



## National societies link up

The cancer nursing societies of Australia and India are developing a collaborative relationship as part of the ISNCC Adopt-a-Society programme.

The Adopt-a-Society programme was established by ISNCC to enable societies from developing countries to be formed and supported by well-established societies or institutions.

The Oncology Nursing Association of India (ONAI), which was formed in 1994, was adopted by the Cancer Nurses Society of Australia (CNSA) in 2003. As part of the adoption process CNSA is sponsoring ONAI's membership in ISNCC.

As one of the first steps in consolidating this collaborative relationship with ONAI, the Hunter and Sydney Regional groups of CNSA carried out fundraising activities to sponsor the attendance of two ONAI members at the ISNCC conference held in Sydney in 2004.

To further strengthen the relationship between the two societies, ONAI invited CNSA to send two representatives to attend their National Conference held in Mumbai, India, in January 2005.

The primary aims of the visit were:

- to develop a greater understanding of cancer nursing in each other's country
- to identify strategies for strengthening the relationship
- to identify areas for collaboration to benefit the societies and their members.

Participation in a variety of activities during the six-day visit to Mumbai provided the opportunity to reflect on a number of key aspects of cancer nursing in India. In particular, we learnt a great deal from the specialist nurses who worked in head and neck cancer, one of the most common cancers in India. These nurses demonstrated a high level of expertise and knowledge of

the needs of patients with this cancer.

The great diversity in cultural and religious beliefs amongst the Indian community meant that Indian nurses made considerable efforts to respect differing needs. Staff also identified a number of ways in which they attempted to cater for the large population who may have limited resources.



Getting to know each other. From left to right, Rohini Bhide (ONAI), Tish Lancaster (CNSA), Vaishali Gadge (ONAI), Patsy Yates (CNSA), Madhuri Dandavate (ONAI)

We were impressed by the creative solutions nurses had for responding to limited resources. For example, we heard about innovative screening programmes and health education programmes that were enabling access for people in isolated rural communities.

During the conference, we heard reports of research being undertaken by Indian nurses on many topics, including: assessment of attitudes of parents towards cancer treatment of their children, changed taste acuity in cancer patients, assessment of anxiety and depression in cancer patients and nutritional appraisal of head and neck patients prior to radiotherapy.

Nurses in India face many challenges associated with heavy workloads and resource limitations. However, we learnt a great deal about creativity, professional commitment and respect during our visit.

CNSA and ONAI will continue to implement a range of strategies for improving communication and sharing resources between the societies, including sharing

newsletters, providing complimentary subscription to the Australian Journal of Cancer Nursing, and providing copies of various positions statements and standards. In the future, CNSA will also investigate ways to undertake other collaborative ventures and identify sources of sponsorship to enable participation in future conferences and educational programmes.

*Tish Lancaster, Clinical Nurse Consultant, Gynaecological Oncology, Westmead Hospital, NSW, Australia*  
*Professor Patsy Yates, Centre for Palliative Care Research and Education, School of Nursing, Queensland University of Technology, Australia*

# Sharing our struggles, sharing our knowledge

I am writing this President's Message on my way home from having participated in three cancer nursing gatherings: the 2<sup>nd</sup> International Institute on Leadership in Cancer Nursing in Cape Town, South Africa; the 2<sup>nd</sup> International Oncology Nursing Conference in Amman, Jordan; and the European Oncology Nursing Society 5<sup>th</sup> Spring Convention held in Innsbruck, Austria.

Needless to say, I am a little tired from the travelling, and I will be happy to be back with my family, but I am so buoyed up by the conversations I have had with cancer nurses during these conferences and gatherings. What a remarkable group we cancer nurses are!

I was struck over and over again in the conversations I had how very similar the struggles, concerns, and challenges are that we face around the world as cancer nurses. We are all confronting common issues in this world of cancer care: growing patient numbers; complex treatment protocols; financial restraints; and shortages of equipment, space and staff.

But I also found a shared vision of quality and concern for patients and families, unbounded passion for being a cancer nurse, and about innovative, creative solutions.

The shared vision was one of comprehensive, quality patient care. It is a vision of patient-centred care that is focused on the whole person and family. It is about care that moves beyond the physical to embrace the emotional, social, and spiritual needs of people.

The passion was about making a difference in the lives of those touched by cancer. In times of struggle this passion is what

keeps nurses going. I heard repeatedly how cancer nurses make a difference by using their knowledge and skill in providing comprehensive cancer care to patients and families.

The solutions were designed for, and embedded in, the context and reality of the practice and political system in a country. The resources available have a key influence on what can be done, where effective action can take place, and where the focus of efforts ought to be. Acting locally is key to finding appropriate solutions. I salute you all in whatever arena you find you are practicing.

We face significant challenges in cancer nursing — growing patient numbers around the world, limited resources, and projected shortages of qualified nurses. We must always remember to think globally — share our struggles, share our knowledge, and learn from one another.

We gain insight and understanding about our challenges from such activity. Solutions shared can be adapted for application at local levels.

I hope this sharing will be a central activity at the 14<sup>th</sup> International Conference in Toronto this September. Remember, many of the nurses who saw the development of cancer nursing will soon be retired. Our present challenge is to ensure the future of cancer nursing is a vital and energetic in the future as it is today. Support our young cancer nurses. Mentor them. Share your vision and passion.

The future is in your hands!

Margaret Fitch  
President ISNCC

## Safe staffing

International Nurses Day (IND) held on May 12, 2006, had the theme of *Safe staffing saves lives*.

Inadequate staffing in health care settings is reaching crisis proportions in all regions. Evidence indicates that this is increasing length of hospital stays, patient morbidity and mortality and preventable adverse events.

Many nurses are challenged with much greater patient workloads on a daily basis. High patient-to-nurse ratios means nurses are at higher risk of emotional exhaustion, stress, job dissatisfaction and burnout. Nurses who continuously work overtime or work without adequate backup are prone to greater absenteeism and poorer health, thus weakening health system responses to communities' health needs.

Nurses used the occasion of IND to call for policy frameworks to ensure serious attention is given to comprehensive health human resource planning and an adequate nurse-to-patient staffing ratio in all health-care settings.

## EU smoke free policy

Comprehensive bans on smoking in public areas and all workplaces, including bars and restaurants, could save the lives of up to 7,000 workers each year in the European Union (EU).

The Smoke Free Partnership estimates that if all 25 European Union countries adopted Ireland's "smoke free" model, many smokers would quit with massive health benefits for both themselves and those exposed to passive smoking.

More than 79,000 adults die each year as a result of passive smoking in the 25 countries of the European Union. The European Commission's health directorate hopes to see all 25 countries become "smoke free" by 2009.

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# How trustworthy are diagnoses of malnutrition in cancer patients?

The goal of this paper is to demonstrate that extremely different subgroups of patients are diagnosed as malnourished based on the judgment of physicians, dietitians, and three different classification tools — and thus to show that the lack of standardised diagnoses is not just an academic problem but has a significant impact on patient care and the allocation of health care resources.

Malnutrition was shown to be a common problem in hospitalised patients nearly 30 years ago (Bistrian et al, 1974, 1976) and has not diminished since (Eisenlohr, 2003). Among cancer patients the presence of malnourishment is unquestioned (Heber et al, 1999; Henke Yabro et al, 2004). With this in mind it is staggering that there is still no common standard for the definition of malnutrition (Corish & Kennedy, 2000).

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), lists kwashiorkor, marasmus, other protein-calorie malnutrition (PCM) of severe, moderate or mild degree as major diagnostic indicators of malnutrition (ICD, 1989).

As Swails et al (1996) stated, these descriptions focus on primary malnutrition in the paediatric population and therefore cannot be used as a standard reference for adults with malnutrition as a secondary symptom.

The current oncology nursing literature focuses on the Patient-Generated Subjective Global Assessment (PG-SGA) (McCallum, 2000). The PG-SGA is functionally orientated, combining patient self-report with subjective physical examination. It has a

sub-section for categorising patients as “well nourished”, “moderately malnourished or at risk for developing malnutrition” and “severely malnourished”. Although relevant as a screening tool, this instrument does not set cut-off points.

## Methods

Within the scope of a study analysing three large data sets of cancer patients for the impact of malnutrition on health care costs (Brown, 2001), we had the chance to compare nutritional diagnoses of physicians with those of dietitians and with other nutritionally relevant indicators.

A database was created by retrospective sampling from hospital charts of a designated comprehensive cancer care centre. It includes all hospitalised patients of the year 1998 who had a diagnosis either of lung, gastrointestinal or head and neck cancer.

For each admission the responsible physician documented all the main and secondary discharge diagnoses of the patient, and these were given ICD-9 codes by clinical staff. If there was an ICD-9 code from 260 to 263.9, the case was interpreted as malnourished according to the ICD-coder.

In addition, it was a policy of the hospital that every inpatient be assessed by a dietitian. This assessment was documented on a special form that was added to the chart, classifying the nutritional status as “adequate”, “at risk” or “compromised”. Cases with a compromised nutritional status were interpreted as malnourished according to dietitian.

The discussion about which formal classification systems to compare to ICD-9

coders and dietitians diagnoses for accuracy, was time consuming and frustrating. In the end we decided to concentrate on three approaches or classifications.

## The three approaches

The first formal classification is the body mass index (BMI) with cut off points as described in by Heymsfield et al (1999). The BMI was calculated using the formula weight (kg) / height<sup>2</sup> (m). Values below 18.5 were interpreted as malnourished. The big advantage of this tool is that it is well known and that it needs only values for weight and height, which are routinely measured. Its disadvantage is that it is not able to detect kwashiorkor because the kwashiorkoric starvation oedema may mask wasting of cell mass (McLaren, 1991).

The second classification was published by Swails et al (1996). It uses a combination of percentage weight loss, percentage ideal body weight (%IBW) and serum albumin values. Out of the reviewed tools, it is the only one without errors in internal consistency, and the only one that explicitly proposes a redefinition of the ICD-9 criteria for malnutrition. A theoretical limitation of the use of albumin as a criterion is that it is sensitive to dilution effects, and that hypoalbuminemia can be caused by the primary disease rather than by malnutrition (Corish & Kennedy, 2000). A practical disadvantage compared to using BMI alone is that albumin and weight change are not measured as consistently as height and weight — only 65 out of 288 cases in our data set have a documented weight change.

We integrated the Manual of Clinical Dietetics criteria (Chicago Dietetic Association, 2000) into the investigation because it illustrates the typical weaknesses of these kinds of instruments. It is a mixture of qualitative descriptions and quantitative thresholds including percentage IBW, weight loss over 6 month, albumin and transferrin. This classification generally includes obese patients as long as they lose weight. In addition it shows significant internal inconsistencies. Diagnoses are not defined uniquely and this classification has large gaps where it does not diagnose patients that present lower values than those that are diagnosed as malnourished. Cases with a diagnosis of kwashiorkor; marasmus; severe, moderate or mild PCM were coded as malnourished according to Manual of Clinical Dietetics (MCD) classification. An alternative variable was created to fill a diagnostic gap by

	All cases n = 288		Gastrointestinal cancer n = 130		Lung cancer n = 111		Head and neck cancer n = 47	
	n	%	n	%	n	%	n	%
ICD-coder	17	5.9 %	8	6.2 %	5	4.5 %	4	8.5 %
Dietitian	79	27.4 %	38	29.2 %	25	22.5 %	16	34.0 %
BMI (a)	32	11.1 %	11	8.5 %	17	15.3 %	4	8.5 %
Swails crit.	60	20.8 %	35	26.9 %	15	13.5 %	10	21.7 %
MCD crit (b)	106	36.8 %	58	44.6 %	32	28.8 %	16	34.0 %
MCD corr. crit.(c)	146	50.7 %	71	54.6 %	53	47.7 %	22	46.8 %
Any criterion (d)	165	57.3 %	79	60.8 %	58	52.3 %	28	59.6 %
All criteria (e)	1	0.3 %	1	0.8 %	0	0 %	0	0 %

a = Body Mass Index (cut-off point: < 18.5)  
 b = Manual of Clinical Dietetics criteria  
 c = Manual of Clinical Dietetics criteria, corrected  
 d = malnourished due to any of the criteria  
 e = malnourished due to all the criteria

**Table 1: Comparison of prevalence resulting from the different methods of diagnosing malnourishment (for all cases and separated for the three different cancer locations)**

also including cases combining 60-90% IBW with albumin < 3 or 80-90% IBW and albumin 2.5-3.5. This variable will be called Manual of Clinical Dietetics corrected criteria (MCD corr.) in the following.

The original sample included 610 admissions of 393 patients. After the following selection criteria were applied, 288 admissions of 227 patients remained:

- documented assessment by a dietician
- documented height
- documented weight before or at the day of the assessment by the dietician
- documented serum albumin.

## Results

Comparing the different diagnosis classifications, the prevalence of malnourishment ranged from 5.9% (ICD-coder) to 50.7% (corrected MCD criteria). 57.3% of all cases were diagnosed by any of the methods. Only one case (0.3%) was diagnosed malnourished by all the six methods. For more details see Table 1.

Comparing the different methods directly to each other, the agreement in positive diagnoses ranges from only 5.7% of the malnourished cases due to MCD criteria being also diagnosed by the ICD-coders, to all the malnourished due to Swails et al being covered by the corrected MCD criteria. Table 2 shows the details.

The comparison of the different tumour sites gives another striking result. Compared to cases with gastrointestinal cancer, lung cancer cases have a lower prevalence of malnourishment using all the methods except for the BMI. The BMI is the only method that definitely does not assess protein reserves, so it seems that the marasmic type of malnutrition is more common in lung cancer where the digestive organs are not directly compromised. Gastrointestinal and head and neck cancer

show a tendency towards kwashiorkor type malnourishment.

## Discussion

The differences between the diagnostic methods compared in this study are tremendous. Depending on the method of diagnosis, there is a nearly tenfold difference in the prevalence of malnourishment. The physician's diagnoses result in the lowest prevalence, nearly doubled by the BMI, the most conservative formal classification. Dieticians are diagnosing more than four times as many cases as malnourished as physicians. The most diagnoses result from the Manual of Clinical Dietetics method.

The different methods diagnose sub-populations that are distinctly unequal. This difference may be due to the fact that the methods are based on different understandings of malnutrition.

Our comparison of the prevalences for the different tumour locations showed that the distinction between kwashiorkor and marasmus type malnutrition is relevant in the cancer patient population.

This investigation is based on retrospective data sampling from hospital charts. Therefore judgements about the value of the different diagnostic methods to predict health outcomes cannot be made. We had limited control over the quality and the amount of the data that was entered into the study, because we had to rely on the data that was documented in the hospital charts.

## Conclusions

In accordance to our goal, we will set out the implications of our findings for research, clinical practice and administration. Researchers need to work towards achieving agreement in the definition of malnourishment and in its assessment. Without this, study results are not comparable to each other. When performing studies

on malnutrition, they should explicitly discuss their definition and chose measurements that are congruent with it. For epidemiologic studies, ICD-9 codes are and will be the only available measure in most cases. Researchers should keep in mind that it underestimates prevalence.

With this background, clinicians are forced to base their practice on weak evidence. Even the theoretically highest level of evidence — meta-analysis of randomised controlled trials — is inaccessible as long as studies are not comparable.

Taking a health care system perspective, it is very hard for administrators to appropriately allocate resources to the problem of malnutrition if the prevalence has such a huge variance. Although we cannot decide which of the investigated methods of diagnosing malnourishment is the most precise, we want to point out that the use of ICD-codes clearly underestimates its prevalence. A consensus is needed for research, clinical practice and health care policy.

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*Jean K. Brown, Professor and Acting Dean, University at Buffalo School of Nursing, State University of New York, USA.*

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	ICD-coder	Dietitian	BMIa	Swails crit	MCD crit.b	MCDcorr. crit.c
ICD-coder	17 (100 %)	12 (15.2 %)	8 (25.0 %)	6 (10.0 %)	6 (5.7 %)	12 (8.2 %)
Dietitian	12 (70.6 %)	79 (100 %)	21 (65.6 %)	34 (56.7 %)	42 (39.6 %)	65 (44.5 %)
BMIa	8 (47.1 %)	21 (26.6 %)	32 (100 %)	16 (26.7 %)	13 (12.3 %)	31 (21.2 %)
Swails crit	6 (35.3 %)	34 (43.0 %)	16 (50.0 %)	60 (100 %)	46 (43.4 %)	60 (41.1 %)
MCD crit.b	6 (35.3 %)	42 (53.2 %)	13 (40.6 %)	46 (76.7 %)	106 (100 %)	6 (72.6 %)
MCDcorr. crit.c	12 (70.6 %)	65 (82.3 %)	31 (96.9 %)	60 (100 %)	106 (100 %)	146 (100 %)

a = Body Mass Index (cut-off point: < 18.5)      c = Manual of Clinical Dietetics criteria, corrected  
b = Manual of Clinical Dietetics criteria

Table 2: Agreement in malnutrition diagnoses

# Cancer nursing education in Palestine

The first national oncology training course has been held for Palestinian nurses. Nurses in Palestine are trained with a college or university nursing programme lasting two to four years, but there is no programme to introduce newly qualified nurses to oncology treatment or prevention.

Oncology nurses working in oncology units rely on "on-the-job training" with no theoretical background as there are no formal educational courses in this specialty. A few nurses get training fellowships for advanced oncology training in neighbouring countries such as Israel or Jordan.

Because of this training need, Hanan Saca-Hazboun and Mariam Awad (lectur-

ers from Bethlehem University) in cooperation with Amal Khlief (head nurse of oncology unit) from Augusta Victoria Hospital in Jerusalem and three Israeli lecturers initiated a cancer course entitled "Advanced Workshop for Oncology Nursing". The course was clinically oriented to help nurses working in oncology departments, from Gaza and West Bank, representing governmental and non-governmental hospitals and academic institutions. The main objective of the training programme was to improve nurses' proficiency in the care of oncology patients in their respective units.

It was held in Jerusalem and supported



Lecturers and a course participant

by the National Cancer Institute, NIH, Bethesda, US, through Professor Silbermann (Middle East Cancer Consortium).

## VIRTUAL CANCER CARE

### Breaking bad news with sensitivity

It was once eloquently said that "Communications like tumours may be benign or malignant. They may also be invasive, and the effects of bad communication may metastasise to the family". The cancer analogy is somewhat appropriate as every health professional who has been present when bad news is imparted to patient and family will testify.

Despite many years of complex research, a vast array of publications and on-going education into this sensitive area, it remains one of the most difficult scenarios to encounter in professional life. This edition of Virtual Cancer Care will take a brief look at what the web has to say about this thought-provoking area.

#### EPERC

<http://www.mywhatever.com/cifwriter/library/eperc/fastfact/ff06.html>

These pages from this well known US palliative care education website are oriented towards helping medical students and junior doctors deliver bad news and have a strong educational orientation. The "fast facts" idea works well and the advice given, which follows accepted strategies, is clear and generic in its application to other professions. Part two is hyperlinked from these pages.

#### Breaking bad news

<http://www.breakingbadnews.co.uk/index.asp>

This entirely text based and drug company sponsored UK site is a good starting point for those who want to know the basics. It is easily navigated and practically oriented. Those of you familiar with the work of Professor Ann Faulkner will recognise the material, which mostly stands the test of time.

#### University College Medical School

[http://www.peps.ucl.ac.uk/commskills/student\\_handbook/bad\\_news.htm](http://www.peps.ucl.ac.uk/commskills/student_handbook/bad_news.htm)

There is a different approach altogether with the information on this UK web site. It is clearly intended to stimulate thought and debate in the area and as such poses a number of reflective questions for the reader to develop further. I liked the simple, but very educational and pragmatic stance which covers all the main principles and even offers a paediatric viewpoint.

#### Auckland District Health Board

[http://www.adhb.govt.nz/downloads/res\\_conf/breaking-bad-news-talk.ppt](http://www.adhb.govt.nz/downloads/res_conf/breaking-bad-news-talk.ppt)

It is always encouraging when professionals take the time and trouble to not only prepare a power point presentation, but are generous enough to post it in the public domain. This straight forward series of slides from Jill Ireland (a clinical psychologist) from New Zealand gives a useful perspective in this area with good reference to resources within the text.

#### Worth a look Skills cascade.com

[http://www.skillscascade.com/badnews.htm#Preparation:](http://www.skillscascade.com/badnews.htm#Preparation)

This page from a UK site contains a bullet listed framework for breaking bad news to patients that has been adapted from a number of acknowledged sources.

#### American Family Physician Journal

<http://www.aafp.org/afp/20011215/1975.html>

This is essentially a journal article published on line, and like many others in this

area contains an easy to remember ABCDE strategy. Written from the perspective of an experienced family doctor, this is a thoughtful and useful article that is well referenced.

#### Ethics in medicine

<http://depts.washington.edu/bioethx/topics/badnws.html>

The material in this US site utilises Rob Buckmans' tried and tested six step formula. To its credit it uses two case studies in an attempt to bring the issues forward and adopts a simple question and answer format.

#### Phuket Gazette

<http://www.phuketgazette.net/pdf/Breaking%20bad%20news.pdf>

This two page document downloadable from a Thai site, written in English, focuses on the often forgotten area of delivering bad news over the telephone. It follows a simple structure and, although not referenced, is a good contribution to the resources in this area.

#### BMJ

<http://bmj.bmjournals.com/cgi/content/full/321/7270/1233>

Finally — something a little different. This personal viewpoint sent into the British Medical Journal makes for fascinating reading, as do the responses to the letter in the ensuing weeks (hyperlinks at the bottom of the page). It's main message is how not to tell bad news and the lessons that must be learnt.

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

# Toronto conference at hand

It is amazing how quickly the year is flying by and preparations for the 14th International Cancer Nursing Conference are steaming ahead.

We had a fantastic response to the call for abstracts, the best ever for an ISNCC conference with over 600 submissions. This is an indication of the interest in the conference this year, and we are looking forward to seeing you in September.

As is the usual process, three independent, blinded reviewers reviewed each abstract. We thank each of the reviewers for their hard work in completing the work in a relatively short time.

The next step was for the Scientific Programme Committee (SPC) to review the completed abstracts and through a deliberative and focused approach, determine the abstracts to be accepted for oral and poster presentations. Because of the large number of submissions, we worked to accept as many oral and poster presentations as possible. Over 400 posters were recommended for presentation.

Delegates evaluate each conference and this feedback is incorporated into the plan-

ning for the next conference. Some of the feedback suggested major changes to poster sessions. We have taken this advice and significantly changed how the posters will be presented.

The SPC took the initiative to group the posters into conference themes. For example, palliative care, supportive care, workforce/healthy workplace environments are themes of the conference. All posters will be available on all three days, but each day, specific content themes will be grouped and the authors of those posters will be available to meet the participants in "Meet the Authors" sessions.

This will give a chance for poster authors and delegates to meet and discuss their work. Each delegate will receive a vote each day and by using this will be able to select the "People's Choice" poster each day.

The conference programme will give information about daily themes and there will also be signs outside every plenary and concurrent session advising you which posters correspond to the oral presentations. And chairs of each session will be reminding delegates to visit specific posters.

In addition to the "People's Choice" awards, there will be new ICCN awards for Best Poster in one of three categories: *Practice, Education and Research*. These new awards will be presented during the closing ceremony. We want to recognise the hard work that authors put towards their poster presentations and the SPC felt that the awards would be the best way to do this.

In the early evening there will be opportunities to meet colleagues within special interest groups. There will also be regional meetings with a chance to meet with your ISNCC board members to discuss how they can work more closely with the issues in your country.

There is a full extra-curricula programme with opportunities to visit local hospitals and clinical areas and meet leading cancer nurses in Canada. There are also tours to the tourist sites across the region. There is also a fabulous social programme with a final night gala dinner.

We are really looking forward to seeing you in Toronto.

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

## EDUCATION COLUMN

### The value of learning in the practice setting

There has always been emphasis on nurses teaching in the practice setting but today, more than ever, there is a need to develop a culture of learning and teaching in the workplace. The term "lifelong learning" is now widely used. This concept came into popular use with the Dearing Report on Higher Education produced by UK Department of Education (1997).

The main principle of this report is that if we each take responsibility for our own learning and development we will create a learning society. In order to keep abreast of rapid changes taking place in our lives in our profession and in our world, we need to develop a philosophy of lifelong learning.

Many nurses are well aware of this philosophy. Our challenge is to ensure all nurses are given the opportunity to embrace this concept. Most pre-registration and post-registration nursing education and preparation is now university based, and help and support is needed for nurses to be able to apply theory learned to their practice.

Among the many recommendations of the UK Department of Health report (2001) is the need for all nursing staff to have an individual professional development plan (PDP). This can be achieved as part of the annual staff development review (SDR). This recommendation provides a good

starting point.

The employer/management has a responsibility to ensure that the workforce is clinically effective and that the practitioners have a commitment to lifelong learning. A lifelong learning strategy provides for the development of skills and can be seen as a "skills escalator" that involves all staff in learning and moving forward.

Learning and teaching from experience is what teaching in the practice setting is all about. A seminal work by Patrick Casement (1985) "On learning from the patient" is still valid today. There are rich learning experiences available in the practice setting;

- the shift handover report — nurse to nurse
- accompanying the medical staff on the medical round
- undertaking a nursing round of the patients
- scanning the medical file with regard to the patient's diagnosis, medical orders and nursing interventions
- reviewing the medication files, medications prescribed, the therapeutic dose for the patient and the potential side effects.

All these activities foster an atmosphere of critical inquiry, always asking questions and developing critical analytical skills.

Learning through clinical experience is far more diverse and pervasive than is often thought. Dewey (1938) stated that all genuine education comes through experience. Certainly in a practice-based profession such as nursing, clinical experience should be the basis for learning.

Usher (1993) reminds us that experience always says less than it wishes to say; there are many readings of it, it is never exhausted and total clarity may never be reached. In the practice setting the challenge therefore is to unearth meaning from clinical experience to enable nurses to develop the skills they need to practice with professional judgment and practical wisdom.

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## Evidence-based practice when research evidence is insufficient

Evidence-based practice (EBP) has been defined as the integration of research, clinical experience, and patient values (Sackett et al, 1996). It is the synthesis of results from scientific investigations such as clinical trials or observational studies with other types of knowledge such as case reports or expert opinion. The purpose of this column is to discuss how to implement evidence-based practice when research, the highest level of evidence, is lacking.

When health care professionals review literature in order to develop evidence-based practice guidelines and find that little research evidence is available, there are ways to overcome this problem. Evidence consists of research, experience, and values. When research is limited other strategies can be used (McGuire et al, 2004). Personal and/or institutional evidence such as quality improvement data are helpful. Consultation with experts and consensus building can be used. Consideration of clinical and cost issues is also helpful to the deliberations. And finally, incorporation of patient, family, and health care provider preferences and values is important.

The Multinational Association for Supportive Care in Cancer/International Society for Oral Oncology (MASCC/ISOO) evidence-based practice guidelines for the management of alimentary mucositis in cancer patients (Keefe et al, 2006) provide an excellent example of how this process can be accomplished. These guidelines were initially developed in 2004 by an interdisciplinary and international panel of mucositis experts based strictly on research evidence (Rubenstein et al, 2004; Sonis et al, 2004). The guidelines addressed numerous areas, and if middle to high levels of evidence (ie research) existed, the panel made specific suggestions or recommendations for practice. There were several basic yet very important areas of supportive care for which there was little research evidence including basic oral care, pain management, and dental care (Rubenstein et al, 2004). The only guidelines that were possible based on research evidence (Rubenstein et al, 2004) were the following:

*The panel suggests the use of oral care protocols that include patient education in an attempt to reduce severity of mucositis (level III, grade B). The panel recommends patient-controlled analgesia (PCA) with morphine for oral mucositis in patients undergoing hematopoietic stem cell transplant (level I, grade A).*

The panel struggled with its perceived inability to write research-based guidelines for these areas, and thus included some brief text emphasising their importance in clinical

practice despite the lack of research evidence (Rubenstein et al, 2004). Recently the Mucositis Study Group updated the guidelines (Keefe et al, 2006), and determined that this time it was imperative to provide more specific direction for clinical practice related to basic oral care, pain management, and dental care (McGuire et al, 2006).

Thus, additional research-based guidelines related to basic oral care in the updated guidelines (McGuire et al, 2006) included the following. *The panel suggests performing basic oral care including a soft toothbrush with regular replacement of the toothbrush (level IV, grade D).* In addition to the original 2004 guideline stating: *The panel suggests use of oral care protocols that include patient education, an update was added: The panel suggests that protocol development be interdisciplinary, education should include staff (as well as patients and families), and quality improvement processes should be used to evaluate both protocols and education.* Unfortunately, as in the original guidelines, there was insufficient evidence to support a guideline for the use of bland oral rinses such as normal saline or sterile water.

In the areas of basic oral care, pain management, and dental care, for which there was little to no research evidence, the panel decided to use a combination of the scant research that did exist and their own professional expertise and experience (McGuire et al, 2006). Through a process of discussion and consensus, they were able to formulate a series of what they called "Good clinical practices" which, while not research-based, were evidence-based. They reflect the combined expertise, experience, and wisdom of a large number of clinical experts from a wide range of fields. The updated mucositis management guidelines include the following good clinical practice recommendations (McGuire et al, 2006):

### Pain management

1. Regular oral pain assessment using validated instruments for self-report is essential.
2. Topical anaesthetics or other agents can be considered.

### Oral Assessment and Oral Care

1. Initial and ongoing assessment using validated instruments, including patient self-report and professional examination.
2. Preventive oral care regimen.
3. Therapeutic oral care regimen.
4. Regular, systematic oral care hygiene with brushing, flossing, bland rinses, and moisturisers using a standardised oral care protocol.

5. Interdisciplinary approach to oral care (nurse, physician, dentist, dental hygienist, dietician, pharmacist, and others as relevant).

### Dental care

1. Dental assessment and dental treatment are important before the start of cancer therapy, for all patients, but especially those with head and neck cancer.
2. Dental professionals should be members of the interdisciplinary health care team throughout active treatment and in follow up care.

Through the development of these good clinical practice recommendations, the MASCC/ISOO Mucositis Study Group's guidelines panel was able to address important areas that were missing from the original guidelines. In the absence of middle to high level evidence, this approach offers an alternative to having no guidelines at all, and relying on individual or institutional practices. It remains imperative, however, to continue the process of amassing evidence to support clinical practice. Therefore the MASCC/ISOO panel also made two important over-arching recommendations (McGuire et al, 2006). Patient and family education should be integrated in all areas. Outcome assessment using quality improvement processes is important.

This strategy used by the MASCC/ISOO Mucositis Study Group panel serves as an example for how health care professionals can develop evidence-based practice guidelines in the absence of high levels of evidence. Nurses or other cancer health care professionals who are engaged in similar endeavours to improve the care of their patients can easily adapt it for their own use. *Deborah B McGuire, Professor, University of Maryland School of Nursing, United States.*

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