

Creating an Oncology Nursing Elective

by

Shellie Steidle
B.S.N, University of Victoria, 2000

A Project Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF NURSING

in the Faculty of Human and Social Development

© Shellie Steidle, 2008
University of Victoria

All rights reserved. This project may not be reproduced in whole or in part, by photocopy or other means, without the permission of the author.

Supervisory Committee

Creating an Oncology Nursing Elective

By

Shellie Steidle
B.S.N, University of Victoria, 2000

Supervisory Committee

Dr. Gweneth Doane, Supervisor
(Faculty of Graduate Studies/ School of Nursing)

Dr. Kelli Stajduhar, Departmental Member
(School of Nursing)

Abstract

Supervisory Committee

Dr. Gweneth Doane, Supervisor
(Faculty of Graduate Studies/ School of Nursing)

Dr. Kelli Stajduhar, Departmental Member
(School of Nursing)

This project describes the conceptual journey of creating an oncology nursing elective for BSN students. The journey begins by defining the specificity of oncology nursing care through a multiplicity of ways of knowing. The journey continues by exploring transformative, narrative, and embodied teaching pedagogy. Lastly, the journey ends by combining the specifics of oncology nursing with a variety of pedagogical approaches. A visual representation of the foundational concepts is provided along with a conceptual blueprint for the course and a course outline.

Table of Contents

Supervisory Committee.....	ii
Abstract.....	iii
Table of Contents.....	iv
Acknowledgements.....	vi
Introduction.....	1
Background Information.....	2
Part I – Defining Oncology Nursing.....	3
Nursing as a Discipline.....	7
Philosophical and Theoretical perspectives.....	8
Ways of Knowing.....	9
Embodiment.....	11
Specificity of Oncology Nursing.....	13
Family Centered Care.....	14
The Art of Oncology Nursing.....	18
Praxis.....	20
Intuition.....	21
Personal experience.....	22
Personal Knowledge in Oncology Nursing Practice.....	23
Reflexivity.....	24
Assumptions and values: Health and healing.....	25
The Ethics of Oncology Nursing.....	25
Nurses’ Moral Agency.....	25
Values and Beliefs.....	26
Competencies/ Practice standards.....	26
Ethical Issues in Oncology Nursing Practice.....	27
The Science of Oncology Nursing.....	27
Pathophysiology.....	28
Treatment Modalities.....	28
Nursing Skills and Interventions.....	29
Sociopolitical Knowledge and Oncology Nursing Practice.....	31
Part II – Exploring Pedagogy and Methodology in Nursing Education.....	34
Historical Context and Influence on Nursing Education.....	34
Emerging Pedagogies.....	38
Transformative Learning.....	39
Transformative Approaches and Nursing Education.....	41

Narrative Pedagogy.....	41
Embodied Teaching and Learning.....	44
Embodied Knowing.....	48
Embodied Teaching and Learning as a Pedagogical Approach....	49
Part III – Combining Oncology Nursing with Pedagogy.....	50
Oncology in Nursing Education.....	51
Creating a Course Outline.....	54
Course Content.....	55
Developing Learning Activities.....	56
Cancer Care Journal.....	56
Community Experience Summary.....	57
Poster Presentation.....	58
Student-led Seminar.....	58
Future Recommendations.....	59
Conclusion.....	60
References.....	62
Appendices.....	70
A: The Foundational Concepts of the Oncology Nursing Care Course.....	71
B: Oncology Nursing - Course Outline.....	72
Table B1 – Conceptual Blueprint.....	74
C: Sample Student Guide: Breast Cancer Care.....	78
Case - Mrs. B.....	79

Acknowledgments

This is my opportunity to formally acknowledge, in writing, the people who have provided me with what I needed to keep moving forward. I would like to thank my husband, Al, and my two children, Luke and Hanna, for their love and encouragement, without them I would be lost. Thank you to my parents for their unwavering support and my friends and colleagues for sharing their experience and wisdom. Finally, to Gweneth and Kelli, who provided me with a delicate balance of support and structure but also the freedom to create and explore.

Creating an Oncology Elective

During my eight years as a nurse educator, I recently began to take notice of the lack of education student nurses receive in relation to oncology nursing. Although I recognize that it is impossible to teach all there is to know about nursing in a four year degree program, the sheer volumes of people diagnosed and treated with cancer per annum should correspond with a significant portion of nursing education. An estimated 159,900 new cases of cancer and 72,700 deaths from cancer will have occurred in Canada in 2007 (Canadian Cancer Society/National Cancer Institute of Canada, 2007). Cancer care is complex and transcends boundaries that include age, gender, and culture. Nurses and student nurses are in a unique position to care for people with cancer and their families in a multitude of settings, from home care to acute care. It can be argued that all nurses will care for someone with cancer at sometime during their career, regardless of the setting in which they work (Pope, 1992; Rushton, 1999a; Sarna & McCorkle, 1995). Unfortunately, the amount of oncology content in nursing programs is limited (Pierce, 1992; Rushton). This limitation can possibly be attributed to the generalist nature of BSN programs and/or the lack of space to add new concepts to a curriculum that is already bursting at the seams.

One of the biggest gaps in knowledge occurs when a student is caring for someone living with cancer and the student is unsure of how to relate to their patient and the patient's family. Due to this lack of knowledge, students find it difficult to explore their patients' experiences and therefore hesitate to engage in dialogue due to a fear of the unknown, or of doing or saying the "wrong thing". Students generally recognize that

'being present' is sometimes more important than providing information, however, their lack of knowledge related to the human experience of cancer can be stifling.

This project aims to bridge some of these gaps in nursing education by creating an Oncology Nursing Elective that will be offered to third year nursing students at the University College of the Fraser Valley (UCFV), centering on the human experience of living with cancer. To begin, a definition of oncology nursing will be presented followed by an exploration of nursing education. Lastly, by combining the definition of oncology nursing with nursing education, an oncology nursing elective will be created that has the potential to influence the ways in which the next generation of nursing cares for cancer patients and their families.

BACKGROUND INFORMATION

At present, the UCFV BSN Program does not offer nursing electives as part of their program. Students are required to complete three electives; none of which are nursing electives. In the spring of 2007, a team of nursing faculty members began the process of investigating the possibilities of injecting nursing electives into the program and subsequently taking the place of one of the three non-nursing electives. As part of the investigation process, nursing students at various points in the program were surveyed to assess interest and guide further course development. The development of an oncology nursing course as an option was well supported by student responses. It was at this time that I offered to develop an oncology course, believing this would coincide well with my requirement to complete a Masters of Nursing (MN) project; one that I had hoped would incorporate both oncology and nursing education. The planned implementation of the oncology course is scheduled for the fall of 2008. Although not included as part of this

project, processes and procedures required for UCFV undergraduate course approval are being completed in tandem with the development of this project. The approval process of course development will be separate from this project due to the complexity of the process and the inability to control timelines.

Before exploring the definition of nursing, the specificity of oncology nursing practice, and different ways of knowing, one important question can be asked, “Why is defining nursing and more specifically, oncology nursing, an important step when creating an oncology nursing elective?” In an attempt to bring all of the ideas and concepts presented in this project together, I have created a visual representation (see appendix A). The petals of the flower represent the specificity of oncology nursing practice, providing room for more petals to grow and allowing some petals to fall in response to changes in practice and the development of new pieces of knowledge. The stem and leaves of the flower represent the pedagogical approaches and the mode of translation. For example, the stem represents how the knowledge (nourishment) from the soil connects with the flower and supports the growth of oncology nursing practice. The sun and rain cloud represent the learning activities or the action and energy that are required to grow and learn. The pot of soil represents the ways of knowing that inform and nourish oncology nursing practice. Central to the flower is the patient and family, without the centre, the flower would not continue to grow and expand.

PART I – DEFINING ONCOLOGY NURSING

Defining oncology nursing is not a simple task. In comparison, defining nursing as a whole discipline is equally as challenging. Epistemological and ontological questions continue to swirl in nursing literature. Polarity abounds as nurses attempt to position

themselves within a variety of paradigmatic approaches and philosophical viewpoints. In the paragraphs to follow, nursing literature is explored while in search of the defining characteristics of the nursing discipline. The specificity of oncology nursing practice will be presented through the description of dominant themes and concepts found within oncology nursing practice.

I would like to begin by telling a story from my own practice that I believe exemplifies some of the essential elements of oncology nursing knowledge which centers on the human experience of cancer.

I was working in the gynecologic cancer clinic as an APN (Advanced Practice Nursing) student completing my final practicum and final semester of studies. My involvement in the clinic was somewhat of an experiment to see if the APN role could result in positive patient outcomes. I looked through the patient list to see if I could spot a patient with complex needs, someone that may require the skills of an APN. I noticed a young woman (29 years old), Jamie, scheduled as a new patient with a hydatidiform mole. These are quite rare and I was interested to learn more. As I looked through her chart I transferred relevant pieces of information onto my assessment worksheet - pain, social history, previous medical problems, and diagnostic results. From this information I had a sense of where my assessment should proceed but was also aware that inevitably Jamie would lead the way and trusted that my both my intuition and clinical reasoning skills based on past experience would guide me to ask the right questions. I looked at the ultrasound pictures and was both amazed and troubled by the image of what began as a planned pregnancy and somehow turned into a mass of abnormal cells. This young

woman was not only dealing with the loss of what she thought was her child but also a diagnosis of cancer. I knew that this young mother of a 7 year old boy would require chemotherapy due to her continued elevations of HCG (human chorionic gonadotropin). I recognized that these continued elevations (despite having the mass removed) indicated that the mole had transitioned into a gestational trophoblastic neoplasia. The chemotherapy protocol would require inpatient hospital admission and I made a note to ask her about child care for her son. After the oncologist had examined Jamie, she brought me into the room for the discussion about treatment. I was then left alone with Jamie to complete my own assessment. After having noticed a previous history of depression I had stuck a 'Patient and Family Counselling' services information sheet along with the chemotherapy sheets I had brought into the room and made a note to explore this as an option with her. She sat quietly alone and I wondered about what kind of supports she had to help her through the tough road ahead. I know that sometimes when a patient is quiet it means "I am in shock, I am processing, and I don't know what to say." But in this case I sensed that her quiet meant "I am settled with what is happening and I am ready to move forward." I began by exploring her understanding of what was happening. Jamie quietly explained to me all the research she had done prior to coming to the cancer centre and was quite prepared for the next step. The next step was admission to the hospital, a hospital unfamiliar to her and away from her own community. I allowed the conversation to flow, only interjecting to clarify with questions related to pain control, social support, depression, and chemotherapy. I made an agreement to visit her in hospital the

following week. I am always curious about patients who come to the centre alone. Why? Wasn't there anyone to come with you? Or, did you choose to come alone? I explored this with her and uncovered the fact that she was the anchor in the relationship with her partner (who was anxiously waiting in the car) and he was having a difficult time with the diagnosis. Jamie had made the choice not to tell her son, not wanting to upset him. I wondered if I would make the same choice under the same circumstances. I thought about my two children at home and my stomach knotted. She had made arrangements for her parents to care for her son during her hospital admissions for the chemotherapy treatments. I explored her history of depression; she attributed these episodes to relational issues and post-partum depression. Jamie was seeing a community counsellor twice per week and was satisfied with her progress and the relationship she had developed. Knowing that cancer treatment can sometimes devastate people financially I asked her about her job security and ability to carry on financially. She was secure at the moment but recognized that there was potential for problems up the road. After seeing Jamie I conferred with the oncologist and informed her of my findings. We both agreed that it would be a good idea for me to follow her throughout her treatment.

The intent of telling this practice story was to exemplify some of the ways of knowing essential to oncology nursing practice. Practice stories such as this can also illuminate the essence of oncology nursing with a focus on understanding the human experience of cancer. The epistemological question, "What do nurses need to know?" will be explored and specifically focused to include "What do oncology nurses need to know about the human experience of living with cancer and how is this knowledge utilized in practice?".

Nursing as a Discipline

Before defining oncology nursing, I find it is necessary to begin by broadening the discussion to the discipline of nursing as a whole. Longstanding debates in nursing surround the issue of nursing as a discipline. Is nursing an academic discipline or a professional discipline (Donaldson & Crowley, 1978/2002)? Is nursing both a discipline and a profession (Parse, 1999)? Closely connected to these questions are issues related to the epistemology and ontology of nursing. For example, epistemology centers on what nurses need to know in order to nurse and ontological questions center on what we know is nursing. Smith (2000) contends that historically nurses argued against the idea that nursing is an academic profession due to the lack of unity in theory, paradigm, and metaparadigm. However, some may argue that nursing does have a clearly delineated metaparadigm including the concepts of (1) person (2) environment (3) nursing, and (4) health (Monti & Tingen, 1999/2002; Thorne et al., 1998). In addition, Smith posits that nursing is not an academic discipline due to the lack of power and self-control, referring to the power and control over its own destiny. Conversely, Smith also contends that there are nurses who believe that nursing truly is an academic discipline due to historical developments, scientific knowledge, and clarity within the domains of research, practice, and education. In their seminal piece of work, Donaldson and Crowley discussed their views on the discipline of nursing. These writers place nursing within the domain of professional disciplines due to the practical aims of developed theories that are both descriptive and prescriptive. Parse presents nursing as both a discipline and a profession. She states, "The goal of the discipline is to expand knowledge about human experiences through creative conceptualization and research" (p. 275). Further, Parse states that "The

goal of the profession is to provide service to humankind through living the art of the science” (p. 275). Parse’s description and differentiation speak to both the art and the science of nursing. Further examination of the philosophical and theoretical perspectives of nursing may reveal greater clarity within the context of epistemology and ontology.

Philosophical and Theoretical Perspective

What is nursing and what is it that we need to know to nurse? At first glance these questions appear quite harmless. However, these paradigmatic questions have caused separation within the nursing community for years. According to Monti and Tingen (1999/2002) the question of which paradigm should guide nursing science has extended past twenty years and remains unresolved. Cody (2000) reveals that the anticipated paradigm shift in nursing has appeared in nursing literature for over thirty years. Where nursing was once defined as a supportive practice to medicine and subsequently empirically driven; modern thought surrounding nursing’s paradigm has shifted toward plurality and includes interpretivism along with empiricism. Therefore, it could be argued that ‘the shift’ has already shifted. The actual definition of ‘paradigm’ is also debatable. Parse (1999) explains paradigms as theories and frameworks. Whereas alternative definitions of a paradigm include terms such as: world view, shared values and beliefs, and scientific perspectives (Monti & Tingen).

The struggle towards defining a dominant paradigm in nursing has transitioned from a debate over “empiricism versus interpretivism” toward a question of “pluralism versus dualism”. For example, Pitre and Myrick (2007) explain that a dualistic approach to epistemological certainty presents an ‘either/or’ position. This position promotes a dichotomy and separation throughout the nursing community. In comparison, a pluralistic

approach recognizes value in a multiplicity of nursing paradigms. Both positions recognize more than one paradigm exists in nursing. The debate, however, centres on how to either embrace all paradigms or align yourself and your nursing practice with one specific paradigm.

Although the nursing community continues to disagree upon one dominant paradigm, I am aligning myself with the belief that there are multiple ways of knowing in cancer nursing care and therefore I will use a multiple paradigm approach when creating an oncology nursing elective. Moving the 'lens' and focusing on different ways of knowing can reveal salient aspects that formulate the whole 'picture' of oncology nursing and the human experience of cancer. In Carper's (1978/2002) seminal piece of work on ways of knowing in nurses, knowledge is categorized into four domains. When combining these categories and other ways of knowing with significant concepts of oncology nursing, the epistemological essence of oncology nursing care can be explored.

Ways of Knowing

I have illustrated the multiple ways of knowing in oncology nursing practice as being represented by the soil in my potted flower (see Appendix A). The multiple ways of knowing combine together to form a rich and nourishing mixture. From the soil a flower emerges, each petal representing a unique way of knowing that inform oncology nursing practice. Although the petals are separate they all come together and overlap in the middle of the flower to circle the patient and family. The discussion to follow will explore the contents of the soil and the unique design of each petal of the flower.

One way to uncover and explore the essence of oncology nursing is to illuminate and examine some of the dominant themes and concepts found in oncology nursing

practice. In Carper's (1978/2002) piece of work, she distinguished between fundamental patterns of knowing in nursing. Carper describes these patterns as "essential for the teaching and learning of nursing" and "...involve critical attention to the question of what it means to know and what kinds of knowledge are held to be of most value in the discipline of nursing" (p. 22). The patterns she identified included: (1) esthetics: the art of nursing, (2) personal knowledge, (3) ethics: moral knowledge, and (4) empirics: the science of nursing.

To follow, I will present a variety of concepts found within oncology nursing practice that can be loosely categorized into Carper's (1978/2002) patterns of knowing. I will also introduce the concept of embodiment as it relates to both the experience of patient and nurse as another way of knowing. Finally, I will also discuss sociopolitical knowing as another essential element that informs oncology nursing practice. The purpose of this process is to identify some of the essential topics or concepts to include when developing the Oncology Nursing course. This discussion is not an exhaustive account of oncology nursing knowledge, simply an illustration of the possibilities found within each way of knowing. Although I have chosen to use Carper's work as a framework for my discussion, I recognize there are limitations and seize these as opportunities to add more ways of knowing and to expand on the original concepts to include current nursing literature and concepts. For example, throughout my graduate studies I have often utilized feminist theory as a lens to deconstruct the cancer experience and in doing so I have discussed some of the sociopolitical constructs of illness. In Carper's work, sociopolitical knowing is not conceptualized as a way of knowing nor is it included in any other defined way of knowing by Carper. I believe it is important for nurses and nursing students to

understand how society and politics (ex. Cultural differences, sexual orientation, gender, and the health care system) influence and inform the cancer experience. Sociopolitical knowing has the potential to expand nursing practice and includes societal and political arenas as well as focusing on individual clients and their families. Another limitation to Carper's work is the focus on empirics as scholarly inquiry or what Carper describes as the science of nursing. I have chosen to include both empirical and interpretive paradigmatic influence within the way of knowing informed by scholarly activity.

Embodiment

As I believe the concept of embodiment as another way of knowing is threaded throughout all of the content to follow (including Part II), I would like to spend some time exploring this concept further before discussing the specific themes and concepts found within oncology nursing practice. As Wilde (1999) suggests, embodiment is not a theory or set of theories but rather a changed way of thinking about and knowing human beings that is in opposition to our traditional dualistic way of thinking in relation to mind and body. Lawler (1991) explains that our understanding of the body has been constructed as not one entity but as separate mind and body. Lawler argues that what she terms as "the problem of the body" is partly due to the composition of knowledges which excludes it. Although Lawler believes that nurses do in fact accommodate the body, it is done so in an implicit way and this leads to theoretical difficulties for nursing as a discipline and in its relationships with other disciplines. Wilde is clear that although the concept of embodiment can be located in nursing and other disciplines, the concept lacks synthesis of literature in defining common themes and understandings. For purposes of clarity, I am aligning myself with Paley's (2004) distinct yet connected notions of embodiment within

the discipline of nursing. First, Paley describes ‘the social construction of the body’; this notion contends that the body is a social, historical, and cultural being. Second, the notion of ‘phenomenology of the body in illness; this notion explores the patients’ experience of body and illness. Third, the notion of ‘the body in clinical cognition’; this notion is related to nurses embodied knowing in clinical practice.

An example of the social construction of the body can be found in the breast cancer experience. For example, in their phenomenological study, Langellier and Sullivan (1998) explore the narratives of women with breast cancer. They uncovered four clusters of meaning: (1) the medicalized breast, (2) the functional breast, (3) the gendered breast, and (4) the sexualized breast. These researchers explain that the medicalized breast conceptualizes the breast as an object and a diseased body part. The functional breast supports breast feeding and the usual activities of life, work and play. The gendered breast is the feeling of wholeness and the visual signal of femaleness. The sexualized breast is related to feelings of being sexually desirable and sexually desiring. These findings exemplify the societal constructs of women’s breasts and may provide a greater understanding of what the loss of a breast may represent to some women. The notion of the body as socially constructed can also be applied to other illnesses and cancers and certainly recognizing cultural and social differences in relation to the body is an important aspect of cancer care.

The patient’s experience of body and illness make up the second notion of embodiment. When faced with illness (and certainly cancer), some people may feel their bodies are adversaries or feel betrayed by their body (Wilde, 1999). McDonald and McIntyre (2001) make the assumption that “...reality is constructed through both our

experiences of a life lived in a body, and through our interpretation of those experiences, and that it is through these experiences and the interpretation of them, that we are able to generate understanding, and attribute meaning to our lives” (p. 234). These authors write of both the embodiment of the patient and the nurse and explain that by objectifying the bodily experience of illness, this then creates a sense of distance and control between the patient and the nurse. When the nurse is inflicting pain or suffering, objectifying the body may result in the nurse feeling less vulnerable (McDonald & McIntyre).

The third notion of embodiment, nurses embodied knowing in clinical practice will be explored further in part II during the discussion on pedagogies. At this point, the first two notions of embodiment: (1) the body as socially constructed and (2) the experience of body and illness will be threaded throughout the discussion on the specificity of oncology nursing.

Specificity of Oncology Nursing

As with most areas of nursing, the patterns of nursing knowledge are contextual in that the current values, beliefs, and standards of nursing practice within the area guide how we practice and provide the questions and phenomenon for which our nursing researchers attempt to explain and explore further. Further, it is recognized that there is a cancer care continuum within oncology nursing practice that also impacts nursing knowledge and a variety of nursing practice settings, such as health promotion clinics (e.x. teaching breast self exams) and hospice nursing care. The oncology nursing ‘lens’ may focus on different aspect of practice and ways of knowing in response to these differences. To begin, an exploration of the art of oncology nursing will be explored. Esthetics or the ‘art’ of nursing will lead to personal knowledge, followed by the ethics or the moral

dimension of oncology nursing practice and lastly, nurses way of knowing through scholarly activity.

By no means are the topics presented in each of the following domains exclusive or exhaustive. I acknowledge and embrace the fluid nature of nursing practice and present the following concepts and topics as merely a guide, recognizing some of the most salient points of oncology nursing practice at the present time. These topics are supported by current oncology nursing literature and my own nursing practice experience. I believe it is important to emphasize the reciprocal nature of these different ways of knowing. Fawcett, Watson, Neuman, Hinton Walker, and Fitzpatrick (2001) state that "...each pattern of knowing is an essential component of the integrated knowledge base for professional practice, and that no one pattern of knowing should be used in isolation from the others" (p. 117).

At the centre of my visual representation of the concepts found within this project is the patient and family (Appendix A) and without this centre the petals of knowledge would fail to grow. Family centred care is essential to oncology nursing practice; spreading throughout all ways of knowing and forming a connection. For example, some of the concepts discussed in the ethics of oncology nursing are closely linked with the notion of family centred care. For this reason, I plan to first spend some time discussing this concept before discussing the specifics of oncology nursing.

Family Centered Care

The effect of a cancer diagnosis in a family can send ripples throughout everyone's lives. The potential for role changes, financial difficulties, intimacy and sexuality issues, and the possibility of death and dying can all have a significant effect on family

functioning (Houldin, 2007; Langhorn, Fulton, & Otto, 2007). Family disturbances do not end with the final cancer treatment; long term survival can also pose significant challenges such as fear of recurrence, workplace discrimination, and financial losses (Langhorn, Fulton, & Otto). In fact, Mellon, Northouse, and Weiss (2006) discovered higher (better) quality of life scores with cancer survivors in comparison to their family caregivers. The authors of this study speculate that the higher scores of cancer survivors could be attributed to reports of higher levels of social support and family hardiness, ability to find more positive meaning in the illness, and less fear of recurrence. With some cancers, such as breast cancer, daughters may have a fear that they themselves may have to face breast cancer in the future (Raveis & Pretter, 2005). Intimacy issues among couples are also included in the core concerns of couples living with cancer (Shands, Lewis, Sinsheimer, & Cochrane, 2006). Given the evidence, it is important to include the family in interactions with our patient and remember to assess family needs along with the needs of the individual. The following is another example from my nursing practice that I believe exemplifies the importance of family care and an understanding of the body illness experience.

A 50-year-old man, Henry, went to his family doctor with a two-month history of increasing bowel frequency and the occasional episode of small amounts of frank blood noted with bowel movements. Henry was also experiencing increasing rectal discomfort when sitting for long periods. His doctor performed a rectal exam and urgently referred Henry to a surgeon. The surgeon also performed a rectal exam and quickly diagnosed Henry with rectal cancer. Henry then proceeded to have an abdominal ultrasound (U/S), biopsy, and computed tomography (CT) scan.

The U/S confirmed the rectal mass and also identified a lesion, 2.9 X 3.2 cm. in size, on the liver. The CT scan also confirmed the rectal mass, 3.9 cm maximum diameter. The CT did not show a lesion on the liver. The pathology report identified an adenocarcinoma, grade II/III. No further evidence indicated metastatic disease. The surgeon told Henry that because the CT scan was clear, the liver mass seen on the U/S was nothing to worry about. The surgeon also told Henry that he would need radiation therapy, an abdominoperineal resection, followed by chemotherapy. Henry was referred to the Cancer Centre for consultation and treatment.

Upon his arrival at the cancer center, Henry was asked to complete a health assessment, which I then reviewed prior to our first meeting. Upon reviewing the assessment, I made note of the following:

- Positive family history of cancer
- Current medications include Paxil 20mg OD and Serax 30mg HS
- Rectal discomfort that “comes and goes”, and feels like a “dull ache” which is exacerbated with prolonged sitting
- Stress level identified as 10, on a scale of 1 to 10 (10 being the greatest)
- Has checked “yes” to the statements; “I cry more than I used to” and “I feel helpless”
- Henry has also indicated disturbances with; sleeping, eating, sexual function, ability to enjoy life, interest in daily living, mood, concentration, and relationships with others
- Henry lives with his 2nd wife and her two teenage children

- Works as a district manager

Upon my first meeting with Henry and his wife I collected the following additional data:

- Henry was visibly stressed with a tense facial expression and does not smile
- Henry was diaphoretic and noticeably uncomfortable in the chair, shifting his weight and grimacing upon movement
- Henry's wife, who is a teacher, continued to frantically knit on and off during the first part of the conversation, she looked up only to add or clarify information
- Henry spoke in short sentences and I found it difficult to extract information
- While I was discussing the counselling services available Henry's wife asked if there are any services available to her

I believe this practice story exemplifies the importance of including family into our nursing care and the importance of recognizing the body in illness and how this bodily experience creates meanings and understandings. For example, Henry recognized that his bodily changes (pain and bowel patterns alterations) and responses to illness had meaning and he sought medical advice.

The students taking the oncology nursing elective will be third year students. In their second year the students take a family nursing course, an assumption can then be made that the students are already familiar with the concepts of family nursing. It then makes sense to build upon what the students already know and blend in the context of oncology nursing. However, the family nursing course is currently being reviewed; recognizing that some changes need to be made. One of the changes currently under

review is the textbook being used in the course and one of the potential contenders is “Family Nursing as Relational Inquiry” written by Hartrick Doane and Varcoe (2005). Obviously the future direction of this course will impact the conceptualization of family centred care within the oncology course. However, there are some specifics related to family and oncology nursing that would remain unchanged, irregardless of prior learning, which is contextually specific to the cancer experience. For example, as previously mentioned, a cancer diagnosis has a large impact on roles, responsibilities, and relationships within a family. Further, a cancer diagnosis can be viewed as a family diagnosis due to the aforementioned changes. Nevidjon and Sowers (2000) discuss the impact of stress on a family living with cancer and describe the importance of nurses working with families to develop coping strategies and support ongoing communication. As cancer care can be viewed as a continuum, the family responds to different points along the continuum in different and varying ways. For example, at the point of diagnosis a family may experience shock and disbelief. At the end of life, the family may experience grief, suffering, a sense of relief, or guilt. I think these examples portray how the concept of family centred care relates with the context of oncology nursing and the lived experience of cancer. I think it is important to recognize the close relationship between some of the aspects of family centred care in oncology and ethical practice. I will expand on some of these relationships during the discussion on the ethics of oncology nursing. At this time I plan to discuss the art of oncology nursing.

The Art of Oncology Nursing

In Carper’s original work published in 1978, the defining characteristics of scholarly activity were historically situated. It can be argued that what Carper originally

defined as esthetic knowledge, not objective, generalizable, or factual, is in fact what we now term qualitative inquiry (Duff Cloutier, Duncan, & Hill Bailey, 2007). Duff Cloutier et al. speculate that if Carper were to frame her definition of esthetic knowledge (the art of nursing) in present day nursing, the epistemological and ontological understandings of naturalistic research would lead to a new definition of esthetic knowledge being equated with the interpretive paradigm. I agree that the placement of interpretive inquiry within Carper's original work is problematic stemming from Carper's focus on the empirical/quantitative paradigm when describing the science of nursing. This does not include methods of interpretive or qualitative scientific inquiry which is a large part of present day nursing research. I have included both empiric and interpretive studies within my discussion of the science in oncology nursing due to this dilemma.

Clearly, defining esthetic knowledge as being based upon methods of qualitative inquiry would certainly make life easier and 'cleaner' when applying Carper's ways of knowing to nursing education. It would mean that teaching all those 'messy little bits' like intuition, personal experience, and praxis can be forgotten. After all, how can you teach someone to be intuitive? Although limiting esthetics as knowledge based upon qualitative inquiry would be easier, I feel that if this path is chosen something will be lost in translation. What I feel will be lost if we simply equate esthetics with qualitative inquiry are the ways of knowing that are not easily explained, researched or explored. My sense is that Carper was attempting to describe a way of knowing not grounded in scholarly inquiry but in nursing practice. For example, nurses do not learn how to nurse by simply reading theory or research, they also learn by doing and responding to embodied knowledge. I recently had a student withhold an anti-hypertensive medication in response

to a low blood pressure reading. The student made her decision based on her knowledge from pharmacologic theory and her nursing drug guide. What she failed to recognize was that the patient had a consistently low baseline blood pressure and her medication profile revealed no other anti-hypertensives that would potentiate the medication's effects along with other situational and contextual features that would cause a more experienced nurse to give the medication even with a low blood pressure. This is not a concrete piece of knowledge that can easily apply to every patient with a low blood pressure and anti-hypertensive medications. The ability to look at the whole picture takes time and practice. This practice knowledge has an important role in nursing practice and can be described as the esthetics of nursing.

Nurse scholars have now reframed and re-invisioned what Carper (1978/2002) termed "esthetic pattern of knowing" into terms of praxis, intuition, nursing skills, gestalt, nursing action, and personal experience (Duff Cloutier et al., 2007). For this reason, I intend to present esthetic knowledge or the art of nursing as: praxis, intuition, and personal experience. I see nursing skills and nursing actions as being informed by more than esthetical knowledge. Empirical knowing is also an important part of skills, actions, and nursing intervention, and is presented within the discussion of the science of nursing.

Praxis

Praxis can be defined as the reciprocal interdependence between knowledge (research and theory) and practice. For example, to complete a dressing change a nurse must have knowledge of surgical asepsis, wound care, and wound care products. Simply applying that knowledge without adding the contextual features of the practice situation would not work. The nurse also has to look at: what is happening with the wound? what is

the goal of treatment? what are the patient's needs? Therefore, the practice situation is guided by the knowledge and the knowledge is guided by the practice situation. Rolfe (2006) defined praxis as "mindful action" (p. 43). Fawcett et al. (2001), explain aesthetic knowing as the nurse's perception of what should be considered significant in the patient's behaviour. Therefore, praxis is the nurse's ability to act based upon knowledge and the perception of significance.

Within the context of oncology nursing, praxis can be seen as the nurse's ability to recognize significant body illness experiences and act accordingly based upon different ways of knowing. For example, while completing a nursing assessment on a patient, it is important to recognize bodily responses and or verbal responses that require acknowledgement and further nursing care.

The ability to recognize significant pieces found within the patient's bodily experience of illness and subsequently, know how to act may be guided by scientific knowledge and/or previous experience. In addition to these ways of knowing, it is also recognized in nursing literature that intuition can also guide nursing practice.

Intuition

As stated earlier, it is difficult to teach a student how to be intuitive, especially when nurses themselves have a difficult time explaining the process. Smith (2007) defines intuition and comments on the challenge of explaining this way of knowing, "It is knowing something or deciding to do something without having a logical explanation. The inability to provide rationale for an action or decision makes intuition challenging for nurses to describe, explain or openly acknowledge"(p. 35). Historically, nurses have been trained to value empirical sources of knowledge. Billay, Myrick, Luhanga, and Yonge

(2007) discuss intuitive knowledge from a pragmatic perspective. These authors differentiate between the beginning nurse and the expert by stating that the expert nurse is able to more quickly identify and act upon clinical problems, demonstrating confidence. However, I believe intuition is more than being able to quickly and accurately identify clinical problems. An example of a nurse's intuitive knowledge in oncology nursing practice is the ability to sense a patient is entering anaphylaxis in response to chemotherapy before actually seeing any classic signs such as anxiety, hypotension, and urticaria. This happens quite often in the chemotherapy room; an experienced nurse is able to recognize subtle signs and has a 'feeling' the patient is going to react. Another example of intuition in oncology nursing practice is the nurse's ability to sense that a patient is suffering (physiologically or psychologically) despite other outward appearances or acknowledgment.

Although teaching a student nurse to be intuitive may not be possible, teaching students to listen to their inner voices, explore feelings, and be open to intuition as a form of knowledge is clearly possible. I believe intuition is closely linked to personal experience and embodied knowing. By listening to their 'inner voice' or 'gut feelings', nurses are then able to better understand the patient's experience.

Personal Experience

As nurses gain more personal experience at handling a variety of situations, they are more able to recognize patterns and target priority problems. Personal experience as a form of esthetic knowledge leads to the seemingly effortless ability to artfully complete nursing tasks and handle a wide range of patient situations. As a new graduate I was always amazed at the nurses who had many years of experience; the way they were able to

handle any experience calmly and effortlessly was awe inspiring. Unfortunately, the numbers of nurses practicing at that level are becoming a rarity in many practice settings. Personal experience as a central way of knowing, is being pushed aside and not given the credit of which it once assumed. Fawcett et al. (2001) explain that esthetic knowing is developed by rehearsing the art and acts of nursing. From this description it is possible to deduce that with added rehearsal (and personal experience); esthetic knowledge can be developed over time.

Personal experiences can act as the precipice to an exploration of our personal knowledge and the ability to recognize the values and beliefs that shape our nursing practice.

Personal Knowledge in Oncology Nursing Practice

Fawcett et al. (2001) describe personal knowledge as the ability of nurses to be authentic with others. Smith (as cited in Hartrick Doane & Varcoe, 2005) explains personal knowledge as woven through other sources of knowledge and therefore all knowing is personally shaped. Further, Smith contends that what Carper identified as personal knowing is essentially self-knowledge. Hartrick Doane and Varcoe explain self-knowledge as an awareness of one's own values and beliefs, and socioenvironmental location. Through this awareness we are then able to better understand our choices and how we shape our knowledge. Through reflexivity, we are able to develop our knowledge of self by uncovering and exploring our own values and beliefs, thoughts and actions leading to thoughtful action (Hartrick Doane & Varcoe).

An important aspect of oncology nursing care is the ability to relate and connect with others; this includes both patient and family. As described above, self-knowledge

through reflexivity can create opportunities to connect with our patients and their families in meaningful and thoughtful ways.

Reflexivity

The skill of reflexivity is an essential element of oncology nursing care. Although I believe that if you asked most nurses they would be unaware that they possess the skill, if you look closely you can 'see' it in some nurses' practice. I see it as the ability to truly be present with your patient and their family, being aware of your own thoughts and feelings about the situation and feeling comfortable to explore avenues that may stir up emotion, both in yourself and in those you are caring for. Hartrick Doane and Varcoe (2005) explain reflexivity as involving "a combination of self-observation, critical scrutiny, and conscious participation" (p. 150). Reflexivity also involves paying attention to bodily sensations, thoughts and emotions. Or, as stated in other terms, reflexivity is related to the embodied knowledge of the nurse and the ability to maintain an open connection between our mind and body. In oncology nursing care, powerful emotions can happen daily. As an oncology nurse I often have people ask me, "How do you cope?...You must get used to it (the dying and grief) after awhile." My answer is always, "You never get used to it and you learn how to live with it." To me, 'living with it' means acknowledging the emotion, the grief, and the sadness when it happens. I take comfort in sharing my experience with other nurses who can relate and can share in my experience. Balanced with the feelings of grief, sadness, and suffering are the feelings of hope, strength, and compassion. I am always amazed by the human ability to retain a feeling of hope and strength through all levels of adversity.

Assumptions and values. I believe an awareness of personal assumptions and values in relation to health and health care are also important aspects of a nurse's relational capacity in oncology care. For example, we may assume that our patient with end-stage colon cancer is in poor health and unable to heal but I have learned along the way that these values are contextual and personally constructed. I cared for a man with advanced lung cancer upon diagnosis and having what I would view as a poor prognosis. He viewed his health completely the opposite of how I viewed his health. He believed that as long as his spirit was alive and happy, he was healthy. If we assume that the definition of health means being absent of disease, that would then mean that everyone we care for with cancer is unhealthy. My guess is that many patients would disagree with that statement; many patients are living with a diagnosis of cancer and have very few (if any) noticeable changes in how they feel in respect of their health.

The Ethics of Oncology Nursing

The moral dimension of oncology nursing practice includes a nurse's moral agency, practice issues, and competencies or practice standards. A nurse's moral agency is multifactorial and consists of several contributing elements. It is the nurse's moral agency that guides how the nurse responds to ethical issues of nursing practice. An exploration of a nurse's moral agency and a look at some of the contributing elements will be followed by an identification of the most common ethical issues in oncology nursing.

Nurses' Moral Agency

A moral agent is one who enacts moral ideals and judgements based upon relationships, professional responsibilities, and accountability. For nurses this includes the relationships we have with our patients and their families, relationships with colleagues,

and our relationship or connection with the institution. Professional responsibilities in regards to the ethical domain of our practice are set by the Canadian Nurses Association in our Code of Ethics (2002). The code guides our practice so that we may make informed moral choices based upon ethical principles and theories. Although it is recognized that nurses also use other means to guide their ethical decision-making (e.x. contextual features and cultural diversity), the code serves as a basis for ethical nursing practice in Canada. Using the code and incorporating the contextual features of a situation enables nurses to enact their moral agency. The enactment of moral agency can sometimes become constrained by intrinsic and extrinsic factors. Constraining factors impacting the enactment of our moral agency and therefore inability to reach the 'moral horizon' or the 'good' of a situation can be attributed to the privileging of biomedicine and the corporate ethos in healthcare (Rodney et al., 2002). Unfortunately, it is this inability to reach the moral horizon that creates moral distress in nurses (Storch, 2004).

Values and beliefs. Understanding our own values and beliefs along with those of our patients and families are essential components of ethical nursing practice. It is important to reflect upon these values and understand how these values guide our decisions and impact our ability to relate to others. For example, in oncology nursing, nurses should reflect upon what they believe as health and healing or what they view as important in the end stages of life. These values will impact how they respond and enact their moral agency when dealing with end of life issues.

Competencies/ Practice Standards. Nursing practice is also guided by practice standards set by professional associations and colleges. Specialty groups in nursing may also hold a set of standards specific to that nursing specialty. For example, oncology

nurses in Canada can use the Canadian Association for Nurses in Oncology (CANO, 2001) “Standards of Care” to guide their practice. These sets of standards and/ or competencies are part of the nurses’ moral agency in that they define the scope of practice and set a structure to apply nursing knowledge and skills (CANO, 2001).

Our moral agency, values and beliefs, and practice standards are all part of the ethical dimension of our nursing practice. It is with these guiding factors that we attend to the ethical issues in our nursing practice.

Ethical Issues in Oncology Nursing Practice

Langhorn, Fulton, and Otto (2007) describe ethical issues of oncology nursing practice throughout the continuum of cancer care. Ethical issues at the time of diagnosis may surround communication, veracity, informed consent, and confidentiality. At the time of treatment, dilemmas may appear that are related to decision making capacity, informed consent, autonomy, advocacy, and clinical trials. Abandonment could be seen as an ethical issue during maintenance therapy and advocacy during survivorship. At the end of life, ethical issues may include a lack of advanced directives, quality of life, nutrition and hydration, and withdrawal or withholding of care. This wide array of potential ethical dilemmas illustrate the need for nurses working with oncology patients to be well informed of the human experience of cancer, have easy access to resources, and also have the ability to enact their moral agency.

The Science of Oncology Nursing

Empirical knowledge contributes to the understanding of the pathophysiological processes and treatment modalities in relation to the diagnosis and treatment of cancer. The nursing skills and interventions related to the delivery of cancer treatments and

adverse effects are included in this domain. CANO (2001) defines standards of care applicable to all roles in cancer care: generalist nurse, specialized nurse, and advanced oncology nurse. The association states that “Individuals with cancer and their families are entitled to care that is based on theory, science (physiologic and psychosocial sciences), and incorporates principles of evidence-based practice, best practice or available evidence” (p. 22). This standard clearly describes oncology nursing practice which is guided by theory and science; traditionally this form of knowledge or pattern of knowing follows empirical modes of inquiry. However, I have chosen to include both empirical and interpretive modes of inquiry into what I have termed as a way of knowing through the science of nursing.

Pathophysiology

Although pathophysiology is a borrowed science to nursing, understanding the processes of cancer are important aspects of oncology nursing care. An examination of current oncology nursing textbooks reveal a strong emphasis on disease pathology, genetics, and cellular biology as a beginning to studying oncology nursing (Gates & Fink, 2008; Itano & Taoka, 2005; Langhorne, Fulton, & Otto, 2007; Nevidjon & Sowers, 2000). Similar to both generic nursing programs and specialty programs, the study of anatomy and physiology along with pathophysiology serve as a basis for continued learning. It is foundational for nurses to understand the physiological processes (such as initiation, promotion, progression, and metastasis) of cancer types to more effectively connect the administration of chemotherapy or the management of symptoms with what is happening with their patient biologically.

Treatment modalities

The discussion of treatment modalities such as chemotherapy, radiation therapy, and biotherapy is also a dominant theme in oncology nursing textbooks (Gates & Fink, 2008; Itano & Taoka, 2005; Langhorne, Fulton, & Otto, 2007; Nevidjon & Sowers, 2000). For oncology nurses to care for their patients they must also have knowledge of treatment modalities and adverse effects. For example, if a patient is undergoing radiation therapy for the treatment of breast cancer it is important to understand the progressive nature of adverse skin effects related to radiation, such as moist desquamation, to be able to care for this patient effectively. The management of moist desquamation in nursing practice settings follow evidenced-based protocols to guide nursing practice. Another example is the administration of chemotherapeutic agents. Chemotherapy protocols (selected chemotherapeutic agents) that are designed to target specific cancers and stages are developed as the result of large scale clinical trials and studies. In following these protocols, nurses are engaged in evidenced-based practice and must demonstrate an understanding of the safe administration, adverse effects, and the required physical and diagnostic assessments prior to administration. Chemotherapy nurses must also possess an understanding of the pharmacotherapeutics of these agents. Although it is recognized that chemotherapy is a certified skill, it would be beneficial for all nurses who care for patients receiving chemotherapy to have a basic understanding of the process.

Nursing Skills and Interventions

The nursing skills and interventions related to caring for someone with cancer are another common and dominant theme in oncology nursing textbooks (Gates & Fink, 2008; Itano & Taoka, 2005; Langhorne, Fulton, & Otto, 2007; Nevidjon & Sowers, 2000). Chemotherapy administration and symptom management are examples of nursing skills

and interventions that are based on empirical research and scientific data. For example, when a nurse administers chemotherapeutic agents, evidenced-based policies and procedures are followed to maintain patient and nurse safety and to maximize the efficacy of the chemotherapy protocol. Another example of the empirical dimension of oncology nursing care is the management of symptoms and adverse effects. Symptom management (e.g. nausea, dyspnea, fatigue) guidelines are also based upon empirically-derived evidence and scientific data incorporating both pharmacological and non-pharmacological nursing interventions. In a descriptive pilot study by Kiteley and Fitch (2006), the experience of symptoms by individuals with lung cancer was explored. These researchers outline implications for practice which include a list of common symptoms and an emphasis on the changing nature of symptoms over time and therefore they make the recommendation for frequent symptom assessments.

Although I believe the teaching/learning experience in cancer care is an art, it also includes empirically derived data, description or explanation. An example is an evaluative study of an educational program for the caregivers of persons diagnosed with a malignant glioma using both qualitative and quantitative methodology (Cashman et al., 2007). Another recent example is an assessment of the information needs of adolescents when a mother is diagnosed with breast cancer in an exploratory-descriptive study (Fitch & Abramson, 2007). Although the research methodology in these studies is not fitting with traditional, quantifiable, empirical approaches, I feel that these studies support the 'science' of nursing through a scholarly approach to inquiry.

A nurse's relational capacity and ability to build relationships is an essential component in all aspects of nursing care. A review of current oncology nursing textbooks

reinforces this important aspect of nursing care. Similar to the teaching/learning experience, I believe this aspect of nursing care contains both art and science. It is important for oncology nurses to be knowledgeable, be able to understand and subsequently respond to the psychosocial experiences of cancer care such as: emotional distress, anxiety, depression, spiritual distress, loss of personal control, loss and grief, and social dysfunction (Grimm, 2005). Sexuality, body image, and intimacy are also common themes in oncology literature. A focus on breast cancer care reveals multiple examples of nursing inquiry into the psychosocial and relational needs of women with breast cancer. One example is a phenomenological study conducted by Arman, Rehnsfeldt, Lindholm, Hamrin, and Eriksson (2004). While using ethical, existential, and ontological perspectives, this group of researchers set out to interpret and understand the meaning of patients' experiences of suffering related to health care. The results of this study revealed that patients experience a lack of caring, feeling that they are not being regarded as a human being, and experience imperceptible calls for help. Although disturbing, this study does demonstrate the need for inquiry in all aspects of oncology nursing care (including the psychosocial care and relational capacity) that will guide practice and explore new directions. The science of nursing in oncology nursing is vast and almost overwhelming as the questions are almost limitless. At this point, I think it is important to recognize that no one pattern of knowing is superior to another. The final way of knowing in oncology nursing practice that I wish to explore is sociopolitical knowledge.

Sociopolitical Knowledge and Oncology Nursing Practice

Until this point the discussion of knowledge has centred on the intrinsic relationships of nurse and the patient/ family and the knowledge that informs the personal

practice of an oncology nurse. The notion of sociopolitical knowledge as another way of knowing that informs oncology nursing practice and opens up these relationships to uncover extrinsic elements that also inform practice.

White (1995) introduced the idea of sociopolitical knowledge as an addition to Carper's original ways of knowing. White describes sociopolitical knowledge as providing the context to nursing practice and includes: (1) the sociopolitical context of the persons (nurse and patient) and (2) the sociopolitical context of nursing as a practice profession. An understanding of the socio-political context of the cancer experience is an essential part of cancer care and I would expand this notion further to include the environment. Certainly, this is true of the breast cancer experience. For example, within the social context of the breast cancer experience lie predominant ideologies that impact and influence the experience of health and health care. Women with breast cancer may face social constructs of a woman's breasts such as the view that women's breasts are equated with femininity and sexuality, therefore, the loss of a breast means a loss in femininity or sexuality. Historically, the deterioration of a woman's health, specifically related to female organs, was seen as a punishment for wrongdoings or promiscuity (Langellier & Sullivan, 1998, Thorne & Murray, 2000). These ideologies are socially and culturally constructed and have the potential to impact the cancer experience as women may feel less than whole or deserving of the disease. The environmental context is a volatile issue; the significance of environmental factors and their role in the development of breast cancer is continually debated among researchers (for further discussions see Brody & Rudel, 2003; Darbre, 2006; Ehrenreich, 2001). However, one theory is that environmental estrogenic sources lead to an increased risk for developing breast cancer. Both social and

environmental contexts pour into the political arena and influence local/federal/global policies and initiatives. For example, government bodies at municipal and provincial levels in British Columbia are currently supporting and implementing bans on smoking in public areas and it is widely recognized that smoking is a causative factor of lung cancer (Nevidjon & Sowers, 2000).

The notion of socio-political knowledge informing oncology nursing practice is closely linked to the idea that the body is socially constructed which is a central element of embodied knowledge as previously discussed. For example, how a woman experiences breast cancer has an element of social construction as previously discussed and this construction impacts how a woman lives through and experiences her body.

I recognize that Part I turned into a lengthy piece of writing. However, the purpose of my writing was both practical and personal in nature. My thought processes tend to be linear in nature and therefore I found it necessary to begin at the beginning; the epistemology and ontology of nursing. Moving forward with a plurality of paradigmatic approaches I introduced the specificity of oncology nursing within the framework of different ways of knowing such as: esthetics, ethics, personal knowledge, sociopolitical knowing, and the science of nursing. I also created and presented a visual representation of the central concepts found within this project that include ways of knowing, oncology nursing care specifics, embodied knowing, and family centred care. These concepts are represented by the flower and the soil in my visual representation (Appendix A).

In Part II of this project I will explore the pedagogies and methodologies in nursing education and look for ways of learning that correspond with the ways of knowing and the specificity of oncology nursing care.

PART II – EXPLORING PEDAGOGY AND METHODOLOGY IN NURSING EDUCATION

I have spent the first part of this project uncovering the philosophy, theory, ways of knowing, and specificity of oncology nursing. During the second part, I will focus on the pedagogical approaches that will inform the teaching and learning experiences I hope to create/ facilitate; these will be foundational to the oncology nursing elective I am developing. Looking at my ‘conceptual flower’ (see Appendix A), I am relating the pedagogical approaches that will be utilized in the oncology course to the stem of the flower. The stem is the medium through which the nutrients (knowledge) are transmitted to the petals (specifics of oncology nursing care). The stem supports the flower and provides the pathway of knowledge to practice; this enables the flower to blossom and grow.

To begin, I will briefly discuss the historical context of nursing education. Then I will briefly look at what has influenced nursing education over the years. This discussion will lead to where nursing education is situated today in terms of pedagogical influence and understanding.

Historical Context and Influence on Nursing Education

As a practical nursing student in 1989 my education composed of little more than classroom lectures, laboratory demonstrations and practice, and clinical experiences. The assignments and evaluative methods were similarly as straight forward; exams for theoretical knowledge, mastery exams for psychomotor skills, and care plan assignments for clinical experiences. In 1992 when I re-entered nursing education to obtain my general nursing diploma, little had changed with the exception of a few more ‘group assignments’

and 'group presentations'. Finally, in 1995 when I once again re-entered nursing education to obtain my bachelor in nursing degree, I experienced many changes. For one thing, I was taking courses one at a time through distance education and subsequently distant from other students and faculty. The instructors at the time were sympathetic to our feelings of isolation and in an attempt to make connections, one day workshops and teleconference were part of some of the course delivery. Although these attempts were marginally beneficial, I believe one of the main struggles for many of us returning students was the change in course delivery and pedagogy. Until that point, my experience with teaching and learning experiences were one-directional or teacher-directed and based upon a specific set of outcomes or goals. In complete opposition, my undergraduate studies were self-directed in terms of covering the course material and completing learning activities. Further, the evaluative criteria were more abstract with a multiplicity of possible interpretations. In addition to this change, the content and subsequent basis for evaluation had also changed. Once focused mostly on assessment of empirical and scientific nursing knowledge, the focus had now widened to include esthetic knowledge (intuition, praxis, and personal experience). These experiences opened my eyes to new ways of thinking about knowledge and new ways of thinking about teaching and learning. When I entered graduate studies in 2004, these new ways of thinking continued to evolve and expand. I focused my graduate studies on the lived experiences of women with breast cancer and gynaecologic cancer through an interpretive, or more specifically at times, a feminist lens. This evolution continues and the completion of this project is an essential part of this growth.

As my personal experiences exemplify, nursing education has changed over the years, albeit sometimes slowly, in response to a variety of historical and theoretical influences. For instance, paradigmatic shifts in nursing and health care as a whole have also influenced nursing education (Yorks & Sharoff, 2001). More specifically, the primary pedagogy of the teaching and learning experience in nursing has undergone significant change (Hartrick Doane, 2002). Historically, the reductionistic approach to health care has influenced nursing education in the past to where the focus was on the students' ability to achieve behavioural objectives and mastery of course content (Yorks & Sharoff). Conversely, changes in nursing education have impacted the delivery of health care. For example, nurses were traditionally trained in the hospital setting and subsequently included as part of the work force within the hospital. Over time, due to political/social changes and a growing sense of nursing autonomy, nursing education moved out of the hospital settings and into colleges and universities (Way & MacNeil, 2007).

With the introduction of the Tyler model in 1949, behaviourist theory became a resounding influence in education and certainly nursing education (Bevis, 1989). The Tyler model begins with the identification of desirable behaviours and ends with evaluation to determine if the behaviours were achieved. One of the main criticisms of following this model in nursing education is the inability to measure characteristics that are essential to the understanding of the human experience (Bevis) such as compassion and caring. More recently, nurse educators have responded to philosophical shifts in nursing by integrating a more humanistic approach to the teaching and learning experience of nursing education (Yorks & Sharoff, 2001). The emphasis has shifted away from the

measurable and towards the students lived experiences and active participation as a learner.

As I had stated in the first part of this project, epistemologically and ontologically, I am aligning myself with a multiple paradigmatic approach towards the development of a nursing oncology course. This is evidenced by my discussion on the multiple ways of knowing. Similarly, pedagogical approaches can also be viewed in terms of plurality. Diekelmann (2001) defines pedagogy as simply as “particular approaches to schooling, learning, and teaching” (p.54). My own understanding and definition includes the relationship between teacher and student and our epistemological and ontological beliefs. Including these elements into the definition adds complexity in many ways. First, my approach includes more than just myself as teacher, it includes the relationships I have with my students, how I work to build these relationships, and how these relationships influence the experience. Second, I am conscious of my own values and beliefs and how these may impact the teaching and learning experiences between me and my students. Third, I believe that approaches may vary according to context and experience and may therefore include more than one approach. For example, my approach/es may vary between my classroom teaching of health care ethics and my clinical teaching of psychomotor skills in home care or palliative care settings. Finally, I believe that pedagogy is sensitive to our social and political environment. For example, as part of a nursing faculty I am compared to other faculty members within our department. My pedagogy will not be exactly the same as others that I work with; therefore, what differences will this make? How will students respond to a new pedagogical approach? How will faculty respond to a course that is not content driven? Also, how do increasing

student numbers in the classroom and increasing faculty workloads impact our teaching practices? Due to these inherent complexities, I believe in pedagogical plurality and openness to new ideas and methods. Further, multiple ways of teaching and learning fit well with multiple ways of knowing. I plan to spend some time looking at a variety of relatively new pedagogies currently located in education and more specifically nursing education.

Emerging Pedagogies

By exploring other pedagogical approaches, I am making the assumption that relying solely on conventional approaches to teaching and learning is ineffective and also that students are willing to experience change. After all, nursing students continue to graduate and function quite well in the health care system, so why implement changes now? I think in this instance the impetus for change is in myself as well as a personal belief that students are ready for a change. After eight years of being a nursing educator, I have created my own style and my own pedagogy that is incompatible with conventional approaches. For these reasons, I am interested in exploring new pedagogical approaches and ways of thinking about teaching and learning.

In Part I of this project, I aligned myself with a multiple approach to both nursing paradigms and ways of knowing. To explore multiple ways of knowing in oncology nursing, a plurality in pedagogical approaches is necessary to create an environment for growth, teaching, and learning. For example, if the only way of knowing was determined to be personal knowledge, the classroom would focus on personal exploration and reflection. Alternately, if the only way of knowing was determined to be through the

science of nursing, the classroom focus would be theoretical knowledge and research-based practice.

Among the pedagogies that I wish to explore during the development of the oncology nursing course are: transformative, narrative, and embodied teaching/learning. Due to the initial structure of the course as primarily a classroom experience, I will focus my discussion on classroom pedagogy. Although my sense is that these pedagogical approaches may not vary significantly in response to variability in settings or contexts, the combination of approaches or primacy may alter slightly. Therefore, due to potential changes with the physical learning environment and back and forth nature of mixing classroom with clinical experience, I believe it is even more imperative to discuss a variety of pedagogical approaches. Also, as stated earlier, the belief in multiple ways of knowing necessitates the course to include multiple ways of learning. My intent in Part II of this project is to explore and reflect upon some of the relevant pedagogies that I plan to integrate into the course delivery phase of this project. In Part III, I plan to discuss this integration more explicitly as I outline the actual learning activities in relation to the teaching and learning of a select number of essential concepts found within oncology nursing practice.

The first pedagogy that I plan to explore is transformative learning, followed by narrative and embodied teaching and learning.

Transformative Learning

According to Mezirow (2003) transformative learning alters problematic frames of reference (ex. assumptions and expectations) with the intent to make these more reflective, open, inclusive, and discriminating. McAllister et al. (2006) explicate that

transformative education is epistemologically rooted in critical social theory which focuses on social inequalities and dominating forms of power. Subsequently, these authors contend that transformative education is mainly focused on students' responsiveness to injustice, oppression, and domination. Although these ideas are central aspects to transformative learning there are other aspects that are equally as important. Lazenby and Morton (2003) explain that through transformative education, students explore alternatives to problem solving at a *personal and social level* (italics added).

An interesting parallel exists between transformative learning and the concept of "Personal Knowing" (as discussed in Part I) informing nursing practice. Foundational to both concepts is the ability of the nurse/ learner to 'unpack' and examine previous values, beliefs, and assumptions. What I find most difficult as an educator is related to knowing what to do next - after everyone has 'unpacked', what happens to all the 'stuff'? Do we put it all back in the suitcase, virtually unchanged? Or, is the actual process of unpacking enough? My sense is that sometimes students become lost and uncomfortable after such an examination, vulnerable in a sense. Berger (2004) describes this point as the edge of understanding. As an educator, I believe it is my job to provide a safe environment for such learning and to also provide the tools necessary to 're-pack' their suitcases that enables the accommodation of both the new with the old. For example, a discussion on the lived experience of breast cancer may elicit a wide variety of responses from the class, based on assumptions, previous personal experiences, and values and beliefs. I could introduce some of the socio-political context to the experience and discuss how these various beliefs intersect and relate to each other. At the end of the discussion I could ask the class how these ideas would/ could inform nursing practice and help formulate an

understanding of the breast cancer experience. However, Berger suggests that the ability of an educator to identify students who are on the edge of understanding is itself a worthwhile accomplishment as this provides an opportunity to slow down and allows us to act as more thoughtful and intentional guides.

Transformative Approaches and Nursing Education

As stated, the oncology nursing course I am creating will not have a clinical component in the beginning. However, it is interesting to note that McAllister, Tower, and Walker (2007) see transformative education as an answer to the theory practice gap in nursing. They contend that a transformative approach values practice linked to theory and theory linked to practice. For example, by focusing on critical thinking and the process of examining hurtful or unjust practices, nurse educators are teaching students to question the ‘taken-for-granted’ practices and become active members of the health care system (McAllister, Tower, & Walker). This notion supports the idea that transformative education occurs at both the personal and social levels.

In some ways nursing education is content-rich and pedagogy-poor. For example, as nursing practices continue to grow and evolve, and technology continues to push forward, it is becoming more and more difficult to manage an explosion of content into the nursing curriculum. Unfortunately, as Diekelmann and Smythe (2004) explain, this difficulty leads to an emphasis on conventional pedagogies. However, there is a move away from conventional pedagogies towards alternative pedagogies (Diekelmann, 2001). These alternative pedagogies offer both challenges and promise to reform current teaching practices (Diekelmann & Smythe). Narrative pedagogy is one such possibility that offers an alternative to conventional pedagogy.

Narrative Pedagogy

Narrative pedagogy was articulated by Diekelmann (2001) based on her 12 year study that explored the experiences of students, teachers, and clinicians in nursing education. Although a narrative pedagogy could be viewed as an alternative to conventional pedagogies, Diekelmann presents narrative pedagogy as an alternative that uses all pedagogies and states, “Narrative Pedagogy exists within and arises out of conventional pedagogies” (p. 61). A commonality between transformative education and narrative pedagogy is the primary focus on questioning, revealing, uncovering, and opening. For example, questioning the meanings and significance, revealing underlying assumptions, uncovering both the known and unknown, and opening up to multiple and alternative perspectives. Although maintaining a focus is important, the central movement shifts away from the content as the focal point and towards the actual learning through thinking and questioning. Certainly, this is what nurse educators’ desire for their students; the ability to think and question more than the ability to memorize, recall, and recite.

As stated earlier, I believe that the relationships between student and teacher should be part of our pedagogy as nurse educators. The narrative pedagogy substantiates this belief through which Diekelmann (2001) explains as concernful practices of schooling learning teaching. These practices describe the experience of teaching and learning and include: (1) gathering (2) assembling (3) staying (4) caring, and (5) presencing (Diekelmann). These are all ways that we connect with students and create an environment for learning and, as Diekelmann explains, these practices can be both positive and negative in nature. For example, we can *stay* with our students in ways that

demonstrate knowing and connecting such as providing support during difficult times or we can *stay* with our students by increasing demands and keeping safely distant.

Another key feature of the narrative pedagogy is the impetus for educators to challenge the assumptions of conventional pedagogies. For example, conventional pedagogical assumptions lead us to believe that we (the educators) control the content and the content drives the course. Obviously, this infers that we know the content quite well; we know what to add and what to take away. Diekelmann (2005) shares the story of an experienced teacher who asked the question, “Why not start the class with articles I have not read or content that I don’t know or have not figured out yet...” (p. 250). This idea intrigues me; I thought about what would happen if I translated this idea into the ethics course that I teach. Although this would cause some stress (both my own and that of the students) I also think about what this would teach the students, how to ask questions with the intent to deepen understanding. Once again this brings up the thinking and questioning involved with learning. As the teacher of the class and being unfamiliar with the content I could role model by demonstrating what type of questions I would ask to explore the concept further. I could also share my way of thinking - my train of thought. By no means would I assume to have the most inquisitive mind or best way of thinking and students always amaze me by asking questions that I had not thought about or provide new ways of looking at ideas that are outside of my view. I believe that this demonstration of alternative views would only add to the experience.

Using a narrative pedagogy as a teaching approach in the oncology nursing course will provide students with the opportunity to hear and talk about the whole experience of someone living with cancer. Listening to a person’s story serves as a foundation to better

understand the meanings of illness and how the person's cancer chapter fits together with the rest of their story or life experiences. In nursing, a common value is that we treat our patients as individuals and therefore respect their own values and beliefs. However, it is through listening to their story that we are better able to understand what these values and beliefs are and how they influence or inform their cancer experience. This provides nurses with the ability and opportunity to provide nursing care that is responsive and reflective.

Until this point, the pedagogies that I have explored mainly focus on thinking and questioning. Only using these pedagogies would fit well if ways of knowing were purely informed by conscious thought. But what about ways of knowing that are also guided or informed by our body? The final pedagogy I wish to look at is embodied teaching and learning and I believe that by discussing this pedagogy the body will be acknowledged as a way of knowing and a way of teaching and learning.

Embodied Teaching and Learning

Having suffered a recent skiing injury and subsequent surgery and physiotherapy, this has given me more than ample opportunity to explore the connectedness of my mind and body. What has been interesting is the ability to bring this experience into my ethics class and to explore some of the related ethical issues and concepts. The students have witnessed my inability to lecture while standing at the front of the class as per the normal practice of our nursing faculty. I have sat in a chair, sat on a table, and limped around on crutches, asking for help with simple tasks. I have spoken about my ethical dilemma when pushed to the front of the surgical line and asked the question, "Why should I have surgery before an eighty year old woman who has waited for months to have a total hip replacement and is in constant pain?". I have also relayed my story of being referred to as

“The Knee” by the emergency room nurse and being assessed by the physician in front of a room full of other patients and families, with everyone able to view my injury and clearly able to hear my answers to the doctor’s questions. Hogan (2006) explores teaching, bodies, and the ethics of multiculturalism and states, “It is not a new insight to point out that our teaching is fundamentally structured by a pervasive and instinctual denial of the body” (p. 358). This author contends that we have to figure out how to acknowledge our bodies and our connectedness as students, teachers, and texts.

Recently, I discussed the concept of embodiment in an ethics class related to nurses’ moral agency. At the very beginning of the course, we discussed our own values and beliefs and at that time I stated to the class, “You don’t leave your values and beliefs at the door before you walk in to see a patient so you need to understand how this influences/ informs your experience and ethical decision-making”. Later on in the course, during the discussion on embodiment I stated “You also don’t leave your body at the door when you walk into a room, so, how can you pay attention to both your mind and your body during ethical dilemmas, and why is this significant?”. As a nursing educator who is definitely looking to shake up the status quo and seek alternative ways of teaching and learning, it is sometimes difficult to know if you are doing the right thing. For example, was it appropriate of me to speak so candidly about my bodily experience of illness and personal struggles with ethical issues? This is a definite acknowledgment of myself as both a mind and body. The students did not appear disturbed or disinterested in my experience; in fact they had many comments, questions, and opinions and the discussion was quite engaging. Perhaps, the fact that these are nursing students and are therefore

expected to maintain a holistic view of the human illness experience makes a difference and adds to their interest in the subject matter.

The final pedagogy that I wish to explore is embodied teaching and learning. I believe that this is an important discussion due to the physicality of nursing work. For example, as nurses we are closely engaged with bodies and bodily experiences. McDonald and McIntyre (2001) state that "...the nurse herself, in her body, is the primary and essential instrument of her practice" (p. 234). Further, we (nurses) respond to bodily changes and experiences with our own bodily actions or reactions. However, the difficulty sometimes lies within this experience, facilitating our students' ability to translate and integrate the knowledge they learn in the classroom into their practice experiences. I believe this inability to translate may be caused by the separation of mind and body that we sometimes tend to perpetuate in nursing education. Dall'Alba and Barnacle (2005) explain the decontextualisation that occurs in many undergraduate programs "through a focus on the acquisition of knowledge and skills that are artificially separated from associated practices" (p. 721). Therefore, by separating the nursing knowledge from the practice setting or merely viewing the practice setting as a place to apply theoretical/classroom knowledge, we are forgetting about our ability to know through our bodily experiences. Perhaps by integrating embodied ways of knowing, the body and the mind will be connected in the classroom and in the practice setting. Unfortunately, I believe that many nursing programs suffer from the same affliction; the inability to create a bridge between theory and practice for the students. To follow is an example from practice:

I was recently observing a student suctioning a patient whose condition was deteriorating. The student was hesitant about suctioning the patient and was

concerned about 'going in too far'. She was demonstrating excellent technique and was performing the skill quite well with little direction. Unfortunately, the student was not able to reach the desired effect and the patient continued to have congested sounding respirations. After we left the room I asked the student how his chest sounded. "Not very good" she replied. I shared with her my thought that the upper airway was perhaps not the problem and I thought he was going into congestive heart failure and probably needed some furosemide to diurese. She reported this to the nurse and we then left for the day. The next morning we checked the chart and read that he was given some furosemide and diuresed over 2500ml in 3 hours. His respirations were now sounding clear and unlaboured. I later reflected upon this experience and wondered why I had thought to question further and the student had not. Was it because her application of knowledge had centred on the skill of suctioning and not on the patient's bodily experience or response? I have previous experience with patients in failure and this surely added to the experience. But I also think it was more than just that. Standing at the bedside I could see the struggle to breath and the laboured respirations, the diaphoresis, and the anxious expression. His body was telling us a story; the difference between what I experienced with this patient and what the student had experienced was that I listened to the whole story and the student had only heard the beginning and only paid attention to the symptom.

I think this scenario exemplifies why it is valuable for nurses to use all available sources of knowledge to inform our practice. To better understand embodied teaching and learning, I plan to first spend some time discussing embodied knowing.

Embodied Knowing

Embodied knowing can be defined as a way of knowing the world through our bodies and can also mean being situated in the world and subsequently affected by historic, political, social, and cultural forces (Wilde, 1999). Paley (2004) argues that Cartesians would not dispute the fact that we know the world through our body, believing instead that the difference between embodiment theorists and Cartesians is that the body does not merely supply information but also processes information. Thinking about the body as having the ability to process information is an interesting idea and does provide an answer to how it is that we are able to perform activities without being consciously aware of every step. For example, a student nurse giving her first injection is consciously aware of the steps required and thinks as she works - gather all the supplies, prepare the syringe, think about where to inject the medication - a methodical and linear process. Compare this with a nurse who has given many injections - all of the above steps are performed almost seamlessly with very little conscious thought, instead the thinking may evolve around the effectiveness of the patient's current pain management and if there should be any changes. Because the body is already knowledgeable in the process of giving an injection, the body is then able to proceed and allow other ways of knowing to gain primacy. However, I believe it is imperative to recognize that not only are there multiple ways of knowing but these ways of knowing occur concurrently not in isolation of each other.

Recognizing that embodiment is another way of knowing has definite implications on nursing education and pedagogical approach.

Embodied Teaching and Learning as a Pedagogical Approach

As a pedagogical approach embodied teaching and learning is multi-faceted. As stated in Part I, the concept of embodiment has varying yet connected definitions. These definitions include and attempt to explain: (1) the body as socially constructed; (2) the experience of the body in illness; and (3) a nurse's embodied knowledge in clinical practice. I have embedded these ideas into the course pedagogy in many ways. For example, I have attempted to include social constructs of illness and the bodily experience of illness into the course content (see Appendix B – Table B1) and will be included into the case studies and practice stories. Further, to include these notions into a pedagogical approach means that the body is recognized as having a primary and connected role in ways of knowing and learning. For example, learning the theoretical-based knowledge of oncology nursing in the classroom is connected with the bodies' enactment of this knowledge in practice. I believe that for this to occur, the multiple ways of knowing must be recognized and equally respected. The essential component for this connection and recognition to occur is through action, both inside the classroom and outside of the classroom. Because this oncology nursing course will occur mostly in the classroom, it is imperative that the classroom structure and other learning activities will provide students with the opportunity to bring their knowledge into interactions and discussions with their classmates and with others. I have created learning activities that I believe will provide students with these opportunities. I have decided to structure the course content by using a case study approach. I have decided on this approach because next to clinical practice I believe that this will provide students with the most effective means of learning and enacting ways of knowing through critical questioning and discourse with others. Most of

the case synopses I have created through reflecting on my own clinical practice and combining concepts that have strong connections in practice. The students are familiar with a case-based approach as this is part of their learning in second year and through casual discussions that I have had with the students I know that they appreciate this approach and believe that it helps them make links and “tie things together”. To use these cases in an embodied way the students will take turns being the patient or a family member with the rest of the class acting as the nursing team. I can add a variety of scenarios to the case as the class progresses and ask the players to act out the scenarios. With each scenario we can dialogue about how the new situation ‘feels’ to the patient, the family, and the nurses.

PART III – COMBINING ONCOLOGY NURSING WITH PEDAGOGY

In Part III of this project I plan to integrate the essential concepts of oncology nursing from Part I with the pedagogical approaches explored in Part II to create an oncology nursing course. At the beginning of my work on this project the actual course approval process had begun. This process has now concluded as the Undergraduate Program Advisory Committee (UPAC) of the University College of the Fraser Valley (UCFV) has recently approved our nursing elective changes. Because this is a change in curriculum and impacts both current students and future students there will be a two year transitional period where we will continue to accept both three non-nursing electives or two non-nursing electives and one nursing elective. This is great news for our program and both the students and the faculty are excited thinking about the possibilities. According to our student survey at the beginning of this process, students were interested in a number of different nursing electives along with oncology and these will provide a

wide variability of potential courses to develop and deliver. The problem at this time is finding the people power to create these new electives. Subsequently, it will take some time to develop a variety of nursing electives for our students to take. Therefore, we will also accept nursing electives from other institutions providing they meet the academic criteria. However, our students very clearly indicated through the survey that their preference was to take their nursing electives at UCFV. I have had many students approach me about this oncology course and I feel that this project could not have happened at a better time.

My plans for Part III of this project are to discuss what I have discovered in the nursing literature in relation to oncology nursing education and to develop an oncology nursing course outline. I will also discuss learning activities and my future plans for the course.

Oncology in Nursing Education

I searched the nursing literature to find evidence of oncology nursing within nursing education programs and was able to find many solid examples. Rushton (1999a) developed an undergraduate oncology nursing course for Brigham Young University's College of Nursing. Rushton based the course objectives on the Oncology Nursing Society standards of oncology nursing practice and included both classroom and clinical elements in course design and delivery. The course is seven to eight weeks in length with 35-40 hours of didactic and 81-90 hours of clinical experience. The course content has a strong emphasis on the empirics of oncology nursing; however, ethical issues were also included. Rushton (1999b) also presented an "Honors Oncology Course" in the literature. This course was developed to teach both nursing and non-nursing students about cancer with

the overall objectives being to "...provide knowledge about cancer to students, upgrading their understanding of the disease and dispelling misinformation and myths prior to being involved in a cancer situation" (p. 77). According to Pierce (1992), nurse educators must determine what the realistic objectives are for an undergraduate oncology course. I believe this is a critical exercise to develop the course content and the course objectives/ goals. As a resource to aid in this decision-making I will access the Canadian Association of Nurses in Oncology (2001) "Standards of Care" and competencies for the generalist nurse. These competencies are aimed toward practicing nurses working in a variety of settings or a nurse who is new to a cancer care setting. The oncology course will be aimed toward nursing students, not practicing nurses, so this is an important factor when considering these competencies as a resource for creating course goals and objectives. Pope (1992) recommends that continuing cancer care education should not replace the gaps in the basic program but extend and take advantage of what is already known. This is another important factor to consider, the students taking this course will have already taken pathophysiology, which includes some limited content on the pathophysiology of cancer and on a few specific cancers types. Musgrave (1997) describes how an Israeli baccalaureate nursing program integrates an oncology component into their standard curriculum. This integration includes a 45-hour lecture series given by a multidisciplinary group with an emphasis on what is considered essential to provide holistic care to people with cancer. There is also a clinical component as part of the oncology course that includes a variety of oncology settings. The literature presents a variety of approaches in providing added oncology content to nursing programs, ranging from: 'bits and pieces' throughout the program, workshops, seminars, and independent electives (Bryant-

Lukosius, Love, Ingram, & Rideout, 1996; Longman, Verran, & Clark, 1991; Love, 2005; Musgrave, 1997; Purnell, Walsh, & Milone, 2004; Rushton, 1999a; Rushton 1999b; Quinn-Casper & Holmgren, 1987; Sarna & McCorkle, 1995; Slaninka, 1992). Although the literature presents wide variability in approach and content, the fact that more oncology care should be part of nursing education is generally undisputed. I have chosen the ‘independent elective’ approach due to the timing of our program changes in relation to non-nursing electives and because I believe an independent course has the most to offer students with an interest in oncology nursing.

I have modified ideas from the literature in terms of oncology nursing course content and student assignments that I feel best fit with the specificity of oncology nursing that I have identified in Part I and the pedagogical approaches I have discussed in Part II. For example, Sarna and McCorkle (1995) present a curriculum guide that is heavily weighted in the empirics of oncology nursing such as carcinogenesis, risk reduction, epidemiology, and diagnosis / treatment. However, these authors also include ethical issues, symptom management, psychosocial aspects of care, and the continuum of care. Unfortunately, like much of the oncology nursing education literature, specifics are not provided in relation to student assignments or specific learning activities. In creating a “Coping with Cancer” elective for nursing students, Slaninka (1992) has addressed multiple ways of knowing in course objectives and includes: lecture, communication exercises, and case study analysis as some of the methods of instruction. As methods of evaluation, Slaninka includes: seminar leadership, seminar participation, a critique of research articles, and a health teaching presentation. Purnell, Walsh, and Milone (2004) chose Carper’s ways of knowing to guide their development of a new oncology nursing

elective and identified three top teaching strategies or learning activities as per student feedback. These strategies included: (1) cancer survivor interview, (2) spirituality seminar, and (3) clinical inquiry. An undergraduate oncology elective discussed by Rushton (1999) describes a variety of student assignments. The students give formal presentations on the specific nursing care related to different types of cancer and complete a movie review on a movie with cancer or death or dying as a main focus. At McMaster University, a Paediatric and adult oncology nursing program is offered to nurses with an interest in oncology and a desire to complete their Baccalaureate in Nursing degree. This program is a year in length and is composed of courses in theory, communication, research, assessment, and nursing practice (Love, 2005). The developers of this program have chosen to use a problem-based pedagogical model which involves small groups of students working through problem scenarios and where the instructor facilitates and encourages in-depth discussion. Although the literature varies in course content, pedagogical approaches, and student learning activities, commonalities are found within the clinical components of the course and in the main focus or objective; developing a greater understanding of the cancer experience. As the course I have created does not yet include a clinical component, I believe it is important to pull together other opportunities or activities that will encourage students to solidify and explore their knowledge through dialogue and interactions.

Creating a Course Outline

As per the UCFV Nursing Program's general format, students purchase a student guide for each of their courses. Traditionally the student guide includes: a course outline, assignments, goals and resources for each individual class. I have created a course outline

for the oncology nursing course as per these general guidelines (see Appendix B). Although I feel somewhat constricted by the necessity to develop course goals, I do recognize that it is necessary for the students to have some sense of structure and expectations. I have attempted to formulate a course description and create course goals that reflect variability and flexibility.

Course Content

To illustrate the course content I have chosen to plot the course concepts according to case and knowledge (see Appendix C). The class format will primarily follow a case study approach with large classroom discussion at the beginning of class followed by small group student-led seminars. The case study/ seminar approach fits with narrative and transformative pedagogy by providing a story and an opportunity to think about and discuss the whole experience of a person living with cancer, rather than a reductionist approach that decontextualizes the experience and examines pieces in isolation. Through student-led seminars students will be encouraged to pose thoughtful and critical questions in relation to the case and/or concepts of discussion. Embodied learning will be pulled through by the students acting and relating to one another as persons with cancer and as nurses caring for persons with cancer. Although I recognize the best approach to integrate embodied learning would be the inclusion of a clinical component, role-play presents an interesting and action-oriented alternative. The concept blueprint will serve as a guide for discussion and seminar group work, however, thinking ‘outside of the box’ will be encouraged. Learning activities will serve to provide students with opportunities to dialogue with others, ask questions, and develop their cancer care capacity. As this is a

new course, the need for a thorough course evaluation will be invaluable to assess the course strengths and areas for change.

Developing Learning Activities

The nursing literature related to oncology nursing education has provided many examples of learning activities and assignments. While looking at these examples and thinking about my pedagogical approach, I have created what I believe reflects a plurality in approach and an attempt to reach different points along the cancer care continuum while exploring essential oncology nursing care concepts.

These learning activities are represented by the clouds and the sun in my visual representation of course concepts (Appendix A). These activities provide the flower with the necessary elements for growth and represent the action (rain and sunshine) that must happen for learning to occur.

Cancer Care Journal

In thinking about the narrative pedagogy and transformative learning, I believe what stands out most from these approaches is the ability to question and uncover personal values and beliefs. The students will be asked to maintain a journal and respond to questions from their student guides (see Appendix C for an example of a student guide). Part of these journal entries will focus on the students' experiences caring for individuals with cancer. As third year nursing students, many of whom are now working as Employed Student Nurses (ESNs), it would be surprising if they had not cared for someone living with cancer. Students will also be asked to formulate their own critical questions and be prepared to ask and answer these questions in class during the large group discussion or during small group seminars. This journal will be handed in twice during the course. To

bring forward the opportunity for embodied learning, I will provide each student with a wrist band at different points during the course. Once given a wrist band, the student has been ‘given’ a diagnosis of cancer. They will be instructed not to remove the bracelet unless absolutely necessary. The bracelet will not provide everything about the illness, only the diagnosis, with an attempt to simulate the uncertainty of illness. Over the course of a few weeks, I will provide the students with more information such as: their bodily responses to illness, their treatment options, their prognosis, and finally their recovery or progression of illness. The students will be asked to journal their responses to these pieces of information including their thoughts and feelings.

Community Experience Summary

I believe that applying the concepts of embodied teaching/learning requires students to interact with people and families living with cancer. I believe that these interactions can happen in a number of ways. When possible, I will ask members of the community to be part of the class and share their lived experiences of living with cancer. Another strategy to provide students with opportunities to demonstrate a greater understanding of the cancer experience is to ask students to become involved with community cancer support groups or cancer – related charity events. As a nursing faculty at UCFV we are discussing the possibilities of introducing service-based learning into our curriculum and this opportunity would potentially provide an avenue for this new direction. Students will also be able to interact with individuals and families who have perhaps completed the treatment phase of their cancer experience and are now moving forward. These will be group experiences and each group will be asked to submit a summary of their experience. To complete their summary, the groups will be asked to

reflect upon their experience and explore implicit and explicit constructs of illness while attending to all ways of knowing. For example, how did the experience confirm or change the student's previous beliefs or understanding about how people live with cancer. Also, what knowledge was gained from the experience and what previous or current knowledge informed the student's experience.

Poster Presentation

With intent to focus on the preventive and early detection point along the cancer care continuum, students will be asked to create a poster presentation on a cancer-related health promotion activity such as: breast self examination, colonoscopies, testicular self examination, dietary risks, and sun exposure. The students will then be asked to display their posters at the UCFV campus or at another community location. The UCFV fourth year nursing students are part of a health fair each year that is located at a local shopping mall. This may provide an opportunity for collaboration between these two student groups and we may be able to combine poster presentations. This learning activity will also provide students with the opportunity to interact with the community and discuss cancer-related care. As transformative learning asks students to engage at both personal and social levels, this learning activity provides the opportunity for both.

Student-Led Seminar

The student-led seminar portion of the class will allow the students to explore an area of interest related to one or more of the concepts from the case study in more depth. The students will take turns leading the seminar and will be asked to provide a 'thought-provoking piece' to the rest of the group one week prior to class. This piece may be a journal article, a video clip, a newspaper article, or a practice story. The student leader will

also be asked to formulate critical questions to encourage thoughtful and critical dialogue which is in line with transformative and narrative pedagogies. Following the seminar, the student will be asked to submit a summary including: the ‘thought-provoking piece’, a summary of the discussion, and the critical questions. Students will be encouraged to bring in practice examples to the discussion.

As stated, these learning activities will require an evaluation and may require modification after living and working through the course. The possibilities are endless but I think these learning activities provide a solid place to begin.

Future Recommendations

Although I have created an oncology nursing course that I feel meets all the criteria (both externally and internally imposed) I also believe the course will require some changes in the future to provide the students with the most effective and meaningful opportunities to learn and experience oncology nursing care. For example, as I have mentioned earlier, my hope is to someday include a clinical component to this course. I am not sure how this will look or fit within the current curriculum. At the moment, the students are already in clinical 2-3 times per week throughout most of the program. One possibility is to exchange oncology clinical practice with palliative/ acute medical clinical time in the 6th semester of study. However, this would require that the oncology nursing course also be delivered in the 6th semester and currently the plan is that the non-nursing electives will be offered in the 5th semester. Another possibility is that the clinical component of the course be individualized according to the students’ availability. However, the logistics of this may pose quite a challenge. With the new hospital and cancer centre opening in Abbotsford this summer, this provides further opportunities. For

example, the plan is to open a 10-bed oncology unit within the hospital. As I will be working with students on the medical and palliative care units, it would be possible for me to also supervise a few students (those taking the oncology course) on the oncology unit. The students could rotate through the unit and each have an opportunity to spend a few days. The cancer centre will provide students with the opportunity to interact with ambulatory care patients and spend time with nurses working in the chemotherapy room, radiation therapy, and in the nurse-led clinics. I have discussed these possibilities with the professional practice leader and the clinical nurse educator who will be working at the new cancer centre and they are willing to look at a variety of student opportunities. Finally, I have considered the possibilities of myself working in a dual appointment role between UCFV and the new cancer centre. This would provide me with the opportunity to bring students into my own oncology nursing practice and could potentially open the door for future collaborative research projects and student involvement.

Conclusion

In Part I of this project I discussed the epistemological and ontological implications on nursing practice. The specificity of oncology nursing care and essential concepts were illustrated through multiple ways of knowing such as: embodied knowledge, the art of nursing, the science of nursing, ethics, personal knowing, and socio-political knowledge. The ways of knowing and the course concepts that I have included in this project are not exclusive nor are they static in that there is room for additions, modifications, and revisions. In Part II, I have discussed a variety of pedagogical approaches that are in line with my own pedagogical approach and included: narrative and transformative pedagogy along with embodied teaching and learning. Finally, in Part III, I

combined the concepts from Part I with the pedagogical approaches in Part II to create an oncology nursing elective for BSN students. A conceptual blueprint for the course was produced along with a variety of learning activities. Although I have completed much of the conceptual work for the course, the student guide with resources and case studies will need to be completed before the course is ready for implementation.

I have enjoyed creating something that encompasses the nursing that I love with the teaching that I enjoy. At the outset, I wanted to create a visual representation of the concepts brought together to create an oncology nursing elective. The potted flower that I have created to represent the concepts found within this project is an organic model; the parts of which are closely related to one another. It is my hope that this model will continue to grow and expand in response to the continued development of oncology nursing practice and nursing education.

References

- Arman, M., Rehnsfeldt, A., Lindholm, L., Hamrin, E., & Eriksson, K. (2004). Suffering related to health care: A study of breast cancer patients' experiences. *International Journal of Nursing Practice, 10*, 248-256.
- Baker, C., Norton, S., Young, P. & Ward, S. (1998). An exploration of methodological pluralism in nursing research. *Research in Nursing & Health, 21*(6), 545-555.
- Berger, J. G. (2004). Dancing on the threshold of meaning: Recognizing and understanding the growing edge. *Journal of Transformative Education, 2*(4), 336-351.
- Billay, D., Myrick, F., Luhanga, F., & Yonge, O. (2007). A pragmatic view of intuitive knowledge in nursing practice. *Nursing Forum, 44*(3), 147-155.
- Brody, J. G., & Rudel, R. A. (2003). Environmental pollutants and breast cancer. *Environmental health perspectives, 111*(8), 1007-1119. Retrieved October 14, 2006 from EBSCO database.
- Bryant-Lukosius, D., Love, B., Ingram, C., & Rideout, E. (1996). Baccalaureate education in oncology nursing: The dream is becoming a reality for Ontario nurses. *Canadian Oncology Nursing Journal, 6*(1), 49-50.
- Canadian Association of Nurses in Oncology. (2001). *Standards of Care*. Retrieved August 14, 2007 from http://www.cano-acio.org/en/practice/standards_of_care.html.
- Canadian Cancer Society/National Cancer Institute of Canada (2007). *Canadian cancer statistics 2007*. Toronto, Canada.
- Canadian Nurses Association (2002). *Code of ethics for registered nurses*. Ottawa: Author.
- Carper, B. A. (2002). Fundamental patterns of knowing in nursing. In J. W. Kenney

- (Ed.), *Philosophical and Theoretical Perspectives for Advanced Nursing Practice* (3rd ed.) (pp. 10-21). Sudbury, Ma: Jones and Bartlett. (Reprinted from *ANS*, 1(1), 13-24.)
- Cashman, R., Bernstein, L. J., Bilodeau, D., Bovett, G., Jackson, B., Yousefi, M., Prica, A., & Perry, J. (2007). Evaluation of an education program for the caregivers of persons diagnosed with a malignant glioma. *Canadian Oncology Nursing Journal*, 17(1), 6-10.
- Cody, W. K. (2000). Paradigm shift or paradigm drift? A meditation on commitment and transcendence. *Nursing Science Quarterly*, 13(2), 93-102. Retrieved October 5, 2007 from Health Source: Nursing/Academic Edition database.
- Dall'Alba, G., & Barnacle, R. (2005). Embodied knowing in online environments. *Educational Philosophy and Theory*, 37(5), 719-744.
- Darbre, P. D. (2006). Environmental oestrogens, cosmetics, and breast cancer. *Best practice & research clinical endocrinology & metabolism*, 20(1), 121-143. Retrieved October 14, 2006 from Sciencedirect database.
- Diekelmann, N. (2001). Narrative pedagogy: Heideggerian hermeneutical analyses of Lived experiences of students, teachers, and clinicians. *Advances in Nursing Science*, 23(3), 53-71.
- Diekelmann, N. (2005). Engaging the students and the teacher: Co-creating substantive reform with narrative pedagogy. *Journal of Nursing Education*, 44(6), 249-252.
- Diekelmann, N., & Smythe, E. (2004). Covering content and the additive curriculum: How can I use my time with students to best help them learn what they need to know? *Journal of Nursing Education*, 43(8), 341-352.
- Donaldson, S. K., & Crowley, D. M. (2002). The discipline of nursing. In J. W. Kenney

- (Ed.), *Philosophical and Theoretical Perspectives for Advanced Nursing Practice* (3rd ed.) (pp. 10-21). Sudbury, Ma: Jones and Bartlett. (Reprinted from *Nursing Quarterly*, 26(2), 1978, 113-120)
- Duff Cloutier, J., Duncan, C. & Hill Bailey, P. (2007). Locating Carper's aesthetic pattern of knowing within contemporary nursing evidence, praxis and theory. *International Journal of Nursing Education Scholarship*, 4(1), 1-11.
- Ehrenreichs, B. (2001, November). Welcome to Cancerland: A mammogram leads to a cult of pink kitsch. *Harper's magazine*, 303, 43-53.
- Fawcett, J., Watson, J., Neuman, B., Hinton Walker, P., & Fitzpatrick, J. J. (2001). On nursing theories and evidence. *Journal of Nursing Scholarship*, 33(2), 115-119.
- Fitch, M. I., & Abramson, T. (2007). Information needs of the adolescents when a mother is diagnosed with breast cancer. *Canadian Oncology Nursing Journal*, 16(1), 16-20.
- Gates, R. A., & Fink, R. M. (2008). *Oncology Nursing Secrets* (3rd Ed.). St. Louis, MO: Mosby Elsevier.
- Grimm, P. M. (2005). Coping: psychosocial issues. In J. K. Itano, and K. N. Taoka (Eds.), *Core Curriculum for Oncology Nursing* (4th Ed.) (pp. 29-52). St. Louis MO: Mosby Elsevier.
- Hartrick Doane, G. (2002). In the spirit of creativity: the learning and teaching of ethics in nursing. *Journal of Advanced Nursing*, 39(6), 521-528.
- Hartrick Doane, G., & Varcoe, C. (2005). *Family nursing as relational inquiry: Developing health-promoting practice*. Philadelphia: Lipincott Williams & Wilkens.
- Hogan, M. I. (2006). Making contact: Teaching, bodies, and the ethics of multiculturalism. *The Review of Education, Pedagogy, and Cultural Studies*, 28, 355-366.

- Houldin, A. D. (2007). Experiences with newly diagnosed advanced colorectal cancer. *Oncology Nursing Forum*, 34(2), 323-330.
- Itano, J. K. & Taoka, K. N. (2005). *Core Curriculum for Oncology Nursing (4th Ed.)*. St. Louis MO: Mosby Elsevier.
- Kiteley, C. A., & Fitch, M. I. (2006). Understanding the symptoms experienced by individuals with cancer. *Canadian Oncology Nursing Journal*, 16(1), 25-30.
- Langellier, K. M., Sullivan, C. F. (1998). Breast talk in breast cancer narratives. *Qualitative health research*, 8(1), 76-94. Retrieved September 29, 2006 from CINAHL database.
- Langhorne, M. E., Fulton, J. S. & Otto, S. E. (2007). *Oncology Nursing (5th ed.)*. St Louis MO: Mosby Elsevier.
- Lawler, J. (1991). *Behind the screens: Nursing, somology, and the problem of the body* (pp. 1-5). Melbourne, Australia: Churchill Livingstone.
- Lazenby, R. B., & Morton, R. C. (2003). Facilitating transformation through collaboration. *Nursing Education Perspectives*, 24(2), 91-93.
- Longman, A. L., Verran, J. A., Clark, M. (1991). Oncology knowledge inventory for undergraduate students. *Oncology Nursing Forum*, 18(1), 107-111.
- Love, B. (2005). Baccalaureate-linked oncology nursing education: McMaster University's pediatric and adult oncology nursing program. *Canadian Oncology Nursing Journal*, 15(2), 80-85.
- McAllister, M., Tower, M., & Walker, R. (2007). Gentle interruptions: Transformative approaches to clinical teaching. *Journal of Nursing Education*, 46(7), 304-312.
- McAllister, M., Venturato, L., Johnston, A., Rowe, J., Tower, M., & Moyle, W. (2006).

- Solution focused teaching: A transformative approach to teaching nursing.
International Journal of Nursing Education Scholarship, 3(1), 1-13.
- McDonald, C. & McIntyre (2001). Reinstating the marginalized body in nursing science: Epistemological privilege and the lived life. *Nursing Philosophy*, 2, 234-239.
- Mellon, S., Northouse, L.L., & Weiss, L. K. (2006). A population-based study of the quality of life of cancer survivors and their family caregivers. *Cancer Nursing*, 29(2), 120-131.
- Mezirow, J. (2003). Transformative learning as discourse. *Journal of Transformative Education*, 1(1), 58-63.
- Monti, E. J., & Tingen, M. S. (2002). Multiple paradigms of nursing science. In J. W. Kenney (Ed.), *Philosophical and Theoretical Perspectives for Advanced Nursing Practice (3rd ed.)* (pp. 10-21). Sudbury, Ma: Jones and Bartlett. (Reprinted from *ANS*, 21(4), 1999, 64-80)
- Musgrave, C. F. (1997). An oncology clinical experience in an Israeli baccalaureate nursing program. *Journal of Nursing Education*, 36(7), 337-339.
- Nevidjon, B. M., & Sowers, K. W. (2000). *A nurse's guide to cancer care*. Philadelphia: Lippincott.
- Paley, J. (2004). Clinical cognition and embodiment. *International Journal of Nursing Studies* 41, 1-13
- Parse, R. R. (1999). Nursing: The discipline and the science. *Nursing Science Quarterly*, 12(4), 275-276.
- Pierce, M. (1992). Undergraduate preparation of the oncology nurse. *Oncology Nursing forum*, 19(8), 1234-1237.

- Pitre, N. Y. & Myrick, F. (2007). A view of nursing epistemology through reciprocal interdependence: Towards a reflexive way of knowing. *Nursing Philosophy*, 8, 73-84. Retrieved October 5, 2007 from CINAHL database.
- Pope, S. (1992). Fundamentals for a new concept of oncology nursing in the professional nursing education program. *Cancer Nursing*, 15(2), 137-147.
- Purnell, M. J., Walsh, S. M., & Milone, M. A. (2004). Oncology nursing education: teaching strategies that work. *Nursing Education Perspectives*, 25(6), 304-308.
- Quinn-Casper, P., & Holmgren, C. (1987). Enhancing cancer nursing concepts in undergraduate curricula. *Cancer Nursing*, 10(5), 274-278.
- Raveis, V. H. & Pretter, S. (2005). Existential plight of adult daughters following their mothers breast cancer diagnosis. *Psycho-Oncology*, 14, 49-60.
- Rodney, P., Varcoe, C., Storch, J. L., McPherson, G., Mahoney, K., Brown, H., Pauly, B., Hartrick, G., & Starzomski, R. (2002). Navigating toward a moral horizon: A multisite qualitative study of ethical practice in nursing. *Canadian Journal of Nursing Research*, 34(3), 75-102.
- Rolfe, G. (2006). Nursing praxis and the science of the unique. *Nursing Science Quarterly*, (19)1, 39-43
- Rushton, P. (1999a). An undergraduate oncology nursing course. *Oncology Nursing Forum*, 26(1), 75-79.
- Rushton, P. (1999b). Teaching cancer principles to undergraduate students. *Journal of Nursing Education*, 38(2), 77-80.
- Sarna, L. & McCorkle, R. (1995). A cancer nursing curriculum guide for baccalaureate nursing education. *Cancer Nursing*, 18(6), 445-451.

- Shands, M. E., Lewis, F. M., Sinsheimer, J., & Cochrane, B.B. (2006). Core concerns of couples living with early stage breast cancer. *Psycho-Oncology*, 15, 1055-1064.
- Slaninka, S. C. (1992). Coping with cancer: Creative teaching strategies in an elective for nursing students. *Journal of Cancer Education*, 7(1), 67-72.
- Smith, A. (2007) Measuring the use of intuition by registered nurses in clinical practice. *Nursing Standard*, 21(47), 35-4.
- Smith, L. S. (2000). Said another way: Is nursing an academic science? *Nursing Forum*, 35(1), 25-29.
- Storch, J. (2004). Nursing ethics: A developing moral domain. In J.L. Storch, P. Rodney, and R. Starzomski (Eds.), *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice*. (pp.1-19). Toronto, Ontario: Pearson Prentice Hall.
- Thorne, S., Canam, C., Dahinten, S., Hall, W., Henderson, A., & Kirkham, S. R. (1998). Nursing's metaparadigm concepts: Disimpacting the debates. *Journal of Advanced Nursing*, 27, 1257-1268.
- Thorne, S. E. & Murray, C. (2000). Social Constructions of breast cancer. *Health care for women international*, 21, 141-159. Retrieved September 29, 2006 from CINAHL database.
- Whall, A. L. & Hicks, F. D. (2002). The unrecognized paradigm shift in nursing: Implications, problems, and possibilities. *Nursing Outlook*, 50(2), 72-76. Retrieved October 5, 2007 from CINAHL database.
- Wilde, M. H. (1999). Why embodiment now? *Advances in Nursing Science*, 22(2), 25-58.
- White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science*, 17(4), 73-86.

Yorks, L., & Sharoff, L. (2001). An extended epistemology for fostering transformative learning in holistic nursing education and practice. *Holistic Nursing Practice, 16*(1), 21-29.

Appendices

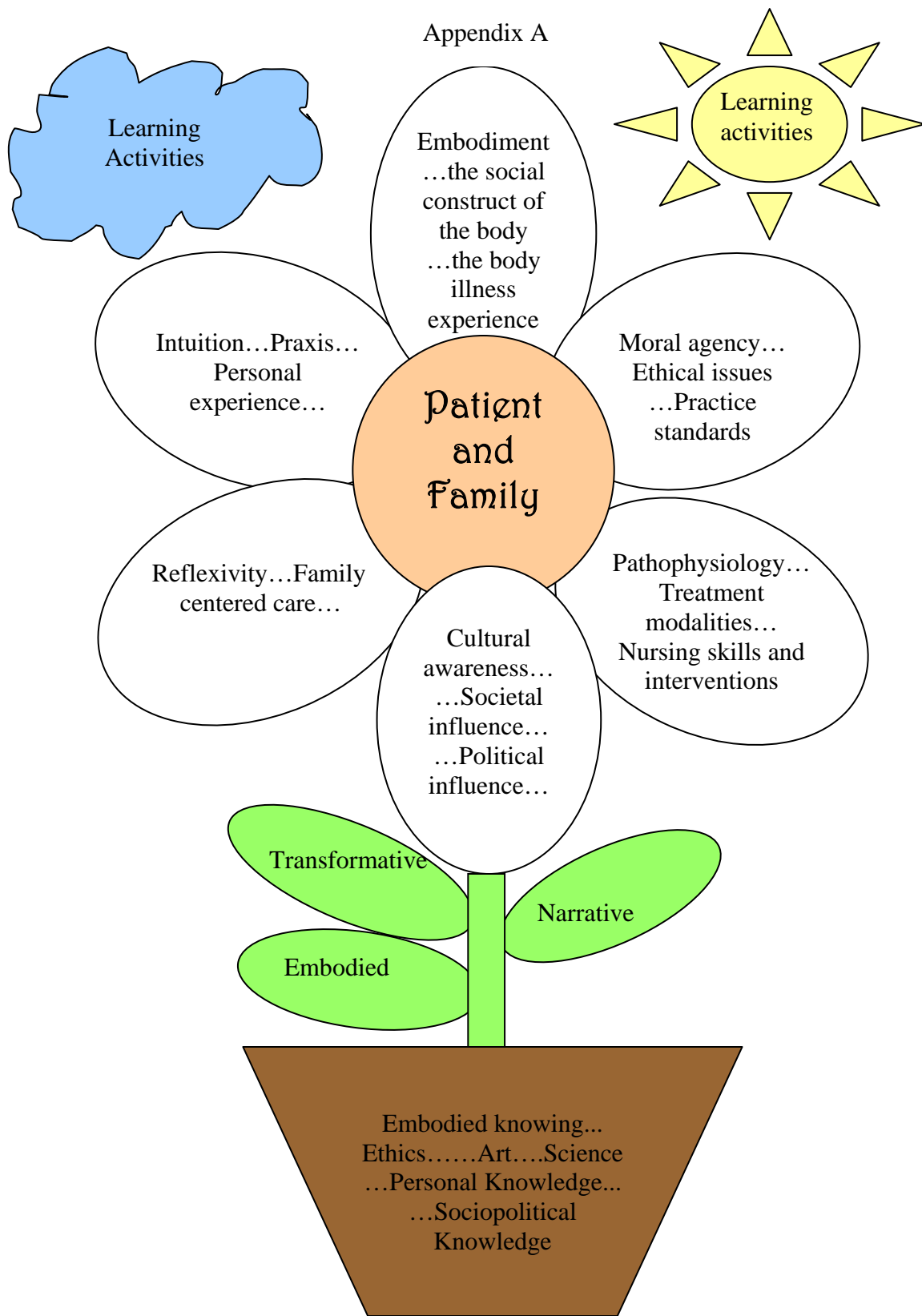


Fig. 1.0. The foundational concepts of the Oncology Nursing Course.

Appendix B

**UNIVERSITY COLLEGE of the FRASER VALLEY
COURSE OUTLINE****DEPARTMENT:** Nursing**DATE:** 2008/2009**NAME AND NUMBER OF COURSE:** Nurs 430a – Selected Topics in Nursing**COURSE TITLE:** Oncology Nursing Care**CREDITS:** 3**COURSE PREREQUISITES:** Nurs 220 or upon permission**COURSE COREQUISITES:** none**HOURS PER SEMESTER:** 42**COURSE DESCRIPTION:**

This course is designed to provide nursing students with the opportunity to explore the human cancer experience. Through a variety of teaching and learning approaches students will uncover personal meanings, examine theoretical knowledge, and discuss ethical concerns related to cancer care. Learning will focus on multiple ways of knowing which may include: embodied knowledge, the art of nursing, personal knowledge, ethics, the science of nursing, and socio-political and environmental knowledge. Course content is primarily investigated through a case study approach and small group seminars. Students will have the opportunity to engage with community groups and individuals living with cancer.

COURSE GOALS: At the conclusion of this course, students will

1. Understand the complexities of the cancer experience along the cancer continuum.
2. Provide individualized and holistic care to people with cancer and their families.
3. Demonstrate the capacity to develop supportive, knowledgeable, and caring relationships with individuals and their families throughout their cancer experience.
4. Provide nursing care that focuses on knowledge-based practice in a variety of cancer care settings and opportunities.
5. Describe a variety of ethical concerns related to cancer care.

6. Understand the role that the environment, society, and cultural constructs have in the cancer experience.

COURSE CONTENT:

See Conceptual Blueprint

RESOURCES:

Selected Readings:

Langhorne, M. E., Fulton, J. S. & Otto, S. E. (2007). *Oncology Nursing* (5th ed.). St Louis MO: Mosby Elsevier

Journal References

Internet Sites:

BC Cancer Agency (www.bccancer.bc.ca)

Canadian Cancer Society (www.cancer.ca)

Canadian Association of Nurses in Oncology (www.cano-acio.org)

Oncology Nursing Society (www.ons.org)

EVALUATION:

Student Seminar Summary (Individual)	20%
Poster Presentation (Group)	25%
Community Experience Summary (Group)	20%
Cancer Care Journal (Individual)	35%

Table B1

Conceptual Blueprint for Oncology Nursing Elective

Case Study Synopsis	Art / Personal Knowledge	Science	Ethics	Sociopolitical - Environmental
Mrs.B – 35 year old woman, married with 2 young children, works at home, recently immigrated from India, strong family history of breast cancer, having chemotherapy following bilateral mastectomy	<ul style="list-style-type: none"> • Family centred care 	<ul style="list-style-type: none"> • Breast cancer • Surgery • Chemotherapy – adverse effects 	<ul style="list-style-type: none"> • Genetic counselling • Cultural relativism 	<ul style="list-style-type: none"> • Cultural constructs of illness experience • Environmental estrogenic sources
Mr. H - 55 year old man, single, smoker, works as a long-haul truck driver, limited support system, having radiation for cancer of the larynx, requires prophylactic feeding tube, having a difficult time coping	<ul style="list-style-type: none"> • Relational capacity 	<ul style="list-style-type: none"> • Head and Neck cancers • Radiation – adverse effects • Dual modality treatment • Nutrition • Teaching and learning 	<ul style="list-style-type: none"> • Moral agency • Euthanasia 	<ul style="list-style-type: none"> • Environmental factors of cancer • Life style factors in cancer
Mr. C – 65 year old man, married with 4 grown children, retired, history of Crohn’s disease, awaiting	<ul style="list-style-type: none"> • Values and Beliefs 	<ul style="list-style-type: none"> • Colon cancer / GI cancers • Cancer-related fatigue 	<ul style="list-style-type: none"> • Informed choice / autonomy 	<ul style="list-style-type: none"> • Dietary risk factors

recent colonoscopy results, does not want treatment if results are positive for colon cancer

Mrs. L – 67 year old woman, widow, worked as a waitress, 2 grown children live out of province, recently diagnosed with advanced stage lung cancer and metastatic disease, will begin short course of radiation with palliative intent

- Interdisciplinary collaboration

- Lung cancer
- Palliative radiation
- Dypnea
- Pain

- Advanced directives

- Occupational risks / factors

Mr. M – 58 year old man, married, construction worker, referred to the cancer centre by the dermatologist, his wife noticed changes in a mole on his back

- Personal experience

- Melanoma/ Skin cancers
- Interferon therapy

- Clinical trials

- Cancer prevention – self examinations, health care provider examinations

Ms. C – 29 year old woman, single, lives with her partner, works as a teacher, first PAP test in 10 years prompted further investigation and subsequent diagnosis of

- Reflexivity

- Cervical cancer / Gynecological cancers
- Surgery

- Cervical cancer vaccine
- Fertility

- Societal constructs of illness experience

cervical cancer

Mr. P – 70 year old man, married, 3 children and grandchildren live locally, noticed increasing nocturia and frequency, diagnosed with prostate cancer, presented with many treatment options, family anxious, not sure of best approach

- Sexuality and Intimacy

- Prostate cancer / genitourinary cancers
- Sleep disturbances
- Hormonal therapy
- Brachytherapy

- Advocacy
- Watchful waiting

- Prostate examinations

Mrs. N – 64 year old woman presents to the ER with a 2 year history of advancing brain cancer and a recent history of decreasing level of consciousness, hemiparesis, and elevated temperature, ex-husband is angry and wants to know what is happening

- Praxis

- Brain cancer / CNS cancers
- Oncologic emergencies

- Confidentiality

- Community palliative care resources/ hospice

Miss. S – 5 year old girl diagnosed with leukemia, recent relapse, scheduled for bone marrow transplant, parents are questioning treatment plan

- Family support

- Acute leukemia / chronic leukemia
- BMT

- Resource allocation

- Community support groups / resources

Mr. H – 50 year old man diagnosed with leukemia, lives with his partner, is running out of traditional treatment options and is looking for alternative therapies

- Intuition

- Lymphoma / myeloma
- Biotherapy

- Alternative therapies

- Marginalized groups – experience of illness
-

Appendix C

NURS 430a
STUDENT GUIDE

2008/ 2009

TOPIC: BREAST CANCER CARE

CLASS: 3 hrs.

OVERVIEW:

During this class students will have an opportunity to explore concepts in breast cancer care through large group case study discussion and small group seminar.

GOALS:

1. Describe the complexities of the breast cancer experience.
2. Identify some of the cultural constructs of the cancer experience.
3. Discuss the basics of chemotherapy treatments and adverse effects.
4. Discuss the potential relationship between environmental estrogenic sources and breast cancer.
5. Include family centred care into nursing care approach.
6. Describe the ethics of genetic counselling and cultural relativism as a part of cancer care.
7. Describe the pathophysiology of breast cancer.

LEARNING ACTIVITIES

Class preparation:

1. In your journal write about any previous experiences you have had with breast cancer. What are your thoughts about the experience-what did you learn-what questions were you left with-? If you have had no previous experience-what are your thoughts about how people experience breast cancer?
2. Read the following:

Crane-Okada, R. & Loney, M. (2007). Breast Cancers. In Langhorne, M. E., Fulton, J. S. & Otto, S. E. (Eds.), *Oncology Nursing* (5th ed.). St Louis, MO: Mosby Elsevier. Chapter 7, pp. 101-123.

Howard, A. F., Bottorff, J. L., Balneaves, L. G., & Grewal, S. K. (2007). Punjabi

immigrant women's breast cancer stories. *Journal of Immigrant Minority Health*, 9: 269-279.

3. Explore the Hereditary Cancer Program at the British Columbia Cancer Agency (BCCA) by accessing the website: www.bccancer.bc.ca and follow the links from "patient/public info" to "prevention" to "Hereditary Cancer Program".
4. Read the following case study and answer the questions in your journal

MRS. B – CASE STUDY

Mrs. B is a 35 year old woman recently diagnosed with infiltrating ductal carcinoma, stage T1, node negative, ER negative. She is receiving her third cycle of the chemotherapy protocol "BRAJAC" and is suffering from significant episodes of nausea 3-4 days following her treatments.

Mrs. B is married with 2 young children and works at home. She has recently emigrated from India and has a strong family history of breast cancer (grandmother and two sisters). She had a bilateral mastectomy prior to starting chemotherapy treatments. She has a supportive network of family and friends. Her two little girls and mother-in-law always come with her to the chemotherapy room.

Mrs. B is concerned about the future of her two little girls and asks you about their risk of developing breast cancer. She is concerned about the effects of her breast cancer diagnosis on her family and is having a difficult time providing emotional support to her family and maintaining her beliefs. She would like to have more children when her treatments are completed and asks you if this will be a problem.

In your journal:

1. After completing the assigned readings and reviewing the case study, formulate 2-3 critical questions that you feel you need to answer before you care for Mrs. B? These questions should reflect multiple ways of knowing.
2. What would your focus/ foci be when caring for Mrs. B and why?