First Helene Hudson Memorial Lecture sponsored by Amgen Canada

Seasons of Caring

By Stella Dyck

Abstract

This manuscript is the Helene Hudson Memorial Lecture presented at the annual CANO meeting in Vancouver August 11, 1994. The lecture was accompanied by a slide show that provided symbolic interpretation to the analogies. It discusses nursing care during the various levels of intervention throughout a client’s experience with cancer. Primary prevention is compared to the spring when the atmosphere is full of the promise of life and health. Secondary prevention is compared to the summer. The autumn of the year, the time of decline in growth and impending death in nature, is related to palliative care. Finally, the winter of silence that follows the death in nature, the waiting for renewal, is likened to the grief and loss that is ever-present in our work. The theoretical framework for caring follows Gutt’s (1983) definition of caring.

At the age of 27, I stood at the graveside of my 29-year-old husband of almost five years. In my arms I held our three-year-old son. The bittersweet memories of coping with Hodgkin’s Disease set me on a career path that led to specializing in oncology nursing. It took more than a decade of nursing in other fields before my own journey through grief, and career circumstances, brought me into the cancer arena in a more deliberate manner. I wonder how many of you have a specific personal story that has been a major factor in making cancer nursing the focus of your career. The personal dimension that has brought many of us into this sphere of nursing endows us with some unique qualifications for the work, but also imposes some specific vulnerabilities. From my contact with nurses here in the Canadian Association of Nurses in Oncology and the Oncology Nursing Society, I am convinced that nurses who choose the oncology field are nurses who have an unusual understanding and grasp of the meaning of caring. Therefore, as I entitled my talk “Seasons of Caring”, I am convinced that each one of you would be able to share a special message about caring.

Seasons of caring reflect the role of caring provided by nurses throughout the seasons of human life. In particular, it relates our caring in cancer nursing to the various levels of intervention provided to clients throughout their sojourn with the disease. I want to compare our role in primary prevention to the spring time, when the atmosphere is full of the promise of life and health. I will compare secondary prevention to the summer time. I will relate the autumn of the year, the time of decline in growth and impending death in nature, to palliative care. Finally, the winter of silence that follows the death in nature, the waiting for renewal, will be likened to the grief and loss that is ever-present in our work. I want to remind us of the rhythm and order that flows through the world of nature, and through us as part of the great design of nature. Even in our relationships with clients, there is an ebb and flow of change, maturation, and finally disengagement.

Before I proceed into a discussion of the levels of nursing intervention, I want to spend some time reflecting with you what I mean when I talk about caring. Caring is more than good intentions and warm fuzzy feelings. Caring calls for a moral commitment that strives to protect human dignity and preserve humanity (Watson, 1985). Care as a noun is derived from “kara” in the Old English and Gothic language where it meant grief, lament, sorrow, or bed of sickness. Its earliest uses were directed at charging the mind with concern or attention (Gaut, 1983) to a hurting situation.

While much has been written about caring by such notables as Watson, Leininger, Parse members of the International Association of Human Caring, I find Gaut’s (1983) description of caring particularly meaningful. She identified three conditions of caring. First, there must be an awareness of the need for care and knowledge that something can be done to alleviate the problem. Secondly, there must be action, chosen from alternatives based on

PREMIÈRE BOURSE DE CONFÉRENCE À LA MÉMOIRE DE HELENE HUDSON PARRAINÉE PAR AMGEN CANADA LES SOINS AU FIL DES SAISONS

Abrégé

Ce manuscrit est celui de la Conférence à la mémoire de Helene Hudson prononcée à l’assemblée annuelle de l’ACIO tenue à Vancouver le 11 août 1994. La conférence était accompagnée de diapositives qui présentaient une interprétation symbolique des analogies. On y trouve une discussion des soins infirmiers aux divers niveaux d’intervention tout au long de l’expérience du client avec le cancer. La prévention primaire est comparée au printemps, lorsque l’atmosphère est pleine de la promesse de vie et de santé. La prévention secondaire est comparée à l’été. L’automne, le temps du déclin dans la croissance et de la mort imminente dans la nature, est relié aux soins palliatifs. Enfin, l’hiver de silence qui suit la mort dans la nature, l’attente du renouveau, est assimilé au deuil et à la perte toujours présents dans notre travail. Le cadre théorique des soins se conforme à la définition des soins de Gaut (1983).

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knowledge, for the purpose of bringing about a positive change. Action involves taking responsibility by providing comfort, facilitative coping, health consultation, health instruction, health maintenance activities, support, and touching, to name but a few (Rosenbaum, 1986). Finally, there must be a positive outcome, to be judged solely on the basis of recipient welfare. Watson (1985) added an additional condition of caring, that is to possess the "underlying value and moral commitment to care" (p. 32). This commitment requires such attitudes as compassion, concern, empathy, interest, involvement, love, surveillance, tenderness, and trust (Rosenbaum, 1986). In brief, this means we must be aware, we must act, we must achieve results; all because we have a commitment to improve the situation for our clients.

During this international cancer nursing conference, we have been sharing learning, stories, resources, problems and concerns with nurses from around the world. We have become aware that our concerns are not all the same. Our ways of approaching problems are different. When it comes to caring, the first prerequisite is that of awareness. This requires undivided attention to the other. My experience with cross-cultural situations is limited, but I have visited other cultures just enough to know that in order to relate effectively, particularly in areas as sensitive as health, we need to equip ourselves with a lot of knowledge about the other culture before we suggest any of our solutions. We must attend unconditionally to their concerns and hear their perspectives. We are a society of "instant": Instant communication by fax, instant food, instant computer analysis, rapid transit systems, microwave dinners, and the list goes on. We are an impatience society - in sharp contrast with some of the more ascetic cultures. Transcultural nursing must take into account six cultural phenomena that vary from one culture to another. These are: The way we communicate; our perception of personal space; how we ascribe authority in our social organization; the meaning of time; our view on environmental control; and obvious biological variations (Giger & Davidhizar, 1991). Developing helping relationships across cultural differences cannot be put on fast forward while giving due recognition to these factors just cited. Patience is of the essence. We must be willing to receive before we give and receive even as we give. Let us keep this in mind as we explore the seasons of caring in relation to our colleagues around the world.

As I address issues in seasons of caring, I hope to challenge us to two or three provocative thoughts on caring for each season. The best time to provide caring in cancer nursing is in the primary preventative phase. During youth and health there is minimal concern about cancer. Therefore we need to emphasize awareness of need. This is the need to prevent exposure to both initiation and promotion of carcinoogens. As nurses, we know many of the carcinoogens. I wish to focus on two of these carcinoogens and suggest some caring approaches.

In North America, we face a long way in creating tobacco risk awareness, both for primary user and second-hand accomplice. This awareness is not yet shared by much of the rest of the world. Smoking incidence has in fact risen in the last 25 years, largely due to the smoking increase in Asian and Middle Eastern countries. We need to encourage our nursing colleagues to work unceasingly for the elimination of tobacco use in both the industrialized and developing worlds.

According to the World Health Organization, Canada and United States currently rank ninth and tenth in the world in male death rates from lung cancer. Female death rates from lung cancer rank second in United States and sixth in Canada. The number-one spot for death rates from lung cancer goes to Hungary for males and to Scotland for females. Other countries scoring high in lung cancer death rates are European and Asian countries (Boring, Squires, Tong & Montgomery, 1994). Several countries still have fairly low death rates from smoking-related malignancies. One can hypothesize several reasons including incomplete vital statistics and the much higher incidence of infectious diseases in these countries, which claim lives before smoking-related cancers have time to develop. As other diseases become more effectively controlled throughout the world, smoking-related cancers will inevitably rise in direct relation to smoking rates. Therefore, we need to be proactive in encouraging anti-smoking activities around the world. As cancer nurses, we should not rest until we have seen the death of the tobacco industry. We should not rest until farmers have turned their tobacco plantations into market gardens, herb emporiums and tulip fields, and retailers stock wholesome merchandise where cigarette packages now are shelved. We need to lobby, boycott, teach, write, make models, and do whatever we can to eliminate tobacco use throughout the entire world, to eradicate this number-one known carcinoen that is implicated in at least eight different body site cancers (Metz & Mirand, 1991).

The second area of primary prevention that I wish to address is that of promiscuous lifestyle-related cancer. The evidence is convincing that malignant changes in the female cervix increase with early onset of coitus and multiple male partners. This is a condition for which we have excellent screening tests available. Yet we continue to see advanced cases of cancer of the cervix in our cancer clinics. In particular we need to target a cross-cultural situation within our own geographical borders. The incidence of cancer of the cervix is two to three times higher among native women than among non-natives. In addition it is very difficult to persuade native women to present themselves at colposcopy clinics and even more difficult to persuade them to come for follow-up visits when deemed necessary (personal communication, C. Haines, Saskatchewan Provincial Cancer Epidemiologist, July 26, 1994).

There are several caring activities we need to become involved with in this area. One of these activities is to convincingly teach young people to abstain from early intercourse. Of course the risk of AIDS and the consequent increase of AIDS-related malignancies is an even more compelling reason for abstinence than cervical malignancies. Pro-abstinence is not a very popular stance to take when we know our children are becoming sexually active at an increasingly younger age and when many advocate safe sex through condom use. Condoms are better than no protection. But we all know that if condoms were absolutely safe the world population would indeed be considerably smaller. To say we cannot tell our teenagers to abstain reminds me of the state of science relative to smoking risks when I first entered nursing. It was considered impolite to request that anyone refrain from smoking in our presence or in our home. Everyone had the right to smoke. It is a mere dozen years ago, while on public transportation in the United States, that I was told that I could not allow my need for clean air to infringe on a fellow passenger's right to smoke. When the risks of cigarette smoke first were reported, the cigarette industry responded by introducing filter-tip cigarettes so we could have the pleasure without the consequences. We now know, of course, that the filter ploy did not work. The medical score is the same on the issue of sexual promiscuity, but the words are different. "You cannot tell young people not to have intercourse." "It is safe if they use condoms." "Let them have their pleasure without the consequences." We need to have the courage to speak out and advocate abstinence until such time that the young person is mature enough to make a lifetime commitment of monogamy. We cannot leave such activity to the isolated fundamentalist church groups who campaign for youth to sign "chastity til marriage" vows. I am not advocating that we keep our children uninformed about sexual issues and simply say "don't do it." Quite the contrary. I believe we need to start sexuality education very early and that this education include the role of condoms, complete with the risks and weaknesses.

The very young are so impressionable. This summer I have been volunteering with the Cancer Society's Mole Patrol sun safety program. Instead of telling the youngsters what they should do, I started my discussions with them by asking them what they knew about sun safety. I was impressed that most youngsters could tell me at least two of the three "Slip, Slap, Slop" (Canadian Cancer Society, 1993) actions recommended. One particularly delightful interaction
involved a bright little girl in the company of her father. She rattled off the "Use a hat, cover yourself, and use sunscreen" answer with confidence. This youngster was going to be three years old at the end of the month. Youngsters like this one will grow up with an established behavior pattern in regards to sun safety. We must in similar manner instill safe behavior patterns in youngsters about sexual behaviors before their hormones begin to run rampant through their bodies.

Obviously there are many areas that could be addressed in primary prevention. Hopefully, these suggestions will trigger ideas for pro-active intervention in other areas as well. Caring, in primary prevention, is creating an awareness of need to prevent exposure to carcinogens, acting on knowledge of known carcinogens, and achieving positive behavioral responses that will result in healthier future generations.

Let us move on into the summer of our caring. This is the time of early detection and treatment. This time of caring is the one with which the majority of us are most familiar.

We meet the clients when they find themselves virtually on a precipice; as they wait for diagnostic results, have just received a cancer diagnosis, face treatment, or anticipate life-altering sequelae of treatment such as loss of a body part or function. Our initial interaction is crucial to client welfare. To relate effectively to the client we must know who the client is, what the client's powers and limitations are, what the client's needs are, and what is conducive to that individual's growth (Mayeroff, 1971). This requires careful assessment. Apparently a farmer was out riding his horse when he was hit by a truck. Several weeks later he was in to see his lawyer and wanted to sue for personal injury. The lawyer expressed surprise. "How is it that the police report indicates you reported no injury?" "Well," replied the farmer, "you have to understand the circumstances. When the police officer came to the scene of the accident he saw my horse on the road with a broken leg, so he shot him. Then he saw my dog in the ditch withing in pain, so he shot him. Then he turned to me and asked me, 'And how are you?'"

In our client assessment, we must always be mindful of the context of the situation. We must be cognizant of concurrent circumstances, the way we ask questions, meaning ascribed to the questions, and the implications the client perceives in the answer. All have a bearing on the response. If a positive answer will lead to difficult diagnostic tests or treatment with intolerable side effects, the answers we get may not always reflect the true status as known to the client.

We must know how to respond to the needs thus identified. One of our oncology social workers said to me one day: "Don't expect me to provide psychological counseling and support to a client who is in physical pain, lying in a messy bed, or whose mouth is crusted, sore and foal. If basic comfort needs are not met, there is no point in attempting psychological interventions. Basic comfort needs are the first order of caring." I am profoundly convinced that, when everything is falling apart, physical comfort and safety needs must be addressed first. Studies that explored both nurses' and clients' perceptions of what constitutes caring show an interesting dichotomy. Clients consistently ranked nurses' technical competence as the most important aspect of caring. Nurses consistently ranked interactive activities such as listening and touching highest (Larson & Dodd, 1991). My own research showed that the families have the same high priority expectations for competent nursing care for their loved ones as do the clients (Dyck & Wright, 1985).

Competent care requires both specific knowledge and general knowledge. This will continue to require a great deal of our energy as we build and update our knowledge base to keep current with up-to-date diagnostic and treatment regimens. It has been conjectured that in the coming 20 years biomedical research will identify some 210 genes that cause cancer. These genes will be mapped and sequenced and the technology will be available to manipulate them back to a healthy state (Brown, 1990). Providing nursing care will require an increasingly more refined biochemical knowledge base. We will have to be committed to continual formal and informal learning to find our way through the maze of new scientific knowledge. We will need to read professional journals, attend in-service workshops and conferences, and some will need to go on to graduate school to provide the essential leadership in nursing.

During the time of initial diagnosis and treatment, the client and family are often in crisis as they are challenged to make decisions, rearrange their life situations, and manage daily treatment regimens. Nurses are usually well-versed in crisis intervention and act appropriately (Aguilera & Messick, 1982). We are adept at assisting the client to bring everything into clear focus. There is a sharpness and immediacy in the situation that demands response and nurses are very good at coaching clients through this phase. When the disease continues, when the client is at home alone and coping with the daily grind, the daily nagging fear and the daily drain of energy with its resultant fatigue, nurses are not readily available to the client. In this chronic phase of the illness, there are unique needs for intervention. A mother of a child with chronic illness expressed this in the following metaphor:

"Chronic illness is like a piece of sand inside an oyster; it irritates and creates a pearl, or it just dies." (Hagedorn, 1990, p.227)

Living with survivorship is not always unqualified pleasure at having beat the disease. It brings with it an array of concerns. These include: physical after-effects of treatment; psychological problems; fear of emotional engagement; finding meaning in the disease experience; isolation; difficulty resuming life-oriented modes of thinking; fear of recurrence; employment discrimination; and changes in relationships (Dow, 1991; Gambosi & Ulrich, 1990).

Sue and Bill were in their first year of marriage when they discovered that Bill had acute leukemia. The diagnosis and initial treatment was a horrendous experience for them, complete with usual and unanticipated side effects that became imminently life-threatening. Bill struggled with the ultimate question of "Why me?" Then he recovered and experienced a complete remission. Again he asked "Why me? When I see other patients deteriorating and dying, why should I be well now?" Years later, I met Sue. Bill was still in remission. But, they were in marriage counseling because, as she put it: "We are now trying to live in a future we thought we wouldn't have and we are having difficulty handling that."

"Surviving is a process, not an endpoint" (Dow, 1991, p.56). Our nursing role is nebulous and ill-defined for such occasions. It is here that nurses in community agencies and wellness centres have a singular role in facilitating coping. Most of all, nurses need to be available to listen to client concerns. The summer of caring requires an awareness of need based on expert assessment, and competent caring actions based on sound, up-to-date theory so that the outcomes for clients in the acute and chronic phases of the illness are positive.

When the seasons turn and fall approaches, health and vitality ebb. As North American nurses, I believe we have a lot to learn from our colleagues around the world when it comes to palliative care. We rely on technical aids to provide comfort. In non-Western cultures, nurses view care as protective and surveillance acts within sociocultural norms. Leininger (1984) found that there is greater congruence between the expectations of care recipients and caregivers in the non-Western world than in North America. Nursing care must always strive to serve client needs, not dictate them.

The terminal illness phase is definitely a time to rise above the biomedical model and focus on the meanings, hopes and dreams of the individuals we serve (Quicero & Knight, 1991). Throughout the cancer experience, the role of hope must always play a key role in our interactions with clients. As the final stages are lived out there is usually an increased awareness of the need to find meaning in life, to put one's life story into a perspective. It is often at this point that we learn so much about the ultimate values of life from our clients. When we see how
they discover, rather than create their lives, we see how many live well in their last days. They do not merely cope, they overcome.

As nurses, we sometimes feel guilty about our health and our joy in living when we care for someone who is dying. This is particularly so when that person is our own age. Weissman recommends that we remember that everyone’s turn will come. He stresses the need for approaching the client with the philosophy: “What can I do now when it’s not my turn that I hope someone else will do tomorrow when it may be?” (cited in Vachon & Stylianou, 1991).

When we care for the dying we dare not minimize the grief of loss, the giving up of one function after the other, the final separation from all that is known and dear. If we act as if the losses were not that bad, or not that difficult, we trivialize the ultimate struggle. What we need to do is to give full recognition of the pain and draw close to the client and the family in this long, final journey to travel it with them. For eventually we all sit “on the mourners’ bench that is longer than we had imagined” (DeVries in Hauerwas, 1990, p.34). It is in giving recognition that we too have the right and obligation to mourn our clients’ losses and death that we deal with this grief at the time of the loss and avoid stockpiling unresolved losses (Vachon & Stylianou, 1991).

Another dimension of caring during the terminal phase that nurses must address relates to ethical decisions. As cancer nurses we are expected to contribute to ethics committee deliberations and policy-setting bodies because of our expertise in caring for those who can no longer speak for themselves. Brown (1990, p.500) stated: “There will be those who don’t know how to die, and if we continue to apply all the expensive medical technologies at our disposal to this institutionalized group, they will become terrible burdens to themselves, their families, and the health care system”. On what basis do we, and will we, make hard decisions about prolongation of dying for individuals whose bodies are riddled with disease? Can we put into a global perspective the implications of spending hundreds of thousands of dollars on complicated technology to prolong the life of one individual whose life expectancy is mere days when there are thousands of children elsewhere who could hope to reach adulthood if only they had access to vaccines and clean water? As nurses, we need to consider our global responsibilities within the perspective of limited resources on a planet that should be a neighbourhood.

In the late twentieth century we have come to a place where we view “Illness as an absurdity” (Hauerwas, 1990, p.63), for in our worship of science with all its answers we conclude that illness should not exist. But it does. In particular this presents problems to us when we are confronted with cancer. In spite of improved statistical five-year survival rates for individuals with cancer, it still ultimately proves to be a fatal disease in many instances. In our commitment to science as providing a cure—all we ascribe to a philosophy that “we ought to do what we can do” (Hauerwas, 1990, p.64) without necessarily asking whether such action will truly be beneficial to the recipient. This is the point at which palliative care has made such a major impact on the health care scene in relation to cancer care. Nurses have had a key role in placing more emphasis on being with and caring, rather than doing for and curing. This ideology underscores all of palliative care. Unfortunately, it still remains a foreign world view for many health care providers.

Several years ago, while on sabbatical, I spent six months studying in the area of palliative care in St. Boniface General Hospital in Winnipeg and in transition services in Seattle. I was duly impressed with the effective implementation of the philosophy of caring and support that I saw. Those six months were followed by another six months at the University of Texas and M.D. Anderson Cancer Center. The latter is one of the leading active treatment centres in North America, where people from all over the world come for treatment. I spent my first month in Texas on location in the bone marrow transplant unit. During the first several weeks I experienced a great deal of dis-ease. Something was terribly wrong for me and I could not identify what it was. Everyone was exceptionally helpful. I was learning a great deal. It was exciting and stimulating. But there was an emotional restlessness within that was most disconcerting. One day I took a long, hard look into my emotional mirror and suddenly realized I was experiencing major cognitive dissonance. My philosophical orientation was still in palliative care, but my professional and academic orientations were in an acute care setting that operated on the motto of “you can’t beat if you don’t treat”. This cognitive dissonance, in the opposite direction, is a factor that makes it exceedingly difficult, if not impossible, to provide true palliative care to clients on an acute care unit.

Don was a 50-year-old man who had to change oncologists because his oncologist relocated to another province. Typically, he experienced some anxiety about this change as he had come to trust his own physician. He made a statement about his new oncologist, who was known for his rather aggressive approach to therapy: “I know Dr. X. will want to treat me all the way to the funeral home if he can have his way, but I guess I will have some things to say about that”.

In the terminal phase we need to be aware of whose need is being served. Our actions will need to be our willingness to be with the client in the final journey. To assure a positive outcome, we need to understand the ideological assumptions that form the underpinnings of our decisions.

After the death in nature we enter the long, cold winter of dormancy. It is important that, as nurses, we recognize that after considerable productivity, continuous giving and extending ourselves for others, there comes a time when we must acknowledge our needs and face the fact that we will go through emotional winters. These are times when the wellspring of our emotional energies lies dormant under the cold snows of fatigue, grief and apathy. To move forward at such times, to prepare ourselves for continued caring and future meaningful involvement with clients, we need time for contemplation. We need time to take stock of our inner resources, values and limitations. There are many aspects to maintaining emotional health, however I will only focus on selected self-sustaining responsibilities.

I would like to share with you three key dimensions that could be part of an introspective stock-taking. First of all, we need to assess where we are in relation to our view of life. Human care needs to be associated with values that ascribe to a deep respect for the wonders and mysteries of life (Watson, 1985). Science has found many answers to questions that a century or two ago were all part of the divine or supernatural realm. Today it is possible to transplant up to five body organs at one time into one person and see that person return to his home. We genetically alter cells. We fertilize ova in vitro. We transplant embryo. We have become slaves to our power over nature and circumstance (Hauerwas, 1990). But let us never forget the wonders and mysteries associated with birth and death, new life springing from the earth, the drama of a storm, the grandeur of the cosmos. Let us take time to marvel at the grandeur and wonder of that which we do not, and perhaps ought not, understand, but merely appreciate.

Secondly, we need to acknowledge a spiritual dimension to life (Watson, 1985) for ourselves and for those for whom we care. Spirituality encompasses the belief systems, religious persuasion, and living experiences that address the existential problems of humanity’s existence and non-existence. It deals with the moral awareness, ethical norms, and the origin and order of the world (Kung, 1977). It is the spiritual dimension that allows us to overcome our own self-centeredness as individuals. It is the will to see beyond our limited and immediate concerns that lead to self-defeating thoughts, emotions, moods and actions. It is the will to instead ascribe to a greater entity in the universe. This view enables us to put our concerns into a better perspective in the total scheme of things. It allows us to draw power and energy to cope with our hurts, losses and failures. Even more than mere coping, it can be a source for a new vibrancy and energy to enrich our personal and professional lives. It helps us to achieve a personal unity and harmony of mind, body and soul (Boyd & Mast, 1989). We name that spiritual experience in different ways. We call that spirit God,
Yahweh or Allah as examples of three great historical religions of the world, but not the exclusive religions.

Thirdly, we need to accommodate to change and strive for growth through that change. Several decades ago, Peplau identified that the therapeutic relationship between nurse and client was one that would lead to maturation and learning for both (Peplau, 1952). This implies that we approach clients as colleagues in their health-seeking behaviour.

When our colleagues at St. Michael's Hospital in Toronto adopted Parse's model for their nursing department, they found that understanding clients was much easier when they worked in partnership rather than in a paternalistic manner. As they entered into joint planning with clients, there was greater client satisfaction and more personal fulfilment for the nurses (Quienno & Knight, 1991).

When we allow ourselves to learn along with the client, we can gain so much wisdom about living from our clients. Although we have not all cared for a Terry Fox, I am sure we can all recall those very special clients who impressed us with their strength of will, their nobility in the face of suffering, their optimism in the face of failing health, and their humour in the presence of sorrow. We all know that in those situations we gained more than we gave. We need to be constantly open to those experiences and they will become increasingly evident to us. Our depleted resources will be restored on an ongoing basis as we derive satisfaction through giving and extending ourselves for, and with, others. We will change and grow as a result, being continually renewed and able to commit ourselves to caring for the protection, enhancement and preservation of human dignity (Watson, 1985).

As we face the future of nursing with its challenges, it calls for each of us to make commitments. We need to accept our full share of life. Each of us must accept full responsibility for our actions, and be willing to take risks. "Lack of commitment, on the other hand, is a refusal to use one's freedom to choose. It implies an unauthentic existence" (Clemence, 1966, p.504). Choosing to make commitments and taking risks allows us to participate creatively in change - and change there will be at an ever-increasing rate.

In summary, I have suggested to you that true caring in cancer nursing occurs at many levels of intervention. In prevention, it is to dare to work against the stream, in acute care to ever be on the growing edge of learning, in palliative care to share the last lonely journey, and in self-care to renew the wellsprings of our inner resources. At all levels we must never forget our moral commitment to care.

The story is told of a small boy, during World War II, who found parts of a broken mirror. He saved the largest piece, about the size of a quarter. With a child's curiosity, he soon found that he could use that piece of mirror to reflect light into otherwise dark places: Holes and crevices, closets. As a man, this became a metaphor for his life. He realized that he was a fragment of a mirror, the whole design of which he did not know. With what he had he could reflect light, truth, understanding and knowledge into dark places and change some things for some people. For the people with cancer and their loved ones, suffering the shadow sides of treatment and disease, so can I. So can you.

Acknowledgement

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Editorial note

It is unfortunate indeed that the reader is not privy to the spectacular slides that accompanied and illustrated this lecture. The photography, also by Stella Dyck, added a significant dimension to the oral presentation.

References