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Reaching new heights together

Over 1200 nurses from 40 countries attended the 14th International Conference on Cancer Nursing held in Toronto, Canada at the end of September. The biennial event was jointly hosted by the International Society of Nurses in Cancer Care (ISNCC) and the Canadian Association of Nurses in Oncology (CANO). The theme was 'Reaching New Heights Together'.

ISNCC President Margaret Fitch welcomed delegates by acknowledging the joint endeavour between the two host organisations that had culminated in the Toronto conference.

She spoke of the global role of the ISNCC saying: "ISNCC has a network of communication with 80,000 cancer nurses around the world. It offers a marvellous opportunity for cancer nurses to influence practice, education, research and policy as it relates to cancer care

"Ultimately the society is concerned that those individuals and families who are touched by cancer receive the treatment and the care that they require."

She told delegates that ISNCC is the voice of cancer nursing in the international arena. ISNCC is affiliated to the International Council of Nurses and is a non-governmental member of the WHO. "We have an association with the International Union Against Cancer and with other cancer control agencies," she said.

"We need to make sure that the nursing voice is heard as plans are developed and implemented. Nursing *does* make a difference to cancer patients and their families."

Margaret Fitch, ISNCC president and Greta Cummings, CANO president jointly open the Toronto conference

CANO president Greta Cummings also welcomed delegates to Toronto. She said: "This conference celebrates the individual and collective knowledge, skills and contribution of oncology nurses in every part of the world in all aspects of cancer care across the lifespan."

She emphasised the diversity offered by the conference programme saying: "We have local to global, paediatrics to geriatrics, prevention to palliative care. This reflects our audience."

Survivor experience

As part of the opening ceremony Canadian cancer survivor Terry Hoddinott gave a moving address about his and his family's experience with cancer which demonstrated not only his extraordinary courage and resilience but also how cancer treatments have advanced in the last forty years.

Born in 1963, Terry was diagnosed with retinoblastoma and lost both eyes to the disease before he was four, despite chemotherapy and radiotherapy. As he put it, his parents were faced with the choice of "blind or dead".

Terry married his wife Patti, who accompanied him to the conference. Before having children they had genetic counselling and were aware that, as Terry had had bilateral disease, there was a 50% chance of passing it on to his children.

Terry and Patti's son Riley was tested for the retinoblastoma gene at birth and found to be positive. He had 13 tumours in his eyes and started chemotherapy when he was five days old. Despite intensive treatment, he had his left eye removed to stop the spread of the disease. He is now fit and healthy. Terry told delegates: "Taking that eye out was the best thing we ever did".

A test developed by Dr Brenda Gallie at the Hospital for Sick Children in Toronto, Canada meant that the Hoddinotts' second child Katie was diagnosed with the gene in utero and delivered a month early to begin treatment. The tumours in her eyes were much smaller than her brother's so treatment was successful and she now has perfect vision in both eyes.

ISNCC Toronto conference report

Terry Hoddinott and his wife Patti sharing their experiences

Terry finished his address by describing how lucky his family felt as a result of improving treatment for this condition. He said: "I lost two eyes, Riley lost one, Katie has two perfect eyes. Step by step it's getting better."

Population-based cancer control

The keynote address at the opening ceremony given by Simon Sutcliffe, President, British Colombia Cancer Agency, Vancouver, Canada was entitled *Population-Based Cancer Control — A Global Priority*. In his opening comments he said that the essence of his presentation was "not so much about what we can do but how we do it".

His talk focused on whether population-based interventions to control death and/or disability change health outcomes, and if so why. He looked at whether we should have population-based cancer control programmes and if we do, how we can ensure that such programmes are successful.

He gave the example of the control of river blindness in West Africa as a successful intervention. Ten countries, who often have difficulties with each other, collaborated on this programme. It was strategically driven with a clear target of eradication not cure. There was a 'no-cost' network of volunteers in the front line and the initiators bowed out over time with transfer to the community. The disease has been eradicated in large parts of West Africa and progress is being made in the remaining endemic countries in West, Central, and Eastern Africa.

Evaluation criteria

Mr Sutcliffe said that the following criteria needed to be used to evaluate the success of programmes:

- Can it be implemented on a significant scale?
- Does it address a major public health problem?
- Does it last at least 5 consecutive years?
- Is it cost-effective?
- Does it have clear and measurable effects on health outcomes?

Programmes utilise various methods, including: vaccines, surgery, behaviour change (for example using condoms), reducing environmental risks (for example spraying).

Mr Sutcliffe pointed out that interventions are not necessarily reliant on treatment. He said: "There never has been a treatment for smallpox and polio, for example. Yet there is no smallpox and very little polio. The power to change things is not contingent on having treatment. It is on having a strategy to control the disease."

Mr Sutcliffe looked at the common features of successful interventional programmes. He said that the involvement of all relevant stakeholders is key and said: "One cannot *do* things *to* a population, one has to engage populations to create change."

Other essential features are that cost-effective interventions are delivered and available to those in need for which adequate public financing is required. He said: "Programmes must not take on what they cannot afford and fail because they have not been financed properly."

Health in context

Having partners who can help is essential, so effective international financial and technical aid are also important as is inter-sectoral collaboration; ie transportation; education; agriculture; law enforcement; finance and health. He said: "It's not enough to offer therapy to patients if they cannot reach the clinic. You can't deal with health in isolation, you must deal with health in the context of transportation, culture, nutrition and so on."

He added that it is important to build knowledge from one intervention to transfer to other conditions. And he said: "It is important to identify the priorities and not to bite off too much at the start. Define what you can do and deliver on that before moving on." He told delegates that the questions that must be answered are:

- Can you reach the population who need to benefit?
- Is the intervention inexpensive, reliable and of consistent quality and known to be effective?
- Will the population accept it?
- Can you establish and ensure compliance?
- Do you have metrics to evaluate and demonstrate outcomes?
- Is the strategy sustainable?

Dr Sutcliffe told delegates: "Healthy societies are wealthy societies. You cannot have wealth without health. Increasing the population's life span by one year is worth four percent on the GDP."

Simon Sutcliffe giving the keynote address

Dr Sutcliffe talked about the role of oncology nurses, emphasising that they have the power to influence other health care professionals and to influence across sectors, professional and governmental.

He concluded by saying that cancer control is a human right to which there should be universal access. Finally he urged: "The information is there. Knowing what to do is clear. The real issue is how do you do it and how do you bring it into action at a population level. Each of us can express our influence and our ability to change."

Information/education resources for cancer control planning

WHO (www.who.int/cancer)
National Cancer Control Programmes — Policies and Managerial Guidelines (2002)
Preventing Chronic Diseases: A Vital Investment (2005)
Cancer Control: Knowledge into Action (2006) – 6 modules
Disease Control Priorities in Developing Countries (2nd Ed; 2006)
Global Burden of Disease and Risk Factors (2006)

UICC (www.uicc.org)
Evidence-based cancer prevention strategies for NGO's
Cancer Basics for All
Planning Resources for NGO's

US Centers for Disease Control and Prevention (2002)
Guidance for Comprehensive Cancer Control Planning — Vols 1 and 2

IARC (2004)
Globocan, 2002, Cancer Incidence, Mortality and Prevalence Worldwide

Cancer Control PLANET (cancercontrolplanet.cancer.gov/)
Plan, Link, Act, Network with Evidence-based tools

National Cancer Control Plans
Australia, New Zealand, France, Ireland, England, Holland, Canada

Challenge of childhood cancer

Great strides have been made in the treatment of childhood cancer over the last 30 years, delegates heard in a presentation which looked at the challenges that face children and their families.

Roberta Woodgate, associate professor in nursing at the University of Manitoba, Winnipeg, Canada reminded delegates of the high mortality rates in the 1960s when survival rates were less than 30%. It was she said: "a story of death and dying" with a lack of information, limited resources and technology.

However by the 1970s, cure rates had increased to 50% with the proliferation of randomised controlled trials, co-operative group trials and effective multi-modality protocols. In the 1980s progress continued with therapy being tailored to risk, a reduction in the radiation dose, and substituting effective drugs for radiation.

Childhood cancer treatment was pioneering. Ms Woodgate said: "Chemotherapy was first shown to be effective in curing children with cancer." In addition the discovery of the first tumour-suppressor gene occurred in children and the principle of multi-modal therapy was first developed for children.

By the late 1990s progress had continued with the five-year survival rate reaching nearly 80% and mortality continuing to decline to the present day. The decline has been greater in lymphoid cancers than in non-lymphoid cancers.

As well as medical advances there have been many changes for nurses caring for children with cancer. Ms Woodgate outlined to the audience that there has been an increase in technology with, for example, the use of central venous devices. Nurses have developed direct patient care and supportive care. Staffing levels have improved, allowing nurses to spend more time supporting families.

Currently three out of four children diagnosed with cancer are cured compared with just one in four in 1975. However this had been a "mixed victory". Ms Woodgate explained that negative effects on the growing mind and body emerge years or decades after the illness leaving survivors facing new challenges.

Ms Woodgate also described how families have to live with fear and uncertainty. She gave the example of a father who, looking to the future. said: "Until then we will not breathe. I will not breathe until she is 15 years old. You never know. We will never know if it is gone forever, we do not enjoy anything the way we did before."

For those families whose child does not survive it is devastating. Ms Woodgate said: "They want to keep the memories alive. Closure does not exist for them, nor do they want it." One parent said: "Life has been shattered. You learn never to trust any one or more to the point, yourself. You lose trust in the world! I'll never feel safe. Your whole safety net is gone, it's gone."

Ms Woodgate turned to the experience of siblings. She said: "Siblings need more help and support. They experience a loss of a sense of a family way of life as well as a loss of a sense of self within the family."

Roberta Woodgate on childhood cancer

Ms Woodgate concluded by describing the difficulties of assessing how children with cancer are suffering. She is currently developing a computer game designed for self-assessment and management of symptoms with the aim of improved quality of life in children with cancer.

Nurse smoking survey

Half of nurses discuss smoking cessation "always" or "frequently" with patients who smoke, according to a global survey.

The survey of 759 cancer nurses from Canada, Japan, Korea, Taiwan, United Kingdom and the United States described and compared their smoking habits, institutional smoking policies and their perceived role and behaviours in smoking cessation.

The nurses discussed the dangers of second-hand smoke less frequently (29%). This was not a result of lack of knowledge, as 95% stated that second-hand smoke is harmful, and 84% worked in smoke-free environments where patients may not smoke.

However only one in four nurses said that nurses have the primary role in discussing smoking cessation with a patient.

This survey was carried out by an international research group. It was presented at the conference by Robin Lally, doctoral candidate at the University of Minnesota, US. She concluded that although nurses recognise the importance of smoking cessation they could discuss it more with patients, recognising it as role of cancer nurses.

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Website learning improves care

An e-learning website initiated by a nurse now has 10,000 nurses from 100 countries registered for its courses, according to a presentation at the International Conference on Cancer Nursing.

The site www.cancernursing.org was set up in 2003 to meet local demand for training. Nurses who wanted to attend training courses were finding it difficult to get released by their place of work to attend study days.

Mark Irving, clinical nurse specialist at North Cumbria Acute Hospitals, UK, who set up the site with e-learning specialists in their spare time, told delegates: "We have harnessed the power of the internet to provide cancer nursing education that is not dependent on resources or geographical location."

The free online courses have been written by experts in their field and cover specific cancers, treatments, and nursing procedures and techniques.

The site has 350 new learners enrolling each month and by the end of next year it is anticipating that numbers will reach 20,000.

The courses are interactive, with nurses able to self-assess their progress and there is the opportunity to ask email questions of nurse experts.

Two acute trusts have carried out a research study to see if the training is effective. The United Bristol Healthcare NHS Trust and the Royal United Hospital Bath NHS Trust in the UK asked 30 nurses to take the www.cancernursing.org course on cancer of the oesophagus.

Preliminary results show that the courses improved knowledge and understanding which would help to improve patient care and outcomes.

The site is planning to expand with a discussion forum, courses in palliative care, a news service and to offer opportunities for accreditation.

Silence can speak louder than words

Purposeful silence is commonly used by nurses providing spiritual care, according to Canadian qualitative nursing research presented at the conference. The research found that silence is used effectively to convey compassion, acceptance and support. Words can be too limited to communicate subtle or intense messages whereas a silent moment can convey a myriad of emotions.

Beth Perry, associate professor, Athabasca University, Open University of Canada identified themes for which silence were used in a study of the work of exemplary nurses providing spiritual care. She said: "We don't have words for every feeling."

She found that silence was used;

- when patients were confused,
- when there are no "right words",
- when everything that needs be said has been said,
- when a person is close to death,
- when there are no words to match the intensity of the situation.

She said: "Sometimes saying nothing is saying everything. If there is a long-standing relationship between nurse and patient the most appropriate form of communication is comfortable silence. Silence speaks more gently than words at times."

She gave many examples of the use of silence including one where it was used when there are no words to match the intensity of the situation. She described a nurse story where a patient had been given a terminal diagnosis in an offhand way by a doctor.

When the doctor had left, the nurse sat in silence with the patient for a prolonged period as she said: "I could not think of a thing to say that would make it better". A few days later the patient thanked the nurse for being there when he needed her.

Many of the patient and nurse stories in the study supported the premise that when a person is close to death, silence can be the most appropriate nursing measure.

Older patients deserve better

Ageism is preventing the elderly with cancer from getting the care they are entitled to and need, delegates at the conference were told.

Deborah Boyle, project leader, Gero-Oncology and Survivorship Nursing Studies Program, Banner Good Samaritan Medical Center, Phoenix, US emphasised that 60% of cancer occurs in 13% of the population of the developed world, the over 65s.

She said: "Children, who have less than three percent of cancers, have a subspecialty devoted to them, unlike the elderly. The elderly are just as important as children and it is time to look at their special needs."

Looking to the future she reminded delegates that the number of people with cancer would continue to increase as would the number of the 'old old', the over 85s. And the majority of cancer survivors are among the elderly, who may live for another ten or twenty years and also have a greater risk of developing a second or third cancer.

Deborah Boyle calls for an end to ageism

Ms Boyle said: "As nurses we identify with the young so when we see a young mother with a toddler it is easy for us to identify with them. Children are vulnerable but so are the elderly. They have a compromised immune system, neurosensory impairment and dwindling social support."

She pointed out that there is a paucity of elder-specific trials. Traditionally the elderly have been excluded from clinical trials which means that they are being treated with results taken from people in their middle age and younger.

She concluded: "Older people have been young but we have never been old. We need to confront insensitivity and stereotypes. As nurses we can take on advocate roles in carrying for the elderly, to speak up for them as they grew up in a culture that does not confront the physician, or make waves. We have to be the voice for these patients."

Placebos destroy trust

Nurses are still using placebos to assess if a patient's pain is real, despite this practice having been denounced by professional organisations.

A study of 380 nurses from different countries including the Philippines, South Africa and the Middle East was presented by Bernard Yam, Lecturer, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, Australia.

The views of nurses attending a one-day pain management workshop at a major hospital in Riyadh, Saudi Arabia were collated. The results showed that a significant majority believed that placebo use could provide reliable information without harmful side effects or patient suffering.

Two out of five of the participants identified or supported the use of placebos for screening patients for analgesia abuse, for ruling out "malingering" behaviour and for use with "demanding" patients.

Very few of the nurses felt that the use of placebo should be prohibited. None of the participants were aware of any hospital policy on the use of placebo.

Mr Yam concluded that despite position statements from professional organisations, including the American Society for Pain Management Nursing, denouncing the use of placebos in clinical practice, their use continued.

He said that deceitful use of placebos destroys patients' trust in nurses and violates ethical and professional obligation. He said: 'We are lying to the patients and it is a breach of our trust with them.'

He called for institutional policies on the use of placebos and education programmes to be implemented to change pain management practice.

Distinguished Merit Award

Lesley Degner (left) received the Distinguished Merit Award from ISNCC president Margaret Fitch at the Toronto conference. The award is given in recognition of an outstanding contribution to cancer nursing which goes beyond what is normally expected of a nurse in his or her particular sphere of professional endeavour.

Lesley Degner, professor of nursing at the University of Manitoba, Canada is an internationally recognised academic and researcher who has had a career-long interest in patient involvement in medical decision making. She has shown outstanding commitment to graduate training in cancer nursing research.

Receiving the award Professor Degner said: "It is a huge honour for me to receive such an award especially as it is from an international body."

She added that she had been involved over the last 30 years in a number of studies and she wanted to dedicate her award to the patients and their families who had taken part in those studies.

Seeing graft photos beforehand helps

Patients are much happier with the result of a skin graft for cancer if they have seen photos of real grafts, says research.

A nursing study of 18 patients needing surgical treatment for skin cancer gave one group information as well as pictures of grafts while the control group received just information.

Patients in the intervention group reported that they were pleased with the results of the grafts. However those in the control group reported feelings of shock and bewilderment and said they thought that health professionals had held back the truth or misled them.

Anne Sullivan, associate director of nursing at the Worcester Royal Hospital, UK said she carried out the study because she observed patients' reactions. She said: "Patients with skin cancer have a limited time to understand their diagnosis and to consider the impact of the surgery.

"Post-operatively patients often seemed unprepared for the results of surgery and shocked by the appearance of the skin graft."

Prior to the study, Ms Sullivan suggested to the medical team that patients could be shown pictures but there were concerns that this would upset them and might put them off surgery.

She concluded her presentation by saying: "From this study I would recommend that pictures are an appropriate method of enriching the quality of information to patients and their relatives."

Acupuncture use

Acupuncture can significantly improve the symptom of fatigue in cancer patients, according to UK research.

A study of 47 patients experiencing moderate to severe fatigue at least a month after completion of chemotherapy, were given either six treatments of acupuncture over two weeks, taught to self-administer acupressure or received a sham form of acupressure.

A month later those patients receiving acupuncture showed a 36% improvement in fatigue levels, the acupressure group an improvement of 19% while the control group had the same levels of fatigue.

Alexander Molassiotis, Professor of Cancer and Supportive Care at the School of Nursing, University of Manchester, concluded that acupuncture is an effective way to treat this common symptom. He added that nurses could extend their role with acupuncture and that acupressure is a simple technique that patients can learn to apply themselves.

Robert Tiffany Lectureship

The Robert Tiffany Lecture was given at the Toronto conference by Professor Marylin Dodd from the Department of Physiological Nursing, School of Nursing, University of California, San Francisco, US.

The lectureship was created to keep alive the memory of Robert Tiffany who was a founder of the ISNCC and the initiator of the biennial International Conference on Cancer Nursing.

Receiving the award from ISNCC president Margaret Fitch, Professor Dodd said she was deeply honoured to have been nominated and chosen for the award. She recalled meeting Bob Tiffany and "loved his commitment and energy".

Professor Dodd has dedicated her research career to decreasing treatment-related morbidity in cancer patients by applying self-care theory.

Translating theory into practice she developed, with her research team, a self-care intervention called the PRO-SELF Program. The programme is designed to provide adult patients receiving cancer treatment with the information, skill, and support, needed to engage effectively and consistently in prescribed self-care symptom management.

Professor Dodd's lecture focused on a series of studies which developed, tested, and refined self-care interventions to decrease symptoms associated with cancer and cancer treatment. Her lecture, which was warmly received by the Toronto conference, will be featured in the next issue of the newsletter.

Course improves skills

Nurses' communication skills are improved by a three-day training programme according to a study which assessed 'before' and 'after' performance.

The study presented at the Toronto conference randomised 172 cancer nurses into two groups. Both groups submitted two taped interviews with patients. Then one of the groups attended a communication skills programme which included role play with actors and playback of the taped interviews.

Twelve weeks after the course the nurses again submitted interviews. These were assessed by an independent researcher. The results showed that the communication skills of the nurses who had attended the programme were significantly improved.

Susie Wilkinson, senior lecturer palliative care, Marie Curie Palliative Care Research Unit Department at the Royal Free Hospital, London, UK told delegates that the nurses were able to structure interviews better, showed more empathy and reflection, and had less blocking behaviour which enabled a deeper level of conversation.

The study also looked at how patients fared. Those interviewed by nurses who had done the course were more satisfied than those who were interviewed by nurses in the control group.

Early reporting needed

Three-quarters of women who present with carcinoma of the cervix in Tanzania present with late stages of the disease.

A study presented to the conference looked at 144 patients in order to identify factors which contributed to late reporting.

The patients were seen at Ocean Road Cancer Institute in Dar es Salem, Tanzania, the only cancer facility in the country offering treatment and screening. The results showed that four out of five patients presented with late stage carcinoma of the cervix.

Among the patients 87% were not knowledgeable on the signs and symptoms of cervical cancer and 95% were not aware of the consequences of the disease. After experiencing first signs and symptoms, almost half of the patients (46%) did not take any action. Of the remainder, 40% went to see a traditional healer.

For those 14% of patients who attended a health facility only 29% were examined, a biopsy taken and referred to the hospital for further management. Other reasons identified for delay were financial constraints.

Jesca Kawagere, nursing officer at the institute, who carried out the study, called for health education for the community on signs and symptoms to encourage earlier reporting of the disease.

Nurses can give diagnosis

Nurses can give patients their cancer diagnosis and gain consent for their treatment, delegates heard.

A study of 30 patients who were given their cancer diagnosis by a nurse and gave consent to treatment found that 29 out of the 30 were satisfied.

The patients commented that the nurse knew what she was talking about, that they did not feel rushed and that it was explained in a language that they understood. The patient who was not satisfied expressed dissatisfaction with the amount of time allocated, not the choice of health professional.

Jackie Green, nurse consultant in haematology, Mayday NHS Trust, Croydon, UK said: "Traditionally it is the doctor that gives the cancer diagnosis and takes consent but I would challenge whether the doctor is the most appropriate person"

She said that, as nurses are taking responsibility for administering treatments such as chemotherapy, they are well placed to give diagnosis and take consent.

At the Mayday NHS Trust, advanced nurse practitioners are giving the diagnosis and taking consent for patients in the urology and haematology department and this could now be extended to patients with colorectal and breast cancer.

Ms Green concluded that: "The factors that enable patients to feel that they have understood are the same irrespective of who obtains consent and gives diagnosis."

Past President's Award

The Past President's Award was presented to Zhang Hui Lan, Professor in Oncology Nursing at the Cancer Institute and Hospital, Beijing, China. The award is given in recognition of a cancer nurse from a developing country who has initiated and sustained a programme of cancer care which has been in place for three or more years and has the potential for replication outside the country's borders.

During 40 years of oncology nursing Professor Zhang Hui Lan has made a huge contribution to the development and training of oncology nursing in cancer care in China. She was instrumental in establishing an oncology nursing association in 1989 which has since organised national conferences and workshops as well as providing a communication network across China. She has worked tirelessly to raise the profile and status of the cancer care nurse in China.

The award was presented by Connie Henke Yarbro, past president of ISNCC (right) and was received on Professor Zhang Hui Lan's behalf by Wang Qi, ISNCC board member.

Bringing palliative care to Jordan

A collaborative international project has introduced palliative care in Jordan and increased the use of pain relief in the country.

Dr Frank Ferris, medical director, San Diego Hospice & Palliative Care, California, US, outlined the history of the project to the Toronto conference. Jordan has a population of 5.7m. In 2000 the country had 3,300 new cases of cancer, 70% who present with stage IV disease.

Before the project began in 2001 the country had no palliative care service and no home care service. There was poor availability of morphine which was only obtainable in an injectable form. It was only prescribable by a medical oncologist at the National Cancer Center in Amman and then only for a three-day supply. There was a fear of opioid use among nurses, doctors and the public. There was one hospice which had been established for 10 years, offering care to 60 patients each year.

Dr Ferris said that a strategy to implement palliative care in Jordan could not be carried out from the outside, without regard for the views of the population. A strategy was needed that looked at policy, education, drug availability and implementation.

Developing opinion leaders was essential. He said: 'We needed opinion leaders, both administrative and clinical, within organisations, and we needed to build strategic and business plans with resources behind them."

He added that "simply providing education, as demonstrated elsewhere, won't work and will change nothing."

The project was in partnership with the Jordan Ministry of Health, WHO, King Hussein Cancer Center, San Diego Hospice & Palliative Care and the Capital Hospice of Virginia. Educational activities for medical staff were based on the Education on Palliative and End-of-life-care (EPEC) project and for nurses on the End-of-Life Nursing Education Consortium (ELNEC) project. An anonymous donor, who died last year, made a significant contribution to the project.

A meeting with the deputy minister of health led to the setting up of a national committee with sixteen leaders in policy, drug availability and education. A new national cancer control policy is planned which will incorporate palliative care.

The project leaders persuaded Hikma Pharmaceuticals in Jordan to manufacture inexpensive 10mg oral morphine tablets for use in the Middle East. From 2005 the opioid quota for Jordan has been quadrupled to 8kg a year. Slow release generic morphine products are now being imported.

Prescribing has been changed to any physician, any dose, any pharmacy and a 21-day supply. Dr Ferris said: "This is a huge shift for a country to take this step."

Education programmes need to be continuing. Dr Ferris said: "We need to build skills and change behaviour which needs mentorship, not just classroom teaching, to have a true impact."

The project has run two three-week courses for 70 doctors, nurses and pharmacists from 10 hospitals

"We found it was critical to have teams from each facility if we were going to make a difference. Without exception, if only a physician or nurse is involved they have not started a programme at their hospital or been able to implement anything," he said.

In the second and third week the participants were taken to the bedside in small groups to do patient assessments and to see patients benefiting from morphine. Dr Ferris said: "To get past fear you have to demonstrate effectiveness." As one of the doctors on the programme said: "During the first week I felt I would not benefit from the course or make any change in my practice, but after starting practical sessions a huge unexpected change happened. I will make every effort to put this knowledge into practice ."

Mr Ferris said that nurses often express fear that morphine will kill the patient and this has to be addressed in the education programme.

An international fellowship has been developed for physicians and a visitorship programme for nurses.

Dr Ferris concluded by stating that while there was still more work to be done to develop palliative care in Jordan, the success of the programme is shown by developments at the King Hussein Cancer Center. It now has a palliative care team with two physicians, 25 specialist nurses, a social worker, clinical pharmacist, 8-bed inpatient unit, an outpatient clinic and a home care service.

Spiritual beliefs must be respected

Competing priorities for resources means that patients needing palliative care for cancer in Africa get little access to care and pain-relieving drugs.

Delegates in Toronto were told that Africa carries two-thirds of the global disease burden but only has five percent of the resources. A presentation by David Makumi, clinical nurse instructor at the Aga Khan University Hospital, Nairobi, Kenya looked at the challenges and opportunities of providing palliative care for cancer patients in resource limited settings.

He described the situation in Kenya where the government has no official palliative care policy. Cancer treatment provision is limited, with radiotherapy only available in the capital. There is scarce palliative care training for both nurses and doctors which means very restricted use of morphine for patients with terminal cancer.

Standards of palliative care for cancer patients in hospitals which are 'cure oriented' vary from one institution to another depending on resource availability and the knowledge base of the carers.

There are six hospices, relying on charity for funding, which serve the Kenyan population of 33 million. The majority of patients admitted are those with HIV/AIDS as it attracts more funding than cancer.

Many terminally ill patients in Kenya are admitted to acute care settings occupying much needed beds. A home-based care network in urban slums and rural areas has been developed in response to the HIV/AIDS epidemic. Mr Makumi proposed that the way forward in Kenya would be to use this existing network to develop palliative care services.

David Makumi proposing a way forward

He told delegates that western palliative care models need to be adapted in Africa to allow for spiritual beliefs. He said: "People in many parts of sub-Saharan Africa have belief in witchcraft or curses and different views of the meaning of death. Palliative care nurses must take cognisance of these beliefs as they have meaning to the patient.

"The meaning and understanding of death and dying varies from one community to another. In Kenya for example there are 42 or so ethnic groups each with its own distinct understanding of death and dying, in terms of whether a patient should die in hospital or at home. For some a death at home brings bad luck."

He added that any programme would need to cover income generation. He said: "Hunger and food security are big issues, not only for the patients but also for the rest of the family. Terminal illness denies not only the patient but also the family a chance to till the land and produce food for the family."

He called for palliative care to be included in the national healthcare agenda, for affordable pricing of morphine by the pharmaceutical industry and for nurses to be licensed and trained in the use of essential drugs in palliative care.

Home-care nursing in Brazil

Teresa Camargo from the National Cancer Institute (INCA), Rio de Janeiro, Brazil described the development of a home-care nursing service.

Ms Camargo told delegates: "The In-Home Patient Care service aims to maintain the patient at home with their family with quality of life and assistance to carry on normal life."

The patients who receive home care are those who have a clinical condition that means that it is physically difficult to attend outpatients, and patients receiving palliative care whose clinical condition has deteriorated. The patient has to live within 70 kilometres of the cancer hospital.

The first visit is carried out by a doctor or a nurse within 7-10 days after the referral. Follow-up visits are carried out by the nurse at weekly intervals. The nurses are divided into four teams, each covering a different area.

The nurses identify patient and family needs and set out an intervention plan.

They give caregivers guidance and training as well as evaluating the intervention plan weekly. They also carry out procedures including wound dressings as well as controlling and alleviating symptoms such as pain. They refer to other professionals where necessary and give guidance to patients and relatives over the telephone.

The service presents significant challenges for the nurses. The first of these is the hospitalisation culture in Brazil. Ms Camargo explained: "Both the patient and the family are under the impression that the patient only gets adequate care when in hospital. The nurse has to change this impression to get the patient to accept home care".

Another challenge is the location of the homes that the nurses visit which can be in an area of social conflict or difficult to get to. Sometimes a family member can come to the hospital to be given instructions on how to care for the patient or the patient can be seen in a relative's home.

Another problem is that the patient's medication may be used by other members of the family so prescriptions have to be carefully supervised.

However, extreme poverty is the most significant problem facing the nurses. Ms Camargo said; "This is the overwhelming challenge facing the nurse on a home visit. The nurse's intervention can fail because, for example, there is no food at the patient's home. And sometimes they have to face extreme sanitation problems."

Teresa Camargo on home care in Brazil

Ms Camargo concluded that despite these problems the home care service was successful in de-hospitalising patients while maintaining quality of life and expanding palliative care.

Workforce issues in cancer nursing

Delegates were offered pre-conference workshops covering a wide range of topics. Here is a report of the pre-conference workshop on workforce issues

Over the past decade, healthcare around the world has experienced dramatic change as a result of innovative new technologies and therapies, availability of qualified healthcare professionals, and changes in population and health demographics.

The steady increase in incidence and prevalence of cancer, aging populations and the global shortage of nurses all create a pressing need to identify ways to build and sustain quality oncology nursing workforces to meet the growing demands for oncology nursing services.

This workshop examined these workforce issues in cancer nursing as a collaboration sponsored by three research projects:

Understanding the factors that influence recruitment and retention of oncology nurses. Bakker, D & Fitch, M (co-principal investigators)

Meeting the needs of cancer patients and families: today and tomorrow: oncology nurses demographics and clinical role functions. Crooks, D & Green, E (co-principal investigators).

Quality workplaces for health professionals: research knowledge utilization. Fitch, M (principal investigator).

Objectives

By attending the workshop, individuals had the opportunity to gain further insight into workforce issues in oncology nursing within their own environment and how they are similar or different around the world. They were also able to network with cancer nurses from their own country and abroad by sharing experiences and innovative strategies to address workforce issues.

Participants

A total of 23 nurses, nurse educators, administrators, and researchers from the United Kingdom, Australia, New Zealand, United States, Canada, Singapore, and Palestine participated in the workshop

Process

The workshop began with presentations from the three studies, describing findings related to workforce issues from national and provincial perspectives. Topics included recruitment and retention, clinical role functions of advanced and specialised oncology nurses, mentorship, and leadership. An international panel from Australia and South Africa shared an overview of the cancer care situation and workforce issues in their regions. They focused on;

- key factors for cancer nurses quality of work-life,
- current research regarding cancer nursing recruitment and retention,
- strategies to encourage recruitment and retention of cancer nurses,
- cancer nursing roles and settings,
- current policies to enhance/stabilise the cancer-nursing workforce.

The afternoon plenary session promoted the transfer of research study findings through question and answer sessions. The breakout group of four small interactive sessions (education, environment, policies, and research) focused on sharing information from different settings.

Education

As oncology is found in all areas of nursing, it was suggested that all nurses should have some understanding of the roles of general and specialised nurses. It was recommended that oncology and palliative care should be introduced much sooner into the nursing curriculum, laying the foundations for advanced practice.

The final issue discussed was the challenge for nurses to keep up to date in terms of knowledge, both individually and within the nursing education curriculum. It was also pointed out that since oncology research is increasing, there is the opportunity to incorporate its results into best practice.

Work environment

This topic sparked an intriguing discussion of the difficulties oncology nurses face and evolving ideas of how to improve the oncology nursing environment, both of which were seen to be global. There is a reported lack of leadership from management and high turnover rates, with many new nurses leaving after a few years of service.

Contributing factors to high turnover may be physical demands, high pressure, lack of support and ultimately burnout. One consistent report was that nurses still perform many non-nursing duties.

Ideas on how to improve the environment and retain oncology nurses included:

- recognition of the importance of planning and leading,
- re-allocation of non-nursing duties,
- open forums where issues can be raised and listened to,
- providing recognition for effort and accomplishments,
- providing a supportive team atmosphere.

Standardisation was also raised as a means to reduce frustration significantly. Lastly it was felt that the retention of nurses could be improved by;

- providing an atmosphere that emphasised support,
- no-tolerance policies dealing with bullying,
- teamwork through a buddy system.

Policies

Common themes were the need for minimum standards for cancer services; issues like the private vs public health sectors, access to treatment closer to home and homecare nursing. It was agreed that governing bodies should set out minimum work environment standards, with an emphasis on orientation, on-going/continued education, and the workforce. The latter should include the shaping of interdisciplinary oncology teams so as to clarify nursing roles.

Another recommendation was development incentive funding so that specialised oncology nurses could go to remote rural areas, where the opportunity to receive treatment is rare.

Policies should be reviewed often, in order for improvements to be made. Appropriate outcomes could be determined through a peer review system.

Research

The workshop's theme of workforce issues in cancer nursing produced many ideas for future research including expanding on studies already completed, new studies, and international and global studies.

One idea related to the definition of 'specialised' and 'advanced' nurses. Further research could be done to define specialised nurses, and their education, as well as research on the evolution of the nursing role throughout a nurse's career.

International research was a large topic of interest. There were recommendations of international collaboration on roles, education, how to add oncology into the undergraduate curriculum, and how help new graduates to make the transition into the oncology workforce.

Finally, there was interest in whether there is an 'Oncology Culture' and if so 'what is it?' and 'does it differ in different countries?' With all of these ideas resulting from the discussion, there are clearly many areas for future collaborative research.

Greta Cummings, CANO President, Esther Green, co-chair of the Scientific Program Committee, Alison McAndrew, Research Project Coordinator

Living the experience of cancer

The Helene Hudson Memorial Lecture was given at the conference by Canadian oncology nurse Vivian Painter and was entitled *How I Learned What I Thought I Already Knew*. Ms Painter described how during her husband Garry's illness and death from adenocarcinoma of the stomach she came closer to understanding the experience of living with and dying of cancer.

After Garry died Ms Painter looked back and she told the audience "through this experience, this hand-in-hand, heart-to-heart and soul-by-soul walk with him, I have come closer to understanding the experience of a person living with and dying of cancer. It was in the re-living that I really learned what I thought I already knew about cancer".

Uncertainty

Ms Painter found that there were a series of issues which she understood differently and which she addressed in this presentation. One of these was uncertainty. She told delegates: "Uncertainty is a much studied concept and the nursing literature is rife with description of the concept and research on its meaning and effect of persons living with cancer.

"I thought I understood that a cancer diagnosis had the ability to make a person wobbly, perhaps throw them into a state of indecision, sometimes overwhelmingly so or at the very least, a place where their bearings are not firmly fixed.

"We know uncertainty causes fear and anxiety and I thought, (as perhaps we all do) that the remedy for this uncertainty was to make as much certain as possible."

She told delegates that the reality is, whether we are living or dying, there is only uncertainty. She said: "What I learned about uncertainty, that I thought I already knew, was that uncertainty is necessary for true healing.

"This is what I learned and now know about uncertainty today – perhaps we in the wellness-world have more fear of uncertainty than the people to whom we ascribe this phenomenon. Be open to embracing it with the person living with cancer."

Hope

The next issue Ms Painter addressed was hope. She told delegates: "Hope is a completely over-rated commodity. This is, of course, the antithesis of what we learn in our professional education."

Although it was accepted by both her and Garry that he was in the last part of his life, she said: "Oddly, and unexpectedly, it felt as though the health care professionals that surrounded us did not seem to accept these facts.

"With much good intention, we were given generous doses of hope along with the cisplatin, epirubicin and 5-FU. When these doses of hope were infused, we were genuinely grateful, for a moment. But hope is a construct of the well-world; I must tell you it causes great pain in the world of terminal illness.

"How could we come from those grim forecasts and shocking facts to being encouraged to hope for a cure? When your hopeless situation and your well-understood hopelessness is not recognised by those supporting and helping you to dwell on this earth for as many more days you will be afforded before you inevitably reach the last day, it makes you a stranger and ultimately separates you from everything you knew."

Vivian Painter giving the Helene Hudson Memorial Lecture in Toronto

She said that hopelessness is a great positive, not the negative it is perceived to be. "Attaining hopelessness does not mean that you give up on treatment or turn away from cancer therapy and care; it means only that you are freed from the bondage of hoping for a cure and living only for an unreal, unattainable future."

Delirium

The next issue Ms Painter addressed was that of delirium. Garry explained it to her in the following way. "He said it was like his conscious and subconscious minds were separated by a rubber-like membrane. He would be talking with someone quite normally, when suddenly, without warning a sharp point would push on the membrane from below until a small hole was made and the subconscious would flood the consciousness with thoughts, ideas, words, even visions that had no relation to the current reality. Just as suddenly, all this subconscious would drain back through the small hole, which sealed itself up until the point started pushing again."

Garry was admitted to hospital for investigation of confusion which resulted in him trying to escape, cutting his intravenous lines and being retained by force. Garry explained to her afterwards that he was trying to get home but that no-one asked him what he was trying to do.

Reflecting on this issue she said: "Perhaps we in the wellness-world, even as experienced nurses, don't listen to the patient's story intently enough, so that we know the person as best as possible when they arrive needing our care.

"Perhaps we focus too much on some of the things that don't require as much of our attention. So, be open to seeing the person living with cancer as much, much more than their disease; see the person who is simply responding to things we cannot understand."

Boundaries

Another issue addressed was boundaries. She recalled caring for her husband: "Every request of his was another opportunity for me to serve him; I saw each task as a privilege to be intimate, to show him my love for his very essence. In his last days."

However every evening she would be encouraged by a nurse to 'take a break'. Ms Painter said: "At first, I tried to get around this nurse and say I didn't need a break, but she was persistent, which I believe was well-intentioned but not very perceptive.

"I grew to hate that time of day because it was becoming so difficult to maintain intimate contact with Garry and after each of these breaks, I would have to make up ground to get back to where we had left off. It is my perception though that the nurse seemed to like, perhaps need, the interactions with him more, otherwise I think she would have felt my palpable unwillingness to leave; she would have perceived my bristling when she entered our room."

Following this experience she told delegates: "Be aware of your nurse's-self in every situation."

Describing how Garry died and how she mourned him Ms Painter concluded by telling the audience: "I learned far more than I ever expected about cancer and about the power of story in all of us: I have had the remarkable and incredible privilege of travelling through this life-world with the one I will always love."

Reviewing the Toronto posters

The Toronto conference offered the biggest number of posters that had ever been presented at an ISNCC conference. Covering a wide range of topics they were of the highest quality and of great interest to the delegates

There were nearly four hundred posters in eighteen categories from over 40 countries at the conference. As there had been such a wealth of abstracts for this conference, with limited time available for oral presentations, the scientific committee wanted to ensure that the poster presenters received the recognition they deserved. For this reason, 'Meet the Author' sessions were developed. In these, poster presenters were given a set time to be by their poster to discuss their work and network with interested conference participants.

Posters were grouped into themes corresponding with the plenary and concurrent sessions for each day and conference delegates were informed which posters would be presented. There was an excited buzz during each lunchtime session, with presenters from around the world talking to delegates about their work.

Each day the delegates awarded a prize for the poster which they felt made the greatest impact. Prizes were also awarded by a team of judges from the ISNCC board and the Canadian Association of Nurses in Oncology (CANO) for the best poster in the categories of education, practice and research. Each day posters were awarded a 'Highly commended' rosette in a particular category and on the final day the judges chose overall winners for each category.

In the current healthcare climate there are grave concerns about the workforce, the safety of staff and the competence level of trained skilled nurses. There were posters from UK, Canada, Australia, Japan, India, Israel and the US which looked at these issues.

As expected some looked at the importance of education within the workplace or supporting staff to attend courses. In Israel they identified that nurses were concerned with their level of knowledge surrounding chemotherapy and how this had led to burnout with some staff.

Conference delegates stimulated and informed by the wide range of posters on display

In India issues surrounding the number of needle stick injuries were identified as a real concern. Despite an awareness of the potential impact on personal health if a sharps injury occurred, staff were reluctant to disclose the injury and so did not receive any necessary treatment. Using incidental teaching, training in the workplace and improved knowledge of policies relating to sharps injuries they were able to ensure staff received rapid treatment.

In Canada, the issue of ensuring the safe handling of chemotherapy was presented, evaluating current practice against clinical standards set in 2003 by the Oncology Nursing Society (ONS). The task force clearly identified there were still areas for improvement.

There were thirty posters presenting new models of care delivery, these reflected services which were new to a country or area

Poster award winners

Category winners

Research
Development & psychological determinants of a delayed presentation in locally-advanced breast cancer
#364: Judy Gould, Canada

Education
A psycho-educational residential forum for younger women with breast cancer
#285: Lisa Grosser, UK

Clinical practise
Development of a strategy to avert hyperglycemic crisis in hematology patients receiving high-dose glucocorticoid protocols
#360: Martha Wright, Canada

Delegate's choice

Day one
The incidences of cancer among nagasaki atomic bomb survivors
#26: Kikuko Iwanaga, Japan

Day two
Crest of a wave
#275: Vivienne Freeman, Australia

Day three
Radiation oncology in Kenya: reflections of a radiotherapy nurse
#336: Roselyne Opindi, Kenya

as well as totally new innovative practices, many of these being led by cancer nurses. In Norway, the introduction of an ambulatory nurse who visits patients post stem cell transplantation clearly demonstrates benefits for the patient's physical and psychological rehabilitation.

In Canada, work is being undertaken in a number of provinces to develop ambulatory chemotherapy. Models of practice which are nurse initiated or which would have traditionally required a hospital admission are being developed. These models of care delivery will enhance the patients' experience and reduce the need for admission to a hospital bed.

Cancer nursing roles are advancing and in the section of 'Expanded and Advanced Nursing' examples of role development were presented. In Japan nurses are supporting and empowering patients to ask questions and be involved in decision making, a real cultural change within this country.

In Taiwan, Chia-Hui Chang from the National Cheng Kung University Hospital undertook a study looking at the variance between the patient's perception of their case management and the health professionals. The study of 189 cancer patients demonstrated the importance of the inclusion of the patient in the development of the plan of care. Other posters presented work that demonstrated the importance of the leadership role within cancer nursing, whether in the development of haematology education and support groups, nurse-led services, or strategies to improve the quality of cancer nursing across a hospital.

Candy Cooley and Esther Green, co-chairs of the Scientific Program Committee

Exercise and the role of the nurse in supporting patients was discussed in a number of categories. Kathleen Shedlock in the US stated that early data showed results demonstrating that exercise improved the immunological status of the patient and enabled them to cope with treatments more effectively.

Marilyn Kirshbaum from the UK undertook a systematic literature review of the benefits of exercise for women with breast cancer. Her conclusion was that the evidence suggested that aerobic exercise limits cancer-related fatigue and while the evidence for the impact on other concerns was less conclusive there were measurable outcomes on overall quality of life, sleep, self-esteem and depression.

Oral healthcare was a problem which received attention from a number of different presenters. Work in Brazil showed that there was limited evidence-based prevention or treatment of mucositis in bone marrow patients. Laila Grothe in Norway identified that oral complications were often under-addressed by doctors and nurses. They have implemented an integrated dental and medical programme to ensure care improves.

Palliative and supportive care was the subject of the largest number of abstracts, this reflects cancer nurses acceptance that, while the focus may be on cure, ensuring the 60% of patients who currently may not be cured receive the best care is the priority for cancer nurses.

Posters presented work that reflected the diversity of nursing roles from high 'tech' supportive interventions through improving patient's experiences throughout their involvement in healthcare to support at the end of life.

It would be impossible to really do the posters justice within this review. All the abstracts are on the ISNCC website, www.isncc.org. We would recommend you contact those presenters who have undertaken work which you may also have done or are thinking about doing.

The poster presenters produced some fantastic work. It will shape the future experiences of cancer patients and cancer nurses and it was a privilege to be able to be involved in their work.

Candy Cooley, co-chair,
Scientific Program Committee,
Diane Batchelor,
Chair, Poster Committee

Interviewing patients by email

A study which explored how cancer is integrated into the lives of young adults used internet-based interviews as a research tool.

The Danish study looked at the views of young adults — defined as aged from 20-35 years. Bibi Holge-Hazelton, senior researcher at the Aarhus Hospital, Denmark told delegates that this group is often overlooked in cancer care. She said that there is a lack of studies about the needs of young people and about how health care professionals can support and communicate with them.

Ms Holge-Hazelton told the audience that the advantages of internet communication are that the participants are free to participate and will not feel obliged to take part, as they may if asked by a nurse on a ward. The young person gets in contact having heard about the project. This method also allows for contact with a broader geographical group.

As part of the project the participants were asked to list the questions he or she would ask if they were conducting the study. This often results in very precise, direct and highly relevant questions. Examples of questions:

- Do you often think about death and if so, when?
- Do you blame yourself for your illness?
- Is it difficult to talk to new friends about your illness?
- Have you changed your hobbies because of your illness?

The young adult is then asked to answer their own questions. Ms Holge-Hazelton said: "The results are intense, sincere and unsentimental. When this process is over I start asking further questions based upon what they have already written. This process goes back and forth; in general about 20 emails are exchanged but a few people I have exchanged up to 200 emails with."

Ms Holge-Hazelton said that this approach means that the questions often reflect in a direct manner what is occupying the mind of the young person as opposed to questions designed by researchers. She said: "This approach generates processes that can be interpreted as therapeutic in the sense that young adults reflect on and describe difficult issues in their personal lives."

The participants gave positive comment about the email-based interview format. One said: "I think it is really good, because you can do it when you have time and feel like it." Another commented: "Sometimes you can become a little mute when you sit face to face, and here you have the possibility to think about the answer."

Ms Holge-Hazelton concluded her presentation by stating that if cancer nurses want to understand what goes on in the lives of young people with cancer, they need to understand and use the communication tools that young adults favour.

Travel scholarship awards

Twenty four travel scholarships were awarded to nurses from 11 countries: Brazil, China, Egypt, Ghana, India, Kenya, Nepal, Romania, South Africa, Tanzania and Thailand. Here are some of their experiences in Toronto

David Makumi

Clinical nurse instructor at the Aga Khan University Hospital, Nairobi, Kenya

Arriving at Toronto Airport, on a bright late September afternoon to find a welcoming party from the local organising committee was the first of the many exciting surprises we were to get over the next few days.

We were treated to a welcome reception during which time we had the honour of being received by the incoming and the outgoing ISNCC presidents as well as other board members.

The performance at the welcome evening reception set the stage for the rest of the conference. The issues displayed in drama in verse were so real the play could well have been a depiction of the situation here in Kenya. Issues of decisions being made for patients and families without involving them, information overload, busy clinicians, fears and uncertainties which come with a cancer diagnosis. These situations cut across social, cultural and economic boundaries.

At the opening ceremony Terry Hoddinott gave his story from the heart. His presentation helped us see how far oncology has come over the last 40 years. In a way it helped me reflect on the cancer situation in my country: we are perhaps where Terry Hoddinott started, we are yet to get where his two children are (see page 1).

There was wide range of themes for the plenary presentation. I particularly enjoyed the sessions on cancer through the ages, cultural and spiritual care across cultures as well as palliative care. I had accepted the challenge of being a plenary speaker. Though I was a little anxious, the audience encouraged me by being very attentive.

The concurrent sessions had varied themes. Making choices was never easy, there were too many good things happening at the same time.

Attending this conference afforded me a tremendous opportunity to learn, and share with some of the global cancer nursing community. Meeting and interacting with nurses from around the world helped me to appreciate that, although I come from a resource-limited country, some of the issues and challenges facing cancer care nurses are the same across the continents.

We plan a feedback continuing-education session for cancer nurses in the greater Nairobi area. Our colleagues here are so keen to hear about the conference; they will not let us get over the jet lag!

Pendo Bukori

Nursing officer, Ocean Road Cancer Institute, Dar es Salaam, Tanzania

With support from a travel scholarship I managed to attend the conference with my colleague, Jesca Kawegere, both as delegates and presenters. We presented two papers in the concurrent sessions. I presented a paper *The prevalence of different breast conditions and yields of early detection through breast clinical examination and self examination*. Jesca presented a paper *Factors contributing to late reporting of patients with carcinoma of cervix for treatment among women in Tanzania*.

During the conference we attended a wide range of plenary and concurrent sessions. The topics enabled us gain experience in different aspects of models of patients' care. For example in supportive care, (symptoms management, prevention of fatigue during treatment for cancer), the use of four different types of interventions — exercise, education and counselling, relaxation and distraction, and sleep promotion — were found to have significant effects on cancer related fatigue. This was the most impressive presentation for me.

Based on what I learned from this conference, my colleague and I have negotiated with our employer to see how we can adapt this knowledge at the institute. Furthermore I have disseminated the knowledge to our colleagues and I am planning to have ongoing educational sessions for our staff in order to help our clients.

I would like to extend my heartfelt gratitude for the financial support that enabled us attend such a wonderful conference and to make our dream possible.

Cristina Mamédio and Geana Kurita

Nurse researchers,
University of Sao Paulo, Brazil

We are grateful for the scholarships that made our participation in the 14th International Conference on Cancer Nursing possible. This conference represents a remarkable opportunity to unite oncology nurses from all over the world to evaluate, compare, rethink and strengthen our professional practice. In addition, it provided an excellent event at which to interact with nurses of different countries.

In the plenary session on palliative care we noticed that, besides Brazil, there are other developing countries that have economic, cultural and social issues that hinder service delivery and research development.

Geana Kurita and Cristina Mamédio

We could see that, despite the differences between developed countries and those in development, nurses have the same scientific interests, and focus care in a very similar way.

The conference gave us the opportunity to evaluate the quality of cancer care, and the practice of oncology nursing in Brazil. We are happy to say that, in spite of the difficulties common to a developing country, we are doing a good job.

There were so many benefits in attending the conference that it would not be possible to list them all here, but the main goals that we established were:

- to strengthen the Oncology Nursing Society in Brazil,
- to create an on-line group with the current members of the Brazilian Oncology Nursing Society,
- to adapt the acquired knowledge to Brazilian reality,
- to develop international partnerships,
- to encourage researchers to present their studies in the next International Conference in Cancer Nursing, not only to share experiences, but also to show the quality of oncology nursing in Brazil.

Thanks to the following for their support of the travel scholarships

Novartis Oncology, Sanofi-Aventis, Clinical Insights, Hoffman-La Roche, SuperGen, Canadian Cancer Society/National Cancer Institute of Canada, CANO Prince Edward Island Chapter, London Oncology Nurses Interest Group, CANO Oncology Nurses Interest, Group of Alberta, CANO 2006 Conference Local Organizing Committee, CANO Toronto Chapter of Oncology Nurses, Kay Lowries, CANO Council of Chapters, 1st International Cancer Control Congress.

ISNCC presidency handover in Toronto

The presidency of the ISNCC was handed over at the Toronto conference to Sanchia Aranda, who holds a joint appointment as the Head of the School of Nursing, University of Melbourne and the Director of Cancer Nursing Research at Peter MacCallum Cancer Centre, Melbourne Australia.

She succeeds Margaret Fitch who has held the presidency for the last four years. Sanchia Aranda is pictured here (right) receiving the medal of office from Margaret Fitch. A profile of the incoming president will be included in the next issue of the newsletter as well as a tribute looking back at Ms Fitch's presidency.

Award winner's gentle quiet wisdom

Barbara Love was awarded the CANO Lifetime Achievement Award at the Toronto conference. Presenting the award Greta Cummings, CANO president said that her "gentle quiet wisdom" had been an inspiration to her colleagues.

The award is given to a nurse who has made a major contribution to cancer nursing in Canada during his or her professional career which continues to be reflected in the advancement of oncology nursing.

Barbara Love, was one of the first clinical nurse specialists at McMaster Children's Hospital, Hamilton, Canada in the late 1970s. Twenty five years later she continued to be a valuable consultant and mentor to staff. Ms Love, who retired this summer, is one of the few nurses who has had an impact on oncology nursing and care for both paediatric and adult populations.

Ms Love was a founding nursing member of the Paediatric Oncology Group of Ontario. Under her leadership the paediatric and oncology nursing programme at McMaster has become the flagship post-basic educational programme in Canada with over 200 graduates.

She has made significant contributions to CANO and oncology nursing in defining and advancing nursing roles within the Canadian health system.

Voices from the conference

Delegate nurses share their views of the conference

Kim Winnicki, Royal Victoria Hospital, Montreal, Canada:
"The poster sessions have been very informative. There are so many to go through — I have to keep visiting them again and again. I particularly enjoyed the session by David Makumi on palliative care on Kenya, giving an idea on how third world countries are deprived and so different. It was emotional."

Hideko Minegishi, School of Nursing, Kitasato University, Sagamihara, Japan:
"I have had a poster here which has been a good experience and have enjoyed many of the plenary and poster sessions."

Jesca Kawagere, nursing officer, Ocean Road Cancer Institute, Dar es Salaam, Tanzania.
"I have attended and enjoyed many sessions at this conference. I particularly enjoyed the session on supportive care and on genetics. And I now have many friends from many different countries."

Don Coan, ward nurse, Vancouver General Hospital, Canada:
"It's my first conference ever. I have been qualified for a year. I liked the exhibition stands with education materials. I like the sessions with an international flavour and those with more of an educational focus."

Lorna Richardson, clinical nurse specialist in breast cancer, Christie Hospital, Manchester, UK;
"I have really enjoyed this conference. I have enjoyed the posters and have liked presentations that I was not expecting to like. I particularly liked the focus on the elderly in the concurrent sessions. And I've made some international contacts for collaborative working in the future."

Prathepa Jagdish, nurse tutor, Tata Memorial Hospital, Mumbai, India;
"I feel that nursing is empowered here unlike in India. I enjoyed most the sessions with a nursing aspect. I have met many people from different countries. The conference has had a friendly feeling."

Wendy Wood, Director of nursing, Peter MacCallum Cancer Centre, Melbourne, Australia;
"I have absolutely enjoyed the conference. What I have got out of it is the spirit of inquiry that conferences like this engenders in nurses. I have also enjoyed the opportunity to network with senior nurses from around the world. I have established links that I will pursue for ongoing relationships."

Mary Agyapong, Komfo Anokye Teaching Hospital, Kumasi, Ghana;
"We have shared many ideas and many new experiences with those in the developed countries. This conference has enhanced the scope of my knowledge which I will apply to my practice in Ghana."