobilisation, visualisation and localisation of tumour have reduced these errors. These errors could further be reduced by the introduction of internal organ immobilisation and tracking during radiotherapy.

Shelly Dolan, UK, described how new advancements in surgical procedures have reduced the impact of surgery for the person with cancer.

During the afternoon sessions it was exciting to learn about the web-based International Oncology Nurse Educational Programme from the University of Florida. This programme consists of four modules

which have been translated into Spanish, Portuguese, Japanese and Chinese.

During the closing day of the conference. Margaret Crighton, US, in a comprehensive literature review found the association between chemosensory changes; alteration in taste and smell, and malnutrition and depressed mood in cancer patients.

Along with these intellectually challenging sessions there were 250 amazing, high quality and impressive posters contributed by nurses from 25 countries. They seemed like another conference in itself.

This conference was a marvellous intellectual event which helped cancer nurses from around the world to share and gain innovative knowledge and skills in order to make difference in their profession and in care of patients with cancer.

I would like to thank the ISNCC, Mediate Health and Nursing Division, Shaukat Khanum Memorial Cancer Hospital and Research Center for providing me this opportunity and helping me to have a successful visit to the conference.

Rehana Elahi, Course Leader, Diploma in Oncology Nursing, Shaukat Khanum Cancer Hospital and Research Center Lahore, Pakistan

Trials take their toll

Cancer patients take part in clinical trials as it offers them hope in fighting the disease, according to a qualitative study of 55 patients taking part in phase I or phase II clinical trials.

Karen Cox, Professor of Cancer and Palliative Care at the University of Nottingham, UK, told delegates that thirty patients (54%) described the offer of the trial as being ‘the light at the end of the tunnel’ because of the hope it offered.

Others cited different reasons: the desire to be in expert hands (54%), to help others (52%), that they felt they had no choice (36%) (if they wanted to live they had to do something) and that they had nothing to lose (23%).

Patients did find taking part in trials difficult emotionally and physically. The side effects of treatment, additional demands of trial participation in terms of personal time, travel, waiting and extra tests all contributed to this burden, which was compounded by uncertainty of outcome.

Ms Cox said: ‘Increasingly, patients talked about weighing up the harm versus the benefits of the trial treatment and, as time progressed, the strong belief that participation was worthwhile was overtaken by a sense of disillusionment and a feeling that they had “had enough”’.

Also when patients talked about how they were dealing with trial involvement, they reflected how they were living a life on hold and that the trial had become the main focus in their lives.

For many patients trial participation also

gave them a purpose in their lives (16 out of 35). This purpose was expressed in terms of doing something and not giving up, helping self and others and contributing to cancer research through their efforts.

Patients experienced difficulties at the end of the trial. Many patients felt disappointed due to the lack of tumour response they had experienced in relation to the trial burden they had endured.

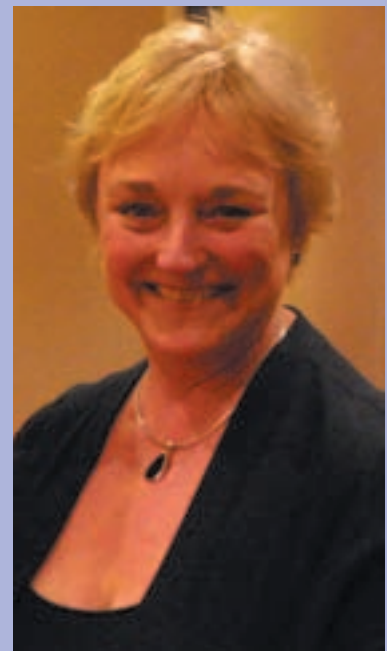
Patients were also full of uncertainty about what the future now held for them and in some cases were questioning whether they had been used merely as a means to an end by those running the trials.

Fear of being abandoned was a feature of all the interviews at trial conclusion and at six weeks follow up. During the post-trial interviews patients talked about the desire to maintain the intensity of attention that they received while on the trial as well as contact with the trials nurses in particular.

As patients moved into the follow-up phase after the end of the trial this fear of being abandoned was even more acute and patients talked about still wanting to be kept an eye on, that they felt they had lost a safety line and increasingly felt the professionals had given up on them.

Yet Professor Cox concluded despite such serious concerns, the majority of patients in this study indicated that they would make the same decision to participate in a similar trial if it was offered to them and hoped that by their participation they had helped others.

Memorial lecture



Barbara Piper, Associate Professor in the College of Nursing at the University of Nebraska, US, delivered the Robert Tiffany memorial lecture at the London conference. Ms Piper gave a lecture on cancer-related fatigue looking at the evidence which supports various strategies to tackle fatigue. Long-term interest has led her to develop the Piper Fatigue Scale, a multi-dimensional subjective fatigue scale used for patients with moderate to severe fatigue. Her work is currently focused on whether other symptoms cluster with fatigue.

Exercise is the answer to fatigue

Exercise is the most widely tested and effective intervention for cancer-related fatigue, delegates were told during a review of evidence-based strategies to alleviate this symptom.

Karin Ahlberg, doctoral candidate, Sahlgrenska University Hospital, Sweden detailed the evidence of the effectiveness of patient education and counselling as well as pharmacological and non-pharmacological interventions.

She told delegates: ‘In the management of cancer-related fatigue (CRF), exercise is the intervention with the most supporting evidence of effectiveness. The theory supporting exercise as a treatment for fatigue proposes that the combined toxic effects of cancer treatment and a decreased level of physical activity during treatment cause a reduction in the capacity for physical performance.

‘When patients must use greater effort and expend more energy to perform usual activities, fatigue levels increase. Exercise training leads to a reduction in the loss or even an increase in functional capacity leading to reduced effort and decreased fatigue.’

Ms Ahlberg described published studies which, although limited in number, have shown consistent results. All demonstrated significantly lower levels of fatigue in subjects who exercised when compared to control or comparison groups.

The forms of exercise in the studies were varied but all were considered aerobic. There were some home-based walking programmes as well as some supervised laboratory treadmill or exercise bicycle formats. The programmes varied in length from six weeks for patients undergoing radiation therapy to six months for chemotherapy and through extensive

peripheral blood stem cell transplantation.

Ms Ahlberg told delegates that although cancer-related fatigue is the most prevalent symptom reported by cancer patients, evaluation and management of this distressing side effect of cancer and cancer treatment has been limited in clinical practice. This limitation is related to many factors including a lack of understanding of the mechanisms responsible for CRF, a lack of awareness by cancer-care providers of the significance of the problem, and a lack of evidence-based interventions to manage CRF.

However she concluded that the science related to CRF is developing rapidly, research-based clinical practice guidelines for fatigue management are now available, and awareness by health care professionals of the significance of this disruptive symptom is increasing.

Reflections on the poster display

Nurses from 22 countries presented more than 250 posters in London. The posters provided many remarkable examples of the ways in which nurses around the world are making a difference to care of people with cancer, through innovation, research, compassion, advocacy, and a commitment to excellence.

Innovation

Several posters illustrated how nurses are taking a leading role in designing innovative strategies for responding to patient needs and the changing nature of cancer care. Examples included posters which described an outpatient pain management programme that had resulted in improved pain outcomes and patient satisfaction (Ellen Matthews, USA), and the development of education resources that helped health professionals to more effectively address their patients' sexual health concerns (Catherine Johnson, Australia). Creative strategies for enhancing body image for patients with alopecia were illustrated in a poster by Rose Maan (UK), while practical ways to enhance patient safety were described in a poster outlining a card alert system for patients who present to emergency departments (Soo Stelle, UK).

Many innovative applications of information technology in practice were also described. For example, the potential uses of telenursing (Beverley Page, Canada), and the use of computerised patient information sources for identifying patient needs, planning care, exchanging information and planning services (Carol Burnett, Canada) were described. Cheng Fong Chiew from Singapore also described nurses' contribution to the development of an online prescribing system for improving efficiency and safety in delivering chemotherapy to patients in an ambulatory treatment unit.

Importantly, a number of posters illustrated that nurses can be integral in developing innovative programs to address inequities in access to cancer care. Linda Krebs (USA), for example, described the development of a curriculum specifically for culturally diverse populations to enhance access to clinical trials for populations that may face specific barriers to participation in trials.

Commitment to excellence

Cancer nurses' commitment to excellence was clearly reflected in this year's posters. Janie Helen Winsnes (Norway) outlined the way in which quality statements can be used to raise patients' awareness of what they should expect from cancer services.

Hilda Vorlickova (Czech Republic) similarly explained organisational strategies for implementing standards for improving pain management. Other nurses used their poster presentations to provide critical reviews of the current state of knowledge and outline strategies for improving practices relating to the nursing management of nausea and vomiting (Ruth Penfold, UK), pain (Bernice Barnes, USA), constipation (Janice Richmond, Ireland; Elly Jacobs, Australia), and terminal restlessness (Sue Tozer, UK). Ways in which nurses can improve the quality of supportive communication with people with cancer was also highlighted in posters from Ikue Ogawa (Japan) and Carol Tishelmen (Sweden).

Evidence based practice

Many posters presented findings from nursing research. Several studies focused on developing a better understanding of experience of cancer for patients and their families, including the experience of recurrence (Catherine Jones, Australia), surviving a bone marrow transplant (Marcia Grant, USA), decision making in cancer care (Noreen Facione, USA), and surviving the death of a family member to cancer (Outi Haggqvist, Sweden).

Other posters illustrated our developing understanding of patient's responses to cancer and its treatments, including symptom clusters (Marilyn Dodd, USA), menopausal symptoms (Midori Kamizoto, Japan), and the relationship between pain and hope (Mei-Ling Chen, Taiwan).

Nurses' work across the lifespan was also highlighted, as posters described processes for identifying paediatric oncology research priorities (Louise Soanes, UK), quality of life for older cancer survivors (Kimberly Christopher, USA), and palliative care in residential aged care (Katerhing Froggatt, UK).

Identifying, interpreting and implementing evidence in practice was covered. For example, Beverley Page (Canada) described the development of a resource centre to facilitate nurses' access to information, while Trevor Saunders (Australia) described a project aimed at enhancing the use of evidence-based practices when taking peripheral blood cultures.

Strengthening the workforce

The challenges facing the cancer nursing workforce across the world were highlighted in poster reporting on the Oncology Nursing Society Workforce Survey (Kathi Mooney, USA). Important developments in cancer nursing education that will ensure cancer nurses are well prepared for the



Patsy Yates addressing the conference on the subject of the posters

future were also described in posters evaluating strategies including educational profiling (Zoe Whale, UK), and programmes designed specifically to enhance links between hospital and community service providers (Mave Salter, UK). The use of flexible strategies for delivering educational programmes to improve nursing skills in managing breathlessness (Carole Walford, UK) was also important for highlighting the need to identify modes of learning that increase access and improve the sustainability of educational programmes.

Making global connections

The potential and challenges associated with using global networks for advancing cancer nursing were illustrated in posters describing international collaboration in the development of paediatric cancer pain management guidelines (Faith Gibson, UK). The benefits of sharing knowledge was also highlighted in posters describing the outcomes of an exchange programme between Israeli and Chinese nurses (Jiang Jong-Qin, China and Ilana Kadman, Israel), and from the networking of nurses working in New Guinea and Australia (Keith Cox, Australia).

Making a difference

The poster programme at the 2002 ISNCC conference covered a vast array of topics, patient concerns, practice settings, and patient populations. Delegates browsing through the expansive display were impressed by the creative use of colour, powerful images and texts, and technology. Indeed, as one delegate said, this year's display offered a conference in itself, with something for everyone. Congratulations to all nurses who presented posters.

*Patsy Yates, associate professor
Director of Postgraduate Programs
School of Nursing, Queensland University
of Technology, Australia*

A celebration of differences

The London conference was brought to a close by cancer nurses around the world sharing their experiences and explaining what their daily work means to them

The 12th Cancer Nursing Conference was brought to a moving and dramatic end with a closing ceremony orchestrated by board member Kevin Sowers.

Mr Sowers, associate vice president, Duke University Health System, USA who sang and played the piano, told the assembled delegates: 'Today we bring this meeting to a close with a celebration. A celebration of differences. Our differences.

'And we celebrate the power of the difference we make in our local communities around the world. We are a healing force around the globe, through our delivery of clinical care to persons diagnosed with cancer, through the research that we engage in to make a difference for the next generation and through our education of future nurses.'

Over the last year Mr Sowers has been in touch with oncology nurses and their patients around the world. In their own words twelve nurses from different countries told the audience what their work meant to them. Here are two of those nurses thoughts.

Gift of care

The first is Chris from Canada who has been an oncology nurse for 16 years. 'When I first graduated there weren't a lot of jobs for nurses, so I was working casual on a surgical floor. I had two patients, a young man with testicular cancer and an older man with kidney cancer. I was so frustrated because I didn't really have the knowledge or skill to help them.

'It seemed, as if everyone had the attitude that there was nothing we could do since they had the big 'C'. I knew this couldn't be true. The cancer agency was one of the few places with full time jobs available so I decided to take a job there even though so many people advised me against it. I just knew not everyone could be dying, and that there had to be ways I could help people with cancer. After many years as an oncology nurse, I now know I have made a difference.

'I remember Sheldon. He was a young

man of 16 undergoing a bone marrow transplant. He was from a small farming community in another province and was not only sick from his treatment, but he was also homesick. Whenever I was Sheldon's nurse, I would ask him to tell me about his life back home. He loved to talk about his



Kevin Sowers leading the closing ceremony

pickup truck, the music he played while driving and the fields he would drive through.

'Sheldon began to have problems sleeping, he went several nights without sleep. I was on duty one of those nights. I went into his room and asked him if he would like to go on a journey? I pretended that we were in Sheldon's pickup truck and together we slowly recounted all the good times and memories that he had entrusted to me.

'He slept that night and later told me that whenever he couldn't sleep or became afraid, he would close his eyes and go for a ride in the pickup truck. We can help cancer patients but we must always remember who they are and where they come from. Making a difference in a patient's life is like receiving a gift and part of that gift comes from the nurse taking the patient on a journey that they've never walked before.'

Dedication

Another of the twelve nurses was Wang Qi from China. She told delegates: 'I was born in China and chose cancer nursing just by chance. After graduation from nursing school I started working as an oncology nurse in Tianjin Medical University Cancer Hospital. Over the years I have really experienced the plainness and yet, greatness of my nursing work.

'I remember that it was two years ago, when we had a patient who was 75 years old, who had colon cancer. His wife had also suffered a stroke. His son was working in another city far away.

'Their daughter-in-law only looked after the older couple intermittently. This patient

had many difficulties in his daily life. I was his nurse and we treated each other with respect and dignity during his first visit.

'Two months after his operation, he came back to the hospital again for a recurrence of cancer. When I saw him, I could hardly recognise him because he was so cachectic. He suffered extremely and had changed a lot, he was very irritable. He was

my patient again, but this time he was much more difficult to deal with.

'I would help him bath, turn over in his bed to prevent bedsores, controlled his pain but he was very seldom satisfied and even cursed at me. However, sometimes he just kept quiet and watched what I was doing.

'One day he asked: "How long could I remain in this world?". I didn't dare see him eye to eye and only said a few casual remarks. Eventually, the last moment came and after suffering for three months, he left this world.

'Just a few minutes before he died, he couldn't speak but he held my hand firmly and whispered weakly in my ear, "thank you". Tears were welling up in my eyes. I felt guilty facing the old man and hearing his grateful words. This experience brought changes to my life and my attitude to work.

'Later, the son of the old man came back and when he met me, he made a very deep bow. He read a letter that his father had written to him. I would like to share a part of that letter with you today.

'The old man wrote to his son: "A nurse gave me the best mental and physical care and now I am no longer afraid of death because I know there is an angel accompanying me on my way to the next world".

'I realised what I meant to the old man. I will dedicate all my life and my love to this plain and yet, great work.'