AONS News

A report on the first Asian Oncology Nursing Society conference

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ABSTRACT

The first Asian Oncology Nursing Society (AONS) conference was held in Thailand from November 22 to 24 2013. It was a significant milestone in the journey of the development of the AONS. The objectives of the conference were to facilitate opportunities for networking, collaboration and exchange of ideas with renowned leaders in Oncology Nursing, to facilitate sharing and collaboration of oncology nursing in Asia and to explore innovative strategies to strengthen the implementation of evidence-based practice in oncology nursing.

Key words: Asia Oncology Nursing Society, conference, oncology nurses

Introduction

The first Asian Oncology Nursing Society (AONS) conference was held in Thailand from November 22 to 24, 2013. It was a significant milestone in the journey of the development of the AONS. The objectives of the conference were to facilitate opportunities for networking, collaboration and exchange of ideas with renowned leaders in oncology nursing, to facilitate sharing and collaboration of oncology nursing in Asia and to explore innovative strategies to strengthen the implementation of evidence-based practice in oncology nursing.

There were three pre-conference workshops:

1. Advanced palliative care for cancer patients internationally hosted by the End of Life Nursing Education Consortium (ELNEC) International
2. How to improve adherence to oral cancer agents
3. Research development in symptom management supportive care hosted by the Multinational Association of Supportive Care in Cancer (MASCC).

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Conference report

The conference was extremely well organized and successful, with the facilitation carried out by the Organizing Committee of the 1st AONS. A total of 464 participants attended the conference, which exceeded what was expected. There were 134 participants from Thailand, the host country, 83 from China, 79 from Taiwan, 57 from Japan, 34 from South Korea, 23 from Indonesia, 15 from Philippines, 14 from Hong Kong, 7 from USA, 6 from India, 5 from Singapore, 3 from Australia, 1 from each of Canada, Turkey, Iran and the remaining numbers unknown. Forty invited speakers and 30 oral presenters from different countries gave informative presentations, respectively, at the plenary sessions and concurrent sessions. One hundred and fifty-seven posters were displayed at the conference. The invited speakers shared their valuable clinical nursing experiences in oncology nursing and findings of nursing researches with the participants.

The category of the presentations at the conference included quality in cancer care, innovation in practice and roles, symptom management in chemotherapy including fatigue, mucositis, and psycho-social problems, spiritual care, quality of life, safety in cancer care, information needs, survivorship, nursing education, oral care, cancer prevention and control, the patient's experience, evidence-based practice, Complementary and Alternative Medicine (CAM) in cancer care, surgical aspects of cancer nursing and roles of oncology nurse.

The keynote speakers at the conference involved a variety of topics related to oncology nursing. Professor Greta Cummings is from the Faculty of Nursing, University of Alberta, Canada and President of International Society of Nurses in Cancer Care (ISNCC). The ISNCC underwrote her presentation. Dr. Cumming's talk was titled: "Leadership Science in Health Services: Outcomes Research." In her presentation, Doctor Cummings stated that leadership is about action, and not position. She demonstrated this by giving two wonderful examples, Mother Teresa and Florence Nightingale, who truly took leadership roles as they executed practical actions. She explained the distinctions between management and leadership. Management is about doing things right and leadership is about doing the right things. There are distinctions between the kind of things managers and leaders do. Management is about reducing risk and keeping things standardized across an organization or across the processes. In comparison, leadership is when you want to create a preferred future that you cannot do when things are done exactly the same way today as yesterday. Leadership is about taking calculated and planned risks to actually achieve a preferred future.

Leadership is founded on emotional intelligence and is a very simple framework, which is easy to apply and easy to remember. It is based on four domains: Two relate to yourself and two are associated with how you relate to other people. Emotional intelligent leadership styles are in six different styles. Four of them create harmony, including visionary, coaching, facilitation and democratic resonant leaderships. The other two, pacesetting and commanding dissonant leaderships, create disharmony.

Dr. Cummings outlined the current situations of many health care settings and indicated that there are a number of issues to be dealt with in the health care environment, such as the increase of higher workloads in many hospitals around the world due to reducing the number of registered nurse positions. Other types of health care staff who do not have the same kind of education or training are hired in the place of the registered nurses. This has resulted in higher job strain, poor health of the nurses and patient safety issues.

Nurses have articulated their preferred future. They desire to give safe quality care that is based on the evidence. They want to be able to influence the patient outcomes, to give meaning to their work, to be effective in their work and balance their lives by giving priority to being with their own families at home when they are not working. Nurses also want, at work, to be part of collaborative multidisciplinary teams.

Dr. Cummings, her colleagues and other researchers have shown some important outcomes in the research performed in many health care settings relating to the impact of different leadership styles. The researches show the following outcomes:

1. Nurses who worked for dissonant leaders were always being driven by hard work without any appreciation. They reported their emotional distress at least once a week. Nurses who worked for resonant leaders who built relationships reported emotional distress no more than once a month. This research shows significantly different outcomes between these two groups of nurses.
2. Nurses who worked for resonant leaders reported that there were many opportunities to work collaboratively with their colleagues, whereas those nurses who worked for dissonant leaders reported that there was almost no opportunity to work in a collaborative group. Collaboration that did exist was very poor.
3. Nurses who worked for resonant leaders reported a significantly higher satisfaction with the supervision they received in the work place, but the nurses who worked for the dissonant leaders were very unhappy with the supervision they received.
4. Nurses who worked for resonant leaders, even when there was emotional distress, were still able to meet the patients' care needs. However, the nurses who worked for dissonant leaders found themselves in conflict. They reported less able to deliver quality care. As the emotional crisis became more frequent, the less able these nurses were to meet their patients' care needs.

The conclusions from this outcome research were as follows:

1. Leadership styles impact not only the nurses themselves but also their ability to give quality care.
2. When there is a very relational approach to leadership, nurses' job satisfaction increases significantly. With a task-focused leadership style, nurses' job satisfaction decreases significantly. Job satisfaction is an important marker for nurses' ability to give quality care. The mortality of patients increases when the nurses' job satisfaction decreases.

3. In regard to the work environment, nurses reported that they have much more empowerment when they work under relational leadership rather than the task-focused leaders. When the climate is better and doctors' and nurses' relationships are better, research is used more frequently as well as innovations.

When talking about leadership development, Dr. Cummings emphasized that if you plan to lead your team or lead your organization, you need to first lead yourself: Know yourself, your reaction, your relationships around you; find your mission, vision and your passion; take risks; develop and empower others; communicate effectively; and check your progress and results. Dr. Cummings finished her talk with these questions for the participants.

Dr. Judi Johnson from the US is a Nurse Consultant for her company, HealthQuest, and has held leadership roles in the Oncology Nursing Society (ONS) and ISNCC. She is also known as a co-founder of the American Cancer Society's cancer patient education course, *I Can Cope*. Dr. Johnson's presentation was titled "Cancer Survivorship Model." The number of cancer survivors has increased rapidly, shown by the US data she gave the audiences: In 1970, there were 3 million cancer survivors, in 2013 13.7 million and in 2020 there will be a projected 18 million. This same increase in cancer survivors is repeated across the world. Cancer changes people's lives forever, and it also changes their healthcare needs forever. Thus, as the number of cancer survivors increases so does their health care needs.

Dr. Johnson highlighted the issues of survivorship by telling the participants a true story about a long-term cancer survivor whose name is Susie. Susie was diagnosed with Hodgkin's disease in 1972 and, at that time, she was successfully treated for her cancer. Susie has lived as a cancer survivor for over 41 years. Dr. Johnson illustrated the phases of survivorship using Susie as an example to show how the impact of treatment for a primary cancer can cause problems for many years to follow even though the primary cancer had never recurred.

Phases of survivorship are divided into three phases:
1. ***Acute survivorship*** is the time when a person is being diagnosed and/or in treatment for cancer
2. ***Extended survivorship*** means the time immediately after treatment is completed, and is usually measured in months and up to 1 year
3. ***Permanent survivorship*** describes a longer period of time after treatment and is measured in years.

Dr. Johnson drew the audience's attention to different areas in which cancer survivors may have problems, such as physical, emotional, spiritual, mental, etc. As patients complete treatment and move from the acute to the extended phase, they need to be given a document that describes the pathology and other details of their cancer, the types of treatment received including dosages, side-effects and any other serious complications that delayed treatment. This document, in addition to being given to patients for them to keep as a record, is also intended for the patient's primary doctor and any other professionals providing follow-up care. Patients are often anxious, fear reoccurrence and continue with fatigue. In Susie's case, she experienced depression, fatigue and menopausal symptoms, along with some persistent pain due to her radiation treatment. Those caring for the cancer survivor need to add their responses to treatment to their survivorship record. As Susie moved from the extended phase to the permanent phase of survivorship, she gained a new sense of purpose and worked along side others to establish the National Cancer Survivorship (NCS) organization and became well known as a speaker and advocate for cancer survivors. However, it was also during that time, 19 years after her initial treatment, that Susie was diagnosed with breast cancer believed to be a result of her first radiotherapy. She chose to have bilateral mastectomy followed by breast reconstruction. Unfortunately, the prosthetic implants shifted several years later. Again, after 23 years, Susie was this time diagnosed with bladder cancer. That cancer was also explained as the result of her earlier radiation treatments. The bladder cancer was treated with chemotherapy, which, although successful, caused the lining of her bladder to become fibrotic and shrink to the size of a tea cup. Consequently, Susie now urinates every 2-3 h around the clock, disturbing sleep and any long-term activity. This demonstrates how a cancer survivor, although cancer free, can experience other serious secondary problems during the permanent stage of survivorship. For Susie, these problems continue when, at the beginning of 2013, she realized she was having shortness of breath that seemed to be getting worse. After having several tests and being examined by a cardiologist, it was determined that she had fluid in her lungs and the beginning of a heart condition. After 41 years, the radiation was once again to be determined to have caused the lung and cardiac problems. Cardiac surgery and a long period of cardiac rehabilitation has set Susie back on her feet and she once again is consulting and speaking out about cancer survivorship.

Judi next pointed out the need to create survivorship care plans as an integral part of providing quality cancer care. Survivorship care plans (SCP) have two components:
1. A treatment summary at the close of the acute phase that serves as a record that provides a historical past of the cancer survivor

2. A follow-up care plan that acts as a guide to providing present and future directives.

As care givers, we spend more time with cancer survivors and thus become more aware of their needs and post-treatment concerns. We are in a key position to develop and implement steps, and are most likely to serve as the prime communicator between oncology clinics and the cancer survivors.

Dr. Betty Ferrell, a professor and research scientist at the City of Hope Medical Center in California in the US, presented a "Palliative Care Model in Cancer Care" as her presentation that was supported by the ELNEC. She first introduced this ELNEC as an international project that was first founded in 2001. This program has its goal to train trainers in how to best care for dying people and incorporate palliative care within nursing care. Much has been accomplished since its inception in 2001, and now there are trainers from 77 countries across six continents who have created or further developed the project of caring for dying people in their local areas and better service are available to their dying patients.

Dr. Ferrell focused on five elements of care for dying patients:
1. Challenging the paradigm of care
2. Creating expertise and knowledge in palliative care
3. Fostering nursing presence
4. Expert attention to the body and relief of symptoms
5. A vision of the end of life as a spiritual experience.

Regarding the five elements, explained Dr. Farrell, nurses around the world are altering cultural practices and rethinking beliefs so that they can change the way that people die.

An excellent researcher in America wrote about the role of nurses as witnesses and moral agents. Nurses globally are advocating for better care for the dying. Nurses are doing that because they are moral agents. They are challenging the existing system. Nurses are first-hand observers; therefore, they can provide a voice for the patients who are too sick to speak for themselves. They perform many ceremonial roles, are expert witnesses and visionaries and, most importantly, are in the best position to care for people who are dying in cancer centers.

Nurses cannot know what they do not know and they cannot practice what they do not know. If nurses are not well educated in pain management, symptom management, bereavement support and caring for people in the last hours, the end result will be that patients will not die well. In the ELNEC project, an eight-model curriculum was developed, which, in turn, has been translated into many languages and has been applied in cancer centers in a number of other countries.

At the end of her presentation, Dr. Ferrell cited the following sentence:

"The legacy of Molokai (where people with leprosy were sent to die) began as one of indignity. We have the opportunity to end the legacy with dignity"

Dr. Patsy Yates, a well-known nurse researcher from Brisbane Australia, delivered very interesting information to the audience. The Cancer Nurses Society of Australia supported Dr. Yates' talk. In her presentation, Dr. Yates spoke of certain biomarkers being associated with patient symptoms. She explained that certain biomarkers are identified in specific tumor types and thus can help identify risks for specific cancers. For example, BRCA1 and BRCA2 genes are used to identify women who are at the higher risk of breast cancer. A higher than normal prostate-specific antigen (PSA) test for prostate cancer can identify tumor growth in a man's prostate.

Biomarkers' role has also been examined to understand variations in symptomology. Dr. Yates explained how biomarkers have helped in understanding why people respond differently when they have the same cancer and have received the same cancer treatments for their cancer.

She explained that certain proteins are associated with high or low expression of symptoms. What this means is that identifying certain biomarkers may predict whether or not the patient has a high risk of symptoms, such as fatigue or pain. There is thought that there is actually an activity at the biological level. The reason for this may be that proteins in certain genes or mutations in these genes are associated with particular neuroendocrine pathways, which, in turn, are responsible for producing these varied symptom experiences.

These findings suggest that the role of clinical nursing of tomorrow could expand to include investigations to identify patients who have a genetic make-up that place them at risk and to guide nurses in making patient education plans that include discussion of risk of symptoms. Such clinical information will assist in decision making regarding symptom management strategies.

In her presentation, Dr. Yates also highlighted the symptom clusters that patients often report. The definition of

symptom clusters is when a person has multiple symptoms that relate to disease, treatment, environment and patient characteristics. For instance, fatigue often occurs with pain and sleep disturbance, nausea is associated with vomiting and depression can be connected to anxiety. Symptom cluster research that has been performed in nursing has helped nurses better understand why patients have several symptoms at the same time, identify common underlying mechanisms, guide assessment, assist in decision making regarding symptoms and predict risk for various symptoms occurring.

Dr. Yeur-Hur Lai is from the School of Nursing and College of Medicine at the National Taiwan University in Taipei, Taiwan. She is a well-known nurse researcher and leader in the community of international nursing. In her presentation entitled "Role of Nurses in Cancer Pain," Dr. Lai gave information related to pain, pain assessment, multidimensional nature of the pain and nurses' roles and positions in cancer pain management. There are factors besides having the right medicine, with the right dose, at the right time and for the right person along with knowing their side-effects and effectiveness. These other factors include:

1. Patients may suffer more than the pain itself. It could be fatigue, sleep disturbance, eating disturbance, depression, uncertainty or even feel that they are not being trusted for being truthful about their pain.
2. Health Care Providers' knowledge, thoughts, attitudes, beliefs and goals play a part in patients' pain managements and may easily add suffering to patients, especially when health care providers do not trust their patients' pain assessment.

Dr. Lai recommended that nurses take on the responsibility of assuming an important role in pain control. This is done by several ways, including:

1. Identify patients who are experiencing pain
2. Assess patients' pain and how it impacts their function
3. Involve patients, family caregivers and other health care professionals to develop timely and appropriate interventions for the pain
4. Prevent, monitor and control adverse effects
5. Make it a goal to decrease the patient's pain intensity and interferences
6. Provide counseling for addressing the patients' concerns
7. Apply a continuity of care concept in pain management
8. Pain control is part of cancer care, not an independent event
9. Integrate giving medicine for pain with non-pharmacological interventions
10. Promote integration of function and comfort with quality of life.

For the final session of the conference, representatives from the nine Asian countries' oncology nursing societies in AONS gave presentations. Each presenter gave a description of oncology nursing in their country along with comments about their societies. The next bi-annual conference of the AONS will be held in Korea in 2015. The Korean Oncology Nursing Society will be responsible for coordinating the conference.

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