



Enjoy the conference city



Sydney, the setting for the ISNCC 2004 conference, is one of the world's great cities. Attend the international conference and there is the added bonus of having the chance to explore this wonderful location.

It has everything: a spectacular harbour, sunny beaches, a superb climate and friendly, easygoing people.

Sydney is a major city in the Asia Pacific region. It is built around a labyrinth of waterways and lies on the south-east coast of Australia, bounded by the Pacific Ocean to the east, national parklands and coastline to the north and south and the spectacular Blue Mountains to the west.

Sydney is an easy place to get to wherever you are coming from. It is Australia's major gateway with 37 international airlines flying into its airport.

Sydney is home to almost four million people and is one of the world's most harmonious and successful multicultural societies, with 100 separate ethnic groups and 160 ethnic communities. This diverse

ethnic mix provides an exciting influence on the city's dining, shopping, entertainment and lifestyle.

Sydney's dazzling range of entertainment promises something for everyone from Broadway musicals to local mainstream and fringe theatre. There is the world of cinema, galleries and museums, sports and outdoor activities, festivals and special events. Best of all, the majority of Sydney's great experiences cost absolutely nothing!

English is the main language spoken. One in five Australians speak a language other than English and most hotels and many restaurants have staff who can speak two or three languages other than English. And it is an easy place to stay. There is a wide range of reasonably priced accommodation available.

Of course the international conference is the main reason for your visit, but no doubt you will have some leisure time to explore this fantastic city which has so much to offer international visitors.

Spreading the word

Chinese cancer nurse Yan Ling describes her experience of attending a *Train the Trainer* for breast cancer workshop.

I am a Chinese oncology nurse educator, working in Tianjin University Cancer Hospital. This hospital is one of the biggest cancer centres in China with an average annual caseload of inpatients of around 18,000, including 1,600 breast cancer patients. The biggest breast cancer prevention and treatment centre in China is now being built at this hospital.

It was my privilege to attend a two-day International Train the Trainer programme for breast cancer in Oslo in 2000. My aim was to gain the knowledge to provide more prevention and treatment information for women in general and breast cancer patients specifically.

Ten breast cancer nurses attended the Train the Trainer programme. We came from different countries, including Brazil, Israel, Greece and Germany. It was wonderful to meet nurses from many different parts of the world. We began with a welcome by the then ISNCC president, Connie Henke Yarbrow. She encouraged all the trainees to take the new knowledge back to their countries to contribute to the international development of breast cancer nursing.

Under the guidance of Professor Karen Hassey Dow, Sylvia Denton, Regina Ferrario and Linda Frame, we learnt about the newest international trends and related theory in the epidemiology of breast cancer, screening and early detection, diagnostic procedures, TNM staging and treatment of breast cancer. We worked in groups to discuss four topics: the breast care model, resources for screening, support groups *story continues on page 8*

**Book early for the conference to get a special discount
See the advertisement inside for details**

Becoming active

In my last president's column, I wrote about one of the challenges we must face as an organisation. That challenge is how we can change the level of involvement of cancer nurses in ISNCC activities so that we become a sustained, credible voice for cancer nursing. I invited you to communicate with me about this challenge and I am looking forward to hearing from you.

In the meantime, I have been thinking about ways the level of involvement can change. I have several ideas I would like to share with you. I think involvement in ISNCC can happen in many ways. Here are a few to think about.

- Join the ISNCC. There is a new membership category in ISNCC. You can now join ISNCC as an individual member. By joining individually you can receive the benefits of membership more directly. Even if your national cancer nursing society is a member, you can join as an associate member. Or your organisation can join as an associate member. For example, you and your colleagues working on a cancer unit could join in the associate member category. The group could be from your institution, hospital, agency, or region.
- Offer to work on a committee, task group, or project team. ISNCC has several committees such as education, research, conference, membership, finance, by-laws/constitution, and newsletter committees. Each of these is engaged in projects that would benefit from the participation of cancer nurses from around the world. For example, if we are producing an educational package or module we must be

certain that it would be appropriate in different countries. We need nurses who can help by reviewing draft documents or helping with translation.

- Organise your group to adopt a society. The ISNCC has a programme called Adopt-a-Society. This programme allows established cancer nursing groups to help newly emerging cancer nursing groups in other countries. This is a good way to help the new group but also is an excellent way to learn from one another about caring for cancer patients and their families in other parts of the world.
- Attend the ISNCC Conference on Cancer Nursing. The ISNCC holds a world conference every two years. It is a wonderful time for meeting other cancer nurses, sharing ideas and learning about cancer care. The next conference is in Sydney, Australia in August, 2004. Why not submit an abstract to present a poster? The deadline for submission is the 30th of September. Or why not just plan to come to the conference?

These are the ideas I have about how you can become more involved in the ISNCC. I would welcome hearing about any other approaches you think would be interesting and helpful.

An organisation is successful when it is able to fulfil its mandate and serve its membership. But it needs members working together to accomplish these goals. Such collaboration starts by individuals like you becoming involved. You have the power to make a difference!

Margaret Fitch
President, ISNCC

World cancer report

The WHO has produced a *World Cancer Report* providing a global and comprehensive overview of cancer. It includes trends in cancer incidence and mortality. The report covers causes of cancer, prevention and screening as well as cancer management. Copies of the report can be ordered online at <http://bookorders.who.int>.

Publish with us

Would you like to write for the newsletter? Do you have a research project that you would like to share? Have you changed the way you work or the way a service is delivered? Would you like to write an article about an aspect of cancer care that you specialise in and would like to see more widely recognised? Is there some aspect of care particular to your country that would interest nurses from other countries?

If you are interested in writing for the newsletter please email the editor who can advise you how to contribute. (see below)

International connections

ISNCC is the only international society for cancer nurses. Why don't you join and widen your knowledge and skills. Membership of ISNCC can bring a whole new dimension to your work and give you access to the international community of cancer nurses.

You can join us as an individual or your institution/hospital can join as an associate member. Visit the ISNCC website for further information: www.isncc.org or email us at secretariat@isncc.org and make a difference to the world of cancer care.

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How culture impacts on death and dying in Africa

ISNCC board member Auxilia Munodawafa explains the cultural beliefs that affect death and burial in Africa. This presentation, first given at the annual congress of the Oncology Nursing Society in Washington DC USA last year, emphasises the importance of the spirit world and focuses on Zimbabwe

Africa is one of the five continents of the world and with its 52 countries has at least that number of variations of cultural practices in death and dying. As in Europe it is always important to recognise that each country is totally different from the next in the languages spoken, the political affiliations and the culture.

However, there is one common thread of a belief system that runs from Cape to Cairo among most African people. This is the belief in ancestral spirits and their influence on the living. This belief may vary within individuals, within families and within different religions.

Zimbabwe

Zimbabwe is a land locked country in the southern part of Africa. It is similar in size to Montana, and lies between South Africa to the south, Zambia to the north, Mozambique to the east and has Botswana to the south-west. The population of Zimbabwe is around 11.5 million.

Ethnic groups

The ethnic groups within Zimbabwe are made up of 98% Africans, of whom 71% are Shona, 16% Ndebele and 11% of other African groups. The remaining 2% of the population is made up of mixed and Asian groups, and whites, who are less than 1% of the population.

The main religion practised by half the population is syncretic (part Christian, part indigenous beliefs). A quarter are Christian and another quarter have indigenous beliefs. There are a small number of Muslims and other religious groups. The official language is English while the two main local languages are Shona and Ndebele (Murungu, 1998).

Value system

Although in some instances death can be sudden, in the majority of patients, dying is usually preceded by a slow deterioration in their condition, indicating the non-responsiveness to treatment of a disease. Human beings are very complex, and as such, the process of dying, the meaning of

death, and implications are closely influenced by different norms and values (Gelfand, 1964).

The African has his or her own value system that may appear strange to others. He or she views a person as a spirit in essence, with the physical and mental components as tools of spiritual development. The human personality is a composite of these factors finding expression in the environment. The healthy physical person seeks self-preservation in order to perpetuate a higher life, which inhabits the body.

Most deaths in Africa are regarded as unnatural, and frequently are seen as being due to the evil intentions of others, or even attributed to the anger of ancestral spirits (Murungu, 1998).

The spirit represents the human potential for perfectibility from birth and through its eternal existence, which continues after death. There is a general belief in the African populations that death is a passage of the body from one physical form to another, and a separation of spirit from the body to a higher world of living spirit.

Ancestral spirits have been a source of comfort as well as the cornerstone of religious activity long before Christianity came to Africa, and continue to be for a good number of families despite education and civilisation (Maradzika, 1998).

Ancestral spirits

Many African people, particularly the Shona tribe from Zimbabwe believe that illnesses may have either a normal or an abnormal cause. Illnesses such as coughs, colds, slight fevers, stomach-aches, and headaches have always been generally regarded as normal, since they occur from time to time in the life of individuals, and are usually short lived and disappear completely (Gelfand, 1964). When any of the above mentioned illnesses persist for a longer time, they are considered abnormal and of deviant nature, and must be explained by the traditional practitioner who is believed to communicate with the

spirits.

There is a general belief that such deviant illnesses are sent by either ancestral spirits or witches for a particular reason. The ancestral spirits are believed to be the dead kinsmen who continue to take interest in the affairs of their descendants by protecting them from evil. This protection can be taken away if, for example, a man commits incest, or fails to perform the necessary ritual for a dead kinsman, or disrespects his parents or the elders. The ancestral spirits may punish him with illness and, in extreme cases, with death. Removal of the protection will also permit evil influences such as witchcraft to harm the individual.

Traditional healers

The traditional practitioner holds several roles within the community. In traditional medical practice, the practitioner is regarded not only as a medicine man, but also as a religious consultant, a legal and political adviser, a police detective, a marriage counsellor and social worker.

In death and dying, the traditional practitioner is involved right from identification of the cause of why the illness occurred, investigating the responsible person, prescribing the remedies required, as well as the rituals to appease the angered spirits. And, if all fails, and death occurs, the traditional practitioner performs the burial ceremony just like a priest would. He will also direct the burial memorial ceremony which is held one year after death.

Impending death

When a man is dying, close relations such as nephews and brothers sit with him. During this time, the dying man recites the final verbal will. The dying man may also reaffirm confirmation of the burial place and requirements at this time. It is assumed that nobody disputes the words of a dying person, therefore his wishes are usually respected and carried out as stated.

A man with several wives will be expected to die in his first wife's hut or kitchen, and she should be by his side. On

the other hand, if a woman is dying, her maternal relations should be by her side (Gelfand, 1964).. The husband does not necessarily have to be present. If the cause of illness is identified as being ancestrally related the woman will have been sent to her parents for rituals to appease spirits in her family. The ill or dying person does not necessarily have to be the wrong doer. The punishment can be inflicted on any member of the family.

After death

After a death has occurred it is customary that there will be open crying and wailing. This is usually among the female relations, since they may be suspected of causing the death through witchcraft. A witch is identified by not crying emotionally when the person they bewitched dies. It is mostly women who are usually suspected of practising witchcraft.

There are designated individuals who will bathe and clothe the deceased in specially chosen clothes. For example, if a woman dies, her brother's wife is supposed to give her the last bath. The body then lies in state over night with crying and wailing and singing going on all night until burial time. There are special dedicated songs for each step of the morning. The singing and wailing is done as part of preparing the deceased for his or her journey to the other side of life where the ancestral spirits reside.

Slaughtering of the beast

When a person dies, a designated person offers a beast to be slaughtered as an honour to the deceased. The beast will also feed the mourners who will usually stay on for a couple of days after the funeral. A brother or son of the deceased man will often offer a beast. A husband or son-in-law will offer a beast for his wife or mother-in-law's death. There are rituals directed by the elders of a family directed by the traditional practitioner that have to be completed before burial can proceed. Some special parts of the cow are prepared without salt and this meat is then used for offerings to the ancestors and is eaten only by close family. This meal is considered as a last meal of passage for the deceased.

Burial

By the time a man dies, he will have told someone, usually his nephew, where he wants to be buried. The close blood relatives, especially those with a maternal relationship, are usually chosen to dig the first shovel as a sign of their relationship. Villagers dig the rest of the grave. When the grave is ready, word is passed down to elders to begin the procession to the family graveyard. The coffin is first carried around the village home before its final

destination so that the deceased can bid farewell to his or her home. At the graveside, specially designated people take down the coffin and make speeches. More rituals are performed and observed. Close relatives will cast the first soil to cover the coffin. Singing and dancing continues late into the night .

One year memorial

This memorial after one year is known as Kurova Guva in the Shona Language and Umbuyiso in Ndebele. Although the majority of African people believe in God, most of them still believe in their ancestral spirits as their supernatural protectors. Hence about a year after the deceased's death, a special ceremony is held to welcome his or her wandering spirit back to the family to protect the living and join the ancestral spirit team. The family representatives carry out several consultative visits with the traditional practitioner before this ceremony.

Usually, there are several pre-requisites from the traditional practitioner before the actual ceremony. These may involve slaughtering of cows and offerings to the ancestral spirits, or payments in the form of penalties either to the elderly representative of the deceased or even to the traditional healer himself. The ceremony includes singing and dancing overnight. This time there is no crying and wailing as these are home-coming celebrations for the deceased's spirit.

There is a great variation of these cultural practices across Zimbabwe and across Africa. During these celebrations, inheritance of both property and the remaining spouse of the deceased is carried out. A widow is asked or expected to choose a successor to her husband among the remaining brothers, cousins, or nephews. A widower may choose among the younger sisters and cousins of his late wife. Property distributed may include money, houses, cars, furniture, and beasts if they have them in rural areas. This inheritance practice is now becoming less common.

Christian beliefs

As stated, about 50% of Zimbabweans practice a syncretic religion (part Christian, part indigenous beliefs), 25% are Christian, 24% follow indigenous beliefs, and 1% practice the Muslim religion. In illness, it is not unusual to find traditional beliefs and Christianity being practised concurrently. This is especially so where medical science fails to cure a patient, and the disease is considered abnormal or deviant. A family will consult the traditional practitioner on 'why's' and the medical practitioner for the 'what' and 'how', yet they will continue to go to

church as well as consult the traditional healer for these abnormal illnesses (Murungu, 1998).

As a result of modernisation, funeral homes now exist in Africa. Most families contribute to burial societies at their workplace for the entire family. Some families now take the option of choosing a funeral home to embalm the body for burial, while others still bathe them in the traditional way. However, certain rituals at the deathbed, graveside, and the one-year memorial ceremony continue to be observed by the majority of people.

Islamic practices of death and dying

Less than one per cent of the Zimbabwean population practice the Islamic religion. When a Moslem dies no-one else is allowed to touch the body other than designated followers from that religion. The body is then taken for cleansing. Men carry out cleansing of a man while women perform the cleansing of a woman. After cleansing, the body is not allowed to be seen by people from the opposite sex until burial. Burial usually takes place within 24 hours of death, no coffins are used.

Impact of HIV/AIDS

According to the National Health Profile, HIV/AIDS-related deaths are among the 10 main causes of death in Zimbabwe (Zimbabwe National Health Profile, 1996). The crude death rate is expected to rise from 10/1000 to 23/1000 by 2005 due to HIV infection. Most affected is the 25-45 years age group. This group is of course the educated productive group, which the country and families have invested in. Traditionally children and young adults were not allowed to view a dead body but now as it is this group that is dying the restriction is falling away.

Older parents are finding themselves nursing dying young adults. They are burying the group of people they would have expected to hand down oral history and traditional practices to. The law of sequence of birth and death has been turned upside down in Africa. A new culture is emerging which will lead to a totally different way of death and dying in Africa.

Auxilia Chideme Munodawafa, ISNCC board member and Lecturer, University of Zimbabwe, Harare, Zimbabwe

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What is a nurse?

The International Council of Nurses (ICN) has published guidelines on what makes a nurse a nurse. Movement by nurses between countries and regions has raised a growing interest in common standards and competencies of nurses. *The ICN Framework of Competencies for the Generalist Nurse* is sufficiently broad to apply internationally yet specific enough to provide guidance to countries developing their own competencies.

ICN intends that these competencies will help clarify the role of nurses and guide future mutual recognition agreements and multi-country licensure programmes. Countries may wish to build upon the ICN framework while developing additional competencies that reflect the current country-specific requirements of the nursing work force.

The competencies were derived following a comprehensive review of literature

from many countries and a series of consultations.

Judith Oulton, ICN chief executive officer said: 'In the current climate of globalisation and mobility, we need to work together to ensure safe professional nursing care.'

ICN plans to regularly review and update the competencies so that they remain relevant in the rapidly changing health care environment.

EDUCATION COLUMN

Learning at work: problems of the workplace as a learning environment

For many cancer nursing educators, the workplace is an important learning environment. Cancer nurses, as adult learners committed to the principle of life-long learning, continue learning in the workplace after graduation from a formal education programme. However, the workplace, by its very purpose, acts against the interests of adult learners and can limit opportunities for learning.

Chris Hughes (1998), an Australian researcher in adult education, argues that the workplace exists to serve the goals and interests of the owners, and managers acting as agents of the owners. The work of the organisation is outcomes oriented, ordered in a hierarchical way, and creates a competitive environment for workers. Each of these aspects challenges the fundamental valuing of the learner as an autonomous individual, embedded in adult learning theories.

- Large health institutions such as hospitals are outcomes oriented and manage to meet the needs of the owners, not the employees. Privately owned workplaces operate to maximise functional efficiency to further economic interests; publicly owned workplaces are also challenged to ensure functional efficiencies in a resource intensive field such as health care. The employee in such organisations is generally not consulted in the process of establishing the organisational outcomes.
- Work is hierarchical in pyramid-like organisations. The situation of the employer and employee is not reciprocal and employees have little control over their work. Employees are rewarded for success as a group, such as an interdisciplinary team, with integrated functions. Real

expressions of individualism are not only discouraged but sometimes punished. The active, outspoken citizen is unlikely to have a successful professional career (Saul 1997, cited by Hughes 1998).

- As a consequence of the outcomes focus and pyramid hierarchy, work is competitive. In today's society, work is not optional. The threat of unemployment hangs over those who do not prove their dedication to the owner's interests by at least matching the efforts of others. The ultimate price of non-conformity is unemployment, the banishment from society and its benefits.

The implications of Hughes' argument are problematic for nurse educators. In this argument, employees:

- are not likely to admit weakness — the person will choose to 'save face' rather than identify learning needs;
- will state what the employer wants to hear rather than what they really believe; and
- may not feel they can trust the educator, who is perceived as an employer advocate, especially if the educator is in a line position (supervisor).

Each of these carries the potential to block learning by cancer nurses because the principles of adult learning are directly challenged. In adult learning, it is assumed that the learner is motivated to learn due to an identified need or deficit, creates meaning through negotiation and reification (Wenger 1998), and requires a trust relationship with the educator to reveal these meanings.

The insights provided by Hughes' argument lead cancer nurse educators to pause and reflect on their practice in their setting. Questions that might be used to facilitate

this reflection include:

- what is the purpose of continued professional education in my organisation?
- what are the benefits of continued professional education for the patients/ families, the staff nurses, the managers, and the organisation?
- what are the potential risks to staff nurses who reveal their lack of knowledge/ skill to me as the educator?
- what are my responsibilities to report lack of knowledge and skill to management?
- how do the above affect student learning?

Workplace educators may choose to discuss the problem of learning in the workplace with staff nurses as well as managers, and identify ways to address the problems that arise for employees as learners.

Establishing the workplace as a learning environment is the biggest challenge confronting workplace educators. Research into the workplace as a learning environment, possibly with comparative work with classrooms, is required.

Adult learning principles are well accepted in cancer nursing as with other professional education. It is time to critically analyse these principles in our day-to-day practice as cancer nurse educators in contemporary workplace settings.

Laurie Grealish, Board Member ISNCC (Far East and Australasia) Senior Lecturer in Nursing, University of Canberra

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continued from page 1
and treatment resources.

When I returned to China I immediately began implementing the ideas into my daily work. In China nursing education is not as developed as in some other countries. Chinese nurses are craving medical knowledge with many nurses developing themselves through continuing education. More and more nurses are studying, hoping to get to degree level.

In my position as nurse educator at the hospital, I also have the job of teaching a course for medical students. I have had the opportunity to incorporate what I learnt into my teaching to bring more new knowledge to these students.

After a year I can see a number of outcomes from what I learnt. These achievements have benefited not only myself, but it has also been meaningful for breast cancer nursing and education in my organisation. Professors teach more theory about the treatment and nursing of breast cancer, at the same time introducing the latest related international information.

Although China is in the low incidence group for breast cancer, the rate has still increased from 10/100,000 in the 1970s to 25/100,000 now. The mortality rate of

breast cancer in United States, Canada and England decreases 1-2% every year. One of the most important reasons for this is the focus on screening and breast self-examination (BSE). Nurses have an important role in this activity. So I arranged a screening and BSE course for nurses in the hospital. The students now promote screening and BSE, not only for the patients in the hospital, but for the residents in every district. They also check the level of BSE practice in female groups with a family history of breast cancer.

During the training course, we recognised that breast cancer patients benefit from support and aid from their relatives, doctors and nurses and that current support is not sufficient to meet their needs. Relieving the patient's psychological pressure is an important task for nurses. As a result of this we now invite the psychologist to see the breast cancer patients regularly and train nurses in psychology.

As an Chinese oncology nurse educator, I want to warmly thank the ISNCC for the opportunity to attend the programme and the Susan G. Komen Breast Cancer Foundation for its sponsorship. The programme has been very beneficial to my work. I have applied what I have learnt to



Chinese cancer nurse Yan Ling

my research and education work and through this, continue to help women with breast cancer by relieving their suffering. I will continue to strengthen the communication with my international colleagues and to devote myself to international cancer nursing.'

How to write an abstract

The quality of an abstract can affect the chances of having your work accepted for presentation at a conference. In this article we give some tips to help you give your abstract a good chance of being selected.

What is an abstract?

It is a summary or short description of a conference paper or piece of research. It should be easy to read and understand.

How long should it be?

An abstract should be between 150-250 words

Is it for a poster or an oral presentation?

Abstracts can be submitted for either a poster or an oral presentation. If you are a first-time contributor to a conference you may prefer to opt for a poster presentation. Posters also have the advantage of giving you the chance to discuss your work with delegates. Authors of posters are required to be present at their posters at specific times to give delegates a chance to ask them questions.

Or if you prefer you can apply to present your work as an oral presentation.

Presenters talk for about 15 to 20 minutes and generally need to also prepare some type of visual presentation such as electronic (PowerPoint) if available, slides, or overheads. This helps keep the audience interested and increases understanding of the topic.

What should I call it?

Either go for a clear factual title which clearly describes what the paper is about. Or you can be creative and think of something that will catch people's interest.

How do I start?

Start with an introductory sentence which should contain the essence of the work. You can do this by using the conclusion of the work or if it is a theoretical presentation, rather than a research project, say what you will aim to cover.

What else should be included?

If it is an abstract of a research project it needs to include a description of the problem or aim of the work. You need to include the sample used and the methodology of the data collection and analysis. Then there are the findings. Summarise the results or findings of the work in two to four sentences. Finish with the conclusion of your

Tips for preparing an abstract

- Follow the instructions in the 'Call for Abstracts' issued by the conference organisers.
- Make sure the abstract title is brief and reflects the content of the work. Or create a catchy title that grabs the attention.
- Make sure your name is included plus the full address of your institution where you work or study. Also clearly mark your phone number, e-mail address and fax number.
- Indicate whether the abstract is for a poster or an oral presentation. If there is more than one author make it clear who is the contact person and who will present the paper.
- Take care that the abstract fits within the designated area on the 'Call for Abstracts' form.
- Check the abstract once more. Make sure it is clear, complete and accurate.

research and any implications this may have, on clinical practice for example.

If your abstract is about a theoretical article then you need to include an overview of the topic and then the purpose or aim of the presentation. Define the limits of the presentation. Identify your sources. Finish with a conclusion and any implications.

Is there anything else I need to do?

Try to arrange to have your abstract read by a colleague or mentor before submission. Ask them to tell you what she or he thinks the paper is about after reading it. If the colleague gives a correct description then you have achieved your aim.

Finally ask your colleague to comment on the words you have used. Is the lan-

guage clear? Is the grammar correct? Is the spelling correct?

When should I submit?

Abstracts for consideration for the 13th International Conference of Cancer Nursing in Sydney, Australia in 2004 need to be submitted by the 30th of September this year.

Conference diary

Preparations for the ISNCC Sydney conference are well underway. Patsy Yates, one of the organisers will be giving us an inside view in her conference diary. Here is the first instalment



Giddy! My name is Patsy Yates and I am one of the cancer nurses in Australia working on the 2004 conference. ISNCC and the Cancer Nurses Society of Australia have put together a Scientific Planning Committee that includes cancer nurses from Australia, as well as the UK, Singapore, Africa, USA and Canada.

The planning committee is already doing a lot of work behind the scenes. Our committee has not yet met face to face. We've been doing all our planning so far across the email. It's quite amazing what creative work can be done across the world wide web. We've had some fascinating email conversations about conference themes and cover designs. It's fantastic to think that we're able to connect with nurses from all corners of the world to shape the conference.

One of the first things the planning committee had to do early this year was to think of a theme that would be suitable for a 2004 conference for cancer nurses. It was quite a tricky job coming up with something that was both catchy and would capture the types of issues that cancer nursing faces today and may face in the future. A couple of key words kept coming up as the committee sent their ideas across the email — diversity and unity, challenging and creating are some examples. We kept coming back to the fact that one feature of today's world that will most likely be part of our

future as well; that people with cancer have enormous diversity in their needs for care and support.

We also thought about the fact that our patients have to work their way through a wide range of health care settings as well as various different treatment modalities and emerging scientific and technological developments. So in the end we settled on 'Celebrating Diversity'. We thought that diversity in cancer nursing is part of what makes our work both exciting and challenging, and that as a theme, we could set the scene for a programme that would be relevant to cancer nurses no matter what setting they may be working in.

After checking out a number of possible locations, we have settled on the Sydney Exhibition and Convention Centre as the venue for this conference. It's a stunning venue located in the centre of Sydney at beautiful Darling Harbour. I've been to a number of conferences there, and it's an ideal location. It's in walking distance to some great accommodation, fantastic restaurants, and many of the well known spots for sightseeing in Sydney.

We've also put out a call for abstracts. In keeping with our theme, we have made it so that abstract submissions can be about almost any topic of interest to cancer nurses. The planning committee is hoping that nurses from lots of different countries and

who come from practice, education and research backgrounds will submit abstracts for the conference.

The Australian members of the planning committee had lots of fun working with the conference organisers choosing the images and designs on the cover. We especially like the images of cancer nurses from around the world on the front cover, and of course, the Sydney Opera House insert — a very Australian touch.

To help the Scientific Planning Committee, an enthusiastic group of local Aussie nurses has been appointed as the Local Arrangements Committee. This committee is responsible for putting together a social programme for conference delegates that will offer choices to suit all tastes. These nurses really know the local scene, so you are in good hands. They are already hard at work checking out the best restaurants, local sights and 'must visit' places to make sure visitors to the conference leave with some wonderful memories. We will update you on their work in progress in the next newsletter.

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Why nurses choose oncology

Global nurse shortages have led to concern that there will not be enough cancer nurses to staff the oncology units of the future. In a qualitative study Patricia Sevean looks at why nurses choose oncology as a specialty from the range of options available to them and how that choice affects both their professional and personal life. She concludes by exploring strategies for improving recruitment and retention in the specialty of cancer nursing

Due to the worldwide shortage of nurses, it is timely for nurse researchers to study nurses' perceptions of job satisfaction and career development. Major print and television media across North America and around the world have reported on the workforce shortages and problems in nursing.

In a publication entitled *Nurses' Reports On Hospital Care in Five Countries* (United States, Canada, England, Scotland, and Germany) 43,000 nurses from distinctly different health care systems reported similar shortcomings in their work environments and the negative impact on quality of care in their hospitals (Aiken et al, 2001).

In the early 1990's, researchers began to notice the decline in the number of young people choosing nursing as a career option, partly due to both the declining birth rate and the women's movement opening up the job opportunities for young women (Buerhaus et al, 2000). They also noted a significant shortage of RN's in specialty areas. Younger RN's would typically seek employment on units such as intensive care, emergency, maternity, operating room and outpatient clinics.

Literature review

In recent studies conducted by the Oncology Nursing Society (2001) researchers have indicated that the shortage of nurses in outpatient and inpatient oncology settings dedicated to the care of cancer patients is particularly acute, and generally reflecting the problems in nursing (Lamkin et al, 2001).

Overall, research findings point to job satisfaction as having a strong relationship with job stress, organisational commitment, work content, and environmental rather than economic variables (Traynor & Wade 1993, Blegen 1993, Irvine & Evans 1995, Levek & Jones 1996, Tonges et al, 1998).

There have been very few studies on the role of the oncology nurse and the relationship between job satisfaction, job turnover, recruitment and retention. Fitch (1998) contends that quality of life is an important dimension of cancer care and 'much of the satisfaction oncology nurses' experience in

their practice emerges from matters related to attending to quality of care issues'.

Therefore, it is very timely to ask oncology nurses why they chose oncology nursing and explore the issues related to the recruitment and retention of nurses to the specialty. In order to strategically plan for future human resources needs, it is extremely important to understand why nurses enter the field of oncology, and how it affects both their personal and professional lives.

The delivery of cancer care is facing unprecedented challenges and oncology nurses have a major role to play in the delivery of quality cancer care. Recently, shortages in nursing have created a high level of concern that there will not be enough cancer nurses to meet the future staffing demands for cancer units. A study by the Canadian Nurses Association (1997) points to a pending shortage of nurses, as many as 113,000 nurses across Canada by the year 2001 (Donner & Wheeler, 1998). To date, these predictions have been realised, and there exists extreme shortages in virtually every province across the country and in most institutions including hospitals, long-term care facilities and community nursing services.

Commitment

Currently, there is an extreme shortage of nurses both nationally and globally, and recruitment of qualified nurses for jobs in oncology will only become more difficult over the next decade. The literature supports the notion that nurses enter the specialty at an older age, and historically tend to stay in the specialty longer than in other comparable specialties. There is also evidence of a high level of commitment to the specialty and nurses participate in many informal and formal continuing education opportunities.

The purpose of the study was to explore those factors and activities that influence the recruitment and retention of nurses to oncology as a specialty. The question of 'Why nurses choose oncology as a specialty?' was explored through 'the eyes' of oncology nurses' in the context of the current problems facing the cancer care system. The

study sample was made up of oncology nurses who had been employed in this specialty area for greater than six months, but for less than one year. The small study sample of five nurses from an urban community in Ontario, Canada participated in the taped interviews.

Themes

The study data was transcribed, coded and analysed according to a procedure outlined by Colaizzi (1978). The procedure involved a process of; identifying significant statements and phrases pertaining to the nurses' career choice and experience as a new oncology nurse; meanings were formulated from the significant statements; the formulated meanings were organised into themes; and the data was then examined for discrepancies among and/or between the various clusters of data. The data was categorised into five main themes: education, career vision, cancer impact, coping and supports.

Education

There were three sub-categories included in the first theme of education; discovery of new knowledge, sequence of the learning experience and synthesis of learning. One of the participants stated: 'Well I learned more about the drugs... what they actually do... it kind of woke me up as to how poisonous this stuff is... I can't just hang this stuff and do my nursing observations there is so much more to it than that.'

Career vision

The second theme of career vision highlighted nurses' intention to enter oncology, suitability of their career choice and the importance of career planning. Another participant stated the following: 'I find it (oncology) really hard, but it is where I am supposed to be right now... what drew me to oncology was the opportunity for expanded learning it is such an incredible field.'

Cancer impact

The third theme of cancer impact was pervasive throughout the transcripts, and inextricably linked to the other four themes.

The participants expressed many statements regarding; their fear of the unknown, the stress of coping with death and dying on a daily basis, and the affect that these experiences had on their personal lives. One participant stated: 'Some days you get a slew of patients who are really bad, and then you get a few weeks when it is not so bad...it's kind of like a roller coaster...I don't know how many years you could do it without burning out.' Another nurse stated: 'Yeah especially the young women you can identify with them, their families, oh I'm getting the goose bumps, you know...they have kids my kid's ages and it is heartbreaking.'

Coping

The fourth theme of coping included statements as to the nurse's ability to deal with loss and grieving and their own personal and spiritual coping skills. One of the participants stated: 'I find nurses bad, they don't go for help for themselves, they are used to helping others...I have a lot of spirituality so I find I can cope with lots of situations.'

Support

The fifth theme reflected the importance that peer support plays in the socialisation of the novice nurse to an oncology setting. Nurses expressed their thoughts regarding the significance of; group cohesiveness, interdisciplinary teamwork, empathy and role models and preceptors. One nurse stated: 'I was crying with the wife and I didn't feel like a very good support for the family... and that was a new experience for me...so the nurse manager came up to me and hugged me and said you are just like me, we all cry... we are really supportive of one another.'

Job satisfaction

A 'Model for the Adoption of the Oncology Nurse Role' (figure 1) based on Tonges et al (1998) evolved from the analysis of the pilot study data and a reflection on the results of several research studies on job satisfaction; recruitment, retention and job turn over.

The factors/activities contributing to

'experienced meaningfulness' for the oncology nurse are listed on the right hand side of the diagram and are in direct relationship to the quality of the 'nurses' lived experience'. These factors directly impact on the 'experienced meaningfulness' which in turn directly influences the perceived 'job satisfaction' of the nurse. If 'job satisfaction' is high then this increases job commitment; but if 'job satisfaction' is low then this increases job turn over.

Professional development

Nurses' intentions to enter an oncology are individual, and it is a relatively new and unknown specialty to a large number of nurses. Therefore, nurse managers need to provide orientation and ongoing professional development to nurses entering the specialty on types of cancers, treatment and supportive care. They also need to include strategies to assist novice nurses to adapt to their role as an oncology nurse. These include; preceptors, counselling and supports to assist the nurses in developing their own personal strategies for coping with death and dying. The evidence points to collegiality and supports as important factors that contribute to quality of work life and improve retention of nurses.

Due to the dramatic shortage of nurses and the high cost of orientation and training to a new specialty, it is imperative nurse managers be more innovative in their approaches to recruitment and retention strategies. The specialty of oncology is relatively new and nurses are often unaware of this unique area of nursing practice.

Nurse managers would do well to market the specialty, and focus on screening and interviewing processes to ensure that candidates who are hired are willing to commit to oncology nursing practice.

The literature supports the fact that nurses are retained in specialties that offer professional development and continuity of care. Nurse managers need to provide novice nurses to oncology an opportunity to work with qualified preceptors in order to acquire competencies and skills necessary for safe practice. They should also offer experienced nurses relevant continuing education programmes as a strategy for

retention.

Due to the future impending shortage of nurses, it is imperative nurse researchers focus on conducting further studies that examine the factors and activities that influence the recruitment and retention of nurses to oncology. Oncology nurses should be surveyed and interviewed in regards to professional commitment, organisational commitment, work place climate, position satisfaction, learning needs, and their intent to remain in their position as an oncology nurse, and what would make a difference in assisting them to stay in oncology.

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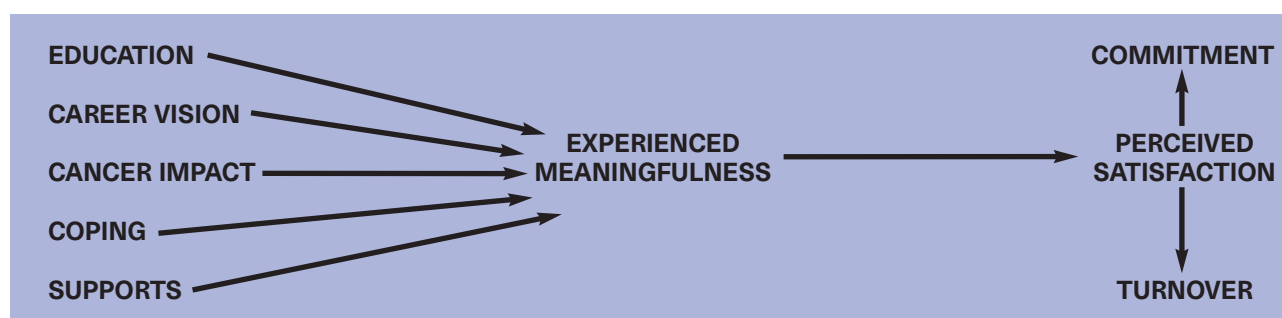


Figure 1: model for the adoption of the oncology nursing role

Enhancing the benefits of nursing research for people with cancer:

Some methodological issues (part 1)

In addition to judging the scientific merit of a study, we increasingly see the social value and clinical importance of research efforts receiving greater attention by funding bodies and ethics review boards. In the next two editions of the ICNN research column, some examples of methodological issues facing cancer nurse researchers as we respond to the challenges posed by these trends are discussed. In this first column, some issues in developing and testing clinically effective and relevant nursing interventions are described.

Clarification

Nursing research is increasingly concerned with issues such as when and under what circumstances an intervention is effective, what specific components of the intervention work in which situations, and how much of the intervention is required to achieve benefit. The current emphasis on developing and testing targeted and tailored approaches to nursing intervention is one example of how nurse researchers are addressing these issues. To advance the science of intervention research however, it may be useful for us to further clarify some of the dimensions to be considered in developing and testing nursing interventions that optimise the benefits for people with cancer.

Current models

In medical research, the model that is commonly used for testing the efficacy of a treatment is the dose testing approach. This is evaluating the effect of the duration of an intervention, or the number of contacts associated with the intervention.

This dose testing model tests the efficacy of a treatment where it is relatively easy to precisely measure the amount of the drug or other treatment being tested.

Is the dose testing model helpful if we are looking to develop models for nursing research that enables us to better understand the processes involved in how an intervention works most effectively? At one level, the approach appears to have merit. For example, we do have some evidence that the

'dose' of psychological interventions may be important, where studies have reported a positive relationship between the number of psychotherapy sessions given and level of patient benefit.

There are some important limitations to this dose testing model in the context of nursing research. Specifically, nursing interventions tend to be comprised of multiple components that are difficult to disaggregate and difficult to precisely measure. Nursing interventions can also have multiple purposes and outcomes, and importantly, a major component of the effectiveness of nursing interventions is responsiveness on the part of the nurse to individual patient needs and responses. Moreover, the concept of benefit and toxicity associated with nursing outcomes has a very different meaning. In nursing, our concerns go beyond a measurable change in disease state, to include a range of psychological, spiritual, and social outcomes that are difficult to define, let alone measure.

Additional dimensions

As we continue to develop intervention research in nursing, it will be important to refine our research methods to make them more suited to the issues with which we are most concerned. In the context of intervention studies, for example, this may involve incorporating an element of 'dose testing'

This dimension is important, as it has many practical benefits for service planning and optimal use of limited resources. However, evaluating the benefits of a nursing intervention goes beyond this in many cases. For example, issues associated with the type of intervention strategies used (ie the intensity of the intervention) also need to be understood. Sidani and Braden (1998) suggest that in designing and interpreting intervention studies, researchers require an in depth understanding of the problem, the nature of processes through which the intervention resolves the problem or provides the desired outcome, and the specific activities constituting the intervention. In other words, theoretically driven

intervention research is important to help clarify and communicate processes and outcomes. In terms of methodological strategies, multi-method research designs where qualitative data are gathered to explore and explain processes involved in how an intervention is best applied in practice may also be useful.

Sidani and Braden also suggest that the specificity and sensitivity of an intervention should be considered in intervention research. Specificity in this context refers to issues such as accuracy and quality in delivering interventions. For example, strategies increasingly being used by researchers to improve the specificity of an intervention include the use of decision support tools and the tape recording of intervention sessions for monitoring and feedback to those delivering interventions. The sensitivity of the intervention refers to issues such as whether the intervention is more beneficial in some situations than others. The application of this sensitivity dimension in intervention research can be seen in studies that seek to evaluate the benefit of the intervention with different groups or in different contexts, thus enabling some assessment of when and how to target the intervention to achieve most benefit.

There is enormous scope for continuing to develop and refine research methods that can improve nursing care for people with cancer. In the context of intervention research, some of the key factors in advancing nursing science are likely to be the extent to which we can design and conduct studies that incorporate research methods which are best suited to the complex and dynamic nature of nursing practice.

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CALENDAR OF EVENTS

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

The 4th European Breast Cancer Conference will take place in Hamburg, Germany, 16-20 March 2004. *For information contact:* FECS Conference Unit, Avenue E Mounier 83, B-1200 Brussels, Belgium; fax: 32 2 775 0200; e-mail: EBCC-4@fecsc.be

The 13th International Conference on Cancer Nursing will take place in Sydney, Australia, 8-12th August 2004. *For information contact:* ISNCC conference office, tel: 44 116 270 3309, fax 116 270 3673, email: conference@isncc.org