international
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First ISNCC Institute of Leadership held in Toronto

The International Society of Nurses in Cancer Care has launched an exciting new learning opportunity for cancer nurses. The first International Institute of Leadership in Cancer Nursing was held in Toronto in June 2005.

The Institute was developed to bring cancer nurses together to learn about leadership and develop their skills in influencing change. Thirty cancer nurses from across Canada participated in the first International Institute in Toronto. They worked with five international faculty and five Canadian faculty members, all leaders in cancer nursing.

The international faculty included Jan Foubert (Belgium), Sanchia Aranda (Australia), Petra Fordelman (South Africa), Cibele Andrucioli De Mattos Pimenta (Brazil), and Kevin Sowers (United States). The Canadian faculty included Esther Green (Toronto), Debra Bakker (Sudbury), Rose Steele (Toronto), Beverly Page (Toronto) and Doris Howell (Toronto).

The Institute was held over two and a half days. A series of plenary speakers, individual and small group learning experiences, and pre-session assessments by co-workers about leadership behaviour provided learning opportunities.

Gail Donner, Professor Emeritus, University of Toronto, challenged participants to think about the evolution of leadership ideas in nursing. She illuminated the way in which nursing has come to think about leadership as the capacity to make change or influence how care is given to patients. She encouraged attendees to share their perspectives and ideas with other colleagues and to work collaboratively when trying to influence change in patient care.

Paula Rieger, Director of International Affairs for the American Society of Clinical Oncology, challenged participants to think about the "power of one". No matter what role any one of us may hold, as an individual there are changes we can influence. As cancer nurses we have opportunities to work with patients, families, and communities as care providers, as well as to work in professional societies and in political activities. If patients are to receive the care they need in the future, leadership is needed from nurses at every level.

Leslee Thompson, Provincial Vice President Cancer System Integration and Performance, Cancer Care, Ontario, provided the third challenge address. She encouraged the participants to think about the kinds of career experiences that would provide the knowledge and experience one would need to be an effective leader within a desired career pathway.

The majority of the time was spent in small groups. The interaction allowed participants to use clinical case studies to test and apply their new knowledge about leadership and skills. The nurses had a variety of opportunities to identify ways to build on their personal leadership strengths and compensate for their leadership weaknesses.

Max Issac of 3 Circle Partners, Ontario led the participants through the small group sessions. He helped the groups learn more about the value of personal insight about leadership behaviour, recognition of leadership behaviour in others, and building effective teams for change using the knowledge of one another's strengths and weaknesses.

For many of the participants, the feedback they received about their personal leadership roles was seen as tremendously helpful. They commented:

"It made me aware of my potential."

"It helped to validate what I thought and areas in which I need to work on."

"I realised that I have strengths and weaknesses as a leader."

The International Society of Nurses in Cancer Care is planning to offer Leadership Institutes to cancer nurses on a regional basis over the coming years. ISNCC hopes

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ISNCC and the European Oncology Nursing Society (EONS) have signed a Memorandum of Understanding. This step will help the two societies, which share common goals, to be strengthened by working together. ISNCC president Margaret Fitch is pictured here with Jan Foubert, EONS president at the signing.

Exciting opportunities

A very exciting event occurred this past May. The World Health Organization passed a resolution concerning cancer control at its 18th World Assembly. The passage of this resolution means that the issue of cancer control is a priority for the WHO. Work is now under way to develop materials that will assist member countries in thinking about, planning, developing, and implementing national cancer control strategies. Documents are currently being designed and will likely be released next year that will be guides for the member countries to use as they design their own approaches.

Cancer control, by definition, means all those activities that might be undertaken with the intention of eradicating cancer or reducing the burden and suffering from cancer. This means that prevention, diagnosing and treating, caring and supporting, research, and advocacy are all aspects that need to be taken into account. Additionally, one could argue that health human resource planning, standards and practice guidelines, information systems, and monitoring of quality should also be included in plans for the future. A cancer control strategy is an agreed upon plan or set of ideas about what needs to happen to achieve improved outcomes for cancer patients and families. Within such a plan there are activities that are priorities for action and assigned roles and responsibilities for achieving the desired end points. Often cancer incidence and prevalence are considered important indicators of the cancer burden. However, I would add that issues of access to quality care, burden of suffering, and quality of life are ones we need to be thinking about as well.

Clearly there are implications for cancer nurses and about cancer nursing involvement if national cancer control strategies are to be developed and implemented. Nurses are key players in the delivery of cancer prevention and care. They can be the backbone of a palliative care service in some countries. They have good ideas about what is needed and what works in the daily delivery of services. Cancer nurses have excellent relationships with patients and survivors and are in a good position to champion the voices of these consumers of cancer care. Furthermore, given their key function in the caring patients and families, the current and projected shortages of nurses needs to be given consideration within any cancer control strategy. Human cancer resource planning must think about cancer nursing roles and the education necessary to support those roles. Cancer nursing societies, as well as individual cancer nurses, need to be thinking about how to influence the work in their own countries.

As the work moves ahead with the WHO, I will keep you informed about its progress. The ISNCC has been invited to participate in the Technical Writing Group that will develop key documents for member countries to use. We need to be certain that cancer nurses participate in the development of their own countries' cancer control plans and subsequent implementation.

ISNCC has created a new committee of the Board to look at issues related to Policy and Planning. Patsy Yates (Australia) and Shelley Dolan (United Kingdom) are co-chairing this committee. The group is charged with providing leadership to ISNCC about activities in policy and planning activities. A report from the inaugural policy and planning cancer nursing workshop, held in Sydney last summer, is due for release soon and will be on the ISNCC website.

Margaret Fitch
President ISNCC

Call for nominations

Please send in nominations for the Robert Tiffany Lectureship and the Distinguished Merit Award. These prestigious international nursing awards are given by the ISNCC.

The lectureship was created to keep alive the memory of Robert Tiffany, founding member of ISNCC. His inspiration lives on through the biennial lectures, given by ambassadors within the profession of cancer nursing.

The successful nominee will be a registered nurse who has made a significant contribution to cancer practice, education, research or management at a national level, and preferably also at a regional or international level.

He or she will be expected to present a lecture of a high professional standard to an international audience at the 14th International Conference in Toronto, Canada in September 2006, and also provide a paper for the ISNCC newsletter.

The second award, the Distinguished Merit Award, is given every two years in recognition of an outstanding contribution to cancer nursing. The award recognises an individual whose contributions go beyond that which would be normally expected of a nurse in his/her particular sphere of professional endeavour.

Nominations for both awards are welcome — the deadline is November 30th 2005.

For further information, please either contact the ISNCC Secretariat (**secretariat@isncc.org**) or visit the ISNCC website (**www.isncc.org**) to obtain a nomination form.

http://www.isncc.org

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New developments in radiotherapy treatment

This detailed paper, presented to delegates at the ISNCC conference in Sydney, gives a comprehensive update on radiotherapy

Radiotherapy is one of the key treatments for cancer with over two-thirds of cancer patients receiving radiotherapy. Radiotherapy is used as a curative or adjuvant modality or as a palliative treatment, highlighting the versatility of this therapy in managing complex cancer disease.

Like most cancer treatments radiotherapy has adverse effects. The aim of therapy is to give a curative dose with minimal normal tissue effects (Tobias, 2000). Late effects of treatment such as fibrosis, brachial plexopathy or cardiac myelopathy can cause long term symptoms. The tolerance of these normal tissues to radiation dictate the dose that is prescribed but this is also balanced with curing the cancer. Many of the developments have been in understanding and balancing this dose relationship with adverse effects.

Biological response

Developments in radiotherapy can be divided into three areas: biological, physical and service-related innovation. Scientists are questioning exactly how radiotherapy works — why some people do better than others and what factors influence curative potential of radiotherapy. However, there are many other clinical questions: how do we provide accurate delivery of therapy? what information should patients receiving radiotherapy get? when should they receive this information? how do we assess and manage side effects as a result of radiotherapy? (Faithfull, 2005)

Radiation affects are complex with biological effect interacting with damage caused by both direct and indirect means, leading to cell death during mitosis or successful repair of the cell. Knowledge of ionisation events and what hinders recovery have been important in predicting how tumours will respond to radiotherapy and may help explain why sometimes radiotherapy treatment fails.

The biological response to radiotherapy is linked to several factors. The tumour size is important, in that the bigger the tumour the greater the radio resistance due to areas of hypoxia as well as the total number of cells that need to be destroyed. Repopulation of existing tumour cells occurs following fractionation. If the cancer is growing exceedingly fast then it may expand between each daily fraction of treatment. This may result in treatment failure. The cells redistribute following initial radiotherapy expanding into the tumour spaces left by those destroyed from the radiotherapy. This can cause pressure or influence symptoms for the patient. Re-oxygenation of the tumour occurs following radiotherapy as poor blood supply within the tumour means that the centre of the tumour often lacks oxygen. Ionisation requires oxygen therefore this indirect effect of radiation damage is limited to those tissues that are oxygenated. Fractionation allows for this re-oxygenation to occur. Radiosensitivty of the tissue involved can also influence the success of radiotherapy. Increased knowledge of radiosensitivity syndromes and ways that sensitivity can be enhanced has led to combined modalities. Chemo radiation is one of these innovations (Lewanski & Gullick, 2001).

Influencing the occurrence of acute and late side effects is more complex as cell death during mitosis is generally caused by un-repaired or improperly repaired chromosomal damage. This may not always occur at the time of radiotherapy. Certain cell types are more sensitive to radiotherapy especially lymphocytes, spermatognia and serous cells. This type of death is rapid and is often associated with cells in specific tissues such as crypts in the intestine. Other cells such have slower cell kinetics and may take several weeks to months before damage is manifested (Hill et al, 2001). Late effects develop through complex interacting processes that are not yet well understood. Patient-related factors such as trauma, and co-morbidities such as diabetes and hypertension can influence vasculature and onset of morbidity (Stone et al, 2003).

Hyperfractionation

Developments in radiobiology have helped clinicians understand and adjust fractionation schedules to match those of the rapidly growing tumour. Repopulation during protracted treatment is one of the reasons for radio resistance. For head and neck patients hyperfractionated radiotherapy (1.2Gy twice daily) or the concomitant boost technique of doses up to 70Gy have been shown to improve local control of the disease and significantly improve long term survival for patients (Burnet, Benson & Williams, 2000). However, this has also had a subsequent effect on acute side effects and need for support.

Although benefits have been identified in adapting treatment to enhance tumour response there are some key considerations in decision making, patient education and scheduling such fractionation regimes. Increasing the number of fractions may increase the life span of the individual but at a cost in toxicity and adverse effects. Providing the additional support and machine time has been challenging in the wide scale use of hyperfractionated regimes in regional centres. This is a balance between treatment resources, scheduling, outcomes and support requirements both for delivery as well as patient care.

Chemo radiotherapy

Another development is chemo radiotherapy. This is a fast moving field using the combined action of both cytotoxic drugs and radiotherapy to work together. This is now an integral part of radiotherapy treatment for head and neck, cervical and anal cancers.

Combined therapy can work in several ways, through spatial co-operation where the treatments are used for different affects, ie radiotherapy for local disease and chemotherapy for systemic spread. In temporal co-operation each treatment modality is used together. Its combined action may increase dose intensity and synchronise cells into the cell cycle as well as inhibiting repair mechanisms. Independent cell kill is where the combination of therapies gives an additive effect greater than the individual therapies. A review of chemo radio-

Table 1: technological advances

- Portal imaging
- Intensity modulated therapy (IMRT)
- Image-guided radiation therapy (IGRT)
- Conformal therapy (CFRT)
- Multileaf collimation
- Steriotactic radiotherapy
- Gated treatment (pulsed according to the phase of the respiratory cycle)
- Therapy with portable photon sources (intraoperative)
- Prostate brachytherapy
- Intraoperative brachytherapy using Flab (flexible tissue-equivalent material)

Symonds R (2001) Recent Advances: Radiotherapy *BMJ* 323 1107-10 therapy for gastric cancer has shown that it is effective in improving both disease-free survival (3 years, 48% vs 31%, $p<0.001$) and overall survival (3 years, 50% vs 41%, $p=0.005$) (Xiong et al, 2003). More modest survival benefits have been seen in other disease sites.

The best chemo radiotherapy regime remains unknown as does the impact for patients in terms of late effects. It is still too soon to understand the true morbidity of such changes in therapy. Part of the issue in developing chemo radiotherapy is the interface between chemotherapy and radiotherapy services and the complexity of organising dual care.

Treatment planning

The other major area of innovation within radiotherapy is that of improving treatment delivery. Developments have been made to enhance the therapeutic ratio, aiming to reduce normal tissue toxicity and increase the dose of radiotherapy. This occurred through better definition of the target volume and normal tissues, 3D planning and scanning technology (Symonds, 2001). Accurately determining the dose of radiation to the tumour and normal tissues reduces the volume of tissues irradiated and therefore reduces late toxicity.

Improvements in diagnostic imaging have revolutionised treatment planning. It is now possible to reconstruct computerised magnetic resonance images reducing the chance of missing part of the cancer and allowing plotting of the differential dose to near or adjacent tissues within the treatment field.

Improved dose distribution and targeting of radiotherapy means that clinicians can now treat irregular volumes, to higher doses and spare some of the normal tissues. New delivery techniques and enhanced old ones such as brachytherapy have influenced many treatments (eg prostate and cervical cancer). To give an example Intensity Modulated Radiotherapy (IMRT) is a new way of delivering radiotherapy in a shaped 3D way (Murthy & Horowich, 2004). In conventional radiotherapy beams are of uniform intensity. In IMRT the dose distribution is non uniform across several radiation beams. Together these beams produce an optimal dose distribution conforming closely to the shape of the target volume. This type of treatment can have advantages in the treatment of pharynx or larynx cancer as it is possible to treat draining nodes in the neck avoiding sensitive structures such as the salivary glands.

Table 2: developments in supportive care with radiotherapy

- Improved patient information, patient education and written consent
- Nurse-led follow up
- Extended therapy radiographer roles

but

- Lack of assessment in radiotherapy
- Large proportion of patients palliative; may have different needs

The major value of this radiotherapy shaping to date is the reduction of late effects. Xerostomia is an unpleasant consequence of including salivary glands in the treatment area of the lymph nodes. Treatment with IMRT has led to the preservation of substantial salivary gland function without compromising target volume.

Developments in services for radiotherapy reflect the changing needs for adjuvant therapy and the scheduling and support required by patients with diverse needs. Advances have been more service led rather than in the management of side effects or patient problems as result of radiotherapy. Advances in the provision of patient information, patient visits to the radiotherapy suite prior to treatment and enhanced informed consent procedures have reduced patient anxiety and increased patient awareness of potential side effects.

Late effects

However there is a lack of consistent assessment within radiotherapy with its high volume low contact time and mainly ambulatory population. Given that over 50 per cent of patients being treated with radiotherapy are palliative, a large volume of those being treated will not benefit from these new technologies. The palliative end of the radiotherapy spectrum is the most neglected. Developments in palliative treatments such as single fraction treatment for bone pain can provide much relief and fewer visits to the hospital for patients.

One of the challenges for those supporting radiotherapy patients is in being able to effectively target those most at need and spread support services over the extended day that treatment machines now operate over. Evidence-based practice is limited with a paucity of studies evaluating interventions for managing side effect. The lack of knowledge around supportive care within radiotherapy may be for several reasons. Machine manufactures often sponsor development work on new technology but not for side effect management, and the pharmaceutical industry has traditionally had minimal input into radiotherapy management. This may change as more combined modality regimes develop.

In the past 10 years the technological advances have been immense. However, some of the advances have not been rigorously evaluated through cost benefit analysis. One of the problems with radiotherapy is that late effects can take many years to develop and few studies are funded to follow such long time lines in reporting morbidity. Also in radiotherapy there is no consensus on the methodology by which to record and analyse the normal tissues effects on patients. This, together with a general tendency to under-report toxicity reduces the possibilities for synthesising information from different studies and clinical sources.

The future

Treatment options for cancer are becoming more complex and the fragmentation of services between chemotherapy and radiotherapy will become less distinct for patients in the future. Lack of consistent assessment in radiotherapy and the ability to transfer such information across different health care settings means that it is vital that patients are able to self assess and identify problems.

With such fast developments in radiotherapy can clinical services keep pace with the changes? Bentzen (2004) argues that these technical developments have a ceiling in that if we don't also invest in optimal management approaches to care for patients increased symptoms and support needs will increase the risk for patients.

Challenges for the future include the need to evaluate new developments and understand how they impact on services in the wider treatment of cancer patients not just the individual. In addition, the need to be responsive to the needs and wishes of those who use the service is important in any future developments.

Sara Faithfull, Senior Lecturer (Clinical) Director of Studies, Doctorate of Clinical Practice, European Institute of Health and Medical Sciences

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continued from page one

to collaborate with other cancer nursing societies or institutions to hold the Institutes and build the capacity of cancer nurses to be effective leaders for change. By working regionally the content of the discussions will be appropriate for cancer nursing in that part of the world.

The ISNCC International Institute for Leadership in Cancer Nursing has been designed to help cancer nurses be successful leaders in today's complex health care environment and to be ready for the future. It has been designed to help them begin to tap their potential to have a positive influence on patient care.

Cancer institutions or agencies are encouraged to use the International Institute as a way to introduce several of their nurses with strong potential for leadership to new ideas and skill development. Sponsoring staff member attendance at a future Institute could be seen as an incentive or as a visible acknowledgement of a nurse's high performance and potential. Oncology nursing societies could sponsor members to attend as well. It could be a way to prepare future leaders for the society itself.

If you are interested in attending an International Leadership Institute or want to learn more about future opportunities, contact the ISNCC Secretariat at **secretariat@isncc.org**. The next International Institute will be offered in Sweden in January 2006.

Participants evaluation comments

"This was the best conference and interactive workshop I ever attended. It promoted both cancer nursing and leadership."

"A wonderful experience! The rigor and the networking activities were invaluable and stretched me personally and professionally."

"This course stimulated an interest in learning more about ourselves and about how others see us. The tools I learned about will be very useful in the work that I do in my clinical setting."

"I learned about the 'power of one' is in us all to make change… you need to take opportunity and risks use the resources you have."

VIRTUAL CANCER CARE

Pain management – finding out about it on the web

The correct management of acute and chronic pain is one of the most emotive topics for cancer patients and the most researched and requested for professionals in the field. Thankfully there is a strong evidence base for the many and varied approaches used in practice today and much quality information is available over the internet to keep people informed. This edition of Virtual Cancer Care takes a look at some of the better and more accessible websites that help to promote this important area.

Pain.com

http://www.pain.com/sections/categories_of_pain/cancer/

The cancer pain section of this highly proficient and attractive site is well worth a visit. For the professional there is a huge database of abstracts that are viewable (nearly 700), expert interviews to read, an "ask the doctor" section and a cancer pain facts section. For patients there is a frequently asked questions area, a useful cancer glossary and information regarding nutrition and prescriptions. Its main limitation is that there is no information regarding cancer pain management strategies, but that aside the comprehensive research base is very useful indeed.

Scottish intercollegiate guidelines network — pain control

http://www.sign.ac.uk/guidelines/fulltext/44/

This very detailed site contains everything the working professional needs to know about cancer pain and its holistic management. It is text intensive, but well laid out. There are comprehensive sections covering everything from assessment, psychosocial issues, use of opiods, adjuvant analgesics, radiotherapy and more radical interventions like epidural and intrathecal drug delivery systems and coeliac plexus block. As you read through there are links in the text to other sections. Every one of the more than 200 references has a hyperlink to take you directly to the research cited. There are no fancy graphics to slow things down and the full guidelines are downloadable in pdf format (readable by Adobe Acrobat Reader) if you want to save and print a hard copy.

Cancer pain.org

http://www.cancer-pain.org/

This understated and simply laid out site contains a wealth of information aimed primarily at cancer patients, but is of sufficient depth to be useful for professionals. It is written in a style which is very user friendly. There is comprehensive coverage of all the principle areas concerning pain management and the references to support the information are all hyperlinks that will take you to either the abstract or full text. I warmed to this site the more I navigated around it; there are hints, tips and practical advice in abundance. It is uncluttered and its simplicity is the key to its success — definitely one for your bookmarks and for your patients.

Cancer pain management in children

http://www.childcancerpain.org/

This terrific site is unusually laid out in a box that fills only about 70 per cent of the screen, but a lot of time and attention has gone into its construction to make it as attractive as possible. All the principle areas of pain management are covered including the non-pharmacological and there is even a section on the dying child. The site is sensitively thought-out with an active glossary of terminology and even an art gallery of pictures from some of the children treated in the Texas Children's Cancer Center who are behind the development of the site. I particularly liked the "nursing implications" section which was present on each page of the site and discussed essential nursing priorities.

Worth a look

Hospice net

http://www.hospicenet.org/html/what_is_pain.html

This is a simple site in which basic information is presented in a question and answer format aimed at patients and families. It is equally informative for professionals and all the better for its simplicity.

The Oxford pain internet site

http://www.jr2.ox.ac.uk/bandolier/booth/painpag/

This drug company sponsored site purports to give the reader an evidence base in all its information. The "knowledge library" is alphabetically organised and the scope of information is impressive. There are plenty of quality downloadable files and a huge glossary.

Robert Becker, Macmillan Senior Lecturer in Palliative Care, Staffordshire University Faculty of Health and Sciences and Severn Hospice

Toronto 2006: reaching new heights

The 14th International Conference on Cancer Nursing theme is intended to offer opportunities to explore new ideas, try out new approaches and consider the possibilities in cancer control.

We selected the theme *Reaching New Heights* to emphasise our "climb" to achieving new heights of excellence in cancer nursing practice, education, research and leadership. As such, a number of new topic areas have been selected, such as: patient safety, expanded and advanced nursing, healthy workplace issues, models of care delivery and politics and policy makers and economics.

With impending global shortages of nurses, we must consider new strategies for making the workplace one that emphasises support for nurses, opportunities for development, retention factors and autonomy in practice.

In the face of changing health needs, as the population ages, we need to consider ways in which the growing incidence and prevalence of cancer can best be addressed through new models of care delivery, expanded scope of practice for nursing and advanced oncology nursing roles.

Evidence-based practice will continue to be a strong theme of this conference. We have invited keynote speakers to share their experience in knowledge translation, using research findings in practice and assimilating them into policy decision-making. We need to understand and develop strategies for effective nursing interventions that apply to the very young, adolescents, adults and the elderly. How can we reach new heights to maximise quality of care for each of these stages of life, for those at risk for or living with cancer?

The Scientific Committee has been working hard over the past year, and has a full programme planned, with exceptional keynote and plenary speakers. New events are arranged for the conference, such as a debate on cancer genetics, plenary focus on the new themes: healthy workplace issues, patient safety, among others. We are hoping for many abstract submissions on the conference themes.

There will be awards for Best Posters in three areas: research, practice and education. Those intending to submit abstracts are reminded that the deadline for submission is January 31, 2006.

The setting in Toronto Canada is outstanding with many places to visit and lots of opportunities to reach new shopping heights! The Local Planning Committee has a variety of events to welcome delegates and help us to enjoy our time together. There will be more news on the conference in the next newsletter.

Esther Green and Candy Cooley,
Co-chairs, Scientific Committee

EDUCATION COLUMN

Research evidence: nurse educator as critical companion

The need to incorporate a burgeoning amount of research evidence into cancer nursing practice is at an all-time high in most health organisations. In today's globalised environment, health service organisations aim to deliver high quality care with reducing resources. This leads to a focus on evidence to inform health care practices that will result in the best, most efficient and effective outcomes for patients.

These directions pose significant challenges for nurse educators. The organisational drive for evidence-based practice needs to be balanced with what is appropriate for the individual concerns and strengths of each patient. Current approaches to implementing evidence-based practice, include:

- individual nurses seek information about evidence to inform personal practice;
- evidence from consortiums is provided to staff members as information/ education;
- practice policy is reviewed at organisational level to ensure most recent evidence informs policy.

There is growing evidence that these approaches, which place much of the responsibility for change on the individual nurse, are ineffective without other forms of support. These approaches assume that nurses have the resources to access the evidence (full review), the skills to appraise the evidence, and the supportive culture within which to implement the change.

The culture of health care, when focused on productivity and efficiency, can lead to nursing work that is focused on tasks rather than people. The work that nurses do to support patients through their cancer journey is rendered invisible when measurements are limited to health outcomes, effectively disregarding the processes of support.

Within such cultures, practices operate based upon common-sense and become taken-for-granted, rendering these practices unquestioned. The challenge for the nurse educator is to develop strategies to bring these practices into the light, where nurses can see how their assumptions about the way the world "is" operate to influence the ways that practices are "done".

One response to these cultures is to develop clinical leaders, individuals who operate to transform the workplace culture through participation, creative problem solving, and provision of localised flexible and quick responses. Becoming a clinical leader, prepared to facilitate change in the workplace, requires support.

Critical companionship is a relatively new notion that nurse educators can develop to support a cultural shift in the workplace — to an environment that values nursing work that focuses on people rather than tasks. Critical companionship combines "the expressive, intuitive processes of relationships and creativity with rational processes of analysis, critique and evaluation of practice and its knowledge/ evidence base" (Titchen 2003).

When the nurse educator uses critical companionship with clinical leaders, there are opportunities for both to become more reflective practitioners and to develop the art of nursing. Critical companions use a range of strategies to facilitate reflection and learning. These can include: articulation of craft knowledge, feedback on performance, critical dialogue, role modelling and drawing out creative imagination. These strategies and more are fully described in Titchen's (2003) work.

Refined understandings can be used to generate new knowledge that can assist the clinician to lead change in their sphere of work, with its social, cultural, historical and political constraints.

Using facilitation of learning, rather than instruction, may provide a more useful framework for bringing evidence into practice. Efforts to implement evidence-based practice, focused upon limited health outcomes and tasks, are not working for consumers or nurses. It is time to try some new strategies. Critical companionship provides a new direction for investigation by nurse educators in cancer care.

Laurie Grealish
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RESEARCH COLUMN

The ISNCC research committee – what does it do?

This research column introduces the International Society of Nurses in Cancer Care (ISNCC) Research Committee to newsletter readers. What is the ISNCC Research Committee? Who are the members? What does the Research Committee do? How does the committee review the applications for the Small Research Grant? Who was the winner this year? This column answers these questions.

The ISNCC Research Committee is a standing committee under the ISNCC Board of Directors. It aims to promote research-based oncology nursing practice. The committee members in 2004-6 include:

- Ann Hilton (Chairperson) from University of British Columbia, Vancouver, Canada,
- Cibele Andrucioli De Mattos Pimenta from University of Sao Paulo, Brazil,
- Sultan Kav from Hacettepe University Nursing Directorate, Turkey,
- Linda Kristjanson from Edith Cowan University, Perth, Australia,
- Deborah McGuire from University of Maryland, Baltimore, USA,
- Alex Molassiotis from University of Manchester, UK,
- Auxillia Munodawafa from University of Zimbabwe,
- Winnie So from The University of Hong Kong, Hong Kong SAR, China,
- Carol Tishelman from Karolinska Institutet, Stockholm, Sweden,
- Patsy Yates from Queensland University of Technology, Brisbane, Australia.

Research Committee activities include:

1) planning and implementing the ISNCC research strategic plan;
2) writing a research column for the quarterly ISNCC Newsletter;
3) participating in the abstract review process for the ISNCC conference;
4) participating in programme development for the biennial ISNCC conference (including the pre-conference workshop on evidence-based practice, the advanced research session, and the session on fostering collaborative research);
5) updating the Directory of Oncology Nurse Researchers;
6) overseeing the small research grant programme;
7) determining members' needs regarding oncology nursing research;
8) determining future strategic plans to promote research and evidence-based practice;
9) fostering collaboration regarding research with other oncology nursing organisations around the world.

Although the Research Committee members are from all over the world and only meet biennially at the ISNCC conference, they work together very well in the interim, using email to communicate and conduct business.

This year, the Research Committee received and reviewed six applications for the ISNCC Small Research Grant. The study entitled *Family functioning among Zimbabwean families of school aged-children with cancer* was awarded the grant to the amount of US$5,000.

The purpose of the study is to describe the family demands and types of coping strategies used by Zimbabwean families living with school-aged children with cancer. It also means to examine the associations among perceptions of family demands, social support, coping, the cultural practice of consulting traditional healers, and family functioning. The results of the study are expected to enrich and expand the existing knowledge of the cultural perspectives of how Zimbabwean families whose children have cancer live with the disease.

The Research Committee congratulates the principal investigator, Auxillia Munodawafa, on this success and looks forward to seeing the study results and final research report. Generally, results are expected to be presented at the ISNCC biennial conference or another oncology related conference and summarised in our ICNN newsletter or in a journal focused on cancer nursing. A summary report is published in the ISNCC newsletter in one of the Research Committee's columns so that other ISNCC members can learn of the outcomes. The research columns from the past are now available on the ISNCC website **http://www.isncc.org/lists.asp?Table=About&Page=Research**. The columns have addressed important areas of research and research methodology and have also been used to report findings from the small grants program. Take this opportunity to read about the previously funded successful projects and important issues in research.

The ISNCC Small Research Grant was established with the aim of promoting clinical nursing research, particularly for pilot and/or feasibility studies. The project should be related to nursing care of cancer patients and their families in more than one country. There is no restriction for the use of research methods and the investigators can choose either quantitative or qualitative methods to conduct their study. The applicant must be a registered nurse who is a member in good standing of a member organisation of ISNCC.

In general, the Research Committee evaluates each proposal on the basis of the following criteria:

1) clarity of the problem statement;
2) international relevance and importance of the research problem;
3) adequacy of the methodology;
4) feasibility of the method proposed;
5) experience and research competence of the investigators;
6) suitability of the facilities;
7) appropriateness of the proposed budget for the study;
8) significance and expected contribution to knowledge relevant to clinical cancer nursing.

The proposal is ranked according to its scientific merit and relevance to the nursing care of patients with cancer and their families. The highest scoring application will be awarded the grant.

The deadline for submission of the proposal and its accompanying materials is October 15th each year. The successful applicant will be awarded a grant in early January. More detailed information and the application forms are available on the ISNCC website **http://www.isncc.org/lists.asp?Table=Grants&Page=SmallGrants**.

The committee is now planning the programmes for the biennial ISNCC conference including the pre-conference workshop on evidence-based practice, the advanced research session, and the session on fostering collaborative research.

The pre-conference workshop aims at providing additional opportunities to learn exchange and network with nurse scholars and experts to move towards evidenced-based practice. The advanced research session is designed to share current research issues with nurses who are focused on outcomes research. This session provides a good opportunity for extended discussion between the audience and the speakers.

The session on fostering collaborative research enables nurses to meet with nurse scholars for discussion of possible projects and to potentially work collaboratively with one of these scholars. The 14th ISNCC conference will be held in Canada in 2006. We look forward to seeing you at the conference.

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