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HAEMATOLOGY SOCIETY OF AUSTRALIA AND NEW ZEALAND NURSES GROUP

HSANZ NG News

From the president

Dear members and colleagues,

As you read this the annual meeting is almost upon us.

This year saw an unprecedented 31 abstracts, all of which are of a very high standard and I, for one, am looking forward to some exciting presentations. Three travel awards are to be granted for best abstracts and these will be announced in the first session of the nurses meeting. This year we have continued to hold quarterly national teleconference meetings with representatives from all states, territories and New Zealand. The plans for the next twelve months are to continue to develop local groups, increase nurse membership of HSANZ and to continue to build and develop the nurse's section on the HSANZ website.

Allan Hayward , our SA representative on the committee attended an APEC course which enables us to accredit our study days and conference attendance with the RCNA – all valuable as you develop your professional portfolios and education points. Money raised from raffles at local education meetings have enabled us to send Allan – so thanks to all members and attendees for making valuable contributions.

So, for those of you attending the conference, have a fabulous meeting and enjoy the weather provided, along with a great programme by Krys Emery and Barbara O'Callaghan and the local organizing committee, and, to those unable to attend this year—have a great October and plan for Adelaide next year!

If you have not yet got around to joining the HSANZ NG, pick up a membership form from the HSANZ stand or from the website. It really is great value for $55 a year, but more importantly, I believe that your membership of this, the only professional organisation for haematology nurses, says something about you as an expert and specialist and, by having a strong membership, says a lot about haematology nursing as a discrete specialty - so stand up and join up!!

Moira Stephens

September 2008

Update from Perth

With the count down to HAA 2008 well underway, we are busy finalising the last few details for the conference. We are very excited about the program with updates being added to the website regularly. Just a quick reminder to register, if you haven't already done so. Its going to be a great conference and we look forward to seeing you in October!

Krys Emery

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Coming in the next issue:

- *Practice Corner—What are you doing on your Unit?*
- *Ask the Expert—email in with your questions and your answer will appear in the next issue.*
- *How Do I — Make a presentation? Understand statistics? Let us know what you want to know.*
- *Tea Room Guru—What's your beef?*

Please send your comments, questions &

Report from the 15th ISNCC

The 15th International Society of Nurses in Cancer Care Conference was held in Singapore in August. Once again this second yearly international conference provided a wonderful opportunity for nurses working in the area of cancer to come together and share their knowledge. With 37 countries from around the world represented, the Singaporean Organising Committee had crafted a diverse program, providing an opportunity for cancer nurses in developed, developing and underdeveloped countries to share their knowledge and experiences. A highlight for local participants was the excitement of Singapore receiving its 1st silver medal at the Olympic games. This set the tone for a successful international forum.

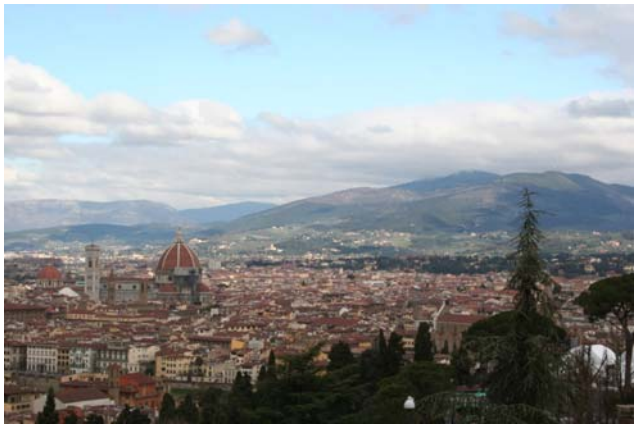
The work of cancer nurses in Australia was showcased through keynote and submitted papers, and posters. In many ways it was reassuring to see that the challenges and trends in cancer nursing were similar across many countries. Role development and coordination was a strong theme throughout, as was nurse led services, strategies to improve supportive care, and survivorship.

Professor Candy Cooley from the UK provided an overview of the new initiative she is leading in genetic education, with an emphasis on this being an area that every nurse requires some knowledge. I would encourage all to have a look at this interesting program (www.geneticseducation.nhs.uk). The plenary session on tobacco control was a timely reminder of all cancer nurses responsibility to become engaged in reducing the number of cancer deaths due to tobacco. This showcased the inspirational work being undertaken by cancer nurses Stella Aguianaga Bialous, Linda Sarna and Sophia Chan.

However it is the conversations had at meal breaks with cancer nurses from India, China and the African nations that, despite language barriers, highlight the similarities and shared experiences of working in cancer care and are at times a useful reminder of how fortunate we are in Australia.

There was a lack of papers from the haematological setting. This is a forum that can provide opportunities for sharing knowledge, experience and expertise across the different tumour groups, and I would encourage all nurses working in the area of cancer to participate in the next conference in 2010 (Location to be advised).

Kate White



Report from EBMT

The 34th annual meeting of the European Group for Blood and Marrow Transplantation and the 24th annual meeting of the EBMT Nurses Group was held in late March 2008 in the beautiful setting of Florence, Italy. Australian and New Zealand bone marrow transplant clinicians were well represented. There were nurses from at least Sydney, Brisbane, Melbourne, Adelaide and Christchurch—apologies if I've missed anyone!

The four day nurses' programme was packed with a wide variety of topics from complementary medicines in HSCT, recent development in stem cell therapy, the ethics of consent in HSCT to updates on aplastic anaemia and paroxysmal nocturnal haemoglobinuria. The physicians programme was equally broad with the latest on the treatment of CML (non-transplant, alternative stem cell sources, the latest on the treatment of Graft versus Host Disease, Veno-occlusive Disease and fungal infections).
From perspective, a couple of highlights were the new trends in treating myeloma, acute leukaemia and lymphoma and advances in cord blood transplantation. I think that it is interesting that the old debate re isolation continues and was the focus of a joint session. Of course the social events were a highlight; not to mention the sightseeing and shopping for those of us who arrived early or stayed on!
Next year's meeting is in Goteborg, Sweden—so start saving now!

Angela Booth

Continuing Nurse Education Points

The HSANZ Nurses Group has been looking at ways of ensuring the educational activities we provide are of a consistent and high quality. As such we have recently applied to become an Authorised Provider of Endorsed Course's through the Royal College of Nursing Australia (RCNA). This will enable the HSANZ Nurses Group to give Continuing Nurse Education (CNE) points to nurses attending our education sessions.

The advantages of endorsing our educational activities are that we will be able to provide educational opportunities to haematology nurses that are of a high quality and adhere to standards as set out by the RCNA. Nurses will then be able to use the CNE points accrued to demonstrate their continuing professional development and competence to practice. This can be very useful should you be audited by your State Registration Board and be required to show evidence of your professional development.

CNE points can also be used in conjunction with the RCNA's Life Long Learning (3LP) programme. This is an online professional resource for nurse's continuing education and maintenance of their own professional development records. More information on 3LP can be found at their website: www.3lp.rcna.org.au/about_us.php

Additionally, with moves towards a single National Nurses Registration Board it is likely that CNE points or a similar system will become the preferred method for demonstrating continued professional development.

We are currently working towards endorsing our first educational event which will be the nursing stream of the upcoming HAA 2008 Annual Scientific Meeting in Perth. We are looking forward to being able to give out our first CNE points to attendees of the conference!

Allan Hayward

Exciting new website for patients and health professionals

When patients face a health crisis, understanding their condition is only part of the challenge. They and their families are confronted by many complex non-medical financial, legal and lifestyle-related decisions that can be emotionally taxing. **HelpDomain.com.au** is Australia's most complete non-medical online resource for patients facing these important issues. It's independent, advertising-free and full of simple, non-directive financial and legal support information.

The site contains:

- a growing library of downloadable videocasts of experts telling their own stories which makes a visit to **HelpDomain.com.au** a personal experience for patients and carers and
- a vast array of links to credible support organisations that offer practical advice, help make **HelpDomain.com.au** a non-medical resource that nurses, patients, doctors and carers will find invaluable.

For health professionals, **HelpDomain.com.au** can become your non-medical card file…putting resources at the fingertips of patients and their families, so that they can focus on managing their ongoing medical care.

At **HelpDomain.com.au** we value your input and comments. You can reach us at **info@pushpullmedical.com.au** where you can also request free patient flyers, cards and referral pads.

Ed: This appears to be a very useful website and I would urge you all to have a good look and provide feedback so that the website that provide exactly what we want and need.

Ask the Experts

Dear Expert, my patients often ask about complementary therapy – can you give me a quick guideline or tell me where I can find out about what is safe?

Complementary therapies (and medicines) are generally considered to include all treatments, practices and products that are not currently accepted as part of conventional medical treatment, but that are *supportive* to it. Some examples of complementary therapies often used by haemato-oncology patients are: massage, meditation, acupuncture, aromatherapy, and reflexology. Complementary therapies are generally not claimed to have curative powers, and are commonly used to provide relief from the side-effects of disease and conventional treatment, and to enhance quality of life. They can provide a sense of agency and/or control in the face of often overwhelming circumstances. Their use may also be a cultural, or personal, value choice.

Alternative therapies and medicines (with which complementary therapies can be confused), are often promoted to be used *instead* of conventional medical treatment, and may purport to be curative. Some alternative therapies and medicines promoted for use as cancer treatments are laetrile (also known as Vitamin B17), iscador (mistletoe), Gerson Therapy, and anti-neoplaston treatment.

Complementary therapies are often considered safe, but – especially in cancer treatment, where the consequences of treatment decisions are crucial - caution should be exercised and specific information obtained before using particular therapies. For instance St John's Wort (which can be a useful treatment for mild depression) interacts with some chemotherapies, anticoagulants and antibiotics. INR levels need to be monitored if a patient is using warfarin or heparin and consuming cod liver or garlic oil. Massage can carry the risks of infection and fractures - especially in cancer treatment, where the consequences of treatment decisions are crucial - caution should be exercised and specific information obtained before using particular therapies. For instance St John's Wort (which can be a useful treatment for mild depression) interacts with some chemotherapies, anticoagulants and antibiotics. INR levels need to be monitored if a patient is using warfarin or heparin and consuming cod liver or garlic oil. Massage can carry the risks of infection and fractures - especially where bones are brittle from the effects of disease or treatment.

But although there are risks to using complementary therapies and medicines, the benefits can be considerable. Reliable information is the key to being able to advise your patients, and a very accessible and comprehensive source of information can be found on the American Cancer Society website at

www.cancer.org/docroot/ETO/ETO_5.asp?site area =ETO. Lists of more detailed scientific papers can be found at HerbMed: www.herbmed.org or PubMed: www.ncbi.nlm.nih.gov/sites/entrez?db=PubMed&itool=toolbar.

Veronica Raszeja,

Veronica is a postgraduate research student at the Centre for Values, Ethics and the Law in Medicine, University of Sydney. Veronica's area of interest is complementary and alternative medicine in haemato-oncology, and her specific research topic is: "A survey and critical review of existing models of service delivery for complementary therapies within Australian haemato-oncology" services"

Dear Expert, one of my AML patient's mother has been talking about having a 'saviour sibling'. What do they mean exactly?

The term "saviour sibling" refers to a child who is conceived (in part) to provide bone marrow or other blood stem cells to their sick sibling in order to treat his/her serious genetic or malignant disease. If there isn't an existing sibling then it may be possible for parents to undergo in-vitro fertilisation (IVF) and have the resulting embryos tested for both disease status (in cases of known genetic disease, not AML) and human leukocyte antigen (HLA) typing (an HLA match is very important for a successful transplant). This process of IVF and genetic testing of the embryos is called preimplantation genetic diagnosis (PGD). Embryos found to be free of the disease (if the disease can be detected) as well as an HLA tissue match with the sick child are suitable for transfer to the mother's womb. After one of these embryos is transferred and implants, the resulting baby is brought to term in the same manner as other pregnancies. Upon delivery of the baby, the blood found in the umbilical cord is collected because it contains a high level of blood stem cells. (Sometimes there are not enough stem cells in the cord blood so additional bone marrow cells are also collected.) These cells are then transplanted to the sick child. The new sibling donor is called a "saviour sibling" because the cord blood transplant is intended to save the sick child. PGD for an HLA matched sibling was first utilised in 2000 by a couple in the United States. Since that time couples around the world (including Australians) have pursued this technology. This process is thought by some to be ethically controversial.

Kimberly Strong

Kimberly has a background in several areas of human tissue transplantation including kidney transplant, bone marrow and umbilical cord blood transplant, and cadaver tissue collection as well as experience in preimplantation genetic diagnosis (PGD), genetic counselling, psychosocial research, bioethics and patient advocacy. Kim is currently a PhD candidate and Research Academic at the Centre for Values, Ethics and the Law in Medicine at the University of Sydney. Her research involves issues related to 'saviour siblings'-children born after PGD for an HLA tissue match.

Ask the Experts—continued

Dear expert, can you please clarify something for me – is valid and informed consent the same thing and which is more important for my patients and why?

Now, that's a tricky question, because as you may know, there is a great deal of debate in the legal literature about the legitimacy of the term "informed consent" and whether consent is ever truly "informed". The use of the term has been strongly discouraged by the High Court of Australia, nevertheless, it has crept into the local vernacular probably from its usage in American television and cinema, and I suspect, regrettably, it is here to stay.

What is of paramount importance is the need to ensure that the patient has consented to the procedure you are about to carry out, bearing in mind that any intervention that entails the physical touching of a patient without his/her prior consent is illegal, and constitutes battery in the eyes of the law. Consent therefore, can be viewed as making legal, an act that would otherwise be illegal.

For consent to be 'valid' or in other words, legal, the patient must;

1. be provided with the relevant information about the procedure, its risks and benefits, any alternative treatments and their risks and benefits,

2. have the mental capacity to consent,

3. make the decision to consent without coercion or threat from anyone including healthcare professionals, family, friends.

So you can see, that for consent to be valid, the patient has to be 'informed', and therefore, to call it 'informed consent' is essentially tautological.

In summary, it is critical that the patient's consent is always sought prior to any procedure. Whether you call it 'informed consent' or 'valid consent' is irrelevant, just as long as you observe the above requirements.

Camilla Scanlan

Camilla's research interests are in the field of medico-legal matters. She is currently undertaking an empirical study examining the legal and ethical limits to consent in high-risk medical procedures as part of her doctoral degree at the Centre for Values, Ethics and the Law in Medicine, University of Sydney. Camilla has a background in laboratory-based medicine, and health law. She can be contacted on camilla@med.usyd.edu.au

HAA 2009: The Festival city beckons!

Don't forget that HAA 2009 will be held in Adelaide and. for the first time, there will be a 3-day nurses' programme! So use the opportunity of this year's meeting to get your thinking caps on for projects to present next year. It's amazing the projects that have been born over a few glasses of alcohol!!

2008/09 Dates for the diary

2008

Sep 25-27 RCNA Annual Conference, Perth

Oct 19 –22 HAA , Perth

Nov 18/19 BMT short course, Royal Melbourne hospital

Nov 20—NSW HSANZ—NG meeting, Sydney

Dec 6-9 ASH, San Francisco, USA

2009

Feb 11-15 CIBMTR/ASBMT, Tampa, Florida, USA

29 Mar—1 Apr EBMT, Gotheborg, SWEDEN

4-7 June EHA, Berlin, GERMANY

18-20 June CNSA Winter Congress, Newcastle

Dec 5–8 ASH, New Orleans, USA

Research News – a short trip around some key journals

Rapid mobilisation of functional donor hematopoietic cells with G-CSF using AMD3100, an antagonist of the CXCR4/SDF-1 interaction
Steven M. Devine, Ravi Vij, Michael Rettig, Laura Todt, Kiley McGlauchlen, Nicholas Fisher, Hollie Devine, Daniel C. Link, Gary Calandra, Gary Bridger, Peter Westervelt, and John F. DiPersio
Blood, 15 August 2008, Vol. 112, No. 4, pp. 990-998

Allografts from HLA-matched sibling donors were mobilized and collected without granulocyte colony-stimulating factor (G-CSF) using AMD3100, a direct antagonist of CXCR4/stromal-derived factor 1 (SDF-1/CXCL12). Donors (N = 25) were treated with AMD3100 at a dose of 240 μg/kg by subcutaneous injection, and leukapheresis was then initiated just 4 hours later. Two-thirds of the donors collected an allograft with a $CD34^+$ cell dose sufficient for transplantation after just one dose of AMD3100. No donor experienced more than grade 1 toxicity. After a myeloablative regimen, 20 patients with hematologic malignancies received allografts collected after AMD3100 alone. All patients engrafted neutrophils (median day 10) and platelets (median day 12) promptly. Acute graft-versus-host disease (GVHD) grades 2 through 4 occurred in 35% of patients. One patient died due to complications related to acute GVHD. No unexpected adverse events were observed in any of the recipients. All 14 patients surviving in remission have robust trilineage hematopoiesis and are transfusion-free with a median follow-up of 277 days (range, 139-964 days). Direct antagonism of CXCR4 by AMD3100 may provide a more rapid and possibly less toxic and cumbersome alternative to traditional G-CSF–based mobilization in normal donors.

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Multiple Myeloma: an update on diagnosis and treatment
Caers J, Vande Broek I, De Raeve H, Michaux L, Trullemans F, Schots R, Van Camp B, Vanderkerken K.
Eur J Haematol. 2008 Jul 11.

Multiple myeloma is a plasma cell malignancy characterized by the accumulation of monoclonal plasma cells in the bone marrow and the production of large amounts of a monoclonal immunoglobulin or paraprotein. In the past years, new approaches in the diagnosis and treatment were introduced aiming to identify high risk patients who need proper anti-myeloma treatment. Intensive therapy including autologous hematopoietic stem cell transplantation and the new agents bortezomib, thalidomide and lenalidomide have improved patients responses. Further optimisation of the different treatment schedules in well defined patient groups may prolong their survival. Patient stratification is currently based on patient characteristics, extent of myeloma disease and associated cytogenetic and laboratory anomalies. More and more gene expression studies are introduced to stratify patients and to individualize therapy.

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The incidence of and risk factors for venous thromboembolism (VTE) and bleeding among 1514 patients undergoing hematopoietic stem cell transplantation: implications for VTE prevention
David E. Gerber, Jodi B. Segal, M. Yair Levy, Joyce Kane, Richard J. Jones, and Michael B. Streiff
Blood 2008;112 504-510

Venous thromboembolism (VTE) is increasingly diagnosed among individuals with hematologic malignancies. However, the risk of VTE among patients undergoing hematopoietic stem cell transplantation (HSCT) is unclear. We examined the incidence and risk factors for VTE and bleeding among 1514 patients undergoing inpatient HSCT. No protocolized VTE prophylaxis was used. By HSCT day 180, 75 symptomatic VTE occurred in 70 patients (4.6%; 95% confidence interval [CI], 3.6%-5.8%). Fifty-five (3.6%) were catheter-associated, 11 (0.7%) were non–catheter-associated deep venous thromboses, and 9 (0.6%) were pulmonary emboli. Thirty-four percent of VTE occurred at a platelet count less than 50 $x10^9$/L; 13% occurred at a platelet count less than 20 $x10^9$/L. In multivariate analysis, VTE was associated with prior VTE (odds ratio [OR], 2.9; 95% CI, 1.3-6.6) and with graft-versus-host disease (GVHD; OR, 2.4; 95% CI, 1.4-4.0). Clinically significant bleeding occurred in 230 patients (15.2%; 95% CI, 13.4%-17.1%); 55 patients (3.6%; 95% CI, 2.7%-4.7%) had fatal bleeding. Bleeding was associated with anticoagulation (OR, 3.1; 95% CI, 1.8-5.5), GVHD (OR, 2.4; 95% CI, 1.8-3.3), and veno-occlusive disease (OR, 2.2; 95% CI, 1.4-3.6). In HSCT patients, VTE is primarily catheter-related and 3-fold less common than clinically significant bleeding. These findings warrant consideration when selecting VTE prophylaxis in HSCT patients.

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Allogeneic stem cell transplantation for chronic myeloid leukemia–status in 2007
J M Goldman

Bone Marrow Transplant 2008 42: S11-S13; 10.1038/bmt.2008.105

Whereas until 2000 allo-SCT was the recommended treatment for all new patients with CML who were eligible on grounds of age and donor availability, approaches to initial therapy have changed very substantially since the introduction of imatinib mesylate. Today, topical questions are (1) Should any newly diagnosed patient receive SCT as primary therapy? (2) How should imatinib failure be de-

fined? (3) Should a patient who has failed imatinib but is still in chronic phase be offered a SCT or further treatment with a 'second-generation' TKI? (4) Would prior treatment with imatinib or concomitant delay to transplant adversely affect the subsequent results of allo-SCT? (5) Once the decision to proceed with allo-SCT is taken, how exactly should this be performed? (6) If a patient relapses after allo-SCT, how should he/she be treated? These questions will be addressed, but definitive answers may not yet be possible.

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Haematopoietic stem cell transplantation in thalassemia
J Gaziev, P Sodani & G Lucarelli

Bone Marrow Transplant 2008 42: S41-S41; 10.1038/bmt.2008.112

SCT still remains the only cure currently available for patients with thalassemia. Results of transplants in this disease have steadily improved over the last two decades due to improvements in preventive strategies, effective control of transplant-related complications and development of new preparative regimens. Currently, high-resolution HLA typing has enabled physicians to perform transplants from unrelated volunteer donors for thalassemia with results comparable with those obtained employing an HLA-identical sibling. The probabilities for obtaining thalassemia-free survival after transplant in thalassemia from an HLA-identical donor, family member or MUD are between 85 and 87%. Therefore, when an HLA-identical donor is present, the transplant of allogeneic stem cell should be performed as allogeneic gene therapy. In the light of advances in transplantation for thalassemia, patients with an HLA-identical donor should be offered SCT.

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Treatment strategies for patients with severe aplastic anemia
A Bacigalupo

Bone Marrow Transplant 2008 42: S42-S44; 10.1038/bmt.2008.113

Treatment strategies for patients with severe aplastic anemia (SAA), depend on the severity of the disease, the age of the patient and the availability of a family donor. Progress in the past has included the early use of combined immunosuppressive therapy (IST) and better matching strategies to select unrelated donors. Currently, the actuarial 10-year survival in 2479 patients registered within the European Group for Blood and Marrow Transplantation (EBMT), is 73 and 68% for patients receiving first-line BMT or IST. The outcome of BMT has significantly improved since 1996, and this is true for both matched sibling donor BMT as well as for alternative donor BMT. Survival is significantly better in children (<16 years) as compared with adults (79 vs 68%, *P*<0.0001). In contrast, there has been no significant improvement over time for patients receiving IST. Again, results were significantly better in children compared with adults (81 versus 70%, *P*=0.001), especially in very severe aplasia (83 versus 62%, *P*=0.0002). This report outlines some of these results as a basis for treatment strategies in SAA.

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Have men been overlooked? A comparison of young men and women's experiences of chemotherapy-induced alopecia

Hilton, S; Hunt, K; Emslie, C; Salinas, M; Ziebland, S

PSYCHO-ONCOLOGY, 17 (6): 577-583; JUN 2008

Objective: The objective of this study is to compare men and women's accounts of chemotherapy-induced alopecia.
Design: Secondary analysis of narrative interview data.
Participants: Thirty-seven people aged 18-38 years, including 11 men and 8 women who had experienced hair loss, interviewed between 2000 and 2005.
Setting: Participants were recruited throughout the United Kingdom.
Results: Hair loss made many men and women acutely aware of their vulnerability and visibility as a 'cancer patient'. Both men and women described a sense of strangeness or shock when they lost their hair and experienced various negative reactions when people assumed their hairless appearance was a lifestyle choice. The most striking contrast in men's and women's accounts was that women spoke solely of the loss of hair from the head and face above the eye line, and men spoke about losing hair from wider body surfaces. Only women mentioned being encouraged by others to disguise or to prevent hair loss. The results are discussed in relation to gendered assumptions about the distribution of body hair.
Conclusions: Contrary to prevailing assumptions, both women and men described negative (and often similar) feelings about hair loss. Understanding these experiences can help professionals better equip their patients to deal with this aspect of their treatment.

News from the regional groups

New Zealand - North Island

The HSANZ NG has had a slow start in the North Island of New Zealand. This has been largely due to staffing shortages in the Haematology and Oncology area, but hopefully things are beginning to look up. In April of this year the local branch of the HSANZ had their annual two day meeting in Rotorua. There was a half day nurses session which was well attended by nurses from around the country. A presentation was due to be done about the HSANZ NG but unfortunately the power was cut leaving the venue without power for some time - I tried not to take this as a bad sign!

A small organising committee has been set up in Wellington to bring education sessions to the central and lower North Island. No sessions have been planned as yet but watch this space - we are hoping to get something up and running in the next little while. The Haematology centres are spread out over the whole of the North Island and it is too difficult to coordinate education sessions for the upper North Island from Wellington. To this end, it is hoped to bring someone on board from either Auckland or the Waikato to get things going there.

Catherine Wood

New Zealand—South Island

The group unfortunately had to postpone the inaugural meeting, but it will go ahead in the near future. The use of a webcam for meetings is being explored due to the distances between centres.

Sharron Ellis

South Australia/Northern Territory

Our first education evening has now been held with more than 40 people attending. From all feedback, it has been very well received! A huge thanks to our speakers Jodie Haecker and Emanuel Raniolo for their excellent presentations and to Sheila Lehmann of The Queen Elizabeth Hospital for her assistance on the night and in organising the evening

The evening was about Autologous Stem Cells with two speakers; an apheresis nurse and bone marrow transplant coordinator to discuss donor selection, mobilisation and collection as well as a laboratory scientist to discuss processing, storage and reinfusion. This event was held at the newly rebuilt haematology/oncology unit at the Queen Elizabeth Hospital. The Queen Elizabeth Hospital provides these services to several other hospitals in the Adelaide Metropolitan area so it's a great opportunity for nurses from those institutions to see what happens when their patients are sent off for stem cell collections and reinfusion.

We are also very pleased to be able to include 3 NT nurses for the event. Through discussions with the NT government we have been able to tie the evening in with some clinical mentorship allowing those nurses to get even more out of their trip to Adelaide.

Additionally, we have been very fortunate to gain the support of four pharmaceutical companies to assist us in holding these educational activities; Thank you to Amgen, Gilead, Novartis and Roche.

We now need to look forward and get cracking on our next planned event, an education/workshop day in late January of 2009.

Allan Hayward

Victoria

Melbourne is abuzz with footy finals fever! Commiserations to my counterparts in the city of Adelaide – as my beloved pies survive to fight another day! For those of you that do not understand the sport of AFL – another small victory for the Victorians as Melbourne Storm take the minor premiership for the third year in a row!

But how is our Nurses Group fairing? I say we have had a stellar year with great performances from all involved!

The Victorian HSANZ NG held the following educational evenings in 2008:
27th March – Current trends in Lymphoma
Speaker: Prof Jeff Szer (RMH).
26th June – Infections in the Haematology Patient.
Speaker: Dr Joshua Wolfe (Peter MacCallum Cancer Centre).

4th September – Innovations in the care and management of CVADs
Speakers: Eugenija Johnson (Alfred) and Amber Carr (RMH)

All educational evenings have been attended by between 30-40 participants and I am hoping for 2009 that these numbers will increase with the increased knowledge and profile of this group.

To continue to strengthen and improve the Victorian Branch of haematology nurses – I am seeking assistance from members to become involved in the state committee. Currently I hold the positions of Chairperson, treasurer, secretary, fundraiser and education officer. I would love to hear from anyone who would be keen to take on a role or share a role with a colleague.

I am in the process of confirming dates and sponsorship for next year – so that we can let you know about upcoming meetings in advance. I am keen to hear anyone's thoughts on topics, speakers, days and times for meetings. I am considering doing some weekend breakfast meetings – if this would suit a majority of people. Please send your suggestions to my e-mail address.

This newsletter is also an avenue to share any upcoming educational programmes that may be interesting to haematology nurses. Please forward the details to me so that they can be put into the newsletter.

Hopefully, some of you will be making the trek over to sunny Perth for the HAA conference in October. I look forward to catching up with you all – get your dancing shoes ready!

Jo West

Tea Room Guru

Dear TRG – Can you tell us which one of us is right? The ward was really busy on Tuesday evening, Matilda had gone home with a migraine (so she said) leaving just three of us to manage a thirty bed haematology ward. We discharged 4 patients (they were fit enough to go, really) and the NUM closed the beds and went home bang on 4 because she had a hot date and couldn't be late. She said something about not wanting to worry about us with a full ward. Then we heard that there were two haem patients in Emergency, one of whom was a really nice bloke who we knew really well. We didn't open the beds and I don't know if they spent the night in ED or went to another ward. I said the NUM should have stayed and helped us out, because it would have made the evening better for everyone, Bertina said we should have opened the beds (I think 'cos she really liked the bloke who we knew) because the 2 patients would have got better care with us as specialists and Esmerelda said that the beds were closed because the rules said we shouldn't have more than 26 patients with 3 staff on and that's that. Bertina said I have no ethics and Esmerelda said that you don't need ethics if you have rules. Who is right?

Well, the first point is that you, that is, we, all have ethics. We use ethics all the time and ask ethical questions everyday. Whenever you preface with the word 'should' you are asking an ethical question! Ethics generally asks one of two questions; what sort of person should I be and; what should I do? These two questions refer to two theories of ethics; character orientated and act orientated.

Character orientated is an Aristotelian approach to ethics, sometimes called virtue ethics. In contrast to the act-oriented approaches, it does not focus on what makes acts right or wrong. Rather, it focuses on people and their moral character. The principal question that character-oriented approaches to ethics asks is; what strengths of character (i.e., virtues) promote human flourishing? And therefore; what weaknesses of character (i.e., vices) impede human flourishing? Virtues are strengths of character that contribute to human flourishing like courage or compassion, while vices are those weakness that get in the way of flourishing.

It is best not to discuss character ethics as you need to work with your colleagues on another day, so, instead we can look at act orientated ethics.

There are two main theories that might guide you in answering the question "what should I do?" These are Consequentialism: when you look at the consequences and choose the action that has the best consequences; and Deontology: which is an approach based on rules. The NUM, you and Bertina all used a consequentialist approach to answer the question. The NUM used an egoist type of consequentialism, considering the consequences of her decision – but- only for herself. Bertina used group consequentialism – considering the consequences for the two haem patients in emergency and you used a utilitarian approach – considering the consequences for the most people – the existing patients on the ward, the two in emergency and the majority of the nurses – but the NUM didn't get such a good deal with your approach!

This is an important point because when you are making a consequentialist based decision, in addition to asking whose consequences are important, you have to ask how have you measured the consequences. Different people have used different yardsticks with different answers. For example Bentham used the yardstick of pleasure and John Stuart Mill used happiness. The same thing you may say! But if you asked Bentham and Mill what you should give your child, who loves all things chocolate and sweet, for breakfast – Bentham would say Coco Pops to give the child immediate pleasure but Mill might say hat high fibre muesli would give the child happiness in a long and healthy life!

So you see even the question of what to have for breakfast is fraught with ethical dilemmas!

Esmerelda maintained a rule based or deontological approach and in deontology, rules always trump consequences – which is an important resource as it maintains codes of ethics that says that no matter how much good might be accomplished, you cannot break the rules (e.g., experiment on infants to develop new medicines). Examples of rule based ethics include religious approaches such as the 10 Commandments or Islamic Sharia Law; Human Rights; Justice and Immanual Kant's Deontology.

I hope this has answered your question and you now realise that you all answered the problem with equally viable ethical consideration and I hope that your NUM enjoyed her evening, you got off on time and the two outliers survived.

Sincerely yours,

TRG

If you have any of life's questions, personal problems or niggling concerns about a major decision and you can't trust your star sign – write to me: Tea Room Guru, c/o The Editor, HSANZ – NG News.

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