



## Celebrating diversity in Sydney

Over a thousand nurses from 34 different countries attended the 13th International Conference on Cancer Nursing held in Sydney, Australia.

The four-day conference opened with a ceremony which included performances by Aboriginal dancers and a colourful parade of flags representing all of the countries attending.

The multi-cultural opening coincided with World Indigenous Peoples' day and underscored the conference's theme: *Celebrating Diversity*.

ISNCC President Margaret Fitch said in her opening address that the current environment of rapid change in cancer, coupled with an increase in the incidence of the disease, gave nurses around the world an unprecedented opportunity to seize the reins.

"We have never been here before, we have never faced such a collection of changes before," Ms Fitch said.

She said advances in science and technology meant more costly and complex treatments were transforming cancer from an acute to a chronic illness.

The location of care was also changing, with more and more people being cared for in the home.

Ms Fitch said there were increasing disparities between cancer care in rural areas and urban centres and different countries faced different challenges, from aging populations to migration and AIDS.

There were looming human resources shortages as well as issues related to funding and research, she said



**Aboriginal dancers performing at the opening ceremony of the 13th International Conference on Cancer Nursing in Sydney, Australia.**

Ms Fitch said nurses needed to arm themselves with knowledge and skill if they wanted to have an influence in the evolving nature of cancer care.

"This environment of change is one that I think holds great potential for us as cancer nurses," she said.

"We have lots of opportunity to influence that change, but to do that you need to be there and you need to be ready. You need to be present and you need to be active.

"Cancer nurses have a great deal of wisdom and experience, and you make a difference in the lives of patients every day.

"That knowledge and wisdom certainly needs to come to bear in terms of policy and influencing cancer strategy directions. To do that we must have access to knowledge and skill and quality workplaces.

"The challenge that faces us is how to ensure that is available to cancer nurses around the world."

Governor of New South Wales and clinical professor of psychiatry Marie Bashir said the mapping of the human genome and advances in immunological research had opened horizons in cancer care that would *story continues on page two*

## opening ceremony

*from page one*

never have been dreamt of ten years ago.

Targeted chemotherapy and radiotherapy, bone marrow transplants and palliative care were all rapidly advancing areas, she said.

"This conference comes at a time when activity around the world in the fight against cancer has never been more vigorous, and never before has collaboration across disciplines around the world been so high," she said.

Professor Bashir welcomed the increased involvement of community groups and consumers in the planning, delivery and evaluation of cancer services, which had been particularly vigorous in Australia. However, preventative inroads were still to be made around the world in areas like tobacco control, nutrition and obesity, she said.

The entertaining keynote address was given by Australia's favourite science presenter Dr Karl Kruszelnicki who told delegates that advances in technology and medical science will spill over into cancer care in the future.

Dr Kruszelnicki outlined some recent scientific and technological advances that he predicted would affect cancer.

Science-fiction concepts like DNA

computers could one day put vast tracts of knowledge at people's fingertips, he said. "Imagine where you have access to all the information generated in every single field on a little grain of sand which is perhaps buried somewhere on your body, and if you want to know something...bingo, that information pops up into your brain."

The mapping of the human genome, meanwhile, raised the possibility of growing new limbs or organs, either inside the body or in a laboratory.

"This genetic revolution is going to take us in many different directions and you can see immediately where it's going to spill over into cancer work," he said.

Genetic research may also allow humans to one day live to between 500 and 5,000 years, Dr Kruszelnicki said.

"I reckon maybe 30, 40 years from now we'll be in the situation where we'll be living for 500 to 5,000 years with an 18 to 25-year-old body," he said.

Death was a new invention, he said. "Life has been on the planet for about 3.8 billion years. Programmed death has only been around for about one billion years — apoptosis is a new invention."

Kate Cameron, chairperson of the Cancer Nurses Society of Australia (CNSA) said more than 1,000 delegates



**Kate Cameron, chairperson of the Cancer Nurses Society of Australia welcoming delegates at the opening ceremony**

had attended the 2004 conference, the highest number in recent years.

This year also marked the first time the CNSA and the ISNCC had met in a collaborative venture.

# 14th INTERNATIONAL Conference on

# Cancer Nursing 2006

September 27th – October 1st 2006

Sheraton Centre

Toronto, Canada

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## Nurses developing role in genetics

Oncology nurses are developing increasing expertise in genetics, but they are being forced to learn on the job and many are confused about their roles.

Joan Botorff of the school of nursing at the University of British Columbia, US, said the recent focus on adult-onset hereditary diseases (AOHD), including cancer, had led to an integration of genetics into oncology nursing with an expansion of genetic services in predictive testing, diagnosis and gene therapy.

"This rapid change in the way we deliver health care and the integration of genetics into health care is starting to have ramifications," she told delegates.

In the US, almost half oncology nurses had received questions relating to genetics. Interviews with 22 Canadian nurses showed they had moved into genetics-related fields in a variety of ways.

Common was a nursing background in the psycho-social impact of AOHD, being part of a multidisciplinary team and having mentors, although these were geneticists or physicians rather than nurses.

But many felt their new roles were ambiguous. "Am I doing nursing? Am I doing genetic counselling or am I doing both?" one respondent asked.

They also suffered from isolation, lack of access to genetic information and concern about displacement of nursing roles.

"Our interview study told us that nurses were developing considerable expertise on the job and were making important contributions but the roles were not very clearly defined in some cases and this was problematic," Ms Botorff said.

Recommendations to advance genetic nursing in Canada included defining genetic competencies to guide nursing practice, increasing awareness of the relevance of genetics to cancer and supporting nurse researchers.



Frances Marcus Lewis was given a standing ovation from delegates after her moving presentation on risk and protective factors for children affected by parental cancer. Accepting the 2004 Robert Tiffany Lectureship from Margaret Fitch, ISNCC President, ahead of her address, Ms Lewis said she was honoured to be on the stage. Ms Lewis, who is credited with developing the "nurse as coach" role, likened oncology nurses to parts of a tree.

"As I sit at this conference for the last two days and hear your words and the other presenters I am humbled," Ms Lewis said. "All of us are parts of a tree and we haven't forgotten our roots and our roots are primary education and our values as well as those who came before us."

Ms Lewis recalled reading nursing texts as if they were novels. "For me I can remember going to school looking at research books and I can remember reading as if it was a wonderful novel, and thinking what a glorious thing that nurses are scientists." But she said she was also a clinical specialist "through and through".

## Supportive care

The role of nurse coordinator enhances supportive care to cancer patients throughout their treatment experience, Meg Rogers, nurse coordinator at Peter MacCallum Cancer Centre, Melbourne, Australia told delegates.

She said that newly diagnosed patients face an intensive diagnostic work-up and complex treatment options and too often these patients are left to navigate their own way through the process.

Nurse coordinators can demystify the treatment planning process, provide ongoing education, psycho-social support and help with symptom management.

Ms Rogers said that the role has shown itself to be advantageous to overall patient care. Patient requirements can be predicted in advance and appropriate allied health referral can be scheduled. It facilitates more patient-focused care and improves communication across all disciplines.

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## europa

### EU benefits not yet felt

The European Union is expected to have a positive effect on cancer nursing in Europe but these benefits may be a long way off, the ISNCC was told.

“In the long term (the EU) will be positive but in the short term one of the biggest challenges is cultural diversity,” said Jan Foubert, President of the European Oncology Nursing Society (EONS).

Mr Foubert said there were big differences in European oncology nursing education from country to country, with Scandinavia, the Netherlands and France the strongest and Spain, Italy and Eastern Europe lagging behind.

Theoretically having the European Union should help spread nurses and expertise around, but this was not as easy as it sounded, Mr Foubert said.

“It is easy to underestimate the impact this has on patients in terms of language and culture,” he said.

“I think it’s dangerous to say ‘in this country we have a lot of nurses, we’ll just put them in that country,’” he said.

Mr Foubert said new European Union laws on clinical trials were also causing some confusion as countries grappled with how this affected national laws.

EONS was established in 1984 and has initiated several pan-European educational programmes.

## africa

### Disease with no name

Cancer has such a low profile in parts of Africa that some countries don’t even have a word to describe it.

Petra Fordelmann, ISNCC board member and founding member of the African Oncology Nursing Society, described health care in Africa as “an ongoing and slowly developing process”.

Nursing standards were high in South Africa and Egypt but lacking in other parts, where surgery is not an option and there are no laboratories to interpret cervical smears.

Cancer in Africa is largely related to other health problems including hepatitis, AIDS and malaria.

Cancer patients often have to do with chemotherapy alone and limited access to pain relief means 80 per cent of patients suffer pain in the terminal phase, Ms Fordelmann said.

The African Oncology Nursing Society (AONS) has been established to address these problems after a meeting of African cancer nurses in Ghana last year. The aim of AONS is to increase communication among nurses across Africa and will be crucial in developing and improving cancer care in Africa.



Discussion panel (right to left) chaired by ISNCC past president Connie Henke Yarbro, Petra Fordelmann, Flora Yong, Jan Foubert, Kate Cameron and Clara Granda-Cameron

## south america

### Cancer increasing in South America

Cancer nursing in South America could not be viewed in isolation from social and political issues, Clara Granda-Cameron, board member of the Colombian Association of Oncology Nursing, said.

Ms Granda-Cameron said Latin America, a diverse region comprising 18 countries, was experiencing an increase in cancer.

“If the current trend continues it is estimated

that by the year 2020 one million people in the Caribbean and Latin America will die of cancer.”

Ms Granda-Cameron said health care reform was in crisis, with poor working conditions, few resources and often on-the-job training for cancer nurses.

Post-basic nursing programmes were only introduced in Latin America in the 1960s, she said.

## australia

### Remote rural care presents challenge

Extending cancer care to Australians in remote and rural areas, including the indigenous population, is one of the biggest challenges facing cancer nursing in Australia

National chairperson of the Cancer Nurses Society of Australia, Kate Cameron said Aborigines have a life expectancy 20 years lower than other Australians and suffer diseases usually associated with developing countries.

“This is unacceptable in a developed nation like Australia,” she said.

There is a lack of information about cancer in this population group. Only three of the country’s eight cancer registries hold

statistics for Aborigines.

Indigenous Australians also had lower rates of screening and less specialist care, and, as a result, often presented with advanced cancer.

“Australia has one of the lowest rates of cervical cancer in the world in their non-indigenous population but one of the highest rates in the indigenous population,” Ms Cameron said.

Some progress was being made, with indigenous groups developing guidelines for universities which are being adopted as core components of undergraduate nursing programmes.

## far east

### Cancer helpline dispels entrenched myths

Nurses in Singapore have embraced technology in the fight against cancer, with a newly established cancer helpline integrating “heart-ware into hardware”.

The cancer helpline links callers to nurse counsellors who use computers to provide an information and referral service. There have been more than 25,000 contacts in the past two years. The population of over 4 million consists of a mix of Malay, Indian and Chinese cultures.

Flora Yong, senior nurse manager in charge of the Cancer Education and Information Service (CEIS) at the National Cancer Centre Singapore said that oncology

nursing has come a long way in Singapore. Oncology nursing courses were first introduced locally in the late 1980s.

Ms Yong said cancer was Singapore’s number one killer, accounting for 28 per cent of all deaths in 2002. Deaths fell for the first time last year, thanks to early diagnosis and better treatment.

But problems in cancer care remained, Miss Yong said, including lack of coordination and poor public responses to awareness campaigns.

“Currently nobody wants to talk about cancer or hear about it for fear of catching the disease,” Miss Yong said.

## Sedation guidelines

Guidelines for palliative sedation have been developed by a multidisciplinary team including oncology nurses.

Palliative care specialist nurse Ellen de Nijs at the University Medical Centre in Utrecht, The Netherlands, explained the difference between palliative sedation and euthanasia to delegates. Euthanasia is legalised in the Netherlands under strict rules and criteria.

She said: "In our view palliative sedation is only the intentional lowering of consciousness of a patient by means of sedatives with the aim to relieve suffering. The intention is not hastening death but the alleviation of refractory symptoms."

The guideline on palliative sedation contains the definition of palliative sedation, the criteria, and advice about how to sedate a patient. There is also an overview about the differences between euthanasia and palliative sedation.

Ms De Nijs said that nurses play an important role in palliative sedation. She said: "This role is comparable with the decision-making process used with other ethical problems like the question of starting or stopping artificial hydration or nutrition at the end of life.



Professor Linda Sarna (right) receiving the ISNCC Distinguished Merit award from ISNCC President Margaret Fitch for her work on lung cancer, women's health and tobacco control. Professor Sarna's work has reached all corners of the world, breaking new ground and expanding the scope of nursing practice. She is based at the School of Nursing, University of California, Los Angeles, US.

"The main point is that the process must be multidisciplinary and the wishes of the patient and his or her family are essential. It is not only the doctor who decides, the decision is made in collaboration."

The guidelines which will be revised in

2006 covers the four phases of sedation: signalisation, decision-making, administration and evaluation. The guideline was developed by regional consultation teams, with help of other regional healthcare workers in palliative care.

# ISNCC INSTITUTE OF CANCER NURSING LEADERSHIP

**ISNCC is pleased to announce the forthcoming International Institutes of Cancer Nursing Leadership.** The aim of these institutes is to develop leadership capacity for the profession around the world through training that combines international and regional expertise.

**Participants will discover** their individual leadership styles and work with the faculty to develop these styles within the oncology team setting. Day two will look in-depth at the application of leadership within specific strands of which participants can choose one: Clinical, Research, Education and Policy making. The political aspects of leadership will also be explored within each strand. Groups will then select a specific challenge for development of a leadership strategy, that will be presented to the main group on the final morning.

**Keynote and plenary speakers** will provide additional insights into the concept of leadership and its manifestations within non-cancer, as well as specific oncology settings.

**Who are the institutes for?** Nurse/Unit managers, Clinical Nurse Specialists, Senior Nurse managers/researchers/ educationalists and other cancer-nursing professionals keen to make a difference for their profession. Employer support will be required for all applications to attend.



### Programme Schedule

North America . . . . . April 9 – 11th 2005, Toronto, Canada  
Europe . . . . . November 5 – 7th 2005 (location TBA)  
Africa & the Middle East . . . . April 8 – 10th 2006 Cape Town, South Africa  
Central & South America . . . . November 2006  
Australasia & The Far East . . . . to be announced

To express interest in a particular Institute obtain a registration form, please contact the Secretariat:

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## Guidelines advance mucositis care

Guidelines published this year on the management of mucositis reflect a new belief that the problem is bigger than previously



thought, the conference was told.

Until recently, treatment has been palliative, consisting mainly of mouth washes and pain relief. However, in the last three years researchers have learned much more about the pathobiology of mucositis, as well as new ways of treating it.

The mucositis study group of the

Multinational Association of Supportive Care in Cancer (MASCC) published new guidelines in the journal *Cancer* in May this year.

The study group's chair, Dr Dorothy Keefe, senior lecturer in oncological medicine at the University of Adelaide, told delegates that compiling the guidelines had resulted in "a great leap forward" in mucositis work, although many areas remain controversial.

Mucositis was once thought of as a surface problem but this had changed in the last decade, Dr Keefe said.

"We now know it goes right through the epidermis and the whole submucosa as well. It's not just a mouth ulcer."

Dr Keefe said studies in animals showed the changes in the tissue occurred in the first 24 hours after treatment, before any damage was apparent. Patients went on to develop ulcers and pain over the next 14 days.

Lessons from oral mucositis could be

extended to the entire gastrointestinal tract. Dr Keefe said: "Maybe we should be looking at global mucosal toxicity as the cause of other treatment symptoms including weight loss, fatigue, vomiting and diarrhoea."

She said the guidelines focused largely on better patient education. They also provide recommendations about what appears to work and what does not in terms of treatment, and make recommendations about pain relief.

Genetic technology would allow better targeting of treatments for mucositis in future, Dr Keefe said. "We need to be able to tell who's going to get it and target very expensive treatments towards patients who are going to suffer."

Mucositis was associated with a threefold risk of chemotherapy reduction, a threefold risk of infection and infection-related death and seven extra days hospitalisation per episode.

The guidelines will be updated for 2005.

## Prostate cancer fatigue warning

Prostate cancer patients undergoing radiotherapy need to be warned that treatment is likely to cause them fatigue, conference delegates heard.

Janet Edrington from the University of California in San Francisco, US, said fatigue was a distressing symptom for radiotherapy patients, with studies showing it affected between 60 and 93 per cent of patients during treatment.

Fifty per cent of patients reported fatigue three months after radiotherapy and there were suggestions that the effects of treatment were cumulative, she said.

Ms Edrington's findings on fatigue and

energy levels in prostate cancer patients arose from a study of 82 men receiving radiation therapy as primary or adjuvant treatment at two outpatients clinics.

The men were assessed before radiotherapy, in the middle, and at the end of treatment using a questionnaire and the Lee Fatigue Scale.

The results showed evening fatigue was higher than morning fatigue but both morning and evening fatigue increased over time. Patients reported their highest level of fatigue at the end of radiotherapy.

Energy levels were higher in the morning than in the evening but did not change

significantly over the course of treatment.

"Clinicians need to assess fatigue in men with prostate cancer who are having radiotherapy," Ms Edrington said.

"Patient education should acknowledge that fatigue will increase during radiation therapy, that fatigue is an expected effect of radiation therapy and that fatigue should be worse in the evening than the morning."

More research was needed to develop tests for fatigue in prostate cancer patients and to help patients undergoing chemotherapy cope with the problem, either through pharmaceutical or non-pharmaceutical means, she concluded.

## Emotions explored through art

Art therapy can help to relieve the emotional distress of breast cancer according to the results of a collaborative arts project.

Maria Noblet, a clinical nurse specialist in the UK, and artist Irene Lumley used art to explore the issues women experience when confronted by the illness.

In 2003 they ran a series of workshops for a breast cancer support group at the South Manchester University Hospitals NHS Trust, UK.

The results of the project — titled 'Beyond the Obvious' — were displayed

for international delegates at the Cancer Nurses Conference.

The aim was to provide a safe and supportive environment for women to explore issues such as femininity, relationships and self-image through a range of artistic mediums.

According to the poster presentation, working together gave the women a unique opportunity to access and share their personal cancer experiences, many of which had remained blocked until then.

The workshops evoked a huge spectrum of emotions from the participants, includ-

ing sadness, anger and humour.

The poster quoted Mrs Shah, one of the participants, who said the arts programme had helped her healing process.

"When I found out about the illness, it felt like a windmill had stopped. My life had stopped," she said. "There was a deadly silence...but now I've started healing. I feel like the windmill is moving towards a new life and a brighter future."

The complete works from the workshops were displayed in the Whitworth Art Gallery, Manchester, UK.

## Morphine access restricted

Ignorance and false beliefs about morphine were preventing nurses in some developing countries from implementing the World Health Organisation (WHO) cancer pain control programme, the cancer conference was told.

South Africa's Petra Fordelmann, an executive council member of the African Organisation for Research and Training in Cancer and ISNCC board member representing Africa, said many African countries had banned the import of morphine.

"The WHO has developed a pain control programme and nurses want to implement this but the reality is that only four countries in West Africa have access to morphine," Ms Fordelmann, who is a founding member of the African Oncology Nursing Society, said.

"Many countries have banned morphine from being imported mainly because of ignorance and false beliefs."

US-based tobacco control consultant and ISNCC board member Stella Aguinaga Bialous described limitations on the availability of morphine as "unethical", and said this was an area where nurses should be campaigning for change.

Dr Aguinaga Bialous said the incidence of cancer in the Americas was comparable to countries like the US and Canada but access to morphine lagged well behind.

"It's not that these countries don't have as much cancer pain, these countries are not having as much access to pain control and that's an issue for nurses to advocate for," she said.

Generic morphine was very affordable, she said. "It doesn't need to be the most expensive brand name, just plain, good old morphine."

Dr Aguinaga Bialous said the issue highlighted how cancer remained a disease divided along class and socio-economic lines.



The Past Presidents Award was given to Ahmad Al Khateib, Director of Nursing Education and Training at the King Hussein Cancer Center, Amman, Jordan by Connie Henke Yarbro, Past President, ISNCC.

After accepting the award Mr Al Khateib described the excellent work that had been done to develop education and professional support for nurses in Jordan.

## Colorectal patients ill-informed

People who have had sphincter-saving surgery for colorectal cancer are poorly informed about the effect it will have on their bowel function, an Australian study has found.

The research found that patients do not know how to manage common problems like diarrhoea, constipation, urgency, incontinence, leakage and incomplete evacuation. Patients often suffer in silence — some as long as twenty years — because of fears of being dismissed as neurotic by health care professionals.

"There was a wide range of long term problems with bowel function after colorectal surgery," Sue Nikoletti of the Centre for Nursing Research at Sir Charles Gairdner Hospital in Perth told the conference.

Colorectal cancer (CRC) is the most common cancer in Australia with 12,000 cases a year. Most research into CRC is focused on patients with a stoma, Ms Nikoletti said, but her work aimed to fill a gap for patients who had survived surgery with their anal sphincter intact and able to function.

The study involved developing, implementing and evaluating an educational programme designed to improve knowledge and management of bowel problems.

Ms Nikoletti said problems decreased among those who did the programme, which involved booklets and educational seminars. Significant improvements were observed in relation to bloating, bowel control and social and sexual relationships.

She said many patients wrongly

believed that eating less would decrease leakage and that soft motions made evacuation easier. They also had poor knowledge about certain foods and drugs that loosened the bowels and the benefits of pelvic floor exercises.

One of the most common dietary misconceptions involved sugarless gums and lollies, which could have a laxative effect.

"Many people said to us, 'we live on these all day, we starve ourselves before going out to a function to prevent leakage'," she said. "Of course it's contributing to their problems."

Ms Nikoletti said education needed to begin at the time of surgery. "Patients and family members need this information and they need it at the time of surgery," she concluded.

## Aromatherapy reduces fatigue

Aromatherapy massage using lavender oil can reduce symptoms of fatigue in breast cancer patients, according to a poster presentation by researchers from Chulalongkorn University in Thailand.

The study suggested that training family members or care-givers in aromatherapy massage could increase the likelihood and speed of recovery by minimising debilitating tiredness in cancer patients.

The participants chosen for the study

were aged between 20 and 59. All had had a mastectomy and were undergoing chemotherapy.

One group had individual education about the causes and effects of fatigue and the positive effects of aromatherapy.

They were also given a 30-minute Swedish massage using lavender oil during the second week of the study. A control group received normal nursing care.

Researchers said the results of the study

revealed that the combination of lavender oil and massage, together with increased education about the treatment, reduced fatigue and increased levels of well-being amongst the study group.

Recommendations have now been made for the evaluation of aromatherapy massage in other groups of cancer patients to find out if it can alleviate symptoms other than fatigue.

# Turn tobacco companies into pariahs to combat cancer spread

Tobacco companies should be treated in the same way as malarial mosquitoes according to a leading Australian anti-smoking advocate.

Professor of public health at Sydney University Simon Chapman told the conference that “vector control” principles could be applied to the makers of cigarettes.

“If you want to do something about malaria you have to study mosquitoes and if you want to do something about lung cancer you have to study tobacco companies,” Professor Chapman told delegates.

“What we want to do in vector control is build a social environment where the tobacco companies’ participation in civil society is seen as being incompatible with the core values of such a society.”

He said “de-normalising” and isolating the tobacco industry from participation in ordinary community affairs would weaken tobacco industry influence and aid tobacco control.

Professor Chapman said tobacco companies would become unappealing political



allies if they could be turned into pariahs.

“We have got to try and turn the tobacco industry into pariahs so politicians don’t want to stand next to them in photo

opportunities,” he said.

“Our objectives become to send a message that embracing the tobacco industry will bring adverse publicity and discredit to you.”

Professor Chapman said tobacco companies had recently adopted a new approach of trying to appear socially responsible by infiltrating ethical corporate conduct conferences, funding corporate responsibility study centres and supporting causes like homelessness and domestic violence.

He said that according to the World Health Organisation (WHO), tobacco was the single highest risk factor for death in the world, beating HIV, diarrhoea, malaria, road accidents, suicide, violence and war.

He said Australia was “doing quite well” in reducing smoking compared to other countries, but one in five adults still smoked daily.

Australia had achieved a large fall in smoking prevalence through cigarette pack warnings, bans on tobacco advertising and smoke-free public transport and workplaces.

## Lobbying success via internet

Tobacco companies were dropped from two recent corporate responsibility conferences as a result of action by anti-smoking lobbyists, nursing delegates in Sydney were told.

Professor of public health Simon Chapman said the communications manager of Philip Morris was “uninvited” from a Sydney corporate communications conference after the Cancer Council of Australia wrote to all speakers urging them to reconsider sharing the stage with a

tobacco company.

The speaker had been scheduled to talk about combining corporate social responsibility with business objectives at the conference in Sydney in September.

Earlier, after a global campaign, British American Tobacco and Philip Morris were removed from the list of sponsors on the website of a conference on ethical conduct to be held in Hong Kong in October.

“Over 80 professional ethicists, some of the biggest names in the world of

bio-ethics, signed our petition,” Professor Chapman said.

“We did all this through the internet, letter writing to delegates, e-mails to ethicists around the world, we used networks,” he said.

“To cut a long story short, the cigarette companies have been taken off the website, and the Australian one similarly has uninvited Philip Morris from the Australian conference.” he concluded, describing the success of the project.

## Nurses can alleviate cancer guilt

Nurses need to help lung cancer patients get over their guilt and shame, and encourage them to speak out against tobacco, US-based tobacco control consultant Stella Aguinaga Bialous said. Ms Aguinaga Bialous said lung cancer suffered from poor public relations and a lack of advocates.

This was partly because of low survivor rates and partly because of entrenched attitudes that lung cancer was a self-

inflicted disease.

Patients, who were a potentially powerful lobby group against the tobacco industry, needed to understand that they weren’t responsible for their illness, she said. This would empower them to speak out against the industry.

“Lung cancer has not received the emphasis that other cancers have,” Ms Aguinaga Bialous told the conference.

“Part of it is because survivor rates are very poor and part is because there’s a lot of guilt and shame.

“A lot of patients think they did that to themselves, so they don’t become advocates because they are embarrassed that they smoked until they got lung cancer.

“As nurses we have a duty to help those patients understand that they didn’t do that to themselves, the tobacco industry did.”

# Partners ignored in sexual problems

Partners of cancer patients are being neglected as potentially indispensable allies in assessing and managing sexual problems related to the illness, Isobel White, clinical fellow in cancer care at St Bartholomew's School of Nursing and Midwifery in the UK said.

Ms White spoke about the often overlooked sexual consequences of cancer and its treatment, saying sex remained taboo for many patients, partners and health care professionals.

A review of the literature showed sex was often lumped in with wider quality of life studies and focused on individuals rather than couples.

The sexual consequences of breast cancer, and more recently prostate cancer, dominated studies but cancers that didn't directly affect parts of the body associated with sex – such as head and neck cancer, lung cancer and colorectal cancer – were not covered.

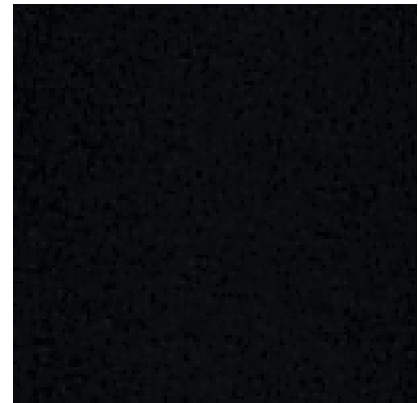
Ms White said cancer nurses ignored patients' partners at their own risk. "An individual focus is likely to limit your assessment and your subsequent management of sexual difficulty," she said.

"Partners are invaluable in being able to offer contrasting views of sexual problems, not just after diagnosis and post treatment but also pre-existing sexual difficulties the couple may have experienced."

"While patient-centred care remains paramount, when it comes to sexual recovery the partner becomes an indispensable ally in both the assessment and the management of sexual problems."

Ms White pointed out that deficits in evidence based reports of psycho-sexual practice were undermining the ability of health care professionals to understand and minimise the sexual consequences of contemporary cancer therapy.

"So we continue to search in vain for the



pink Viagra or a biomedical or pharmaceutical panacea to soothe our collective conscience," she said.

Ms White said there was a need to promote the study of sexuality and develop assessment and intervention tools for cancer-related sexual problems if oncology practice was to be brought into the 21st century.

# Thai massage recommended

Traditional Thai massage is being recommended as an adjuvant therapy for cancer.

Jeujan Watakiecharoen, a doctoral student in the Faculty of Nursing at Chulalongkorn University Thailand, said that massage has long been recognised as beneficial in nursing, but scientific literature specifically addressing the benefits of Thai therapeutic massage was scant.

Thai massage, a 2,500-year old method, is an interactive manipulation of the body incorporating every area including the hands, feet and tongue to stimulate the

movement of energy through the body. It is traditionally viewed as a powerful healing art, which benefits the mind, body and spirit.

A search of all databases in five Thai universities found 11 suitable studies on the physiological and psychological effects of Thai massage.

The studies included cancer patients who had undergone mastectomy and patients with tension headaches, diabetes and thyroid disorders as well as chronically ill and post-operative patients.

Subjects received Thai traditional mas-

sage for five to 60 minutes on the head, shoulders, neck, back, arm, hand, foot, leg and abdomen. The research was assessed for outcomes including pain, numbness, patient satisfaction and vital signs.

Ms Watakiecharoen said the studies surveyed showed traditional Thai massage could relieve pain and muscle tension and improve fatigue, mood, sleep and appetite.

"Given the inexpensive nature of this intervention and the lack of adverse events, it is recommended as an adjunct to nursing care practices," she said.

# SARS impacts on cancer care

The Canadian outbreak of severe acute respiratory syndrome (SARS) last year delayed treatments for cancer patients and put significant stress on nursing staff.

Nurses were having to inform patients that chemotherapy treatments were postponed indefinitely. SARS was declared a national emergency in Canada in March 2003.

Mandy Townend-Kolodziej, a nurse at the Princess Margaret Hospital in Ontario, said: "Many chemotherapies and cancer treatments were cancelled in the first few days of the outbreak."

She described to delegates attending the cancer nurses conference the fear,

desperation and anger experienced by cancer patients and their families. Those emotions were often vented directly at nursing staff.

"When I told one man he wasn't allowed to take his wife into the hospital [because of the risk of SARS], he started threatening me," she said. "He was a huge man and was looming over me and trying to intimidate me, and I had to say 'Back off buster, I'm not doing this because I want to, but because it's the law'."

Ontario hospitals were totally unprepared for the effects of SARS and fell into chaos Ms Townend-Kolodziej said.

Huge stress led to a high turnover of

staff. Her own feelings of guilt and helplessness even made her hand in her own resignation, but it was refused.

"I wasn't supposed to be hurting these people", she says. "I was supposed to be helping them. And if I couldn't do that, why was I nursing? I felt useless."

Yet she said the SARS epidemic had a silver lining. She feels colleagues gained new respect for each other, a new sense of team-work emerged, and they learned the value of humour as a coping mechanism.

"It's definitely made me a better person", she says. "No one was to blame for the crisis, but a huge lesson should be learned from it."

# Review of the Sydney posters

Undertaking a review of the posters presented at the Sydney conference is a huge responsibility. It is a challenge to do justice to the excellent work that represents cancer nursing from across the world.

As Gabrielle Prest and I stated during the closing ceremony, with 277 posters covering 13 topics from over 20 countries, this has to be both a 'whistle-stop tour' and a fairly subjective view.

For the purpose of this report I have attempted to present the diversity of the topics but have also focused on the similarities and problems faced by nurses from very different clinical and cultural areas.

Posters have a dual role. They allow those nurses who dread the thought of presenting to a large audience the opportunity to share their work. It also ensures that a conference can cover a much wider range of work.

It would have been impossible to have the time to cover all this work with seminars. However it must be acknowledged that the initial research, audit or educational initiative and the effort in poster design and development must never be underestimated.

## Early detection and screening

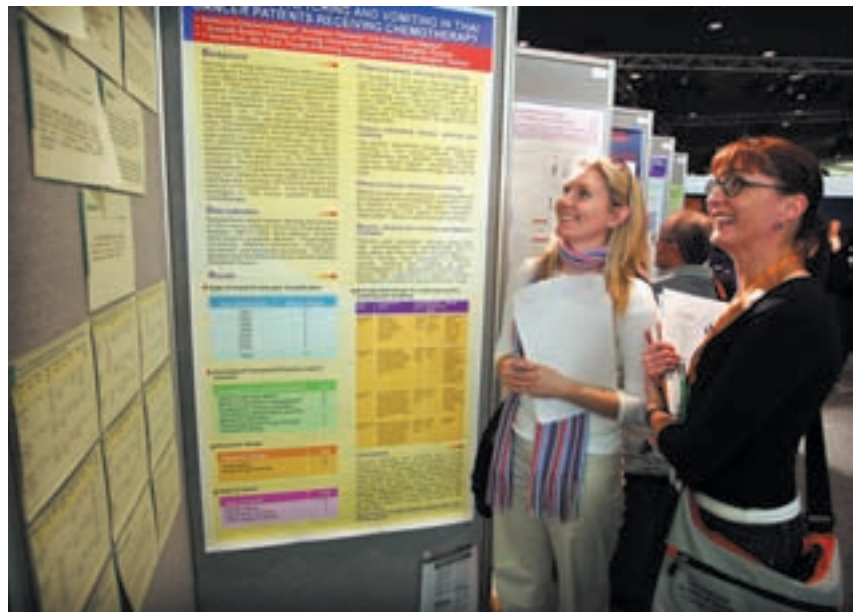
It is difficult to know where to start but issues around early detection and screening seem appropriate. This subject was covered from many countries and communities. The needs of African-Americans were clearly identified at the University of Arkansas, US as needing a different type and style of information to encourage them to attend breast-screening programmes.

South Korean researchers had also looked at breast self-examination in women who had already had breast cancer, clearly demonstrating a differing need for information.

Cervical screening was a particular topic of research for the National Cancer Institute in Rio de Janeiro, Brazil, an area of the world with significant mortality statistics for cervical cancer. However, researchers in Ontario, Canada also identified that women in remote communities had a negative attitude to attending both breast and cervical screening.

## Breast cancer

Breast cancer remains a topic which attracts much research and discussion. Chulalongkorn University, Thailand was particularly interested in the factors predicting Quality of Life (QOL) for women post-mastectomy. This was also the subject of work from the Milovic Sanja College of Nursing, Serbia and Montenegro with interestingly similar findings.



The psychological impact at initial diagnosis as discussed in work from Singapore and the role of a breast cancer link support nurse as discussed in the work from Napier University, Edinburgh, UK all impacted on the women's ability to cope.

Work from Brazil and by the Inner and Eastern Melbourne Breast Cancer Consortia, Australia, clearly highlight the complex pathway a woman with breast cancer will have to undertake.

## Care pathways

Ensuring access to information throughout the cancer experience/pathway/journey was the theme in many topic areas and many languages. The Reinier de Graff group of Hospitals in Delft and Voorburg, Netherlands had developed a website for information needs. The Ishikawa Prefectural Nursing University, Japan looked specifically at information needs for patients attending outpatients. The University of Tokai, Kanagawa, Japan considered the information-seeking behaviours of patients undergoing stem cell transplants. An information strategy for men with prostate cancer was the subject of the work from Queens University School of Nursing, Ontario, Canada.

This leads to one area which can often be overlooked or forgotten, sexuality. Elizabeth Searle from Cancer Relief Macmillan, UK examined the need for sexuality and palliative care to be discussed openly and not hidden. Nurses from Barcelona, Spain had looked at the impact of cancer of the testis on male sexuality. A senior sister from the cancer research team at the Mid-Yorkshire Trust, UK, and the Institute of Cancer, New Jersey, US, both considered the impact of

cancer on sexuality and fertility.

Another topic area was symptom management. Symptoms caused by both the cancer and the treatments were considered. Radiotherapy and its potential side-effects were considered in relation to sleep disturbance for men treated for prostate cancer by the University of California, US.

Dealing with radiation wounds and skin burns was the subject of similar work from China and Westmead Hospital, Australia. Foot reflexology was considered in work by Inje University, Busan, Korea as supportive for radiation induced nausea.

## Complementary therapies

The role of complementary therapies in the support of many patients was considered. Researchers from the Gunma University Hospital, Japan asked the question 'what did cancer patients hope to get from traditional Japanese/Oriental medicine?' Another poster from the Red Cross Hiroshima College of Nursing considered current attitudes to complementary therapies.

A poster from Southampton Hospital, UK discussed the lack of scientific evidence for complementary therapies but acknowledged the anecdotal belief in their benefits.

Nurses from the Chulalongkorn University in Thailand demonstrated the benefits of massage on fatigue in women with breast cancer.

Palliative care was also extensively discussed with the impact of improving the delivery of this care in the acute setting the subject of work from the Aga Khan Hospital Nairobi, Kenya. Nurses from New Zealand discussed the importance of

developing palliative care teams to support staff in acute settings whilst the Queensland University of Technology, Australia emphasised the importance of palliative care for all transplant patients.

Education was a recurring theme. Posters from Hertfordshire and Birmingham, UK, Odense, Denmark and the National Cancer Institute, Cairo University Egypt all agreed on the importance of including education on cancer in the pre-registration curriculum.

The research undertaken at the Mount Royal College, Alberta, Canada, clearly demonstrated the lack of knowledge about cancer by nursing students. And the City of Hope Medical Center, US demonstrated the benefits of end-of-life education in cancer centres.

Where the patient receives their care was varied and often locally driven. For example, the University of Africa, Pretoria are developing community-based home care.

Aarhus University Hospital Denmark has developed patient-hotels to keep the patient outside the acute setting but ensuring access to professional support.

Finally the theme of recruitment and retention. This topic was discussed often throughout the conference both formally and informally during networking. Many posters echoed the Western Cape, South Africa research demonstrating the need for employers to support their staff if they wish them to remain. Work on clinical supervision was presented by Misemcordiae Hospital, Australia, amongst others.

Supporting the development of nurses from 'generalist to specialist' was the theme from Scotland, Birmingham and London, in the UK. The University of Texas MD Anderson Cancer Center, US reflected on the importance of the management of the multi-diversity of the workforce if the cultural mix is to be a benefit not a problem for service development.

### Conclusion

I hope this has given you a flavour of the excellence and diversity of the poster exhibition in Sydney. We anticipate that in Toronto, Canada in 2006 we may do things slightly different, always learning from our experiences! There will be specific time allocated for posters within the day, not just at break times, where authors and participants can meet to discuss work and share ideas.

We will also encourage all poster presenters to have handouts to share their research and developments with others. My final advice to future presenters would be to keep the poster interesting and eye catching, not too abstract but informative and to the point, and to keep statistics and in-depth discussion for a handout.

*Candy Cooley,*

*ISNCC Secretary/Treasurer,*

*Palliative Care Development Manager,  
Worcestershire, UK*

## Pre-conference workshops report

### Palliative care

A workshop on nursing strategies in palliative care attended by over 70 nurses from 10 countries was held prior to the conference.

The event was sponsored by the Centre for Palliative Care Research and Education, Brisbane, Australia, and the diversity of nurses attending brought with them a range of experience and a great deal of energy and enthusiasm.

The first half of the day was designed as a 'skills update', focusing on current evidence-based interventions and developments in the areas of pain and nausea symptomatology.

Cathie Piggott, Nurse Researcher at the Peter MacCallum Cancer Centre, Melbourne

highlighted important issues regarding optimal pain management through the use of small group case studies.

Dr Kate Clark, Staff Specialist Physician at the Central Sydney Palliative Care Service gave a comprehensive and stimulating overview of a recent study, which involved a systematic review of the management of nausea and vomiting.

The latter half of the day, led by Laurie Grealish, Senior Lecturer in Nursing at the University of Canberra, Australia, focused on professional issues from both local and global perspectives exploring contemporary developments such as the nurse practitioner role, the need for global partnerships and innovative models of

care to meet the challenges that face those involved in cancer care.

Although there are many countries still to see the development of such advanced nursing positions, discussion around the scope of nursing practice and the current situation, and how it would best meet the future needs of oncology/palliative care patients, was significant.

In the last session of the day, Ms Grealish challenged the group to come up with concrete strategies to build meaningful and sustainable networks across the globe. A group e-mail has been developed and hopefully networks and relationship across cyberspace will continue to grow at least until 2006 when we meet in Toronto.

### Evidence-based practice

A one-day workshop was held prior to the Sydney conference focusing on moving towards evidence-based practice. This event was co-sponsored by ISNCC and the Oncology Nurses Society (ONS) US.

This was the third such workshop held with the first held in Oslo, Norway (2000) and the second held in London, England (2002) during the ISNCC biennial convention.

The purpose of the 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 is oncology nurses who have minimal or no research knowledge but who are interested in understanding more about evidence-based practice. It is an excellent opportunity for nurses who are being asked to engage in research and research utilisation but do not know where to begin.

This time, Dr. Debbie McGuire from the University of Maryland, US and Dr. Debra Bakker from Laurentian University in Canada were the instructors.

Twenty nine nurses attended from

Jordan, UK, Hong Kong, Sweden, China, US, Taiwan, New Zealand, Tasmania, and Australia. Their rich backgrounds and experience added a wonderful flavour to the discussions.

Participants said that the workshop was very useful and not complicated to understand. From comments that they made it was clear that the workshop assisted them in moving forward in learning more about evidence based practice.

It is clear that such a workshop is needed and plans are to continue it at the ISNCC Toronto Conference in 2006.

## Voices from the conference

Delegate nurses share their views of the conference

**Stephanie Churchill, senior sister, Southampton Cancer Centre, UK**

“The conference has been really good. There’s a lot of information and many different subjects have been covered. I work on the leukaemia and transplant unit. We heard some really interesting stuff on mucositis this morning, a really good talk, and they’ve got some guidelines out that we’ll have a look at. There are things we’ll definitely take back home with us.”

**Donna Gerber, clinical nurse specialist, MD Anderson Cancer Center, US**

“The organisation has been excellent and the range of subjects very good. I read every one of the posters because if someone has put that much work into it, I like to read them. Plus they give me ideas. But I’d like to see the next conference focus more on targeted therapy.”

**Catherine Spencer, MacMillan clinical nurse, specialist gynae-oncology, Barts and The London NHS Trust, UK**

“It’s been a great conference. I was really moved hearing about family-centred care

this morning, and the whole question about children being left out or being over protected. I got some really practical tips.”

**Violet Platt, clinical nurse manager, medical oncology, Sir Charles Gairdner Hospital, Perth, Australia**

“Every single speaker’s been wonderful and what’s been really good about this conference is that they’ve really got down to clinical issues. They’ve really tried to marry up what we’re doing on the floor with what’s going on out there. I’ve found it really beneficial.”

**Janice Middleton, oncology nurse, lecturer practitioner, Southampton University, UK**

“I’ve been to a few of the international conferences and this one is more focused on what I’m interested in, which is acute oncology care. So far, most of the sessions have been very interesting. I went to a session about fatigue which I was particularly interested in, with very good speakers — very interesting perspectives from different parts of the world.”

**Sue Perrot, nurse unit manager, Townsville Cancer Centre, Australia**

“There’s been some really good work on palliative care and looking at new treatments. And it’s been great networking. I’ve made heaps of contacts in other countries. And the posters have been really good — there’s lots of information there.”

**Sue Palmer, sister, Wellcome Trust Clinical Research Facility, UK**

“It’s awe inspiring, I wasn’t expecting the conference to be so huge. It’s fabulous that there are so many different nations here. What worried us was whether we were offering a good service. But listening and looking and reading posters, we’re actually on the right track and that’s encouraging.”

**Jason Bowie, senior staff nurse, Poole Hospital, NHS Trust, UK**

“The smoking cessation issue seems to be big here in Australia. It doesn’t get the same coverage in the UK. It’s interesting to get a view of what cancer treatment is like in poorer nations, where perhaps it’s not as high a priority as it is the Western world.”

## Psychological care integral for patients

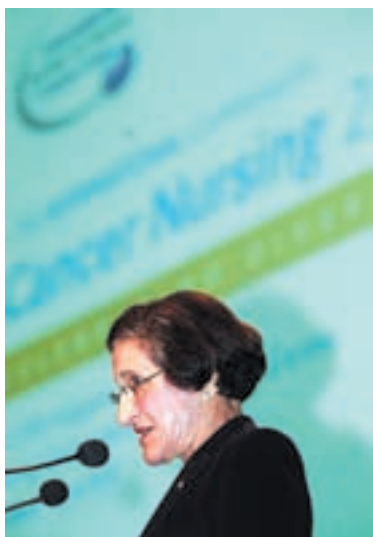
The increased role of psychological treatment in cancer was welcomed by Governor of New South Wales and clinical professor of psychiatry Marie Bashir.

“I am pleased to note the increased acknowledgement of the benefits of psychological insights as an integral component in the improved care of cancer patients,” Professor Bashir said in her address to delegates.

“Nurses have a vital contribution in this regard, with their long acknowledged skills of sensitive communication.”

The 2004 conference heard numerous presentations on the traditionally neglected psycho-social aspects of cancer, both for the individual and families.

Professor Bashir also welcomed a plenary session by Karen Luxford, programme director of Australia’s National Breast Cancer Centre, on the role of psycho-social clinical practice guidelines for health professionals.



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