Nurses on Cancer
Breast and Prostate Care

Betty Ferrell
RN, PhD, FAAN
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PRESIDENT'S MESSAGE

PEER SUPPORT, COLLABORATIONS BUILD STRONG NURSING SOCIETIES

During the past four years as an officer, I have visited many chapters, spoken with many members and listened to chapter leaders at regional conferences, learning essential elements of success from each of them. Together, these ideas create a blueprint for a successful chapter.

Chapter membership, the essence of the organization, cannot be fulfilled at the board, presidential or headquarters levels—but only through chapters. Members belong to a chapter and their degree of involvement derives from there.

Active members of successful chapters reflect the gender, racial, ethnic and religious diversity of the general membership. Chapters have some of the best talent and expertise in nursing, and those that are successful showcase and deploy that talent and expertise. Also, successful chapters are those that are truly creative in programming, community activities, fund raising, and newsletters.

Current members of successful chapters are constantly on the lookout for potential recruits, especially for community leaders. They recognize that many excellent nurses did not have the opportunity to become members when they were in school (only recently did Sigma Theta Tau have chapters in so many schools). These individuals, established in their profession and their communities, make an excellent contribution to the chapter and the organization. But members of successful chapters don’t stop there. When identifying a potential member, either student or practicing nurse, they begin their recruitment, asking what the person knows about Sigma Theta Tau, and they explain the membership benefits. They regularly discuss membership, emphasizing how an individual could contribute to the goals of the chapter as well. They hold events for potential members to provide an opportunity for informal socialization with members, who make certain they circulate and talk with the newcomers. As a result, the successful chapter has a high percentage (they aim for 100 percent) of invited members accepting membership and attending the induction ceremony.

After induction, established members reach out to new ones and show them what this organization is all about, which is mentoring. They encourage and support the new members, as well as invite them to programs and events. After a time, chapter leaders actively recruit specific individuals for positions on committees and the board. They point out how valuable the person’s potential contributions might be, and they encourage members to support election of newcomers. Leaders recognize that the future of the chapter (and of Sigma Theta Tau International) depends on the involvement and commitment of newer members.

Successful chapters look for collaborative opportunities with their sponsoring schools, other honor societies at their universities, other local professional or community groups, and among other nearby chapters. They have learned they can’t do it all themselves, and that their sphere of influence and power is far greater when resources—human and fiscal—are pooled.

The most important attribute of a successful chapter, however, is its “can-do” spirit. The members don’t give up. If one thing doesn’t work, they try another. They view failure as a challenge, not an excuse.

Nurses have always taught their peers and learned from each other. I offer you these ideas from your colleagues in chapters throughout the society. They are my parting gift to you.

Helen Keller said, “Life is either a daring adventure or nothing.” Which will it be for your chapter?
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DEVASTATING DIAGNOSIS

My father died of cancer; my mother and one of my best friends are cancer survivors. And throughout their diagnoses, treatments, remissions, cures and even death, nurses were omnipresent. These nurses comforted, taught, treated, examined and most of all, cared for us; patients and families. They were our stabilizing force in dealing with this insidious life-threatening and life-taking disease. How many of you have had similar experiences?

During those experiences, I did find myself marveling at that unique ability of nurses to know just what we needed and just when we needed it. These nurses possessed such an intelligence and command of the situation needed to move us through a matrix of systems, treatments and specialists. We all came to understand the true meaning of patient advocate—people not to know how nurses turn this devastation into hope and advocate.

It speaks to the genius of nurses, as they pursue with their patients, appropriate levels of health. Learn from them; then tell your versions of how nurses demonstrated in a Harris public opinion poll that gauged public attitudes about nursing. This poll also revealed that the public is worried about the ability of nurses to know just what and when decisions were appropriate, as they guided patients to the right treatments, remissions, cures and even death.

Cancer is a devastating diagnosis and illness. But it is also devastating for survivors. And throughout their diagnoses, nurses comforted, taught, treated, examined and most of all, cared for us: patients and their families. These nurses provide leadership and scholarship in practice, education and research to enhance the health of all people. We support the learning and advancement of health care workers who strive to improve nursing care worldwide.

Reflections magazine communicates nurses' contributions and relevance to the health of people. Reflections is published quarterly by Center Nursing Press, a division of Sigma Theta Tau International Honor Society of Nursing, and distributed to the society's active members, health care organizations and subscribers. It is listed in MEDLINE and CRINAL Information Systems in the scientific resources of libraries.

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During these experiences, I did find myself marveling at that unique ability of nurses to know just what we needed and just when we needed it. These nurses possessed such an intelligence and command of the situation that they knew what and when decisions were appropriate, as they guided us through a matrix of systems, treatments and specialists. We all came to understand the true meaning of patient advocate.

No wonder, then, that the public is so trusting of nurses, as recently demonstrated in a Harris public opinion poll that gauged public attitudes about nursing. This poll also revealed that the public is worried about the quality of care because of the nurse shortage. And all this leaves me wondering why, as nurses, and the public are so reticent to speak about our good deeds of comfort, managing and caring. There is a natural alliance here between nurse and public that has the potential to significantly change health care. Communicating all this is needed.

Cancer is a devastating diagnosis and illness. But it is also devastating for many others of you who have had similar experiences?

My father died of cancer; my mother and family. They were our stabilizing force in dealing with this insidious life-threatening and life-taking disease. How many others of you have had similar experiences?

ELEANOR J. BULLIAM
President

This issue of Reflections presents the work of nurses in cancer care. It speaks to the genius of nurses, as they pursue with their patients, appropriate levels of health. Learn from them; then tell your versions of how nurses made your life circumstances just a bit better.

Nancy Dickerson-Hazard
Nancy Dickerson-Hazard, RN, MSN, FAAN
Sigma Theta Tau International Honor Society of Nursing

Women’s Status Vision & Reality

Bridging East & West

International Women’s Conference
Ashoka Hotel, New Delhi, India
February 27 - March 3, 2000

Women, Men and Youth Join Us!

This program is for those individuals (doctors, nurses, social workers, human rights activists, lawyers, nutritionists, health economists and environmentalists) who are from all parts of the world to come together to collectively share their knowledge and expertise on issues relevant to women’s health.

Conference Objectives

• To share knowledge related to illnesses affecting women’s biological health, such as cardiovascular, diabetes and cancer; reproduction and family planning
• To explore female adolescent health issues
• To address HIV/AIDS issues among women
• To explore and assess educational programs (theory on various assessment and counseling of victims)

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Oncology researcher Betty R. Ferrell discusses the devastation of breast and prostate cancers and the humane requisites of life's endings. Recommendations to improve practices that lead to a peaceful death are included from the American Association of Colleges of Nursing and the Institute of Medicine.

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A nurse, noted for charting the course of scientific ideas, faces her own breast cancer survival, shaping her own patient model for hope and health.

10 Nursing's holistic impact
Managing symptoms and improving the quality of people's lives describes nurses' work with the National Cancer Institute in the United States.

11 Early detection of breast and prostate cancers
Why are there varied opinions about tests for cancer? A nurse at the American Cancer Society discusses the controversies.

14 The supportive survivors
Therapy that reduces stress and deters debilitation to immune systems inspired one psychosocial nurse to create support groups for breast cancer survivors.

17 The fatigue of treatment
Cancer treatment-related fatigue may not be routinely assessed or managed. Depending on the type and sequence of breast cancer treatment, fatigue may continue long after the treatment has ended.

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Adequately treating prostate and breast cancer pain involves use of several therapies, beginning with treatment of causes.

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Rehab Nursing

This is where my heart is, over here in the niches and the small worry knots in the crack and crevice of curbstone of slanted path and walkway
A step that begins with a wiggle of a toe, recall of a cindered road chips and scattered stone
See how the tiny mosses grow so slow
Observance through the night is an unrewarding chore
See how the tiny mosses grow sprigs unseen root tenacious quiet tender shoots bandaged still until one bright sunsplashed moment on the rock above the salty pulsing surf
This is made of climate, rain and sun storm and lightning and washed out bridges and new canals
This is where I am, over here in the cinder path with you.

"Rehab Nursing" by Judy Schaefer was first published in a collection of poetry and prose by nurses in Between the Heartbeats, University of Iowa Press, Iowa City, Iowa, 1995, and is reprinted with permission.
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The diagnosis of breast cancer hung in the air, a palpable barrier between us.

The physician stood blandly by the bed, as I lay frozen in solemn dread. Addressing the virtues of chemotherapy, radiation and mastectomy, she did not seem aware of the truisms that I was to learn later from master patients. First, breast cancer relentlessly demands movement, creative effort and performance from patients. Second, breast cancer — without a bit of remorse — forces patients to points-of-no-return that forevermore govern life choices.

Experts suggest that a breast cancer diagnosis generates fear of death initially. Indeed, cancer is neither innocent nor hesitant when it boldly validates the finiteness of existence. Knowing that the diagnosis brings seismic tremors in which linear time (chronos) stops, the professionals try to relieve a patient’s fear with teaching; to reintegrate time with kindness; and to offer hope. Despite their efforts, it is the wise master-patients who divulge to novice-patients a great secret:

It is creation which is the solution to the fear of death.

In creating a prayer, a garden, a poem or a journal, the patient-artist sculpts something immortal, and the fear of death is overcome by simply loving the act of creation more. Through the process of creation, intuition and cognition mysteriously unite. The union allows the cancer patient to swing between suffering and production, order and disorder, child and adult, inner and outer freedom. Being free, wise cancer patients are perpetually driven toward life and creativity. It is a point-of-no-return.

Paradoxically, the master-patients caution novices that the fear of life may also be exceptionally powerful. The risks and the dangers of life, as well as the laughter, intimacy, and discovery involved with trying to survive cancer is quite astonishing. Rather than the obituarist’s idea of “waging a fight with cancer,” one is forced to wholeheartedly enter into a dance with life. The novice-patient learns not to escape from struggle, but to go straight into it, because she cannot do otherwise. It is a point-of-no-return.

As you penetrate the struggle deep enough, you touch your core of vulnerability, enter into it, share it, and taste it — in so far as that is possible. The person-one-has-been, whose goal was happiness, is replaced by the person-to-be, whose goal is living. The dance of life is not about avoiding suffering. It is not about making nice. It is not about the power of positive thinking. It is about being real and authentic, about understanding that life’s joy and suffering are somehow two sides of the same thing.

Points-of-no-return are not simply part of emotional recovery. They reawaken. While distinctive among patients, they are real. Patients frequently tell nurses, “Cancer was a blessing in disguise,” or “I learned so much.” Nurses nod knowingly but often do not understand. Forevermore, points of no return give patients new markers for what nourishes the soul, what provides interconnections, what reconnects split-off parts of themselves, and what is right for them.

Before embarking on any experience, master-patients ask these questions: Is this path creative? Does it give wonder and healing? Does it have joy?

KALAMAZOO, Mich. June 15, 1999—Diane Hamilton, a breast cancer survivor, sits in a field of yellow wildflowers near her home. This is her favorite place to walk in the late spring and early summer while the flowers are in bloom.

Diane Hamilton, R.N., Ph.D., a historian of ideas within nursing, is an associate professor at Western Michigan University School of Nursing in Kalamazoo, Mich. She is a breast cancer survivor.
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BY CLAUDETTE VARRICCHIO

Nursing's holistic impact

BY TERRI B. ADES

Early detection of breast and prostate cancers

Specific symptoms that may be experienced by persons with breast or prostate cancer and that have been the target of nursing research are: pain, fatigue, psychological adjustment ... and the impact of the diagnosis and treatment on the patient and the family.

Prostate Cancer Rates

United States

Prostate cancers diagnosed when localized—58%

5-year survival rate—100%

Prostate cancers diagnosed when spread to local tissues—31%

5-year survival rate—94%

Prostate cancers diagnosed when distantly spread—11%

5-year survival rate—31%
Nursing’s holistic impact

BY CLAUDETTE VARRICCHIO

BETHESDA, Md., August 1999—Nursing research reflects the focus of the definition of the discipline of nursing: responses of the holistic person to health and illness as the person interacts with an ever-changing environment. Nursing activities, the focus of nursing research, are implemented to promote the health of the person and to facilitate the person’s growth toward his or her potential within the environment (Keller, 1981). Consistent with this approach, we find that nursing research, looking at the period of time that an individual is undergoing treatment for breast or prostate cancer, is predominantly focused on symptom management and the outcomes of nursing interventions to improve the quality of life of these persons.

The management of symptoms related to the cancer and its treatment, including physiologic and psychologic, is approached through the evaluation of interventions to improve specific outcomes, often encompassed under the concept of health-related quality of life. These interventions may include drugs, nonpharmaceutical interventions of an educational or behavioral nature, psychological support and promotion of adaptive behaviors, and self-care. Methodologies include both quantitative and qualitative approaches and methodology studies. A significant contribution made by nurse researchers in this area is the development and validation of new assessment methods.

Nurse researchers are contributing to the developing field of patient-oriented outcomes following the diagnosis and treatment of both breast and prostate cancers. These diverse outcomes, such as quality of life, treatment side effects and the economic impact of cancer, are being investigated by nurse-led research teams so that beneficial interventions can be designed and tested, and so that the interaction of biological and psychosocial variables can be understood with the goal of improved patient care and outcomes.

Patient-focused outcomes that have been targeted by nurse researchers are:
- Quality of life comprised of four dimensions: health and physical functioning, social and economic, psychological well-being and family.
- Specific symptoms that may be experienced by persons with breast or prostate cancer and that have been the target of nursing research are: pain, fatigue, psychological adjustment and the impact of the diagnosis and treatment on the patient and the family.
- Patient preferences and factors affecting treatment decisions.
- Treatment toxicities and their effects on function.

Specific symptoms that may be experienced by persons with breast or prostate cancer and that have been the target of nursing research are:

<table>
<thead>
<tr>
<th>Symptom</th>
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<tr>
<td>Pain</td>
<td>Keller, 1981</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Leitch, Dodd &amp; Costanza, 1997</td>
</tr>
<tr>
<td>Psychological</td>
<td>Merlin, Jones &amp; Averette, 1993; von Echeschack, Ho, Murphy, et al., 1997</td>
</tr>
</tbody>
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Prostate cancer

Prostate cancer, unlike many other cancers, often grows slowly. For men with cancer that has not spread beyond the prostate gland, the five-year relative survival rate is near 100 percent, whether or not they are treated. Therefore, it remains unclear as to whether treatment will help all men with prostate cancer to live longer. Before early detection tests were widely used, most men with prostate cancer were diagnosed with advanced disease, and most died within a few years of the diagnosis. Although early diagnosis and treatment of prostate cancer may help some men to live longer, it will have no impact on the life span of other men. And, prostate cancer treatments can affect a man’s quality of life.

Since testing for early detection of prostate cancer became relatively common (about 1990), the prostate cancer death rate has dropped. But it has not been conclusively proven that this is a direct result of screening. Studies are underway to try to prove that testing for early detection of prostate cancer in large groups of men will lower the prostate cancer death rate, and the results may not be known for several years. Until then, the decision as to whether or not a man should be tested should be left up to the individual and his health care provider.

Prostate Cancer Rates

The American Cancer Society recommends that health care providers offer the prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) annually, beginning at age 50, to men who have at least a 10-year life expectancy, and to younger men who are at high risk. Information should be given by health care providers to their patients regarding potential risks and benefits of early detection and treatment, to assist men in making informed decisions about testing. Men who choose to have early detection testing should begin at age 50.

High risk groups

However, men in high-risk groups, such as those with two or more affected first-degree relatives (father and a brother, or two brothers) or African-Americans may begin screening at a younger age, 45 for example.

Prostate care controversy

Most major scientific and medical organizations do not advocate screening for prostate cancer. There remain many uncertainties surrounding the early detection of prostate cancer.

The American Cancer Society, the American Urological Association, and the National Comprehensive Cancer Network do believe that the majority of available evidence, though not conclu-
Breast cancer

In 1999, there will be about 43,300 deaths from breast cancer in the United States. It is the leading cause of cancer death among women age 40 to 55. The breast cancer mortality rate, a measure of breast cancer deaths per 100,000 women, has been decreasing during the past few years. Increased screening of women, leading to detection of cancers at an earlier stage, and more effective treatments are most likely responsible for lowering the breast cancer mortality rate.

Although we know some of the risk factors that increase a woman’s chance of developing breast cancer, we do not yet know what causes most breast cancers, nor do we know how to prevent it. Scientists are making great progress in understanding how certain changes in DNA can cause normal cells to become cancerous. Until we learn more, the early detection of breast cancer improves the chances that breast cancer can be diagnosed at an early stage and treated successfully.

The American Cancer Society recommends the following for the early detection of breast cancer in asymptomatic women: Women 40 and older should have a screening mammogram every year. Between the ages of 20 and 39, women should have a clinical breast examination by a health professional every three years. After 40, women should have a breast exam by a health professional every year. Women 20 or older should perform a breast self-examination every month. By doing the exam regularly, women get to know how their breasts normally feel and can more readily detect any change.

Breast care controversy

In March 1997 the American Cancer Society revised its guidelines for mammography for women in their 40s. The National Cancer Institute, about that time, issued a recommendation that women in their 40s receive routine mammograms.

The two organization guidelines differ slightly, with the ACS recommending annual mammography and the NCI recommending that women in their 40s receive mammograms every one to two years. Both organizations agree that mammographic screening for women in their 40s is beneficial and supported by current scientific evidence. The organizations have pledged to work together to provide guidance to women about the risk of breast cancer and the value and limitations of screening mammography.

The ACS concluded its 1997 revisions with recommendations that include: evaluation of techniques and methods that improve compliance with breast cancer screening; greater emphasis on improving clinical breast exam techniques; and improved communication to women about the importance of clinical breast exam and breast self-examination.

American Cancer Society Guidelines for the Early Detection of Prostate

**PROSTATE CANCER TEST OR PROCEDURE**

**SEX** | **AGE** | **FREQUENCY**
---|---|---
Prostate-Specific Antigen (PSA) & Digital Rectal Examination (DRE)
Pre-1990 | M & F | 40 & over | Every year as part of regular health checkup
1990 - 5/97 | M & F | 40 & over | Every year
6/97 - Present** | M & F | 50 & over | For prostate cancer detection, should be offered annually (together with the prostate-specific antigen blood test) to men who have at least a 10-year life expectancy, and to younger men who are at high risk. For colorectal cancer detection in men and women, it should be done at the time of flexible sigmoidoscopy, colonoscopy, or double contrast barium enema.

**Digital Rectal Examination**

Pre-1980 | M & F | 40 & over | Every year as part of regular health checkup
1980 - 5/97 | M & F | 40 & over | Every year
6/97 - Present** | M & F | 50 & over | For prostate cancer detection, should be offered annually (together with the prostate-specific antigen blood test) to men who have at least a 10-year life expectancy, and to younger men who are at high risk. For colorectal cancer detection in men and women, it should be done at the time of flexible sigmoidoscopy, colonoscopy, or double contrast barium enema.

**BREAST CANCER TEST OR PROCEDURE**

**SEX** | **AGE** | **FREQUENCY**
---|---|---
Mammography
Pre-1980 | F | 35 - 39 | Only if personal history of breast cancer
1980 - 1982 | F | 35 - 40 | Under 50
1983 - 1991 | F | 35 - 39 | Between 40 and 49
1992 - 3/97 | F | 40 - 49 | Every 1-2 years
4/97 - Present | F | 40 & over | Every year
Clinical Breast Exam
Pre-1980 | F | Over 20 | Periodically
1980 - Present | F | Over 20 | Every 3 years
Breast Self Exam
Pre-1980 | F | Over 20 | Every month
1980 - Present | F | Over 20 | Every month

*Both Prostate-Specific Antigen (PSA) and Digital Rectal Examination (DRE) should be offered annually, beginning at age 50, to men who have at least a 10-year life expectancy, and to younger men who are at high risk, such as those with a strong familial predisposition (e.g., two or more affected first-degree relatives) or African-Americans who may be at a younger age (e.g., 45 years).
sive, supports the view that prostate cancer screening can save lives. These organizations recommend that health care providers offer men 50 or older the option of testing for early detection of prostate cancer.

Because the exact cause of prostate cancer is not known, we do not know if it is possible to prevent most cases of the disease. Cancers found by early detection testing (using the prostate-specific antigen blood test and/or digital rectal examination) are, on average, smaller and have spread less stage, and more effective treatments are available, and more effective treatments are more likely to improve the chances that breast cancer can be diagnosed at an earlier stage and treated successfully.

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References, page 45.

**Both Prostate-Specific Antigen (PSA) and Digital Rectal Examination (DRE) should be offered annually, beginning at age 50, to men who have at least a 10-year life expectancy, and to younger men who are at high risk, such as those with a strong familial predisposition (e.g., two or more affected first-degree relatives) or African-Americans may begin at a younger age (e.g., 45 years).**

**American Cancer Society Guidelines for the Early Detection of Prostate**

<table>
<thead>
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<th>SEX</th>
<th>AGE</th>
<th>FREQUENCY</th>
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<tr>
<td><strong>Prostate-Specific Antigen</strong></td>
<td>M</td>
<td>50 &amp; over</td>
<td>Every year</td>
</tr>
<tr>
<td>11/92 - 5/97</td>
<td>M</td>
<td>50 &amp; over</td>
<td>Offered annually (together with digital rectal examination) to men who have at least a 10-year life expectancy, and to younger men who are at high risk</td>
</tr>
<tr>
<td>6/97 - Present**</td>
<td>M</td>
<td>50 &amp; over</td>
<td>Every year as part of regular health checkup</td>
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<tr>
<td><strong>Digital Rectal Examination</strong></td>
<td>M &amp; F</td>
<td>40 &amp; over</td>
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**Breast CANCER TEST OR PROCEDURE**

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<tr>
<td>F</td>
<td>35 - 39</td>
<td>Only if personal history of breast cancer</td>
</tr>
<tr>
<td>F</td>
<td>40 - 49</td>
<td>May have mammography if they or their mother or sisters had breast cancer</td>
</tr>
<tr>
<td>F</td>
<td>50 &amp; over</td>
<td>May continue to have mammograms annually</td>
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<tr>
<td>F</td>
<td>35 - 40</td>
<td>Baseline mammogram</td>
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<tr>
<td>F</td>
<td>Under 50</td>
<td>Consultant personal physician</td>
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<tr>
<td>F</td>
<td>50 &amp; over</td>
<td>Every year</td>
</tr>
<tr>
<td>F</td>
<td>35 - 39</td>
<td>Baseline mammogram</td>
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<td>F</td>
<td>40 - 49</td>
<td>Every 1-2 years</td>
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<td>F</td>
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Research has established that many kinds of support groups improve quality of life and mood (Bottomley, 1997). Research suggests that support groups may improve immune function. Levy examined the role of social support in mediating negative mood states and found that social support helped to predict the variance in NK activity in breast cancer patients (Levy et al. 1990). Also, Levy found that higher NK cell activity at follow-up predicted disease-free survival over the follow-up period and also found that psychosocial factors were strongly predictive of the rate of disease progression (Levy).

Levy examined changes in immune function after patients received an individually administered cognitive therapy program. Gruber studied immune function in patients using guided imagery (Gruber, Hall, Hersch & Dubois, 1988). Fawzy tested immune function of patients attending a support group (Fawzy, Kemeny, Fawzy, et al., 1990) In all three studies the pattern of improved quality of life and mood paralleled the immune measures. As the quality of life improved, both the number and activity of NK cells increased. These studies suggest that therapeutic groups may enhance crucial immunological mechanisms or attenuate the adverse effects of breast cancer and its treatment on immune function.

The value of such groups is supported by the findings of a landmark study in which breast cancer patients who attended a support group had increased survival over patients in a control group (Spiegel, Kraemer, Bloom & Gotheil, 1989).

Telephone support group
Women with breast cancer are especially vulnerable to emotional distress due to demands of the disease, its treatment, work responsibilities and family demands (Lewis & Hammond, 1992). Twenty-five to 30 percent of women having a mastectomy had such psychological distress that they required referral for psychiatric evaluation (Schler, 1991). In fact, 20 to 30 percent of breast cancer patients experienced long-term psychological distress and deteriorated quality of life (Keller, 1998). Unlike the negative impact of stress on the illness is minimized, women may be unable to resume career and family responsibilities. Yet, the challenge to clinicians is to provide support to women who face demands of home and work while receiving treatment.

A telephone support group, including both rural and urban patients, allows access via a home phone, and in some cases, an office phone, during a lunch break. The needs of women in rural communities have been especially acute as they have often been isolated from support groups and educational programs.

The group, funded by seed money from the Charleston, S.C., Race for the Cure, was created to focus on issues such as image, self-esteem, sexuality, family demands and wellness. The group has been in existence for three years and continues to be well received by participants. Approximately 15 to 20 participants are linked through conference calls for each session.

Participants have chosen to be known only by their first names, demonstrating one of the unique benefits of telephone support. The intimate, yet anonymous, nature of the group reduces fears of rejection and allows women to explore many sensitive issues, such as sexual and family problems.

Each group features one topic that is discussed for 30 minutes, followed by open group discussion about the topic and other matters. Although the topic session leader may change, the group leader remains constant, thus providing continuity of the support. The program has been so beneficial to patients that a pilot study is being conducted to empirically evaluate the efficacy of a telephone support group targeted specifically for women with breast cancer.

Based on the women's responses in the support group, there are psychological and emotional benefits, which include improving moods and the quality of their lives. Potentially such groups also may improve immune function.

Written evaluations were solicited from the women to determine if the group should continue. They commented on the open-ended question: "The best part of the group was . . ." Typical answers were: "I could hear others and their problems and compare them to mine." "Having someone who understands and someone that has been through or is going through what you are." "Being able to communicate and express our concerns and feelings.

In forced-choice responses, more than 75 percent of the women felt supported by group members, felt they learned other ways to deal with problems, and felt hopeful about the future when hearing from other people in the group. Eighty-nine percent stated the group would be useful to other patients.

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Creative and unique programs may reach patients who would not use typi-
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Breast Cancer

The fatigue of treatment

BY LILLIAN M. NAIL

SALT LAKE CITY, August 1999—Women with localized breast cancer experience multiple cancer treatments that cause fatigue. Surgery, radiation therapy, chemotherapy and drugs that block estrogen are all potential contributors to fatigue, although the precise causal mechanisms for cancer related treatment-fatigue are not known (Winningham et al., 1994).

Psychosocial factors, such as bad dreams, anxiety about the future or intrusive thoughts are also believed to contribute to the sensation of fatigue. Depending upon the specific type and sequence of treatment that is recommended, some women undergo many months of therapy and experience a marked decline in their quality of life as a result of feeling tired and worn out (Berger, 1998; Cimprich, 1992; Ferrell et al, 1996; Hoskins, 1997; Irvine, Vincent, Graydon, & Bubela, 1998; Vogelzang et al., 1997). However, they still may not be told that fatigue is an expected side effect of treatment so they are not able to plan for it. Because fatigue may not be routinely assessed in clinical practice, approaches to managing it may not be suggested as part of the care plan.

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Women who experience fatigue as a side effect of treatment may find that the sensation of tiredness persists beyond the completion of treatment (Weiss & Weiss, 1997). It is important that women understand that treatment-related fatigue may continue beyond the end of treatment, so they do not become concerned that ongoing tiredness means that the treatment did not work, the cancer has recurred, or they have experienced an irreversible toxic effect. Some women—especially those who have undergone bone marrow transplant—feel that their energy level is lower than it should be for months or years following the completion of treatment.

Because fatigue is a common side effect of cancer treatment that is often not recognized or treated, oncology nurses, researchers, clinicians and educators have made fatigue a major focus of cancer nursing. The rate of growth of knowledge about cancer treatment-related fatigue is remarkable. In the early 1980's, literature searches yielded only two research reports that addressed cancer treatment-related fatigue. By 1998, there were more than 200 research reports, clinical papers and book chapters on cancer treatment-related fatigue with the majority published after 1995. Most of the studies include women with localized breast cancer receiving radiation therapy or chemotherapy and some of the major studies are limited to women with breast cancer.

The research conducted to date provides only part of the strategy for preventing and managing cancer treatment-related fatigue. Each area of research has made a contribution to its understanding and provides specific information needed to guide clinical practice and direct future research.

Cancer Treatment-Related Fatigue: Current Recommendations for Practice

- Give all people beginning treatment preparatory information about fatigue, including the pattern of fatigue experienced with their specific treatment regimen.
- Routinely assess cancer-related fatigue based on self-report.
- Recognize and correct physiologic problems (anemia, hypoxia, infection, dehydration, hormone imbalances, electrolyte imbalances, etc.).
- Effectively manage other side effects and symptoms.
- Promote adequate sleep.
- Encourage moderate-level exercise as indicated, using appropriate safety precautions.
- Encourage energy conservation techniques (organizing work area, sit rather than stand, take advantage of offers of help, etc.).
- Support appropriate nutrition.

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Descriptive studies consistently demonstrate increases in fatigue over the course of treatment, followed by a gradual decline in fatigue once treatment is completed, which challenges the assumption that fatigue resulted from cancer related rather than from cancer treatment. Nurse researchers are now examining the relationship of other symptoms and side effects, such as pain, hot flashes and trouble concentrating, to fatigue in order to begin sorting out complex causal relationships like fatigue interfering with concentration or pain and hot flashes disrupting sleep and increasing fatigue. Because fatigue is a common side effect of cancer treatment that is often not recognized or treated, oncology nurses, researchers, clinicians and educators have made fatigue a major focus of cancer nursing. The rate of growth of knowledge about cancer treatment-related fatigue is remarkable. In the early 1980's, literature searches yielded only two research reports that addressed cancer treatment-related fatigue. By 1998, there were more than 200 research reports, clinical papers and book chapters on cancer treatment-related fatigue with the majority published after 1995. Most of the studies include women with localized breast cancer receiving radiation therapy or chemotherapy and some of the major studies are limited to women with breast cancer.

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Cancer Treatment-Related Fatigue: Other interventions which are suggested to people experiencing cancer-related fatigue but which have not been tested, such as energy conservation, are now being investigated as well. A major gap in knowledge relates to the mechanisms underlying fatigue. Only one of these, chemotherapy-induced anemia, has been investigated to the point where a clear link to cancer treatment-related fatigue is demonstrated (Glaspy et al., 1997). Examples of potential physiologic mechanisms for cancer treatment-related fatigue that require intensive research include chemotherapeutic agents released as a result of triggering immune responses or administered when immune responses are produced (Glaspy et al., 1997). These studies include nursing, clinical psychology, medical oncology, social work, exercise physiology and psychiatry.

Nursing's historic interest in health promotion is evident in the studies investigating the influence of aerobic exercise on cancer treatment-related fatigue and quality of life. The beneficial effect of exercise on cancer treatment-related fatigue was first demonstrated in the mid-1980's and was replicated in several studies conducted over the following decade (MacVicar & Winningham, 1986; Mock et al., 1997). These studies demonstrate that regular, moderate level aerobic exercise decreases fatigue and improves quality of life in women with localized breast cancer receiving either radiation treatment or chemotherapy. Additional studies are underway to examine the optimum timing of exercise and explore the effects of muscle strengthening regimens on cancer-related fatigue.

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Other interventions which are suggested to people experiencing cancer-related fatigue but which have not been tested, such as energy conservation, are now being investigated as well. A major gap in knowledge relates to the mechanisms underlying fatigue. Only one of these, chemotherapy-induced anemia, has been investigated to the point where a clear link to cancer treatment-related fatigue is demonstrated (Glaspé et al., 1997). Examples of potential physiologic mechanisms for cancer treatment-related fatigue that require intensive research include chemicals released as a result of triggering immune responses or administered when cancer treatment includes biologic response modifier treatment like interferon, muscle mass loss, sleep disruption, changes in neurotransmitters in the brain, and nutritional deficits. Knowledge of causal mechanisms is essential to developing and testing the next generation of interventions for cancer treatment-related fatigue. Current recommendations for practice are based on a combination of research results and expert clinical judgment.

References, page 45.

Lillian M. Nail, RN, PhD, FAAN, is Professor & Louis S. Perry, MD, and Janet B. Perry Endowed Chair in Nursing at the University of Utah in Salt Lake City. She chaired the planning committee for the Oncology Nursing Society's FIRE Project, served as principal investigator of a multi-institutional/fatigue instrumentation study, and is a coauthor of a study examining the impact of an energy conservation intervention on cancer-related fatigue.

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Siga Theta Tau International Honor Society of Nursing
Breast and Prostate Cancer

BY SUSAN BECK

SALT LAKE CITY, August 1999—The suffering that results from cancer pain is unnecessary. In fact, according to the World Health Organization, implementation of existing knowledge of pain and symptoms can achieve critical improvements in the quality of life for cancer patients and their families (WHO, 1996). The Agency for Health Care Policy and Research (a United States government body) rigorously reviewed existing knowledge related to pain management resulting in the 1994 publication of an evidence-based Clinical Practice Guideline on Management of Cancer Pain (Jacox et al., 1994). The translation of this knowledge into practice is slow.

Inadequate treatment of pain is recognized as an international health problem. However, certain groups may be at higher risk. Studies in the United States indicate that minority patients and the elderly are less likely to receive adequate pain treatment. In my own research in South Africa, nonwhites had significantly higher pain levels than whites. From a health policy perspective, countries that still do not allow the manufacture or importation of opioids lack the basic tools to provide analgesia. Studies of cancer pain prevalence indicate that approximately 30 to 50 percent of patients receiving cancer treatment experience pain. The prevalence may approach 70 to 90 percent in patients with advanced cancer.

In patients with breast cancer, two types of pain predominate (Mikowski & Dibble, 1995). Many women suffer from a neuropathic pain syndrome following surgery for breast cancer. This type of pain is neuropathic in origin; the patient describes it as a tight, constricting burning pain in the anterior axilla or anterior chest wall. The other common type of pain is due to metastasis to the bones. This type of pain is usually localized and is described as dull and achy. One patient aptly described it as a "tooth-ache in my bones."

This type of pain is also common in men with prostate cancer, as bone is the most common site of metastasis. Growth of prostate tumors within the pelvis can also cause pain in the back, pelvis, and lower extremities (Payne, 1993).

For persons with cancer and their family caregivers, pain can be overwhelming as it negatively influences the quality of lives. Pain may cause or enhance the intensity of other distressing physical symptoms, such as sleep disturbances and fatigue. Pain limits an individual's ability to carry out responsibilities at home, work, and in the community. Pain causes emotional distress and has been associated with changes in mood states, including depression, anxiety and anger. Some patients may choose discontinuation of treatment, or even consider assisted suicide, because of unrelieved pain.

Individuals caring for patients in pain describe feelings of helplessness, frustration, isolation, futility and anger. As one caregiver explains, "It's just difficult ... you're helpless. You have to watch somebody agonize, and you can't help them" (Perrell et al., 1993).

Therapies for pain must be integrated into the overall management of the patient. If possible, the first approach to pain management is to eliminate the cause. Thus, treatments such as radiation therapy, chemotheraphy, hormonal agents, biological response modifiers and surgical therapy may be useful, depending on the type of cancer.

The mainstay of cancer pain relief is pharmacologic management. A simple method to guide pharmacologic management has been developed by the World Health Organization. Three steps are summarized:

WHO Analgesic Ladder, 1996

Step 1: Use non-opioid analgesics, including acetaminophen (paracetamol) and the nonsteroidal anti-inflammatory drugs for mild pain.

Step 2: When pain persists or increases, add an opioid conventionally used orally for mild to moderate pain, including codeine, oxycodone, hydrocodeine or dihydrocodeine.

Step 3: When pain is persistent, or moderate to severe at the outset, use adequate doses of a strong opioid, including morphine, hydromorphone, oxycodone (as a single entity), levorphanol, methadone or fentanyl.

Adjuvant drugs to enhance the analgesic effect or manage concurrent symptoms, such as nausea or constipation, should be added at any stage as needed.

Effective management of cancer pain requires an integrated approach of primary therapy (i.e., treatment of the tumor itself) and pharmacologic and nonpharmacologic analgesic strategies. The nurse is usually on the frontline in pain management and must advocate for adequate drug therapy and use complementary therapies to augment pain relief.

References, page 45.

Dr. Susan Beck's cancer work in South Africa

Although health services in South Africa have been plagued by inequity and inadequate resources, new health policies have set a path to ensure universal access to health care, including palliative care for cancer. Dr. Beck's research has been distributed to governmental bodies. Her 1998 and 1999 research validated the importance of cultural beliefs and practices for understanding cancer pain and how it is managed.

In several studies conducted to help alleviate suffering, Dr. Beck examined pain treatment to support South African efforts to improve care. Her findings showed management of pain varied by provider and setting, with major problems for access to care in the rural areas.

In African cultures, views about cancer are thought to prevent patients from seeking treatment, including for pain. Without a uniform concept of cancer as an entity, Africans have historically denied that cancer is a community problem. One resident explained, "Cancer is only for whites." In a study of 426 patients in multiple settings, nearly one-third of the cancer patients experienced pain of severe intensity. Thirty percent were not treated with adequate drugs, according to the WHO Analgesic Ladder.

Nonpharmacologic approaches to pain

- Movement, exercise, positioning
- Massage
- Progressive muscle relaxation
- Distraction and cognitive techniques
- Music
- Heat/cold
- Menthol
- Prayer

Dr. Susan Beck is a nursing professor at the University of Utah College of Nursing in Salt Lake City, Utah. In 1996, she was a visiting professor and Fulbright Scholar at the University of Pretoria in South Africa. She currently serves as President of Cancer Pain Relief Utah, Utah's state cancer pain initiative.
Breast and Prostate Cancer

The pain

BY SUSAN BECK

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PAIN PERSISTING OR INCREASING

Opioid for moderate to severe pain

1. Non-opioid + - Adjuncts

PAIN

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SUPPRESSION OF CANCER PAIN

Opioid for mild to moderate pain

1. Non-opioid + - Adjuncts

PAIN PERSISTING OR INCREASING

Opioid for moderate to severe pain

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PAIN
Prostate Cancer

The high risk of low literacy

BY SALLY P. WEINRICH

LOUISVILLE, Ky., June 1999—Informed decision making for prostate cancer screening requires high levels of literacy, problem solving, and reasoning skills.

The 1998 National Adult Literacy Survey documented that 21 percent of Americans have impaired literacy skills (National Institute for Literacy, 1998). Unfortunately, impaired literacy skills are closely connected to the social problems of poverty (National Institute for Literacy, 1998). Men with impaired literacy often do not have the range of economic, social and personal options that are open to men with higher levels of literacy skills (National Institute for Literacy, 1998). Yet it is important for nurses to target this at-risk group of men for prostate cancer education.

In the South Carolina Prostate Cancer Study, 190 (12.7 percent) out of the 1,500 men who received a prostate cancer education program had less than a ninth grade level of education. However, this group of men had a significantly greater percentage of prostate cancers than men with higher levels of education, 6.8 percent in contrast to 1.2 percent. How can nurses educate literacy-impaired men so they can make informed choices about prostate cancer screening? A critical component is to continuously assess and respond to each man’s individual and unique knowledge and questions concerning prostate cancer.

In addition, nursing assessment of literacy ability is critical. However, sensitivity is required, as persons with reading difficulties have spent a lifetime hiding it. Questions and comments to assess literacy level may include: Many people do not have the chance to finish school. What grade were you able to go to in school? Do you like to read or watch television? What do you read? How often? Do you read the newspaper? In addition to an assessment of literacy, nurses need to assess previous history of prostate cancer screening and individualize health teaching.

In research-based clinical intervention trials, nurses found success in identifying literacy-impaired men by going to work sites, churches, housing projects, and barber shops, for example (Weinrich, Boyd, Greene, Mossa & Weinrich, 1998). Key community leaders, such as ministers, athletes, elected officials and businessmen served as liaisons. Depending on which community was targeted, educational program times varied, from weekends to evenings and night shifts.

Handouts appropriate for a man’s reading level were distributed for later reference (Weinrich, Boyd & Powe, 1997). Key community leaders, such as ministers, athletes, elected officials and businessmen served as liaisons. Depending on which community was targeted, educational program times varied, from weekends to evenings and night shifts. Tokens, such as pencils and key rings that bore slogans, increased participation in screenings (Weinrich, Weinrich, Boyd & Mettlin, 1998). A critical component of each educational program was the active involvement of the men during a question and answer time, which enabled a nurse to verify comprehension and clarify misconceptions (Doak, Doak, Friedell & Meade, 1998).

Attention spans may be shorter in men with impaired literacy, making it critical to focus clearly on the key concepts, which include a description of the digital rectal examination and the prostate specific antigen blood test used in prostate cancer screening. In addition, the controversies in screening must be presented along with the potential risks and benefits.

A nurse needs to differentiate the risks and benefits for prostate cancer screening from the risks and benefits for treatments. It has been the experience of this author that men will readily discuss sexual issues and concerns if the nurse initiates a dialogue on the related issues. Education about prostate cancer is a process that occurs best over an extended period of time, and not simply at one interchange. Informed community leaders and lay persons can be very helpful in expanding the knowledge to men (Weinrich, Weinrich, Boyd & Mettlin, 1998).

The names, addresses, and phone numbers of health providers need to be disseminated, for literacy-impaired men may not have regular health maintenance. In addition, nurses need to allocate time and resources to follow men with abnormal screening results to ensure that medical care has been obtained, and that they understand the various treatment options.

Many commonly used prostate cancer terms may not be familiar to medically underserved men (Weinrich, Boyd & Powe, 1997). For example, I have talked with many men who did not understand the word “screening,” but they readily understood “test” and “checkup.” Most of the existing prostate health education materials are not meaningful to men with reduced literacy and need to be adapted (Michielutte, Bahnson & Beal, 1990; Doak, Doak, Friedell & Meade, 1998). A wide range of impaired-literacy levels exists. Some men may have difficulty un-
Prostate Cancer

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A wide range of impaired-literacy level exists. Some men may have difficulty un-
understanding printed materials, even when the reading level is reduced. Videos or slide-tape shows on prostate cancer screening that present the pros and cons—using nurses, physicians and patients speaking—would be an excellent method of education.

Impaired literacy may be an overlooked but significant barrier to the diagnosis of early-stage prostate cancer (Bennett et al., 1998). The controversies and unanswered questions surrounding prostate cancer screening—as well as gender differences—could lead nurses to avoid prostate cancer discussions. But involved nurses are vital to interventions aimed at helping literacy-impaired men face complex issues associated with prostate cancer.

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Columbia, S.C., June 9, 1999—On his front porch, Robert Henry, a prostate cancer survivor, meets with Sally Weinrich, RN, who takes her health education into communities. Mr. Henry says prostate cancer often has no noticeable symptoms and may spread, as his did, which is why he believes in helping others understand the disease.

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Nursing Assessment Tool
Previous History of Prostate Cancer Screening for Literacy-Impaired Patients
By Sally Weinrich, RN, PhD, FAAN

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Winston-Salem, N.C., August 1999—George Vincent, a prostate cancer survivor, sought his wife Norma’s advice and support as they made treatment decisions together. According to prostate cancer researcher Dr. Maureen O’Rourke, RN, left, the two most influential factors in couples’ decisions are agreement between the primary care physician and urologist and personal beliefs about cancer and cure.

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Prostate Cancer
How men choose a treatment

BY MAUREEN E. O’ROURKE

Greensboro, N.C., Aug. 10, 1999—Although most health care decisions are laden with uncertainty, the decision regarding whether to treat or not treat early-stage prostate cancer is extremely controversial. The scientific community remains at odds as to which treatment, if any, is most appropriate given the delicate balance between disease-induced morbidity or mortality and treatment-induced morbidity or mortality. Treatment-related side effects include incontinence, impotence and impaired bowel function.

The initial decision regarding prostate cancer treatment selection and the continuation of therapy represent critical junctures where nurses can intervene. Worldwide estimates project 396,000 new cases of prostate cancer and 165,000 deaths in 1999. Aside from North America, incidence is high in northern and western Europe, Australia, New Zealand, developing countries such as sub-Saharan Africa, tropical South America and the Caribbean. By contrast, rates are low in China and in other parts of Asia. Differing diagnostic practices, especially prostate-specific antigen testing (PSA), and environmental influences contribute to disproportionate incidence rates worldwide. On a worldwide basis, 81 percent of cases occur among men age 65 and older (Parkin, Pisani & Ferlay, 1999).

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diagnosed prostate cancer patients and their spouses, utilizing a grounded approach. While the controversy continues within the scientific community, patients and their partners seem to be formulating their own opinions. Building upon my prior research in this area (O’Rourke & Germino, 1998), I recently conducted a longitudinal study examining the decision making process of 18 newly diagnosed prostate cancer patients and their spouses, utilizing a grounded theory approach (O’Rourke, 1997, O’Rourke, 1999).

Couples were interviewed conjointly and individually to explore their perceptions of the decision making process. Interviews were conducted within six weeks of the initial diagnosis and before a treatment choice was declared. Interviews were again conducted using the same format at three and 12 months, following the completion of treatment, to examine satisfaction with their decision and the decision process, and how decisions affected their daily lives. Couples presented their final choice as a consensus decision, but throughout the conjoint and individual interviews they struggled to integrate two sometimes differing opinions and life experiences. While the spouses of men participating in this study identified their roles as mainly supportive, they discussed their own personal and family experiences with cancer, adding to the complex decisions. The two most influential factors affecting preferences were the consensus of the primary care physician and the urologist regarding optimal treatment, and ingrained beliefs about cancer and cure. Couples consistently expressed the belief that surgery was the optimal, if not only way to cure cancer. Only one patient sought a second opinion with a radiation oncologist, and only patients older than 70 years—or those with pre-existing medical conditions precluding surgery—opted for radiation therapy. This surgical bias and couples’ expressed fears regarding radiation therapy may represent cultural and age-related biases among a generation who witnessed the horrors of atomic radiation and its cancer causing effects, and suggests an area for future investigation.

Concerns about potential impotence and incontinence, although identified, did not deter men from selecting surgery. Women were less concerned about these potential side effects and focused more on quantity of life. These findings are consistent with those reported in the literature (Volk et al., 1997; Mazur & Merz, 1995).

Women revealed more alterations in the couple’s sexuality before diagnosis than did their husbands. Both the men and their wives had some misconceptions about potential side effects related to surgery and radiation therapy. Some couples understood that the side effects of these two modalities were essentially similar. Other couples attributed higher risks of impotence and incontinence to surgery; both beliefs are inconsistent with the current nursing and medical literature. Such misconceptions must be clarified by nursing and medical personnel before radiation therapy can be viewed as an acceptable option. Among the 18 couples involved in the study, only one couple chose the “watch and wait” approach. Men viewed this option as “doing nothing,” a label they attributed to their physicians. This was viewed as an automatic death sentence, and taking no action was simply unacceptable. Cross-cultural comparisons are necessary to examine this bias as well as the manner in which this option is presented to couples by health care providers.

Increasingly, individuals within the western culture are seeking out alternative or supplemental natural therapies. Several men in this study routinely took saw palmetto berry extract both prior to diagnosis and following treatment. In some cases, it was unknown by their physicians. The efficacy and safety of saw palmetto has not been conclusively demonstrated; however, some evidence of clinical benefits for the treatment of benign prostatic hypertrophy has been reported in numerous European trials. Additionally, this herbal preparation has been widely accepted by both men and physicians in European countries and is rarely associated with any side effects other than occasional mild gastric upset (Marks & Tyler, 1999).

While saw palmetto’s role as a complementary therapy in the treatment of histologically diagnosed prostate cancer remains unknown, nurses are in a position to obtain accurate usage information from patients. This may at least facilitate retrospective analyses by examining outcome differences among men treated with conventional therapies alone versus conventional therapy coupled with saw palmetto. Currently, couples make prostate cancer treatment decisions within the context of great personal and scientific uncertainty. Couples are being bombarded with mass media information through the lay press and the Internet. They desperately need assistance in evaluating the credibility of this information. One of the most unique and valuable roles that professional nurses can play is to become the portal for health information.

While my own research was intended to be descriptive/exploratory, the repetitive contact with couples led to perceptions of a powerful intervention. They identified that interviews stimulated discussion of issues and concerns that had been difficult to initiate. Couples said the initial interviews gave them an opportunity to think through their decisions along with the information available. Families need to feel good about the health care decisions they make, and each decision should prepare and strengthen them for future decisions that may follow. Nurses can reinforce this sense of empowerment. This program also began to identify concerns regarding patients’ access to and evaluation of information available through nontraditional sources. Nurses who pursue cross-cultural, research-based practices and compare and contrast processes that improve patient satisfaction with choices will help develop informed consumers. &

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The effects of uncaring

BY SIGRIDUR HALLDORSDOTTIR

Long nights await us in Iceland
Winter greets us with snow today
Long shadows move above the mountains
The moon greets the curious child...

—S. Halldorsdottir

REYKJAVIK, Iceland, August 1999—The effects of the lack of professional caring by caregivers are rarely discussed. When a person becomes ill, the basic human need for caring and connection grows more prominent. Needing and expecting professional caring in a dependent situation—separated from loved ones and feeling weak in spirit and body—create vulnerability and insecurity within patients. The experience of uncaring in this situation fosters helplessness.

Caring, competence and connection, or lack of these, greatly affect the patient for better or for worse (Halldorsdottir, 1996). Many former cancer patients have expressed how their anger and frustration advanced to despair, helplessness and hopelessness after experiencing uncaring acts while hospitalized.

Psychoneuroimmunology, a new multidisciplinary area of research, focuses on the dynamic interactions among behavioral factors, the central nervous system and the endocrine and immune systems (Bauer, 1994). This rapidly expanding field of research is of particular importance to professionals within health sciences, since their common goals are to empower people and increase their health. In this endeavor, knowledge of what is immunoenhancing, as well as what is immunosuppressing, is an important aspect in the understanding of health.

Stress is known to depress the immune system severely (Kemeny & Gruenewald, 1999). It can alter enumerative and functional aspects of the human immune system, and chronic stress may increase vulnerability to infectious disease (Brosschot, Gaedert, Benschop, Olff, Ballieux, Heijnen, 1998). It is also known that perceived uncontrollability of an acute stressor can have immuno-modulating effects over and above those of the stressor per se (Pert, Dreher & Ruff, 1998). Furthermore, depression has been associated with functional immune decrements and immune overactivation, and cognitive states such as perceived control, views of the self, and views of the future have been associated with immune parameters and health (Brosschot, Gaedert, Benschop, Olff, Ballieux, Heijnen, 1998).

Moreover, research on emotional expression or disclosure suggests that emotional expression generates balance in the neuropeptide-receptor network and functional healing system (Bergsma, 1994). Emotional expression is also a marker for psychospiritual vitalization (Bergsma, 1994).

Finally, social support is labelled as a “stress buffer” (Maier & Watkins, 1998). And, the perception of high quality social support—including spouse, intimate friends and health care professionals—significantly correlates with a higher natural killer (NK) cells activity (Levy, Herberman, Whiteside, Sanzo, Lee & Kilwood, 1990).

Research has shown that many stressors can decrease the immune system’s resources. Stress decreases levels of B lymphocytes (B cells) and T lymphocytes (T cells), and natural killer (NK) cells become less effective (Schindler, 1988). Furthermore, recent research in behavioral immunology suggests that stress and helplessness are likely to compromise immunity and promote ill-health (Atrens, 1994).

To increase understanding of caring and uncaring encounters experienced by patients, I developed a theory based on seven phenomenological studies that included 91 interviews with 57 patients. The patients’ perceptions of caring and uncaring encounters with nurses and other health professionals were examined (Halldorsdottir, 1996). The theory also involves examination of the lived experience of being a recipient of nursing and health care, and what it means to have cancer.

Only a few research participants through the years complained about uncaring to someone in authority. It is apparent that while still in the midst of the hospital experience the patient is sometimes fearful about retaliation for complaining. They perceive it may make the situation worse. This is probably particularly pertinent for a long-term hospitalization, where a patient realizes he will more than likely meet the same health professional again. In this regard, concern needs to be extended to the elderly and others in long-term care facilities.

Cancer is a disease, but it is also a lived experience that involves existential changes, which profoundly affect the person who has the cancer and those who share the lived experience (Halldorsdottir & Hamrin, 1996). Nurses and other health professionals need to see people with cancer in the context of what they are going through. Only then can they offer support and caring that has meaning for the person with cancer (Halldorsdottir & Hamrin, 1996).

The empowering effects of professional caring that former cancer patients reported included a better self-image, an increased sense of security and well-being, a sense of acceptance and an increased internal sense of healing. They felt the nurse was on their side, which gave them a sense of solidarity and increased sense of control (Halldorsdottir & Hamrin, 1997).
The effects of uncar1n

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Long shadows move above the mountains
The moon greets the curious child

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A bridge disappears into fog over water in Iceland. The bridge—symbolizing the openness in communication and the connectedness experienced by the recipient of care—is one of two major metaphors in Dr. Halldorsdottir’s theory of caring and uncaring.

The discouraging effects of uncaring included insecurity, uneasiness, anxiety and stress, decreased self-confidence, decreased sense of control, feeling of rejection and even of being broken down. All the former cancer patients felt it negatively affected their well-being and sense of healing (Halldorsdottir & Hamrin, 1997). Perceived uncaring, therefore, most often results in severe stress.

Results of an analysis of two phenomenological studies, and research findings from five other phenomenological studies, were used to develop a theory for caring and uncaring encounters in nursing and health care (Halldorsdottir, 1996).

There are two major metaphors in the theory. The bridge symbolizes the openness in communication and the connectedness experienced by the recipient of care in an encounter perceived as caring. The wall symbolizes negative or noncommunication, detachment and lack of a caring connection, experienced by the recipient in an encounter perceived as uncaring. The bridge is developed through mutual trust between the professional and the recipient, which is a combination of professional intimacy and a comfortable distance of respect. On the other hand, uncaring involves perceived incompetence and indifference, creating distrust, disconnection and a wall of negative or noncommunication.

Receiving professional caring influences the recipient positively, and the perceived consequences can be summarized as empowerment. Uncaring, however, has negative consequences, which can be summarized as discouragement. Empowerment and discouragement in this context are defined as a subjective experience of the recipient of care.

The importance of seeing the recipient in his or her context, inner as well as outer, is emphasized. The inner context involves perceived needs, expectations, previous experiences and sense of self, which in the context of the recipient of health care can be summarized as a sense of vulnerability and the need for professional caring. The outer context comprises the perceived environment.

Because uncaring is an ethical and professional consideration in practice, nurses will need the courage to confront and deal with these issues to benefit their patients. In addition, nursing goals can include security, control and connection needs to enhance the patient’s well-being.

The community of cancer nursing extends across the disease trajectory and does not abandon patients as treatments fail.

BY BETTY ROLLING FERRELL
City of Hope National Medical Center
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DUARTE, Calif., August 1999—Despite the advances in early detection, active treatment and focus on survivorship, the unfortunate reality is that many individuals die of cancer. In the United States alone, more than 500,000 people will die each year from cancer (Field and Casel, 1997).

Just as cancer nurses have focused on quality of life concerns during treatment and survivorship, they also pioneered the focus on end of life. Quality of life, even at the end of life, has been a major concern for cancer nurses. Care across the disease trajectory does not end at the completion of treatment or even in successful remission or long-term survivorship. Cancer nurses continue to provide care even amid terminal disease.

Care at the end of life spans the dimensions of quality of life and involves various experts and disciplines. Physical well-being is paramount, as dying patients and families confront multiple symptoms such as pain, dyspnea, terminal restlessness, cachexia, wound care and a multitude of other physical and cognitive disturbances. Psychological well-being is threatened by fears surrounding the dying process and by anxiety and depression that often accompany life’s end. Patients struggle to maintain a sense of control at the end of life.

Continued, page 33
Social well-being is threatened by the loss of one's roles and relationships, and by the intense financial burdens of advanced disease. Spiritual well-being, the fourth dimension of quality of life, becomes a priority as patients deal with issues such as uncertainty, hopelessness, religious faith, and transcendence (Ferrell, 1996).

Several recent events have highlighted the importance of increased attention to end of life care. The Institute of Medicine issued a 1997 report on care of the dying (see page 37). This report calls for widespread reform in the health care system and leadership by the medical and nursing professions to reform this aspect of health care.

The social demand for improved end of life care has been voiced in part by national legislation on assisted suicide and euthanasia. Many agree that this has been the wake-up call signifying dissatisfaction with the care one will likely receive at the end of life in the United States and other nations.

Yet, nurses have provided grassroots leadership in the evolution of the hospice movement in the United States since the early 1970s. Nurses continue to advocate for better care of the dying and to play a pivotal role of the reform of health care systems, the integration of palliative care beyond hospice, and by addressing the many clinical and policy issues relevant to end of life care (Matzo & Emanuel, 1997; Oncology Nursing Society, 1995; Scanlon, 1996). Improved end of life care is critical not only in oncology, but in many areas including geriatrics, critical care, AIDS care and for nurses caring for patients with chronic health conditions, such as end-stage renal, cardiac or pulmonary disease.

In recognition of the universal need for humane end of life care, the American Association of Colleges of Nursing (see page 36), supported by the Robert Wood Johnson Foundation, convened a roundtable of experts to stimulate scholarly discourse and initiate change on this important reality in fall 1997 (American Association of Colleges of Nursing, 1998). It was in accord with the International Council of Nurses' 1997 mandate that nurses have a unique and primary responsibility for ensuring that individuals at the end of life experience a peaceful death (International Council of Nurses, 1997).

The roundtable's ethicists and palliative care experts developed the End of Life Competency Statements to affect what is taught in nursing schools to increase the focus on symptom management and psychosocial support. Then, too, it includes the importance of helping students alter their goals. We do not want students to graduate believing the essence of nursing relates only to health care recovery or wellness: The patient gets up and walks; The wound heals; The patient gets off the ventilator and leaves the ICU. Students need to understand that excellent care at the end of life is also an integral part of nursing. The AACN will disseminate results from its meeting and has plans to improve end of life education.

In cancer care, there is a focus on cure. For example, a woman with breast cancer has had a stem cell transplant, with the hope of cure. If that woman has a recurrence of cancer and is back in the hospital and is now at the end of her life, our mindset is that we, as health professionals, have failed. What we want practicing nurses to understand, when this patient comes back into the hospital with lung metastasis and bone metastasis, is the tragic nature of her state. She is dying, and nursing goals shift to keeping her comfortable. Nursing care to ensure this is vital. At a more generalized level, we, as nurses, hope to advance care to enable more women to be cured.

Now our goals for this woman are to treat her bone pain, ease her shortness of breath, provide support to her children and husband, and involve them in helping her toward a peaceful death. By fulfilling these goals, the mother would not face death alone, in pain, on a ventilator in ICU. That would be a dreadful manner to experience life's ending. A more peaceful death may occur if she were at home. If that cannot occur, she may remain in the hospital with as few invasive treatments as possible and her family or friends actively comforting her. She would have spiritual care. And, nursing goals would consider her family's needs beyond her death.

The AACN would like students to understand this scenario is not one of failure but of successful care. We have met the hope of cure.

Betty Ferrell
Photography by Nick Souza

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Now our goals for this woman are to treat her bone pain, ease her shortness of breath, provide support to her children and husband, and involve them in helping her toward a peaceful death. By fulfilling these goals, the mother would not face death alone, in pain, on a ventilator in ICU. That would be a dreadful manner to experience life's ending. A more peaceful death may occur if she were at home. If that cannot occur, she may remain in the hospital with as few invasive treatments as possible and her family or friends actively comforting her. She would have spiritual care. And, nursing goals would consider her family's needs beyond her death.

The AACN would like students to understand this scenario is not one of failure but of successful care. We have met the hope of cure.
Social well-being is threatened by the loss of one's roles and relationships, and by the intense financial burdens of advanced disease. Spiritual well-being, the fourth dimension of quality of life, becomes a priority as patients deal with issues such as uncertainty, hopelessness, religious faith, and transcendence (Ferrell, 1996).

Several recent events have highlighted the importance of increased attention to end of life care. The Institute of Medicine issued a 1997 report on care of the dying (see page 37). This report calls for widespread reform in the health care system and leadership by the medical and nursing professions to reform this aspect of health care.

The social demand for improved end of life care has been voiced in part by national legislation on assisted suicide and euthanasia. Many agree that this has been the wake-up call signifying dissatisfaction with the care one will likely receive at the end of life in the United States and other nations.

Yet, nurses have provided grassroots leadership in the evolution of the hospice movement in the United States since the early 1970s. Nurses continue to advocate for better care of the dying and to play a pivotal role of the reform of health care systems, the integration of palliative care beyond hospice, and by addressing the many clinical and policy issues relevant to end of life care (Matzo & Emanuel, 1997; Oncology Nursing Society, 1995; Scanlon, 1996). Improved end of life care is critical not only in oncology, but in many areas including geriatrics, critical care, AIDS care and for nurses caring for patients with chronic health conditions, such as end-stage renal, cardiac or pulmonary disease.

In recognition of the universal need for humane end of life care, the American Association of Colleges of Nursing (see page 36), supported by the Robert Wood Johnson Foundation, convened a roundtable of experts to stimulate scholarly discourse and initiate change on this important reality in fall 1997 (American Association of Colleges of Nursing, 1998). It was in accord with the International Council of Nurses' 1997 mandate that nurses have a unique and primary responsibility for ensuring that individuals at the end of life experience a peaceful death (International Council of Nurses, 1997).

The roundtable's ethicists and palliative care experts developed the End of Life Competency Statements to affect what is taught in nursing schools to increase the focus on symptom care and psychosocial support. Then, too, it includes the importance of helping students alter their goals. We do not want students to graduate believing the essence of nursing relates only to health care recovery or wellness: The patient gets up and walks; The wound heals; The patient gets off the ventilator and leaves the ICU. Students need to understand that excellent care at the end of life is also an integral part of nursing. The AACN will disseminate results from its meeting and has plans to improve end of life education.

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The AACN would like students to understand this scenario is not one of failure but of successful care. We have met the hope of cure.

Consider the prostate cancer patient. An elderly man, who now confronts a new set of decisions. Under current thought, the general public often believes a patient should....
keep going for the cure. In doing so, this gentleman would undertake clinical trials and spend much of the last three months of his life in a hospital receiving investigational chemotherapy. Most likely he will have many symptoms related to treatment, including nausea, extreme weight loss, pain, diarrhea and extreme fatigue. He would die, in all likelihood, in the hospital with the devastating effects of the advanced disease and all of the additional side effects of treatment. A better picture for this elderly patient would be to sit down with his physicians, a nurse clinical specialist and other members of his cancer team at the clinic and discuss his treatment options, including aggressive palliative care. The aggressive palliative care would include aggressive symptom management. He has choices over his remaining life. He may choose palliative care, and continue to do what he enjoys in his last few months—travel possibly, visit children and grandchildren, and surround himself with what brings him comfort.

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Good end of life care is, most likely, best described as the kind of care we would seek for ourselves or our loved ones if faced with terminal illness: palliative care; quality of life; symptom management; communication of prognosis and options and discussions of sensitive issues; policy, ethics and law (such as drug regulations that may restrict access to pain medications, policies on advance directives or ethical/legal issues related to withdrawing fluids or death at home); bereavement services.

Unfortunately, the Institute of Medicine's report and extensive other literature have documented that many barriers exist to quality end of life care. As a part of the study at the City of Hope, "Strengthening Nursing Education in End of Life Care," supported by the Robert Wood Johnson Foundation, we recently surveyed clinical nurses to determine their perceptions of the current status of end of life care. A total of 2,333 nurses responded to this survey, of which 70 percent were oncology nurses. Respondents cited frequent dilemmas such as failure to use advance directives, uncertainty about the patient's prognosis, fear of hastening death by giving pain medications, and responding to patient questions regarding assisted suicide.

The common barriers they cited included the influence of managed care on end of life care, lack of continuity, patient/family avoidance of death, lack of knowledge or discomfort of health care providers, fears of addiction when giving pain medications, and cultural influences (Ferrell, Virani, Grant, Coyne & Uman, 1999).

Another major issue is the lack of continuity in the current health systems. The moment patients come into the hospital we begin thinking of early discharge. They are not referred to home care. Often in previous years, patients might stay in a hospital for a week, and home care nurses would come to the hospital and meet with the patient, arrange for equipment, speak with doctors and talk with family members. Now they are in the hospital without the opportunity to make referrals and facilitate collaboration. You may be in the ER and home two days later, and the home care nurse that comes to your house may not have had time to speak with your cancer team. The nurse is walking into an acute care situation without even the history, prognosis and goals. She walks into a fragmented system.

This same ongoing study includes three goals: reviewing nursing textbooks for end of life content, improving end of life content in the nursing license exam, and supporting the efforts of key nursing organizations to improve end of life education for nurses. The first goal, review of nursing texts was recently completed. Fifty texts (45,683 pages), selected from a potential of more than 700 texts, were reviewed. Findings revealed only 2 percent of the overall content and 1.4 percent of chapters in nursing texts were related to end of life care. Based on the analysis, many deficiencies were identified in the texts, including inaccurate information and a lack of information regarding critical end of life topics (Ferrell, Virani & Grant, 1999). Nine areas of end of life care were reviewed, including: palliative care defined; quality of life; pain; other symptom assessment, management; communication with dying patients and families; roles/needs of family caregivers in end of life care; death; issues of policy, ethics and law; and bereavement. These nine areas of end of life content are also applicable to clinical practice.

A second ongoing project, "HOPE: Home Care Outreach for Palliative Education," funded by the National Cancer Institute, is designed to develop and implement a program to extend palliative care knowledge into hospice home care agencies. City of Hope investigators are currently implementing the HOPE program in Los Angeles-area agencies, and in the year 2000 will host a national training program to extend this knowledge into 50 home care agencies selected nationally.

The key components of this training program include a general overview of palliative care in home care, pain management, symptom management, communication with dying patients and families, and the death event. This project acknowledges the importance of extending palliative care beyond the hospice setting. It also recognizes that home care is the predominant setting of care and that family caregivers assume responsibility of caring for the dying patient (Ferrell, Virani & Grant, 1998).

Nursing, as a profession dedicated to care of people at all phases of life and across all clinical settings, has always been involved in care of individuals at the end of life. Current social demands, such as an aging population, burdened health care system and the prevalence of diseases such as cancer, AIDS, and other chronic diseases, have necessitated increased attention to care at the end of life. The community of cancer nursing extends across the trajectory and does not abandon patients as treatments fail.

See pages 36 and 37 for nursing and medical recommendations. References, page 45.

Betty Rolling Ferrell, RN, PhD, FAAN

Research and Special Projects Related to Pain or End of Life Care

- Her qualitative study on ethical decision-making in pain management, funded in 1991-92 by the National Institute for Nursing Research, included interviews of patients, family caregivers and home care nurses. This study demonstrated the complex nature of managing pain as everyone involved struggled with decisions regarding medication use, denying pain in order to avoid the reality of death and the many psycho-social and spiritual issues that influence the physical dimension of pain. Findings revealed the tremendous burden of pain management in terminal illness and need for education and support for all involved.

- A Pain Resource Center was formed as a clearinghouse of information related to pain and end of life care in 1994. In the first three years of operation, this resource center distributed more than 45,000 materials to more than 19,000 professionals in all 50 states and 30 countries. An index to the more than 300 materials can be found on the web site http://mayday.cal.org

- In a study of pain education for elderly cancer patients at home, funded by the National Cancer Institute from 1994 to 1998, she developed and evaluated a pain education intervention in 360 cancer patients and family caregivers in home care. This research, which is the culmination of a series of studies beginning in 1984, has defined the core content for cancer pain education for patients. Findings demonstrated the impact of pain education and quality of life. This nursing education intervention has increased patient compliance with pain medications, improved side effect management and decreased patient and family caregiver fears and misconceptions about pain.

- Patient and Public Education in Cancer Pain Management was recently initiated to train 120 professionals to implement improved pain management through a national program. This is one of the first national efforts to focus on educating the patient and public about pain.

Research scientist at City of Hope National Medical Center in Duarte, Calif.
AMERICAN ASSOCIATION OF COLLEGES OF NURSING

Competencies Necessary for Nurses to Provide High-Quality Care to Patients and Families During the Transition at the End of Life

1. Recognize dynamic changes in population demographics, health care economics and service delivery that necessitate improved professional preparation for end of life care.
2. Promote the provision of comfort care to the dying as an active, desirable and important skill, and an integral component of nursing care.
3. Communicate effectively and compassionately with the patient, family and health care team members about end of life issues.
4. Recognize one's own attitudes, feelings, values and expectations about death and the individual, cultural and spiritual diversity existing in these beliefs and customs.
5. Demonstrate respect for the patient's views and wishes during end of life care.
6. Collaborate with interdisciplinary team members while implementing the nursing role in end of life care.
7. Use scientifically based standardized tools to assess symptoms (e.g., pain, dyspnea [breathlessness], constipation, anxiety, fatigue, nausea/vomiting and altered cognition) experienced by patients at the end of life.
8. Use data from symptom assessment to plan and intervene in symptom management using state-of-the-art traditional and complementary approaches.
9. Evaluate the impact of traditional, complementary and technological therapies on patient-centered outcomes.
10. Assess and treat multiple dimensions, including physical, psychological, social and spiritual needs, to improve quality at the end of life.
11. Assist the patient, family, colleagues, and one's self to cope with suffering, grief, loss, and bereavement in end of life care.
12. Apply legal and ethical principles in the analysis of complex issues in end of life care, recognizing the influence of personal values, professional codes and patient preferences.
13. Identify barriers and facilitators to patients' and caregivers' effective use of resources.
14. Demonstrate skill at implementing a plan for improved end of life care within a dynamic and complex health care delivery system.
15. Apply knowledge gained from palliative care research to end of life education and care.

INSTITUTE OF MEDICINE

Key Recommendations for Improved End of Life Care in the United States

1. People with advanced, potentially fatal illnesses and those close to them should be able to expect and receive reliable, skillful and supportive care.
2. Physicians, nurses, social workers and other health professionals must commit themselves to improving care for dying patients and to using existing knowledge effectively to prevent and relieve pain and other symptoms.
3. Many problems in care stem from system problems, policymakers, consumer groups, and purchasers of health care should work with health care practitioners, organizations and researchers to:
   a) strengthen methods for measuring the quality of life and other outcomes of care for dying patients and those close to them;
   b) develop better tools and strategies for improving the quality of care and holding health care organizations accountable for care at the end of life;
   c) revise mechanisms for financing care so that they encourage, rather than impede, good end of life care and sustain, rather than frustrate, coordinated systems of excellent care;
   d) reform drug prescription laws, burdensome regulations, and state medical board policies and practices that impede effective use of opioids to relieve pain and suffering.
4. Educators and other health professionals should initiate changes in undergraduate, graduate and continuing education to ensure that practitioners have relevant attitudes, knowledge and skills to care well for dying patients.
5. Palliative care should become, if not a medical specialty, at least a defined area of expertise, education and research.
6. The nation's research establishment should define and implement priorities for strengthening the knowledge base for end of life care.
7. A continuing public discussion is essential to develop a better understanding of the modern experience of dying, the options available to patients and families, and the obligations of communities to those approaching death.
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4. Recognize one's own attitudes, feelings, values and expectations about death and the individual, cultural and spiritual diversity existing in these beliefs and customs.

5. Demonstrate respect for the patient's views and wishes during end of life care.

6. Collaborate with interdisciplinary team members while implementing the nursing role in end of life care.

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12. Apply legal and ethical principles in the analysis of complex issues in end of life care, recognizing the influence of personal values, professional codes and patient preferences.

13. Identify barriers and facilitators to patients' and caregivers' effective use of resources.

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7. A continuing public discussion is essential to develop a better understanding of the modern experience of dying, the options available to patients and families, and the obligations of communities to those approaching death.
Sigma Theta Tau joins health coalition to promote nursing profession

INDIANAPOLIS, Sept. 7, 1999—With the United States facing a potentially dangerous shortage of nurses, Sigma Theta Tau International joined 17 of the nation's leading nursing and health care organizations to form the coalition "Nurses for a Healthier Tomorrow."

The group kicked off a $1 million fund-raising drive and search for sponsors to help underwrite a national advertising campaign. The ads will be designed to recruit new nurses and encourage existing ones to remain in the profession.

In its quest for funding, the coalition hopes to work with major health insurers, managed care companies, pharmaceutical firms and health care providers to join the effort. In addition to seeking sponsors, the coalition will ask nursing schools and hospitals—the organizations most directly affected by the nursing shortage—to contribute seed money. Individual supporters of nursing are also encouraged to participate.

In addition to Sigma Theta Tau, coalition members are: American Association of Critical-Care Nurses/AACN Certification Corp.; American Association of Nurse Anesthetists; American College of Nurse Practitioners; American Nurses Association; American Organization of Nurse Executives; American Red Cross; Association of periOperative Registered Nurses; Association of Women's Health, Obstetric and Neonatal Nurses; Department of Veterans Affairs; Emergency Nurses Association; National Association of Neonatal Nurses; National League for Nursing; National Student Nurses Association; Oncology Nursing Society; and Arthritis Foundation.

Organizers say the message of the campaign is simple: A nursing education teaches highly versatile skills, such as critical thinking, customer service, decision making, science and technology, that lead to exciting jobs. Few people are aware of the range of positions available for professional nurses, not only in direct patient care, but also in roles as researchers, entrepreneurs, managers, corporate board members and more.

"By showing people all the things they can do with a nursing degree, we can help ensure that nurses will be available in the future to care for and advocate for patients everywhere. Nursing is a profession that combines the use of your head, hands and heart to make a difference in people's lives," said Nancy Dickenson-Hazard, RN, MSN, FAAN, executive officer of Sigma Theta Tau International.

"This important efforts of this coalition can help build up our profession and prevent a costly and dangerous nurse shortage," said Eleanor J. Sullivan, RN, PhD, FAAN, president of Sigma Theta Tau International.

Contributions, which are tax-deductible, should be made payable to Nurses for a Healthier Tomorrow/ Sigma Theta Tau International and sent to: Nurses for a Healthier Tomorrow, 550 W. North Street, Indianapolis, Indiana 46202. For more information about the campaign, contact Kathy Bennison at 1.888.634.7575 (toll free in U.S. and Canada) or via e-mail: bennison@stti.iupui.edu. ▶

New poll shows public concern about health care

INDIANAPOLIS, July 7, 1999—More than half of Americans believe the quality of health care is affected "a great deal" by a shortage of nurses, according to a new public opinion poll released in July. Only four percent of those surveyed say the quality of health care is not affected "at all" by a nursing shortage.

Sigma Theta Tau International and NurseWeek Publishing Company, publishers of NurseWeek and HealthWeek magazines, commissioned the poll conducted by Louis Harris & Associates, Inc. More than 1,000 people were surveyed in an effort to gauge public attitudes about the nursing profession.

"This poll reaffirms what we already know: that nurses are the critical difference in today's health care system and they are well trusted by the general public," said Nancy Dickenson-Hazard, RN, MSN, FAAN, executive officer, Sigma Theta Tau International. "We feel it is crucial to promote nursing as a scientific profession with multiple career options."

Other poll results include:

- An overwhelming majority of the public (92 percent) said they trust information about health care provided by registered nurses, ranking nurses even with physicians. Nurses ranked even higher than teachers (62 percent) or journalists (51 percent).
- 85 percent of Americans said they would be pleased if their son or daughter became a registered nurse. Americans on average would be considerably more pleased if their son or daughter said they wanted to become a registered nurse than a journalist or a lawyer. And much more pleased if they wanted to become a registered nurse than a police officer. Nursing ranked approximately the same as teaching.
- 76 percent of the public thinks nurses should have four years of education or more past high school to perform the duties of their job. Nearly one-half of the public said nurses should have four years of education beyond high school. Three out of 10 Americans think nurses should have five to 10 years of education as a base for becoming a nurse.
- When asked about specific duties of registered nurses, the public recognized that nurses monitor care and provide a demand for nurses in specialty areas.
- The total of negotiated "a great deal" and "some."
Sigma Theta Tau joins health coalition to promote nursing profession

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In its quest for funding, the coalition hopes to work with major health insurers, managed care companies, pharmaceutical firms and health care providers to join the effort. In addition to seeking sponsors, the coalition will ask nursing schools and hospitals—the organizations most directly affected by the nursing shortage—to contribute seed money.

Individual supporters of nursing are also encouraged to participate.

In addition to Sigma Theta Tau, coalition members are: American Association of Colleges of Nursing; American Association of Critical-Care Nurses/AACN Certification Corp.; American Association of Nurse Anesthetists; American College of Nurse Practitioners; American Nurses Association; American Organization of Nurse Executives; American Red Cross; Association of periOperative Registered Nurses; Association of Women’s Health, Obstetric and Neonatal Nurses; Department of Veterans Affairs; Emergency Nurses Association; National Association of Neonatal Nurses; National League for Nursing; National Student Nurses Association; Oncology Nursing Society; and Arthritis Foundation.

Organizers say the message of the campaign is simple: A nursing education teaches highly versatile skills, such as critical thinking, customer service, decision making, science and technology, that lead to exciting jobs.

By showing people all the things they can do with a nursing degree, we can help ensure that nurses will be available in the future to care for and advocate for patients everywhere. Nursing is a profession that combines the use of your head, hands and heart to make a difference in people’s lives,” said Nancy Bennison, RN, MSN, FAAN, executive officer of Sigma Theta Tau International.

"A nursing education teaches highly versatile skills, such as critical thinking, customer service, decision making, science and technology, that lead to exciting jobs."

Organizers say the message of the campaign is simple: A nursing education teaches highly versatile skills, such as critical thinking, patient service, decision making, science and technology, that lead to exciting jobs.

In general, how much do you trust information about health care provided by each of the following?

Physicians

- 93% They trust nurses...

- 69% They trust pharmacists...

- 51% They trust journalists...

- 34% They trust magazines...

The total of “a great deal” and “some” is not affected by a shortage of nurses, according to a new public opinion poll released in July. Only four percent of those surveyed say the quality of health care is not affected "at all" by a nursing shortage.

Sigma Theta Tau International and NurseWeek Publishing, Inc., publishers of NurseWeek and HealthWeek magazines, commissioned the poll conducted by Louis Harris & Associates, Inc. More than 1,000 people were surveyed in an effort to gauge public attitudes about the nursing profession.

“This poll reaffirms what we already know: that nurses are the critical difference in today’s health care system and they are well trusted by the general public,” said Nancy Dickenson-Hazard, RN, MSN, FAAN, executive officer, Sigma Theta Tau International. “We feel it is crucial to promote nursing as a scientific profession with multiple career options.”

Other poll results include:

- An overwhelming majority of the public (92 percent) said they trust information about health care provided by registered nurses, ranking nurses even with physicians. Nurses ranked even higher than teachers (62 percent) or journalists (51 percent).

- 85 percent of Americans said they would be pleased if their son or daughter became a registered nurse.

"The campaign promotes the message of the nurse as a leader in health care, and they are well trusted by the general public,” said Nancy Dickenson-Hazard, RN, MSN, FAAN, executive officer, Sigma Theta Tau International. “We feel it is crucial to promote nursing as a scientific profession with multiple career options.”

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- 76 percent of the public thinks nurses should have four years of education or more past high school to perform the duties of their job. Nearly one-half of the public said nurses should have four years of education beyond high school. Three out of 10 Americans think nurses should have five to 10 years of education as a prerequisite to entering the health care field.

"When asked about specific duties of registered nurses, the public recognized that nurses monitor care and provide advanced practice services. Responses were as follows:

- 91% said nurses monitor the condition of patients

- 69% said nurses provide counseling to patients

- 28% said nurses decide on treatments for patients

- 14% said nurses prescribe medications

An executive summary of the Harris Poll results is available on the society's Web site at: www.nursingsociety.org. Copies of the poll data and executive summary are available for $25. For more information, contact Andrea McDonald, Sigma Theta Tau International, 550 W. North Street, Indianapolis, Indiana 46202, or call: 1.888.634.7575 (toll free, U.S. and Canada) or, 1.800.634.7575.1 (global), or e-mail: mcdonald@sni.iupui.edu.
CLINICAL
Vicki Drager, RN, BSN, staff nurse at Christ Hospita l and Medical Center in Oak Lawn, IL, and Tom Tremback, MS, anesthesiologist at Christ Hospital and Medical Centers, have received first place in the clinical category of the 1998 Association of Operating Room Nurses' Journal Writers Contest for their article, "Blood and Blood Product Use in Peripерative Patient Care."

Colleen Dunwoody, RN, MS, clinical coordinator of pain management at the University of Pittsburgh Medical Center in Pittsburgh, PA, has won the American Society of Pain Management Nurses' Clinical Practice Award for 1999. Ms. Dunwoody was honored for her development of programs to improve pain management care and for her advocacy on behalf of patients to ensure optimal pain relief.

Janelle Johnson, RN, MS, APM, adult nurse practitioner at Advanced Cardio Specialties in Gilbert, Ariz., has won a first-place award for innovation in health promotion and disease prevention from the Department of Health and Human Services. Her proposal, "Final Choices: Keeping Your Dignity in Palliative Care," has won a first-place award for innovations in health promotion and disease prevention.

Alexandra, June 23, 1999—Mary C. Clark, RNC, BSN, CHNC, assesses patient Harry Drake at the Veterans Administration Medical Center. A community health nurse coordinator, she works with home health agencies to provide skilled post-hospitalization care for veterans. Ms. Clark is the recipient of the James MacGregor Burns Academy of Leadership Award for her work with the Community Stakeholders in Education to Improve Rapesis Parish, La., public schools.

EUGENIA FLANDERS

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Ruth Ellen Miller Van Gerpen, RN, BSN, OCN, oncology program coordinator at Bryan LGH Medical Center in West Lincoln, Neb., and an American Cancer Society volunteer, is the 1999 recipient of an Oncology Nursing Foundation Master's Scholarship.

LEADERSHIP
Helen Fao, RN, PhD, associate academic dean at Whee jing Jesuit University in Wheeling, W. Va., has been appointed to the West Virginia Board of Examiners for Registered Professional Nurses. Dr. Fao is also the state advisor for the West Virginia Student Nurses Association and a volunteer for Whee jing Jesuit Health Right Inc., which serves patients with no medical insurance.

Georgia L. Nussavong, RN, PhD, CS, is associate professor and director of the MSN program at Case Western Reserve University Frances Payne Bolton School of Nursing in Cleveland, Ohio. The MSN program provides opportunities for international nurses to study in Ohio and later develop programs in their own countries to enhance primary health care.

Barbara Ann Ross, RN, EDD, director of nursing programs at Indiana University-Purdue University in Columbus, Ind., visited five universities and two hospitals in Rio Grande do Sul in Brazil. During the one-month trip, sponsored by the American Red Cross, Ms. Ross gave presentations on nursing research and Web-based nursing courses.

Michael Segal, RN, BS, is professor of Gunn Prefectural Junior College of Health Sciences in Maebashi, Japan. He is the first nurse elected president by the college faculty, with approval of Governor Koder, of Gunn Prefecture.

Cathy Minnepompeo, RN, PhD, CCRN, assistant professor at the University of Colorado Health Sciences Center School of Nursing in Denver, Colo., is the executive of the Cheltenham Area Community Recognition Award for the School of Nursing. Students select the faculty member who receives the award.

RUTH ELLEN MILLER VAN GERPEN, RN, BSN, OCN, ONCOLOGY PROGRAM COORDINATOR AT BRYAN LGH MEDICAL CENTER IN WEST LINCOLN, NEB., AND AN AMERICAN CANCER SOCIETY VOLUNTEER, IS THE 1999 RECIPIENT OF AN ONCOLOGY NURSING FOUNDATION MASTER'S SCHOLARSHIP.

SANDIE FLANDERS

People

BAROTONDA, Cook Islands, April 1999—Candice Osuga, RN, MSN, CCRN, ACNP, a global volunteer, takes a patient outside for relaxation. A staff nurse at University of California, San Francisco Stanford Health Care, Ms. Osuga is part of a three-week service program offered by Global Volunteers, a non-profit, nonsectarian organization that coordinates human and economic development projects in 20 countries.
CLINICAL

Vicki Dreger, RN, BSN, staff nurse at Christ Hospi
tal and Medical Center in Oak Lawn, Ill., and
Tom Tremback, MS, anesthetologist at Christ Hospi
tal and Medical Centers have received first place in
the clinical category of the 1998 Asso
iation of Operating Room Nurses' Journal Writ
ers Contest for their article, "Blood and Blood
Product Use in Perioperative Patient Care."

Collene Dunwoody, RN, MS, clinical coordinator
of pain management at the University of Pittsburgh
Medical Center in Pittsburgh, Pa., has won the
American Society of Pain Management Nurses'
Clinical Practice Award for 1999. Ms. Dunwoody
was honored for her development of programs to
improve pain management care and for her
advocacy on behalf of patients to ensure opti
mal pain relief.

Julianne Johnson, RN, MS, AMP, adult nurse practi
tioner at Advanced Cardiac Specialists in Gil
ter, Ariz., has won a first-place award for in
novation in health promotion and disease pre
vention from the Department of Health and
Human Services. Her proposal, "Innovations in Health Promotion and Disease Prevention from the Department of Health and Human Services," has won a first-place award for innovation in health promotion and disease prevention from the Department of Health and Human Services. Her proposal, "Innovations in Health Promotion and Disease Prevention from the Department of Health and Human Services," has won a first-place award for innovation in health promotion and disease prevention from the Department of Health and Human Services.

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cal Center in West Lincoln, Neb., and an Ameri
can Cancer Society volunteer, is the 1999 re
ipient of an Oncology Nursing Foundation's
Master's Scholarship.

LEADERSHIP

Helen Fass, RN, PhD, associate academic dean at
Wheeling Jesuit University in Wheeling, W.Va.,
has been appointed to the West Virginia Board of Examiners for Registered Professional Nurses. Dr. Fass is also the state advisor for the West Virginia Student Nurses Association and a vol
unteer for Wheeling Health Right Inc., which
serves patients with no medical insurance.

Jeanne Floyd, RN, PhD, C, CAE, director of research and evaluation at Sigma Theta Tau International, is president elect of the American Society of As
sociation Executives and has been named to two national positions with the organization.

Sharon Hoffman, RN, PhD, FAAN, is a se
nior vice president for academic affairs at Spalding University in Louisville, Ky. She previously was dean of the Uni
versity of Wisconsin-Milwaukee School of Nurs
ing.

The Robert Wood Johnson Executive Nurse Fellows Program has chosen 15 nurses as 1999 fellows: Patricia G. Butterfield, RN, PhD, Pamela Clarke, RN, MSN, MPA, Tricia Booth, RN, MHA, and Lisa Sheid, RN, MBS, PhD, CNE.

Karen S. Cox, RN, MSN, CS, PNP, is associate professor and director of the MSN program at Case Western Reserve University Frances Payne Bolton School of Nursing in Cleveland, Ohio. The MSN program provides opportunities for international nurses to study in Ohio and later develop programs in their own countries to enhance primary health care.

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sentations on nursing research and Web-based nursing courses.

Midost Supphat, RN, BS, is president of Gunn Prefectural [Junior College of Health Sciences in Kaohsiung City, Japan. She is the first nurse elected president by the college faculty, with
approval of Government Kodera, of Gunn Pre
fecture.

Cathy Minnepoose, RN, PhD, CCRN, assistant pro
fessor at the University of Colorado Health Sci
ences Center School of Nursing in Denver, Colo., is the recipient of the Chancellor's Teaching and Service Recognition Award for the School of Nursing. Students select the faculty member who re
ceives the award.

Jenifer Judeikis and Kelli Melhorn, stu
dents at the University of Pittsburgh School of Nurs
ing in Pittsburgh, Pa., have been elected to office in the Stu
dent Nurses Association of Pennsylvania.

Ms. Judeikis is a region coordina
nier and Ms. Melhorn is a regional treasurer.

A staff nurse at University of California, San Francisco Stanford Health Care, Ms. Osuga is part of a three-week service program offered by Global Volunteers, a nonprofit, nonsectarian organization that coordinates human and economic development projects in 20 countries.
Baltimore, Md., May 1999 — We failed to sell readers in Reflections, Third Quarter 1999, that this exceptionnal photo was taken by Ted Kinsman, who captured young nurse Nancy Glass, RN, MS, right, seen regularly at the House of Ruth shelter for battered women. Mr. Kinsman is photo editor at the Baltimore Sun. Reflections is proud of the association that photojournalists like Mr. Kinsman bring to its pages.

We would also like to say to you that Mr. KJ Enterprises, Lebanon, and — the printing house for Reflections — reproduces the photojournalism with integrity for color, tone, and detail. KM won the 1999 distinguished achievement award from the Indianapolis Club of Printing House Craftsmen for Reflections.

ロスト H. Neuman, RN, a lecturer at the University of Maryland School of Nursing in Baltimore, Md., has been honored by the Maryland House of Delegates and Prince George's County Council for her contributions to nursing. She is the former chair of Prince George's Community College Department of Nursing in Largo, Md. Carmen J. Pertilla, RN, PhD, FAAN, associate professor at the University of California, San Francisco School of Nursing, has been appointed to the National Advisory Council for Nursing Research. Dr. Pertilla is president of the National Association of Hispanic Nurses and is educational coordinator for the Center for Women's AIDS Research and Clinical Training in Nursing at the University of California, San Francisco.

Katherine Sanford, RN, PhD, vice president at Harrison Memorial Hospital in Brentwood, Wash., has been named Busyest Working Mother by Mother Mother Magazine and the Kellogg Company. Dr. Sanford, an author and a lieutenant colonel with the Washington State National Guard, is a staunch advocate for military nurses.

Judith Shamian, RN, PhD, CHE, the former vice president of patient services at Mt. Sinai Hospital in Toronto, Canada, has been named by the federal government to the top nursing post in her nation. She is executive director of nursing policy for Canada.

Nancy Shields, RN, MSN, business unit director for Unicol in Minneapolis, Minn., has been re-elected president of the Society of Gastroenterology Nurses and Associates Foundation for Education and Research. Nancy M. Shoop, RN, BSN, CHRM, an education and sales consultant for LincolnLife of Lincoln, Ala., has been elected executive vice president.

Bunny Skovbrott, RNCH, RN, MA, RNCC, project director for the League of Catholic Women's Nursing: Assessment and Intervention, 3rd edition, Mosby Year Book, St. Louis. This edition further incorporates cultural variations found in different ethnic and cultural groups.

Lois P. Homer, PhD, professor of nursing at the University of Saskatchewan in Canada, and Theresa George, PhD, associate professor at the University of Manitoba in Canada, are editors of International Perspectives on Women, Health and Health Care. The book was published by Allen Press Publishing, Ltd., Sheridan, United Kingdom. This is a cross-cultural text, with authors from 13 nations.

Naoe Funahashi, RN, MS, PhD, assistant professor at Chiba University School of Nursing in Chiba, Japan, has published A Challenge to Qualitative Analysis, Iksughon, Tokyo. This is the first qualitative nursing research methodology book by a Japanese author. She is the newly elected president of the Japan Academic Society of Nursing Education.

Tina M. Marrelli, RN, MSN, MA, Boca Grande, Fla., and Linda H. Kroll, PhD, have written Home Care Therapy: Quality, Documentation, and Reimbursement. Marrelli and Associates, Englewood, Fla. Ms. Marrelli is the recipient of the Arizona Association for Home Care's 1999 Geriatric Award.

Research

The University of California at San Francisco has announced its 1999 Geriatric Nursing Research Awards. The awardees are: Dr. George Vosch, RN, PhD, FAAN, professor and director of the University of California's Division of Geriatrics, who was presented with a Bellman award for his research; Dr. Howard B. Baker, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for his research; Dr. Jane F. Belden, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for her research; Dr. Christine Kovach, RN, PhD, FAAN, who was named as a fellow and will receive a $10,000 award toward her research; Dr. Howard B. Baker, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for his research; Dr. Jane F. Belden, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for her research; and Dr. Christine Kovach, RN, PhD, FAAN, who was named as a fellow and will receive a $10,000 award toward her research. The awardees are: Dr. George Vosch, RN, PhD, FAAN, professor and director of the University of California's Division of Geriatrics, who was presented with a Bellman award for his research; Dr. Howard B. Baker, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for his research; Dr. Jane F. Belden, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for her research; Dr. Christine Kovach, RN, PhD, FAAN, who was named as a fellow and will receive a $10,000 award toward her research; Dr. Howard B. Baker, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for his research; Dr. Jane F. Belden, PhD, RN, professor at the University of California, San Francisco, who was presented with a Bellman award for her research; and Dr. Christine Kovach, RN, PhD, FAAN, who was named as a fellow and will receive a $10,000 award toward her research.

Publications

Barbara Barnum, RN, PhD, FAAN, of New York, N.Y., nursing author, has written her first novel, The Last Call of Tilden, Vista Publishing, Longbranch, N.J. Ruth Davidson, RN, DNS, CS, FAAN, dean of nursing at the College of Nursing at the University of Massachusetts, Amherst, and Joane Giger, PhD, ED, CS, FAAN, professor of graduate studies at the University of Alabama at Birmingham, are co-authors of Transcultural Nursing: Assessment and Intervention, 3rd edition, Mosby Year Book, St. Louis. This edition further incorporates cultural variations found in different ethnic and cultural groups.

Jennifer Lillibridge, RN, PhD, senior research fellow at Deakin University in Melbourne, Australia, is a participant in a research agreement with Box Hill Hospital that facilitates research links between academic and clinical practices. Academic nurses and clinicians collaborate to develop and design research projects about current issues in practice, foster skills and knowledge transfer between the university and hospital to inform both education and clinical practice.

Kathleen L. Walker, RN, PhD, FAAN, associate professor of nursing at the University of Pittsburgh Medical Center in Pittsburgh, Pa., is the recipient of the American Psychiatric Nurses Association Award for Excellence in Research for her research on the mental health of women and adolescents who experience stressful life events.

Mary Radio Sipin, RN, MS, associate professor of nursing at Phaseone College in Philae, Nile, is the recipient of the 1999 Oncology Nursing Society Foundation/Bristol-Myers Squibb Oncology Division Community Health Research Grant for her study "Nature of Religion for Women with Breast Cancer in Central Appalachia.

Brian A. Wroblik, RN, PhD, doctoral student at the Frances Payne Bolton School of Nursing, Case Western Reserve University in Cleveland, Ohio, is the recipient of the Oncology Nursing Society/Frontier-Rouen Pharmaceutica Research Award for his study "Dysplastic Bonding in Prostate Cancer.”

Former dean advanced nursing education

Mary Kelly McIlvane, 89, former dean of the University of Illinois at Chicago College of Nursing, died July 30, 1999, in Naples, Fla. During her tenure as dean, 1967 to 1971, the College of Nursing gained nationwide stature, and the university added graduate education in nursing to its baccalaureate programs. Known for her strong leadership, political and organization skills, Dr. McIlvane helped spur the movement of nursing education programs from hospitals into de...
Lots H. Neuman, RN, PhD, a lecturer at the University of Maryland Study Group Center in Rockville, Md., has been honored by the Maryland House of Delegates and Prince George’s County Council for her contributions to nursing. She is the former chair of Prince George's Community College Department of Nursing in Largo, Md.

Carmen J. Portillo, RN, PhD, FAAN, associate professor at the University of California, San Francisco School of Nursing, has been appointed to the National Advisory Council for Nursing Research. Dr. Portillo is president of the National Association of Hispanic Nurses and is educational coordinator for the Center for Women’s AIDS Research and Clinical Training in Nursing at the University of California, San Francisco.

Kathleen Sanfor, RN, PhD, vice president at Memorial Hospital in Brentwood, Wash., has been named Buisest Writing Mother by Alzheimer’s Mother Magazine and the Kellogg Company. Dr. Sanfor, an author and television colonel with the Washington State Army National Guard, is a past editor at The American Journal of Nursing

Judith Shamian, RN, PhD, CHSE, the former vice president of patient services at Mt. Sinai Hospital in Toronto, Canada, has been named by the federal government to the top nursing position in her nation. She is executive director of nursing policy for the Canadian government.

Nancy Shields, RN, MSN, business unit director for Unict Inc. in Minneapolis, Minn., has been re-elected president of the Society of Gastroenterology Nurses and Associates Foundation for Education and Research. Nancy M. Shoop, RN, BSN, CRNP, an education and sales consultant in Indianapolis, Ind., has been elected vice president.

Ronny Skovbroten, RNC, BSN, MAN, RNCC, project director for the League of Catholic Women’s Nursing: Assessment and Intervention, 3rd edition, Mosby Year Book, St. Louis, Mo. This edition further incorporates the cultural variations found in different ethnic and cultural groups.

Leundrea R. Thompson, EdD, PhD, professor of nursing at the University of Saskatchewan in Canada, and Theresa George, PhD, associate professor of nursing at the University of Manitoba in Canada, are editors of International Perspectives on Women, Health and Aging from the Nursing World. The New York Select Publishing Ltd., Whitby, United Kingdom. This is a cross-cultural text, with authors from 13 nations.

Narumi Funahashi, RN, DSc, professor at Chiba University School of Nursing in Chiba, Japan, has published A Challenge to Qualitative Analysis, 8thgkou, Tokyo. This is the first qualitative nursing research methodology book by a Japanese author. She is the newly elected president of the Japan Academic Society of Nursing Education.

Tina M. Marrelli, RN, MSN, MA, B SNA, former chair of the University of Chicago Health System in Chicago, IL, has been appointed to the Medicare Management Unit of the University of Chicago.

 решение of the John Hopkins University, Baltimore, Maryland. A collaborative effort with The University Press of America, Inc. in Maryland. The book, titled "Assessment and Intervention: An Approach to Clinical Practice," is a comprehensive guide to the evaluation and treatment of physical and psychosocial health problems.

Jennifer Lillibridge, RN, PhD, senior research fellow at Deakin University in Melbourne, Australia, has been elected to serve on a board of directors at the Neuroscience Institute, which focuses on research on the mental health of women and adolescents who experience stress-related life events.

Mary Radio, RN, MS, associate professor of nursing at the University of Hawaii in Honolulu, is the recipient of the 1999 Oncology Nursing Society Foundation/Bristol-Meyers Squibb Oncology Division Community Health Research Grant for her study "Nature of Religion for Women with Breast Cancer in Central Appalachia."

Brian A. Wiberg, RN, PhD, FAAN, associate professor of nursing at the University of Pittsburgh Medical Center in Pittsburgh, Pa., is the recipient of the American Psychiatric Nurses Association Award for Excellence in Research for her research on the mental health of women and addictions who experience stress-related life events.

Mary O. Sullivan, RN, MS, associate professor of nursing at the University of Illinois College of Nursing in Champaign, Ill., is the recipient of the 1999 Oncology Nursing Society Foundation/Bristol-Meyers Squibb Oncology Division Community Health Research Grant for her study "Optimal Bonding in Prostate Cancer."

"May '99" page in June Journal, Bethesda, Md. 500 West North St., Indianapolis, IN, USA, 46204. Send mail to JuneJournalBethesdaLpna.

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Virginia Henderson Fellows top 200

Chuck Perkins, RN, MSN, CNS, and his wife, Kathryn C. Perkins, BSN, MBA, of Austin, Texas are the first married couple to jointly become Virginia Henderson Fellows. Mr. Perkins is an instructor in MSN clinical nursing at the University of Texas at Austin, and Ms. Perkins is the assistant chief nurse at the Bureau of Emergency Management and director of the State Trauma System for the Texas Department of Health.

Joanne K. Olson, RN, PhD, associate professor at the University of Alberta and a former Sigma Theta Tau International director, is the first Virginia Henderson Fellow from Canada. Joining Dr. Olson is her University of Alberta colleague Lillian Douglass, BScN, MSc(A), PhD, who is the historic 200th Virginia Henderson Fellow and second Canadian to enroll in the philanthropic society. Dr. Douglass is the associate dean of the undergraduate program. She currently serves as a Sigma Theta Tau International director.

Other notable new Virginia Henderson Fellows include: Lee Ann Boyd, RN, BSN, ARNP, Betsy Frank, RN, PhD, Peg Greaves, RN, ΜSc(A), F. H. University, ΜSc, Carol Jorgensen Huston, RN, MSN, DPA, Sharon Jacobs, RN, PhD, Joyce M. Kiser, RN, MSN, Martha Conrad, RN, MSN, CNS, C, Maureen Niland, RN, PhD, CNAA, and Larry D. T. Purnell, RN, PhD, FAAN.

Selected gift options

By Pamela Jones Davidson, JD

Many attractive charitable gift planning options exist that will allow you to support favorite charitable organizations while meeting your personal goals. Planned gifts often are contributions of assets rather than income. This may yield many flexible and donor-advantageous methods of support for beloved organizations, such as Sigma Theta Tau and/or its chapters. Planned gifts enable us to be philanthropic as we advance personal objectives in tax, financial, and estate planning.

Bequests are popular because you can leave a gift to charity after enjoying use of the assets during your lifetime. A bequest requires appropriate language in a properly executed will or testamentary trust. As most United States citizens die without wills, their charitable wishes unfortunately die with them. We hope you've prepared for your future and for your loved ones with estate planning. For those of you considering a bequest benefiting Sigma Theta Tau and/or your chapter, the appropriate language to employ is:

I give, devise and bequeath (the sum of $______) or a percentage, or residue of my estate) to Sigma Theta Tau International, Inc., Honor Society of Nursing, a nonprofit organization with principal offices in Indianapolis, Indiana, to be used in furtherance of its charitable mission in developing professional excellence in practice, research, scholarship, and leadership to enhance world health.

Gifts of retirement plan assets frequently are a first avenue of consideration for charitable giving, as inheritance of these assets can be quite costly for beneficiaries. Qualified retirement plans owned at death potentially have both deferred income tax and estate tax liability. As much as 75 percent or more of a plan balance can be eroded by the application of the two taxes. A better method might well be to designate all or a portion of the plan proceeds to charity by a change of beneficiary designation, by establishing a charitable remainder trust, the income from which supports a surviving spouse, children or grandchildren.

Appreciated securities are ideal charitable gift vehicles that provide an income tax deduction. They can be converted into higher income through a charitable life income plan without first paying capital gains taxes and investing an after-tax balance. These appreciated assets can be outright gifts that reduce estate size during your lifetime, and you — rather than your estate — receive the tax benefits.

You also may want to consider participating in the society's charitable gift annuity program or contributing life insurance policies. Please contact Linda Brimmer by phone: 1-888-634-7575 (U.S. and Canada toll free) or by e-mail: lbrimmer@uth.tmc.edu to explore how these options might affect your situation.

Virginia Henderson Fellows listed in this section are included in Sigma Theta Tau International's national Rolodex database. The database includes health-related and philanthropic opportunities from Dr. Brown.

Donor Activities

Dr. Dagmar Brodt joined Dr. Billye Brown, Sigma Theta Tau International past president, and other members at a luncheon in Naples, Fla. Dr. Brown presented information on the new Virginia Henderson Fellow program and the new chapter planned giving initiative.

Dr. Denise Heinemann, associate professor at Florida Gulf Coast University School of Nursing, hosted an evening reception at her home in Naples. Members learned about the society's philanthropic opportunities from Dr. Brown.

Dr. Brodt, left, and Dr. Billye Brown

 Collective wisdom

By Nancy Dickenson-Hazard, Jeanne Floyd

INDIANAPOLIS, September 1999—The Sigma Theta Tau International Strategic Planning Task Force has worked intensely this bimonth, involving hundreds of members into its process of asking, listening, analyzing and crafting ideas for the future. Strategic Plan 2005 represents the collective wisdom of Sigma Theta Tau International members, leaders of other nursing organizations, representatives of a variety of disciplines and health care consumers who shared their perceptions about the future of nursing and the society. Through a survey, focus group discussions, interviews, and responses to videotaped point-counterpoint dialogues, members identified compelling issues that affect nursing and the society. As the issues were isolated and summarized, members were invited to further examine their positions and provide feedback.

During the two-year process, the information directly influenced board decisions. Common elements of the mission, vision and goals of the society were clearly articulated by the membership in this unprecedented, organization-wide approach. The timeless qualities of humanity, love and honor and courage were reaffirmed. Members envisioned a society dedicated to blazing trails on behalf of nursing scholarship, research, professional development, technology and leadership. During the meeting of July 1999, the board of directors approved the plan.

Over the next five years, the organization will weave the goals and strategic actions into successful outcomes. As the society continues to listen, invite comment and use the talents and expertise of its membership, the plan will come alive and evolve to create a global community of nurses who lead in using scholarship, knowledge and technology to improve the health of the world's people. To realize this vision, Sigma Theta Tau International accepts as its mission the provision of leadership and scholarship in practice, education and research to enhance the health of all people by supporting the learning and professional development of our members, who strive to improve nursing care worldwide.

To fulfill this mission, members affirmed that the work of the society must be focused on seven goals that: develop members across the span of their careers; build strong chapters and foster collaborative leadership; advance global linkages at the organizational and member levels; prepare and position nurses to lead in diverse, complex, health-related environments; advance the scientific base of nursing practice through the scholarship of research; stimulate scholarly practice in the professional lives of members; and identify, secure and use a variety of resources that ensure the organization's future.

The Strategic Plan 2005 has captured the voice of the organization. This would not have been accomplished without the commitment, tenacity and long hours of work by the Strategic Planning Task Force. The society owes a debt of gratitude and many thanks to the members of this group, who include Eleanor Sullivan, Patricia Thompson, Daniel Pesut, Marla Salmon, Barbara Langner, Marlene Ruiz, Joanne Olson, Suzanne Prevost, Sue Harshman, Linda Britten, Marge Pike and facilitator Pat Turner.

A precedent has been set for eliciting perceptions and opinions, discovering critical issues and examining options. As the organization-wide plan is implemented, members will be invited to engage in dialogues about their profession and organization. Reports of systematic evaluations will be widely distributed. The next round of discussions are slated to occur in 2001. In two of the sessions, members will join a facilitated discussion, focusing on how the plan might be implemented within and across segments. Additional groups will illuminate the contributions that select segments of the membership are poised to make in implementing the plan and will include the Past Presidents' Fellowship, Virginia Henderson Fellows, inductees, those nearing retirement and retirees and members residing outside the United States. All members are welcome to participate in the discussions.

Clearly, the sphere of the society's influence and success rests in its chapters and members. A final note of thanks to each member who took the time to express thoughtful responses to the strategic planning queries. As a result, new organizational paths to nursing excellence were discovered. The five-year strategic planning process is designed to enrich the lives of members and thus the profession of nursing.
Virginia Henderson Fellows top 200

Chuck Perkins, RN, MSN, CNS, and his wife, Kathryn C. Perkins, BSN, MBA, of Austin, Texas are the first married couple to jointly become Virginia Henderson Fellows. Mr. Perkins is an instructor in MSN clinical nursing at the University of Texas at Austin, and Ms. Perkins is the assistant chief at the Bureau of Emergency Management and director of the State Trauma System for the Texas Department of Health.

Joanne K. Olson, RN, PhD, associate professor at the University of Alberta and a former Sigma Theta Tau International Fellow, presented MSN, CNS, Dr. Jorgensen Huston, RN, to jointly become Virginia Henderson Fellows. Mr. Dr. Dagmar Brodt is her University of Alberta and a former Virginia Henderson Fellow from Canada. Joining Dr. Olson is her University of Alberta colleague Lillian Douglass, BScN, MSc(A), PhD, who is the historic 200th Virginia Henderson Fellow and second Canadian to enroll in the philanthropic society. Dr. Douglass is the associate dean of the undergraduate program. She currently serves as a Sigma Theta Tau International director.

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Gifts of retirement plan assets frequently are a first avenue of consideration for charitable giving, as inheritance of these assets can be quite costly for beneficiaries. Qualified retirement plans owned at death potentially have both deferred income tax and estate tax liability. As much as 75 percent or more of a plan balance can be eroded between the application of the two taxes. A better method might well be to designate all or a portion of the plan proceeds to charity by a change of beneficiary designation, by establishing a charitable remainder trust, the income from which supports a survival spouse, children or grandchildren.

Appreciated securities are ideal charitable gift vehicles that provide an income tax deduction. They can be converted into higher income through a charitable life income plan without higher income through a charitable life income plan without tax consequences. A better method might well be to designate all or a portion of the plan proceeds to charity by a change of beneficiary designation, or residue of my estate) to (____ chapter of) Sigma Theta Tau International, Inc., Honor Society of Nursing, a nonprofit organization with principal offices in Indianapolis, Indiana, to be used in furtherance of its charitable mission in developing professional excellence in practice, research, scholarship, and leadership to enhance world health.

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Appreciated securities are ideal charitable gift vehicles that provide an income tax deduction. They can be converted into higher income through a charitable life income plan without tax consequences.
Gain professional experiences around the world!

If your journey to the future includes adventures in international employment, the World Health Organization (WHO) offers opportunities for Sigma Theta Tau International members.

Since short-term and long-term staff positions are available, you are able to apply for the position that best suits your personal and professional goals.

Benefit from once-in-a-lifetime opportunities to share your expertise as you gain valuable insights into the delivery of culturally competent care. Check all of the WHO position announcements.

Cast a wide net! Your qualifications may match a posting for scientist, technical, administrative services, managerial and information services, as well as nursing.

To learn more about the positions:

www.nursingsociety.org/career

(see opportunities at the World Health Organization)

Evolution of a Leader

Hussein A. Tahan, RN, MS, CNA

Manager, Clinical Pathway Program
Mount Sinai Hospital
New York City, New York

Education
BSN  American University of Beirut, Lebanon
MS  College of Mount Saint Vincent, New York

Hussein Tahan was already an emerging leader, when he left his native Lebanon to broaden his career in nursing in the United States of America. Through the Sigma Theta Tau International Leadership Extern Program (now expanded as Chiron: The Mentor-Fellow Forum), he continues to cultivate essential abilities. Now he is an influential nurse leader who manages Mount Sinai Hospital’s clinical pathway program in New York City.

Why pursue a career in nursing?

I was attracted to nursing to improve the health and well-being of others and to collaborate with other professionals to build healthier communities. For me, nursing starts at the bedside but opens doors for key administrative and leadership positions that positively influence health care delivery.

How have you evolved as a leader?

My current status as a nurse leader—and my continual development as one—is attributed to my perseverance, willingness to seek help when needed, when they think critically and express themselves, volunteer for community work, pursue new knowledge and ask for mentoring or advice.

How do you recognize potential leaders?

Potential leaders stand out when they take risks and seek help when needed, when they think critically and express themselves, volunteer for community work, pursue new knowledge and ask for mentoring or advice.

Call for Abstracts

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"International Collaboration in Nursing: The Influence of Ethics and Policy on Health and the Quality of Life"

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ENROLLMENT SURVEY

Fourth Quarter 1999

REFLECTIONS

48
Evolution of a Leader

Hussein A. Tahan, RN, MS, CNA

Manager, Clinical Pathway Program
Mount Sinai Hospital
New York City, New York

Education
BSN American University of Beirut, Lebanon
MS College of Mount Saint Vincent, New York

Hussein Tahan was already an emerging leader, when he left his native Lebanon to broaden his career in nursing in the United States of America. Through the Sigma Theta Tau International Leadership Extern Program (now expanded as Chiron: The Mentor-Fellow Forum), he continues to cultivate essential abilities. Now he is an influential nurse leader who manages Mount Sinai Hospital’s clinical pathway program in New York City.

Why pursue a career in nursing?
I was attracted to nursing to improve the health and well-being of others and to collaborate with other professionals to build healthier communities. For me, nursing starts at the bedside but opens doors for key administrative and leadership positions that positively influence health care delivery.

How have you evolved as a leader?
My current status as a nurse leader—and my continual development as one—is attributed to my perseverance, determination, ambition and positive thinking. Also, I wouldn’t have been able to accomplish what I have, if it were not for those nurse scholars and mentors I have met and continue to meet throughout the profession.

How do you recognize potential leaders?
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• Authors: Begin new line two spaces below title. Use initials, first names followed by surnames, title(s) and addresses(s). Underline presenting author’s name if more than one author.
• Aim: (New line three spaces below key words) State the main objectives/questions of the study or hypotheses to be tested

Method: Briefly describe design, procedures, data analysis, (indicate sampling technique, sample size)
• Results: (if available) Present only the main findings
• Conclusion: Include implications for nursing
• Keywords: List 5-7 words that give the gist of the study

Mail to:
Nursing/Midwifery Research Conference
P.O. Box 192
Kingsport 7
Jamaica, West Indies
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Presented by:
Department of Advanced Nursing Education
Mary J. Stevinson Building
Faculty of Medical Sciences
University of the West Indies
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In honor of Sigma Theta Tau International’s 75th Anniversary, popular artist Nancy Noel has generously offered society members the opportunity to purchase signed prints of her original oil painting, “Always.” Proceeds from the sale of the prints will be donated to the society’s nursing research endowment.

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