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I feel particularly honoured to be the first nurse from Latin America to be ISNCC’s President. I feel no weight of representing an entire region because I have the most wonderful friends and colleagues carrying it right along with me. But I do know what is it to take care of cancer patients in a general hospital, to interrupt treatment because the pharmacy has run out of funds, to work in conditions where occupational health is an afterthought.

These experiences shaped my nursing career. Further, my international work has helped me understand how to focus our nursing advocacy. I understand when, being the only nurse around the policy table, you may just have to be a little louder, but you persist. I will try to make my experiences an asset to the society’s goals of better serving our members’ needs and implementing our strategic plan.

Balancing priorities
At our recent conference in Panama, a good friend tried to explain to a colleague what she thought of me becoming President. She said, “We were moving along and then came Stella…” Yes, I tend to be passionate, get very excited, shake things up, and think very big. I am hoping I will make productive use of these characteristics on behalf of ISNCC.

We have several projects in motion that will be unveiled in the next few months, including our move to an annual conference to strengthen our research capacity, building initiatives and share evidence-based practices.

Globally, cancer care needs are numerous, but we heard from our members that we should promote prevention and palliative care, the extremes of the cancer care continuum. We will balance these priorities with the ongoing needs of treatment and rehabilitation.

Our global experience means that we will continue to position ourselves as pivotal stakeholders contributing to reach the United Nations’ targets for reducing cancer related morbidity and mortality, within the framework of non-communicable diseases. We have to ensure that the voices of cancer nurses are heard in the discussions of the post-2015 health agenda.

Meeting members’ needs
With immediate past president Greta Cummings, board members, committee members, international and regional partners, nursing associations, individual members, associates, and colleagues carrying it right along with us, we will work in conditions where occupational health is an afterthought.

Together, we will ensure that we remain ambitious, that we meet our members’ needs, and that we are the voice of cancer nurses worldwide. We would like to work for a healthy and productive 2015!

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Stella Bialous, ISNCC president
Increasing global access to palliative care: pushing boundaries

Robert Tiffany lecture

I have been privileged to meet many inspirational people over the years, and was fortunate to meet Robert Tiffany twice. As was written in the Independent Newspaper [1], “Robert Tiffany's legacy to cancer nursing is immense and his ideals will continue to influence and shape continuing care of patients” — indeed his influence lives on.

Another person who I worked with was Darme Cicely Saunders — her words, often quoted, are the essence of why I am involved in palliative care: “You matter because you are, and you matter to the end of your life. We will do all we can, not only to help you die peacefully, but also to live until you die. How people die depends in the memory of those who live on.”

Overwhelming need

This lecture is about pushing bounds. Increasing access to palliative care around the world can only be achieved through hard work and effort. As we strive to push boundaries, we see things happen; people, who previously had no access to palliative care, are receiving care.

There are sacrifices for all of us who work in this field, we have to step out of our comfort zones and take risks, but if we can make a difference to the lives of so many people.

There is an overwhelming need to push boundaries, thus increasing global access to palliative care?

Cancer rates are expected to grow by over 40% over the next 20 years with 70% of new cancer cases being in sub-Saharan Africa have advanced and incurable cancer, and where they present early there are inadequate diagnostic and treatment facilities, thus the need for palliative care is great.

Tiffany [2] there were 5.6 million deaths, 66% of them due to non-com municable diseases, and over 29 mil lion dying from conditions requiring palliative care [94% adults, 69% > 60 years of age and 6% < 15 years] (Conor and Sepulveda Bermendo 2014). In 2006 the provision of palliative care around the world was mapped (Wright et al 2008), categorising countries according to their level of palliative care provision. This mapping was revised in 2011, providing a global update and noting areas of significant palliative care development (Lynch et al 2013) along with ‘gap analysis’ of gaps in current care services.

Increasing access

These studies demonstrate the great need for palliative care provision around the world and the gaps in that provision — therefore there is a need to push boundaries to extend palliative care. There are various underlying principles to pushing boundaries to increase access to palliative care, including:

- that access to pain control and to palliative care is a human right (Brennan 2007);
- the need to collaborate;
- the need for a united vision and way forward so that the momentum is moving in the same direction;
- clear and strategic leadership;
- compassion and a belief in and passion for palliative care.

Challenges

In order to move things forward we need to be confident of who we are, as individuals, as professionals and as nurses. Nurses are at the forefront of cancer and palliative care and of the integration of palliative care into all levels of care.

They are in a unique position to show leadership, unity and compa nion in shaping palliative care in Africa, Europe, Asia and worldwide. However, there are many challenges including, among others:

- meeting the complex needs of those needing palliative care;
- limited/ lack of resources;
- lack of recognition of the nurses role and of palliative care;
- high burden of disease;
- the need for different models of palliative care service delivery;
- child-headed households;
- conflict and war zones;
- the fear of providing palliative care for children.

There are many different ways of developing palliative care, with the public health model for palliative care being a key driving force (Stensward et al 2007). This model recognises the need for policy, drug availability, education and implementation of services in the development of palliative care and more recently, the need for increasing the evidence base through research (Harding et al 2011).

In May 2014, at the 67th World Health Assembly (WHA) meeting in Geneva a resolution was passed on palliative care on Strengthening palliative care as a component of integrated treatment throughout the life course (WHA, 2014). This was the first time in the history of the WHA that a palliative care resolution has been discussed.

The resolution, developed under Panaman’s leadership and wide and encompassing membership. States have to report back in 2016 in progress on developing palliative care.

An essential component of the development and implementation of palliative care is the need for ongoing advocacy and to report back in 2016 on progress in developing countries (HRH, 2011). Thus there is a need for ongoing advocacy and research in this field to ensure that the needs of those with life-limiting conditions are met.

A paper was published in the Lancet in 2014, “Is palliative care a human right” [3]. In this study the Lancet Commission on palliative care was established with the aim of highlighting the importance of palliative care and identifying gaps in palliative care services.

The Lancet Commission report was published in 2015, “The Lancet Commission on palliative care: Developing a Global Agenda for Action” [3]. The report highlights the need for palliative care to be a public health model for palliative care (94% adults, 69% > 60 years).

This report highlights the need for palliative care provision around the world, which range from a delivery of modalities such as pain relief, hands-on clinical care, education and training or undertaking advocacy at the national and international level. Tiffany’s legacy to cancer nursing is immense and his ideals will continue to influence and shape continuing care of patients — indeed his influence lives on.

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References


Harding et al (2013) Cancer Control in Africa 6: The need to push boundaries in order to increase access to palliative care for all in need, in order to reduce suffering and improve care to be able to enable people "to live until they die". Can we push boundaries in order to increase global access to palliative care — in the words of President Obama — "Yes we can!"

It is not easy, and there is a cost to us as individuals, but for us to do so in order to step out of our comfort zone, to open our doors and to step out in faith, to be a difference, to be a voice, to be a change in the beginning, chaotic in the middle, and awesome in the end… Because in the end, it shows you a whole new world! Make an attempt (Manoj Arora). All of us can make a difference, wherever we are working, whether we are provid

Robert Tiffany lecture

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Figure 1: Paediatric palliative care provision around the world (Knapp et al 2011)
Asia accounted for 60% of the world population in 2008. It is the most diverse region in terms of ethnicity, socio-cultural practices, traditions, economic and political situations, life expectancies, and human development (United Nations, 2009).

Cancer is one of the biggest health problems in Asia, with an estimated increase in the incidence of cancer cases from 6.1 million in 2008 to 10.6 million in 2030 and cancer deaths from 4.1 million in 2008 to 7.4 million in 2030 (Ferlay et al., 2008). According to this report, all new diagnosed cancer cases in the world, 50% of cancer deaths occurred in Asian countries.

The changing cancer pattern in these areas is mainly due to changing lifestyles, increasing urbanisation, obesity, tobacco use, alcohol drinking, and increasing life spans with the proportion of people aged over 65 years being estimated to double from the current 7% by 2050 (Sankaranarayanan et al., 2014).

Asian countries are becoming more westernised and as such the pattern of cancer incidence could be the same as those seen in high Human Development Index countries with, for example, an increasing cancer burden associated with reproductive, dietary and hormonal factors (Yoo, 2010).

Asian countries are divided into four regions:

1. West Asia — Bahrain, Cyprus, Israel, Jordan, Kuwait, Oman, Turkey;
2. South Central Asia — India and Pakistan;
3. Eastern Asia — China, Japan, Korea, Taiwan;

Overall, the most common cancers in men are lung, stomach, liver, colon/rectum and oesophagus while in women are breast, lung, stomach, colon/rectum and liver cancers (Moore et al., 2008). Among the four Asian areas, the most common cancers in men and women are shown in Table 1.

It is a known fact that the cancer burden in Asia is continuing to increase. In spite of having varied levels of health services development, healthcare infrastructures, policies and investments, Asia is still home to half of the world’s poor population and this further contributes to the cancer burden. In most low-income and low-to-medium income areas, cancer health services are not adequately developed with few cancer prevention, diagnosis and treatment facilities and referral systems. Despite the growing burden of cancer, it remains a low priority in healthcare planning and expenditures (WHO, 2002).

Although there have been a number of discussions to address disparities in global control of cancer, it has been recognised that guidelines from wealthy countries cannot be implemented in low-income and low-medium income Asian countries because of resource constraints. Therefore, it was suggested at the Asian Oncology Summit in 2013 that what is needed is a resource-stratified guideline that could be applied in Asia that will provide clinicians with a framework to manage cancer patients and allow policy makers to plan appropriate resource cancer control (Kawashara et al., 2011).

In addition, the establishment of efficient control strategy in each country requires that cancer control programmes must be site-specific as well as country-specific.

**Strategies for control cancer**

As cancer incidences and cancer types and distribution of resource varies across Asian countries, cancer prevention and management needs to be tailored accordingly. In some Asian countries, cancer registries are not well-developed which could affect the effectiveness of prevention strategies being implemented (Lyerly et al., 2011).

However, there is a need for robust health promotion strategies that could influence sharing and exchange of cancer control activities through international collaboration by various organisations within the region. For example, as lung cancer is the most common cancer among Asian countries, primary prevention aimed at reducing carcinoma initiation included:

- raising public awareness of risk factors;
- anti-smoking programmes, increasing tax on cigarettes;
- bans on smoking on public places;
- limiting cigarette advertising;
- warnings in cigarette packets (Yoo, 2008).

It was noted that variation in risk factors depends on the level of economic development but overall, Asian countries face similar challenges in achieving effective cancer control. It was suggested that cooperation across the Asian countries be facilitated by developing a coordinated approach to cancer control programme to reduce the cancer burden (Long et al., 2010).

**Supportive and palliative care**

The burden of cancer in Asia is high, as most patients who are diagnosed have advanced disease not amendable to curative treatment (Payne, Cha, Davies, Poon, Connor, Goh, 2012). They are faced with uncertainty about their future, painful symptoms and psychological concerns. However, many Asian countries do not have palliative care services and professional training in palliative care. Only the high-income countries
First time conference attendee

Oncology nurse Ai Tanimizu from Toronto, Canada reflects on attending the ICCN – networking and mentorship.

I was very excited to meet a nurse leader in oncology from the UK and emailed her before the conference to introduce myself. Candy responded back to me right away with a very warm welcome. On the first day of the conference there was time dedicated to meet your mentor. Candy was very helpful in navigating me through the conference programme and providing me with tips on how to absorb the content from the conference as well as how to enjoy the conference at the same time. We went through the poster session during the welcome reception as she introduced me to her colleagues from around the world. Throughout the rest of the conference we would check in with me to see how I was doing. I felt that I had a personal career coach and I know that our mentorship relationship will go beyond the conference.

The ISNCC was an organisation in which I could envision my future. Each nurse that I met was passionate in what he or she was doing and was proud to be a nurse in oncology care. I kept thinking that one day, in the future I would like to be one of the leaders who can share their successes and challenging experiences and be a mentor introducing a novice nurse to all my international colleagues.

At the opening ceremony of the conference, the room was big and spacious and I didn’t know many people sitting around and I had no idea where to sit. The room was no longer overwhelming as I was busy saying my farewell to the new friends and colleagues I had met during the conference. It truly was a conference with nurses who shared their work, ideas, and passion about strengthening leadership, unity, and compassion in cancer care. After returning from the conference I was fully energised and felt even more passionate about oncology nursing. Ai Tanimizu, clinical nurse coordinator, Jenner Urgency, Princess Margaret Cancer Centre, Toronto, Ontario, Canada. ai.tanimizu@uhn.ca

RESEARCH COLUMN

Promotive interaction in the process of breaking bad news

Background
Currently, multiple or combined treatment tends to be used to treat cancer. Because of the complexity and variety of cancer treatment, there are increased demands on the medical and psychological knowledge of patients in order to protect patients’ rights under local medical law. In turn, effective communications between physicians and patients in informed consent is a challenge. Informed consent for cancer treatment means that disclosure of bad news to patients is an inevitable part of decision-making. At present, disclosure of bad news is governed by a local code of conduct for physicians. Nurses provide support to patients during and after disclosure, as well as in the process of decision-making.

Purpose
The purpose of this study was to examine the effect of nurses’ interventions on strengthening patients’ decision-making following disclosure of bad news. Process evaluation was used to investigate how such news is disclosed and to explore the roles of physicians, patients, and nurses in the process of disclosure.

Methods
This study used descriptive-inductive design. The participants (23 physicians, 21 patients, and 22 nurses) were recruited from eight medical institutions. Data was collected through semi-structured interviews, after obtained an informed consent from all participants.

Results
A descriptive process of disclosure of bad news to decision making (figure 1) consisted of five stages that focus on nurses’ roles in patients’ decision making. The process of disclosure of bad news to decision making consisted of five stages that focus on nurses’ roles in patients’ decision making (figure 1).

The actions of the nurse to promote the process of disclosure of bad news to decision making were any activity that facilitates advancement of the five stages process of disclosure of bad news, aiming at shared but self-directed decision-making by the patient. In addition, these actions taken by the nurse, consist of three elements such as determining signs of possible stagnation/suppression, correct appraisal of the situation surrounding both patient and physician and nursing measures appropriate to the situation regarding both patients and
physician (figure 1). Among the above three elements, the last two are activated by “four basic approaches of nursing” revealed in this study (figure 1).

Discussion
This study examined the “collaborative process of disclosure of bad news to decision making” in association with nursing practice. One of the main differences between this model and other models of disclosure is that the patient is taking an active role in the decision-making process.

The other is the collaboration among patients, physicians and nurses according to the principles of partnership, use of mutual resources, sharing of information, sharing goal of treatment, and broadening outlook on life.

The role of nurses in this process is believed to go beyond the passive approach stated in the problem-solving model. That is, to take self-directed actions for fortifying the patient’s promotive factors to facilitate decision making, and to elevate the patient’s powers of decision making in an early stage. This collaboration model can be adopted when physicians disclose bad news to patients and to facilitate treatment decision making. This model can also be used as a conceptual framework for multidisciplinary care aimed at enhancing the patient’s quality of life.

Yoshiko Teramachi and Ryo Inoue, School of Nursing, Faculty of Medicine, Oita University, Yufu City, Japan

EDUCATION COLUMN

ISNCC releases new tobacco position statement

In July 2014, the ISNCC released a new tobacco position statement. The Tobacco Taskforce under the direction of Linda Sarna and Stella Bialous, reviewed and updated the document. The knowledge development and dissemination portfolio committee provided review and comment.

The statement reviews the significant impact of tobacco use on health. It is estimated that by 2030 more than 8 million people will die annually because of tobacco use; 80% in developing countries (WHO, 2013). At least one dozen different types of cancers are causally related to tobacco use (US HHS 2014).

Nurses are essential to delivering evidence-based interventions to reduce tobacco use. Nurses must also continue to assume leadership in influencing tobacco control policies in their communities and countries. What can you or your organization do to distribute this report and enact the recommendations?

All ISNCC member organisations and individual members should consider endorsing and adopting this statement for educational and advocacy use in their own country, region, or organization. The complete report is available at www.isncc.org/news/182782/New-Tobacco-Position-Statement.htm

Recommendations

1) Nurses must be fully educated about the effects of tobacco products.

a) Nursing curricula should include information about the health effects of tobacco use and exposure to secondhand smoke, prevention of tobacco use, and science-based strategies for tobacco dependence treatment, as well as clinical practice opportunities, to ensure that all nurses are competent in tobacco control and providing evidence-based cessation interventions.

b) Practicing nurses should be provided with educational opportunities and continuing professional education regarding tobacco control and delivery of evidence-based cessation interventions.

c) Tobacco control is included in the agenda of scientific and educational nursing programmes.

d) Benefits of cessation of tobacco use in all clinical contexts (eg sex, age, type of disease) must be recognized and articulated as part of a nursing plan of care.

2) Nurses must support the implementation of the WHO Framework Convention on Tobacco Control (FCTC).

3) Nurses must be prepared to lead in tobacco control activities at local, national, regional and international levels, including participation in World No Tobacco Day celebrations (May 31 of every year).

4) Nurses must take an active role in initiating and supporting local, national and international tobacco control policy and legislation.

5) Nurses must ensure that tobacco use assessment, documentation and dependence treatment is an expected part of care in all cancer inpatient and outpatient treatment programmes and protocols, including addressing the stigma faced by many patients affected by a tobacco-related cancer and specifically highlighting the benefits of smoking cessation in the context of a cancer diagnosis.

6) Nurses must be prepared to discuss exposure to second hand smoke at home and workplaces with patients and families, including strategies to create tobacco-free environments.

7) Nurses and those entering the profession should become non-smoking role models for their own health and the health of their patients.

8) Nursing organizations should encourage and support cessation attempts by nurses and maintain or advocate for a tobacco-free workplace.

9) Nurses should collaborate with other healthcare organizations, public health, and tobacco-control groups to strengthen and fund tobacco control at all levels, including by increasing and supporting nursing research on tobacco use, prevention, cessation interventions, and reduction of exposure to secondhand smoke in people with and at risk for cancer.

Furthermore, ISNCC declares that all society meetings, scientific and social activities, be tobacco-free. ISNCC recommends to all organizations the endorsement of the no-tobacco policy at scientific meetings and other health related events.

Susan Beck, board member, ISNCC

References: