



Nurses worldwide attack poverty to improve health

The theme of this year's International Nurses Day on the 12th of May is working with the poor against poverty.

More than half of the developing and transitioning world lives in poverty. About 1.2 billion people or 23 percent of the world's population live on US\$1 or less per day. An additional 1.6 billion people make do with between US\$1 to \$2 per day. This means they lack the basic necessities for a healthy life — adequate food, water, clothing, shelter and health care.

In most countries poverty has a female face, as about 70 percent of the 1.2 billion people living in poverty are female. In many countries, poverty of women has risen significantly over that of men during the last two decades.

Women are twice as likely as men to be



illiterate and significantly more likely to suffer from poverty-related health conditions.

The International Council of Nurses is urging nurses worldwide to draw attention to the links between poverty and health and to call for multi-sectoral action to reduce poverty and improve health.

'Poverty is the greatest misery we face today. As nurses, everyday we encounter people that are unable to meet their basic needs due to poverty, and we see how this makes them more susceptible to disease and early death,' said Christine Hancock, President of the International Council of Nurses.

'The particular cruelty of poverty is its vicious circle, whereby people do not have access to health, education and other means to increase their income,' she added.

Sydney conference workshops

Nurses attending the 13th International Conference on Cancer Nursing in Sydney, Australia will have the opportunity to take part in pre-conference workshops in research and palliative care.

Both workshops take place on Sunday August 8th, the day before the full conference proceedings begin.

The introductory research symposium entitled 'Moving Towards Evidence Based Practice' is being jointly run by the US Oncology Nursing Society and the ISNCC.

The purpose of this workshop is to provide an opportunity for nurses from around the world to be introduced to the concepts and strategies necessary to move towards evidence-based practice.

The target audience for this symposium

is oncology nurses who have little or no research knowledge but who are interested in understanding more about evidence-based practice. It will be an excellent session for nurses who are being asked to engage in research and using research, but who feel they do not know where to begin.

The symposium will include both plenary and small group sessions. Deb Bakker from Canada and Debbie McGuire from the US will lead the workshop.

The workshop in palliative care entitled 'Nursing Strategies in Palliative Care' is being chaired by Debbie Canning, Australia.

It aims to provide delegates with an opportunity to learn about and discuss recent developments in palliative care, and reflect on how palliative care nursing prac-

tice may be improved along the cancer continuum.

Specifically, it will provide a 'skills update' on current evidence-based interventions and developments in specific areas of symptomatology. It will also focus on professional issues from both local and global perspectives exploring contemporary developments such as the nurse practitioner role, and the need for global partnerships and innovative models of care to meet the challenges that face those involved in cancer care.

- This issue's research column on page eight evaluates the pre-conference workshop held at the 12th International Conference on Cancer Nursing in London, UK in 2002.

See you in Sydney?

Practically every conversation I have had lately about the International Society of Nurses in Cancer Care contains the question: 'How are things going for the conference in Sydney?' And I can say, with every assurance: 'They are going well, very well!' And I usually add: 'And I hope you will be able to join us. Are you thinking about coming to the conference?'

I can still remember the first International Conference I attended that was organised by ISNCC. It was 1988 at the Royal Festival Hall in London, UK. That was a time when there were very few conferences around the world solely for cancer nurses and very few national cancer nursing societies.

That conference introduced me to the remarkable learning and exchange that can happen at international conferences. It was like having a door or window opened. Suddenly there was a whole new viewpoint or perspective in front of me. Over the years, each subsequent international conference has offered the same thrilling opportunity for learning and the wonder of being together with so many other cancer nurses.

When I think of various conference experiences I recall certain moments — they remain as pictures in my mind:

- watching African nursing colleagues singing and dancing a song about cancer prevention — it was the approach they used for health teaching in their villages,
- learning about the one Polish nurse who had had cancer nursing training in a country of 18 million people,
- hearing stories of traditional healers in Australia, Canada and China — all using methods that are centuries old,
- hearing about the difficulties in giving palliative care in parts of the world where telling a person they

have cancer is a cultural taboo,

- providing cancer nursing care in the tents of a Bedouin tribe, in the outback of Australia and in the villages of Africa.

Each conference I am struck by the similarities and differences in cancer nurses and nursing around the world. We all share a sense of commitment to helping people diagnosed with cancer and their families; we share a common goal of learning what we can to be the best at what we do; we share a common experience of seeing, feeling and being present with others who are suffering.

The differences emerge around our rich array of cultures and the challenges in providing the care we want to provide. Scarce resources, fiscal constraints, lack of education and training for cancer care, few programmes to support patients, little diagnostic and treatment equipment are all factors we live with to greater or lesser degrees. And how we work in these circumstances is a testimony to the ingenuity and fortitude of cancer nurses. So many have overcome incredible odds to provide care to patients. I salute you!

We all have lessons to share with our colleagues — and we all have learning that we can gain from one another and adapt to our own home environments. And, to me, that is what an International Conference is all about. It is a time to share and a time to learn; it is a time to reach out and support each other and a time to listen and be renewed.

The conference in August is certain to provide ample opportunity for all of these experiences. So I ask my question of you, 'Are you thinking about coming to Sydney and the 2004 ISNCC Conference?'

I do hope to see you there!

Margaret Fitch
President ISNCC

Researchers – be part of the action

If you are an oncology nurse researcher, make sure you are included in the updated version of the ISNCC Directory of Oncology Nurse Researchers. Go to the ISNCC website — www.isncc.org and download the information form. Complete it and email it by attachment to Ann Hilton, Chair of the ISNCC research committee, hilton@nursing.ubc.ca.

ONS international award

Congratulations to former board member of the ISNCC, Aliza Yaffe, who has been awarded the US Oncology Nursing Society's International Award for Contributions to Cancer Care. Ms Yaffe is head nurse at the Israel Cancer Association in Israel. This award recognises her outstanding contribution to the improvement of cancer care in Israel.

Palliative care society established

A palliative care society has been formed by the Nagasaki Prefecture, Nagasaki, Japan. The society aims to improve knowledge of palliative care in hospitals, hospices and in-home hospices in Nagasaki by exchanging information and establishing a liaison network.

The society will hold regular lectures, seminars and clinical case conferences as well as carrying out specific projects determined by the members.

Since being set up in the autumn of last year the society has held a special lecture on the treatment of cancer pain.

Another lecture on the subject of the use of fentanyl patches was attended by nearly 300 health workers in cancer care including nurses, doctors and pharmacists.

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Core skills for nursing cancer

Cancer patients are often cared for outside of cancer units by nurses who do not have specialist training. How much do these nurses know and understand about cancer and the care needed? Candy Cooley explores the extent of oncology education in pre and post registration training in different parts of the world

By the year 2015 one in two people will have been affected by a diagnosis of cancer. Thirty million people will be living with a diagnosis of cancer at all stages of the disease process. We also know that people with cancer may spend only a small part of their disease 'journey' within a specialised cancer clinical setting. A fairly large proportion never go to a cancer centre, chemotherapy unit or radiotherapy department.

Individuals diagnosed with cancer state that there is a need for good information, knowledgeable health professionals and realistic expectations. They need to have access to health professionals who have a good understanding of their disease and the possible treatment choices and decisions.

However, data from the Oncology Nursing Society (ONS) in the US, (Satryan 2001), the European Oncology Nursing Society (EONS) and the Royal College of Nursing (RCN) in the UK identify the shortages of registered nurses in all areas and the impact on the workforce within oncology. It becomes apparent that in order to ensure that individuals with a diagnosis of cancer have access to health professionals who have the skills, confidence and understanding to deliver the best care, this education needs to be included in the training of all nurses.

Common curriculum

Since the 1970s there has been interest in the cancer content of nurse education and training programmes (Craytor 1982). In the United States in 1980 the Oncology Nursing Society (ONS) proposed a common curriculum for schools of nursing to adopt at a 'fundamental level' (Pope 1992). They identified that nursing knowledge about cancer was varied on completion of training programmes. Bush and Muskovin (1980) indicated a need for standards within nursing education to ensure students developed a 'positive outcome towards caring for persons with cancer'.

Brown et al in 1983 undertook a comprehensive study of cancer nursing education in US schools of nursing. They clearly identified a wide range of variation in both the content and the time given to cancer education. A similar study undertaken by Copp (1988) demonstrated that a similar situation, with some exceptions, occurred across Western Europe. She identified a lack of effective cancer teaching at all

levels of nursing education, both within pre-registration and post-registration, except specific programmes for staff working on designated cancer wards.

Core content

Since then a considerable amount of research has looked at the role of the oncology nurse and the needs of the oncology patient. The work of Corner and Wilson-Barnett (1992) highlighted the extent to which newly qualified nurses felt ill-prepared to care for individuals with a diagnosis of cancer. They often held fixed or negative views about the disease and associated cancer with inevitable death regardless of the site or extent of the disease.

So despite recommendations for a core content of cancer knowledge being delivered as part of the curriculum, within American, Europe and Australasia, the reality was that many nurses were still qualifying with limited confidence in their skills to care for this patient group. In 1986 the Commission for European Communities recommended that training in cancer nursing within basic/pre-registration nurse training should be standardised. EONS and the 'Europe Against Cancer' Programme (1991) also supported a call for a common core programme.

There are a number of countries where the importance of cancer knowledge in the education of health professionals has been clearly identified. There is a common core of 'basic' content around causes, aetiology, epidemiology and possibly some treatment interventions. Similarly, the time and delivery of education and skills in topics such as communication for the cancer patient is extremely varied. Some institutions feel that a common core will enable students to learn the 'basics'. What is often lacking is the development of transferable skills where the student can take a concept from one field of care delivery and utilise it within another.

The World Health Organisation (WHO 2002) strategic document for nursing and midwifery services identifies not only the importance of ensuring that nurses have the competencies to deliver care (4.1.2) but also that their education is based on methodologies that link practice and theory (4.1.8). They also identify the importance of collaboration between disciplines, institutions and at a global level.

In researching the information for this

paper I discussed anecdotal evidence with individuals across the globe. My experience within the UK is that education within pre-registration programmes is at best patchy. It would seem that the inclusion of a significant content of cancer education within a pre-registration curriculum is based on the enthusiasm of specialist lecturers within an institution. Having discussed this situation with colleagues from an international perspective this situation would seem to be relatively common. There are individuals who have developed comprehensive modules on cancer for their pre-registration programmes, in both medicine and nursing. These are often optional modules and are only rarely the recommendation of a governmental or professional quality-auditing department.

Mandatory courses

The WHO plan (2002) calls for nurses to have the competence to deliver care. As cancer care is delivered in such a wide spectrum of clinical areas, it should be possible to say that cancer education should be mandatory in all pre-registration programmes.

One of the other key issues within education and clinical practice is the common misconception that cancer and palliative care (caring for the dying) are the same subject. During the development phase of a module for nurse trainees at my own university, a colleague from outside the field of cancer but highly experienced in pre-registration education, asked if I intended to include 'laying out' within my 30-hour module. If cancer and 'laying out' are considered connected in the mind of an educator then what chance do we have of altering this view of cancer in the mind of the student?

Negative attitudes

One of the concerns about having health professionals who have a negative attitude to cancer is that this negativity is reflected into society. This can be seen in the portrayal of the health professional as a role model. Callaghan (1995) considered the health behaviours of a group of nurses and found that whilst they were often well aware of the lifestyle issues associated with increasing the risk of cancer they often ignored these messages.

The other concern about a negative attitude to cancer is that this leads an individual to delay seeking medical help as they

believe it is pointless. Unless the health message is altered at an early stage within their training, health professionals don't change their attitudes and beliefs. This can be reinforced by the attitudes of the trained professionals. This negativity is then reflected into their clinical practice and their expectations for the patients with cancer in their care.

Changing people's beliefs about the possibilities for the individual with cancer should improve the speed of access for initial diagnosis, the rapid intervention for the management of the disease, and interventions to deal with symptoms.

Inequality of care

Post-registration education in the field of cancer care for all health professionals has had a greater focus but still lacks equity around the world. In the mid 1980s, the European Commission stated that every member state should be aware of the specialised nature of cancer care and ensure that health workers could have access to education on cancer. In 1991 EONS organised a consensus conference of clinical specialists, educators, advisors and other interested parties who endorsed the content of a core curriculum for post-basic courses in cancer care (EONS 1991). The document was reviewed and revised in 1998 and published in 1999. It clearly identifies that courses are not consistently available across the European Union. This has led to inequities in care since many cancer patients have limited access to nurses specifically trained in cancer care.

During 1998 the English National Board (ENB 1999) commissioned a year-long literature review and documentary analysis of cancer nursing education. They identified a number of issues. These included the fact that less than two per cent of qualified nurses who were working with patients whose primary diagnosis was cancer had received any specialised cancer education. This work reflected that of Closs et al (1997) who identified similar numbers of trained nurses in cancer care.

Anecdotal evidence from a UK teaching hospital identified that over 60% of patients who had a cancer diagnosis were being cared for outside designated cancer wards, but only nurses within the cancer setting had access to funding and support to access cancer education programmes.

The ENB project also identified the shortage of research and evidence base concerning the effectiveness of specific cancer education programmes. Their data demonstrated that there was a lack of consistency across the UK as to the access of cancer programmes. In February 2004, discussion and a small audit undertaken with a number of lecturers at a UK nursing education conference, demonstrated that these same variations still occur across the country.

Cancer education programmes within the USA and Australia are on the whole more widely available. However there are still some areas where access to education programmes is very difficult due to distances and staffing shortages.

Work has been undertaken and is being further developed into distance learning education programmes for both national and international audiences. The ISNCC education programme and web sites such as www.cancernursing.org/ enable nurses to access on-line education to develop the individual practitioner's understanding and knowledge about generic and specific cancers, and treatments.

The International Union Against Cancer (UICC 1998) has been organising workshops and symposia in countries as diverse as Poland and Nicaragua for health professionals specifically targeting the skills of health education, early detection and diagnosis, nursing care and rehabilitation of cancer patients. Within Western Europe similar education opportunities are being developed with 'master classes' for specialised 'expert' cancer nurses (EONS 2003). Within the UK the emphasis has been placed on the importance of communication skills. Fallowfield et al (2002), clearly demonstrate in their study the improvement in doctors' skills following an intensive programme, based on a skills model.

Limited knowledge

The issue still remains as to whether the amount of cancer education currently within the pre-registration curricula for nurses is appropriate. This has to be considered within the context of the fact that not all nurses wish to be cancer experts. However the evidence from the ENB (1999), EONS and ONS clearly identifies that all nurses will care for an individual with cancer many times during their career.

An audit at my own university of over 725 third-year students has identified fewer than 10 who have not cared for someone with cancer during their first two years of nurse training. Whilst all these students had had education and skills training on communication, breaking bad news, health education, informed consent in decision making and clinical assessment, many of them did not feel they were competent to talk and deliver best practice to individuals with a diagnosis of cancer. A number stated that they were unsure of what to say and therefore at times avoided the patient. They also felt that they were helpless to offer suggestions of how to improve care and relieve symptoms, both physical and psychological. Their knowledge of the causes of cancer and treatment choices at the commencement of the module was varied and often determined by their personal and professional experiences. They also had

limited knowledge of the possible side effects of treatment and the disease process often reflecting society's generic vision of a cancer patient, 'bald, vomiting, thin, pale, in pain and dying'.

None of this information is very different than that identified by Brown et al in 1983 or Corner and Wilson-Barnett in 1992. However it seems unsatisfactory that at a time when those working within the field of cancer see a number of positive developments this positive view is not necessarily the view of health professionals who may ultimately have a greater contact with the patient with cancer and their family. There is a real need for those responsible for influencing the political and strategic developments around cancer services to consider this issue and express a concern at the current situation which is of benefit neither to patients nor to the nurses trying to ensure best care.

Candy Cooley, Head of Division, Cancer and Palliative Care, University of Central England, Birmingham, UK

• See the education column for an update on developments in Australia

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Global workforce

The International Council of Nurses (ICN) is carrying out the first systematic investigation of the nursing workforce globally. The global analysis aims to identify the policy and practice issues and solutions that should be considered by governments, international agencies, employers and professional associations when addressing the supply and use of nurses.

Liver cancer risk for diabetics

Men with diabetes have about a two-fold greater risk of developing chronic non-alcoholic liver disease and hepatocellular carcinoma (HCC) compared with non-diabetic men.

Results of a large prospective cohort study suggest that the risk is even higher in patients who have had diabetes for 10 years or more. Previous studies have found an association between diabetes and HCC but until now it was not clear whether the diabetes followed or came before the cancer. The researchers recommend regular testing of liver enzymes in diabetic patients. *Gastroenterology* 2004;126:460-468,604-605.

Exercise to survive

Moderate exercise may improve odds of surviving breast cancer according to a study presented to the American Association for Cancer Research's annual meeting. Harvard University researchers used the Nurses' Health Study to assess the impact of physical activity on breast cancer survival. Walking one to three hours per week was found to improve survival odds.

WHO essential list

Paediatric oncologists are lobbying the World Health Organisation to add leukaemia therapies to the essential drugs list. The International Society for Paediatric Oncology is concerned that four out of five children with cancer still do not get treatment. Placing anti-cancer drugs on the essential drugs list would reduce their price in developing nations. This would require the agreement of the WHO, the World Trade Organisation, and the pharmaceutical companies.

Address change

Please note the the US Oncology Nursing Society has a new address: 125 Enterprise Drive, Pittsburgh PA 15275, US.

VIRTUAL CANCER CARE

Help with ethical decision making

This edition of virtual cancer care will cast a critical eye over some of the most interesting sites that deal with the complex area of ethics in cancer care. It is often said that the study of ethics provides more questions than answers, but it is also true that all health care professionals encounter difficult ethical dilemmas in every day clinical practice, and can benefit from some expert guidance. It is useful therefore to be able to go to some key sites that will provide up-to-date and relevant information.

British Medical Association

http://web.bma.org.uk/ap.nsf/Content/_Hub+ethics

The Medical Ethics Committee of the British Medical Association is respected for the quality of information it produces to guide doctors in their practice. The ethics page of this large site is no exception. There are reports, codes of practice and discussion documents on topical and often controversial issues. These include physician-assisted suicide, genetic technology, euthanasia, and organ donation. The site is easy to find your way around and although the visitor is invited to subscribe in fact you can access the publications available without doing so.

One of the more interesting recent additions to the site is the patient information leaflet on cardio-pulmonary resuscitation (CPR) which has been endorsed by the UK charity Age Concern, the UK Resuscitation Council and the Royal College of Nursing. Copyright has been waived in the hope that health care establishments that need to provide patients with information about CPR will use the text as the basis for their own

leaflets, by taking the relevant questions and adding in local information.

MedEthex online

<http://griffin.mcphu.edu/MedEthEx/intro.html>

This fascinating US site makes excellent use of technology and goes beyond the presentation of guidelines and standards. It engages the user in an interactive way by asking them to study a small series of brief cases and make decisions about what should be done, with feedback offered which is based around sound ethical principles. In essence it is rather like a virtual classroom, but without discussion and of course is non-threatening, so whatever decision you make is yours alone to ponder over. It is oriented towards medical students and doctors but this does not detract from its usefulness for all health professionals. You will need to set aside a little time to make best use of this site, but it is worth the effort as few other sites offer the chance to be this interactive with your computer.

StopPain.Org

http://www.stoppain.org/palliative_care/ethics.html

This well laid out US site is clearly written and is a useful starting point for those who need some foundation reading about ethical principles and practice. Case studies are used in some parts to illustrate the issues and this helps to bring the information alive to the reader. Its clarity is to be commended. Issues discussed include competency, informed consent, truth telling, advance directives, sedation, euthanasia, do not

resuscitate orders and withdrawal of treatment. There is no need to register on this site and the information is presented in one long page which can be quickly negotiated by clicking on the links at the top of the page.

The National Hospice for Hospices and Specialist Palliative Care Services

<http://www.hospice-spc-council.org.uk>

Although oriented towards palliative care this UK site contains some excellent guidelines and clearly thought out position statements on ethical issues on subjects such as artificial hydration, resuscitation and euthanasia.

BBC Ethics Home Page

http://www.bbc.co.uk/religion/ethics/sanctity_life/euthpallcare.shtml

This final web site is a little unusual yet well worth a visit if you would like to gain an overview of the broader issues in medical ethics today including end of life concerns. Produced by the British Broadcasting Corporation, it offers an interesting educational diversion yet challenging at the same time. Each of the ethical subjects discussed is presented in clear easily understood language with for and against arguments from well informed sources. There is a message board if you are brave enough to join the debate, and a fascinating ethical quiz which tests your honesty and value judgements.

Robert Becker, Macmillan Senior Lecturer in Palliative Care, Staffordshire University School of Health and Shropshire and Mid Wales Hospice

Conference diary

Programme planning complete as Sydney countdown begins

It's less than six months until the Sydney conference begins. Our major programme planning activities are now complete, with plenary topics and speakers in place, and concurrent sessions organised into some very interesting themes.

We've filled over 25 concurrent sessions, with more than 160 abstract presentations by nurses from over 20 countries. One of the advantages of chairing the planning committee is that I've already been able to mark off some 'must attend' sessions that are of particular interest to me.

We are now about to start work on compiling the full abstract booklet. The poster programme at this year's conference will be enormous. There will be around 200 posters presented, covering the most diverse range of innovative practices and

some important research outcomes. I recommend that you plan to make some time in the busy programme to visit and review the work presented in these posters.

The planning committee is now working on the last pieces of the programme — some pre-conference workshops on palliative care and research, as well as an interesting selection breakfast and evening symposia.

These symposia will cover topics such as safe handling of hazardous substances, writing for publication, technological innovations in cancer nursing research, and cross cultural research issues. Together with the industry-sponsored lunchtime lectures on the Monday and Tuesday, the conference will certainly provide non-stop learning opportunities.

The great thing is that all of these ses-

sions will be held in a central location, so that it is easy to take some time out for sightseeing. Next week I am heading to Sydney to do a final check on the conference venue, and to visit some of the locations where the social events planned for the conference will be held.

I'll also be catching up with Keith Cox and Tish Lancaster from the Local Arrangements Committee, to talk about plans for the opening and closing ceremonies. I'll update you on these plans in the next newsletter (the last one before the conference!).

Patsy Yates, Associate Professor, Director of Research, Centre for Palliative Care Research and Education, School of Nursing, Queensland University of Technology, Australia

EDUCATION COLUMN

Development of a credentialling framework for nursing

In 1990 the World Health Organisation identified the lack of education for health care workers as one of the major reasons for inadequate palliative care globally (Kristjanson et al 1997). More recent literature indicates little has improved in regards to education in death, dying, bereavement and the issues surrounding terminal care.

Literature suggests that improved palliative care education at undergraduate level will improve practitioners' preparation to provide care at the end of life. However, there is some debate over the best means by which to effect this improvement.

Palliative care, although still regarded as a relatively young specialty, is now incorporated into many core areas of Australian health care delivery. However, up until now, there has been no comprehensive review of undergraduate education of palliative care across the health care disciplines.

As such, palliative care content has often only incidentally rather than systematically been addressed in most educational programmes preparing practitioners for professional practice (Ross et al, 1996 in Canning et al, 2003). Issues such as crowded curricula, evaluation methodology and how to best encourage uptake of best practice education strategies also need to be investigated.

The Australian Government has committed \$55 million over four years (2002/3-2005/6) to implement a National Palliative Care Program, a group of targeted initiatives to improve the standard of palliative care offered. This national programme is consistent with the goals of the Australian Government's 2000 National Palliative

Care Strategy (www.health.gov.au), which highlights the provision of education and training opportunities for specialist and generalist palliative care staff as one of its four core policy objectives.

This has led to the development of several major palliative care research and education collaborations. One such project has recently commenced which will focus on the issues of undergraduate palliative care education across the health disciplines.

Led by Associate Professor Patsy Yates, Queensland University of Technology (QUT)/Centre for Palliative Care Research and Education (CPCRE: www.cpcpre.com), the research team traverses three states of Australia and brings together a wide range of expertise in education, palliative care and undergraduate curriculum design. QUT is joined by Flinders University of Adelaide, South Australia, and the Northern Territory University, Northern Territory.

Multi-disciplinary

The PCC4U project aims to develop a multi-disciplinary undergraduate palliative care curriculum together with high quality educational resources. These will include printed, video and on-line/web-based resources. This project will also identify strategies to facilitate its uptake within the tertiary education sector.

Widespread national consultation with a variety of stakeholders and interested parties is seen to be integral to the project's success. This includes collaboration with a Project Advisory Group represented by all health care disciplines, and the use of a

National Consultative and Information Sharing Network primarily through the project's website: www.pcc4u.org

Progress

A scoping study of all Australian university faculties offering undergraduate courses to health professionals has been completed along with a nationwide palliative care community survey. The data is currently being analysed. Focus groups are about to be undertaken across the country to assist in the identification of key areas and resources, together with uptake strategies by education facilities.

An interactive workshop is also going to be held during the 2nd National Palliative Care Education Conference, which will take place 13-14th May, 2004 in Adelaide, South Australia.

The project, which is due to be completed in December 2004, has the potential to lay the foundations of change and validate the need for all health professionals to be adequately prepared to care for those with life limiting disease.

Debbie Canning, Director of Education, Centre for Palliative Care Research and Education, School of Nursing, Queensland University of Technology, Australia

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Evaluation of the 2002 London ISNCC/ONS pre-conference workshop

The London workshop 'Moving towards evidence-based practice' offered an introduction to the research process and concepts of evidence-based practice.

The focus was on finding relevant research reports and systematic reviews, critically evaluating the evidence within research reports, understanding the research process, identifying researchable problems and 'getting started' with a project.

Both didactic and small group sessions were used. Jean Brown (USA) was the faculty member representing ONS and Patsy Yates (Australia) was the faculty member for ISNCC. Ann Hilton (Canada), chair of the research committee, chaired the session. Twenty nurses attended the workshop from countries including the UK, Australia, Japan, China, South Africa, New Zealand, Sweden, US, India and Malta. They included staff nurses, nurse specialists and instructors.

Survey

The evaluation of the workshop consisted of two parts. The first part included a survey conducted at the end of the workshop. It asked delegates about the degree they had achieved the objectives, their rating of the teaching strategies, organisation of the workshop, facilities, the level of the workshop and the teaching effectiveness of each presenter. They were asked in a more open-ended manner about what they liked and did not like about the workshop and how they anticipated using the information they learned.

To evaluate the impact of the workshop they were asked to write one or two specific research or evidence-related goals that they would work on in the following six months. This would include how they would know if they accomplished their goals, what barriers they anticipated, and what resources they had to help them.

Six months later a member of the ISNCC Research Committee would contact them to see how they were doing in relationship to the goals they set and what additional assistance/education/consultation would help them to keep moving.

In March 2003, a survey was e-mailed to those who gave an email address or mailed by post to those who did not. Goals specified by each individual were written into each evaluation form. After two reminders, 10 forms had been returned. A 50% response rate was considered very successful.

Responses from the survey conducted on the day of the workshop indicated that participants found the symposium very helpful and the majority found it was at an appropriate level.

The lectures and the handout materials provided an opportunity to learn new content, while the small groups facilitated consolidation and application of the material as well as facilitating networking and sharing of strategies/actions. They rated the instructors highly.

When asked about what they did not like, at least half either left the item blank or said 'nothing.' Comments indicated that some felt the workshop was too short, the classroom was too cold, and a couple said that some sessions were too intense or too dry.

Goals

Goals identified on return to their home setting included sharing their knowledge with others to raise awareness and interest in research, starting a journal club, identifying what research had been done in their area and helping staff to search for studies, working to increase opportunities for staff to be involved in research, examining and updating standards so that they were more evidence-based, and networking with others doing research.

At least seven participants wanted to do a study or continue with a study already planned. When asked about barriers they anticipated in carrying out their goals, the main barrier was time. The next major barrier related to lack of support or resistance from others and lack of interest from others. A lack of experienced researchers to give support was also identified as well as limited resources. Some did identify people resources that would assist them in their goals. A few had access to someone with research expertise. Mostly it was their colleagues and their superior who they identified. When asked to identify available resources, a few indicated they had very limited resources. The main resources were library and internet/computer access. Others included colleagues and two indicated the possibility of getting financial assistance.

Six-months on

The six-month survey reflected that participants had applied what they learned in a number of ways in their own settings. Seven of the 10 who returned the survey said they had applied what they learned. Based on their ranking of the commonly referred to goals in 2002, some had met their goals fully or partially, while others had done other things reflecting involvement in research and evidence-based practice.

The goal most fully met was learning more about evidence-based practice where seven said it had been moderately or fully met. The next highest-met goals related to working towards increasing staff interest in

research, doing sessions with staff about a study or something to do with research or research methods, and examining or re-examining standards of care for them to be more evidence-based.

Goals that received a lower rating of completion related to identifying the research done in the area, starting a journal club, networking with others doing research in their area of interest, planning a study, and conducting a study. When asked about goals six months-on, many had goals of learning more about evidence-based practice, increasing availability of tools/time for staff to be involved in research-related activities, examining and working on standards of care to be more evidence-based, and networking with others doing research in their area of interest.

Barriers

The barriers they anticipated in meeting their goals were the barriers they encountered. Other barriers were the feeling of not being as prepared as they needed to be and difficulty in accessing research articles in their language. They identified several people who helped them when they returned home. Although some received considerable support, others did not. They also asked what education topics would be considered helpful for them to reach their goals. Their suggestions included information on how to make evidence-based guidelines, how to facilitate use of guidelines, and more on research methods, getting grant support, doing internet searches, and how to organise and lead a project.

Positive impact

From the evaluation, it is clear that the workshop made an impact on these nurses. Even though they faced challenges, particularly related to time and resistance, they did receive support in their home environments. They had worked towards meeting their goals and although all of them may not have been accomplished, many of them were being acted upon and were continuing to be pursued.

It is clear that the workshop should continue to be offered but that further refinement would be helpful. Although it was clearer in the 2002 workshop that the focus was on implementing evidence-based practice, there were some participants who either felt it was too basic or too complex. For the 2004 workshop the focus has been clarified even more to decrease any confusion and any expectations that the goals include teaching of 'doing research'.

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