Advancing the quality of oncology nursing care: Interlink Community Cancer Nurses’ model for reflective practice

By Doris Howell and Beth Pelton

Abstract
Since 1996, Interlink Community Cancer Nurses have been using reflective practice as a team to share knowledge and experience amongst peers. The use of reflective practice enables the nurse to examine decision-making in patient situations and uncover the knowledge and artistry that is embedded in nursing practice. This article describes how reflection is practised by specialist cancer nurses to advance the quality of caregiving. The use of a structured framework for reflection which incorporates ways of knowing in nursing is an essential feature of the Interlink model for reflection. The development of a process for reflection within the Interlink program has at times been challenging. However, the Interlink nurses’ experience with reflection is believed to be critical to the ongoing development of the program and the individual nurse. Interlink nurses have found that guided reflection, the creation of an environmental milieu for reflection and personal knowing, and self-evaluation are critical to the process of becoming a self-reflective practitioner.

Reflective practice has been described as a method for understanding the artistry of nursing practice and for realizing therapeutic potential (Antrobus, 1997), and as a means of uniting the gap between theory, practice, and evidence-based decision-making in nursing (Johns, 1996). Interlink Community Cancer Nurses have been utilizing self-reflection to explore the cancer patients’ experience with illness, to uncover knowledge to guide decision-making and practice, and to illuminate nursing interventions used in the therapeutic process. The process of reflection provides the Interlink nurse with an opportunity to uncover the reasons for adopting ways of caring for patients, and for exploring new avenues for supporting patients through the experience of cancer.

Interlink Community Cancer Nurses is a nonprofit, community nursing agency which is modeled after the Macmillan nurse program in the United Kingdom (Bunn, 1988). Interlink nurses function as independent consultants providing expert oncology nursing support to patients and families across the continuum of cancer from early diagnosis through to cure/remission or palliation and bereavement care. Interlink nurses contribute to the clinical management of disease symptoms and treatment side-effects while providing essential psychosocial support. Interlink nurses empower adults and children with cancer and their families to access the care and support required at all stages of illness. The goals are to lessen the burden of living with cancer, promote optimal functioning and well-being, and improve or maintain quality of life. Interlink nurses also act as a specialized education and resource to health care professionals working collaboratively with them in meeting cancer patients’ needs.

The independent nature of the Interlink nurse’s practice and the provision of consultative support to other care providers in the community demands that Interlink nurses continually advance their expertise in order to realize positive patient outcomes, and to demonstrate their contribution in the care of persons with cancer and their families. Interlink nurses use reflection to increase their understanding of the empirical and humanistic foundation of caregiving and as a means for advancing the quality of their nursing care.

Reflecting on care can provide nurses with insight into their practice and an opportunity for learning. Using a reflective process to explore nursing practice with people with cancer can provide a rich detailing of their experience and the therapeutic role of the nurse. Interlink nurses have noted that the reflective process stimulates their personal growth and development, deepens their individual practices, enhances relationships with patients, and improves problem-solving. The use of reflection in practice has been thought to contribute to the enhancement of deep learning (Lowe & Kerr, 1998), and to facilitate effective problem-solving through a self-evaluation process (Kolb, 1975).

Reflective practice also assists Interlink nurses in identifying gaps in their knowledge and topics for future learning. For instance, in reflecting upon an adolescent’s response to cancer, Interlink nurses identified the need to learn more about the stages of human growth and development, as well as adolescent grieving and coping. Reflective practice has been identified as a method for nurses to assess their personal level of competence in order to maintain licensure as a registered nurse in Ontario (Wansbrough, 1996). Schon (1983) and Powell (1989) believe the ability to reflect is essential for nursing competence, creates effective practitioners, and sustains practitioner development.

A conceptual model for reflection
The use of a conceptual model to guide reflection, the development of personal knowing or self-reflection, and the creation of an environment for reflection have been identified as the critical success factors in implementing reflective practice within the Interlink program.

Johns (1995) identified the need for reflection to start with a model to provide guidance and structure and to facilitate the development of the skills of reflection. Implementing a structured model for reflection assists Interlink nurses in critically analyzing a patient situation rather than merely retelling the patient’s story and the events surrounding the nurse’s interaction with the patient. A structured model for reflection allows the practitioner the opportunity to understand deeper meanings in situations, uncover the theoretical and scientific knowledge utilized, and explore with peers new knowledge or experience that might have been helpful in caring for the patient. Johns’ (1995) model for structured reflection, which incorporates Carper’s (1978)
fundamental ways of knowing in nursing, was adapted as the framework to guide the process of reflection within the Interlink program (see Table One).

The framework is particularly useful because it provides the nurse with an opportunity to explore not only the scientific or evidence base incorporated within nursing care but also the art of caregiving. Carper’s four patterns of knowing have been described as providing a pathway through which the fullness of the nursing situation can be known (Boykin & Schoenhofer, 1991). Critical patient situations are described and explored utilizing the four parameters of knowing in nursing: empirics, moral (ethical) knowing, personal knowing, and aesthetics (Carper, 1978). The framework provides a structure for reflecting on care and guides the nurse in uncovering the knowledge embedded within his/her practice and additional knowledge that might have been incorporated to advance therapeutic nursing care. The model promotes the nurse’s ability to reflect on his/her own practice behaviour through an exploration of which aspect of knowing has influenced caregiving and has contributed to the adoption of particular nursing interventions and decision-making.

**Expanding the framework for reflection**

Interlink nurses are frequently involved in patient situations that require negotiation and advocacy for resources to meet the needs of the cancer patient and the family. The need to be aware of the social and political environment in which care is provided is becoming an important element of the Interlink nurse’s role. Interlink nurses are thus exploring the ways in which they can use the principles of community health promotion and advocacy in their practice. Through the reflective process, Interlink nurses uncover system issues that require system change and political action. For example, an Interlink nurse wrote a letter to the chair of a local cancer hospital’s community advisory committee seeking a voice for those receiving care within a restructured cancer care system. In addition, an Interlink nurse and a student met with women at a housing complex to provide education on breast health to this group who seldom use formalized breast screening programs. Subsequently, a fifth pattern of knowing, namely sociopolitical knowing (White, 1995), has been added to the framework for reflection.

**Table One: Model for structured reflection (10th version)**

<table>
<thead>
<tr>
<th>Carper’s ways of knowing</th>
<th>Questions for reflection</th>
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<tbody>
<tr>
<td><strong>Aesthetics</strong></td>
<td>Art of nursing care</td>
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<td></td>
<td>What was I trying to achieve?</td>
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<td></td>
<td>What feelings were described to me by the patient?</td>
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<td></td>
<td>Why did I respond as I did? What were the consequences?</td>
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<tr>
<td><strong>Personal</strong></td>
<td>How did I feel in this situation?</td>
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<tr>
<td></td>
<td>What internal factors, belief systems or values were influencing me?</td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>How did my actions match with my beliefs?</td>
</tr>
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<td></td>
<td>What ethical principles were involved?</td>
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<td><strong>Empirics</strong></td>
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<td></td>
<td>What evidence exists for the interventions utilized?</td>
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*Reprinted with permission from Johns (1995).*

Sociopolitical knowing has been envisioned as useful for both activism for change within a community (Hagedorn, 1995), and for understanding power relations that may influence health within a community (Sheilds & Lindsey, 1998). Interlink nurses are learning through reflection to be conscious of the ways in which change can be influenced in order to mobilize a community of support around the person with cancer and the family. Interlink nurses reflect on the need to be politically active in the context of their own personal resources, energy, and belief systems.

As the Interlink nurses explore patient situations, they frequently uncover the art of care or an intuitive element (Benner, 1984) which has guided nursing practice. The aesthetic way of knowing has been described by Johns (1995) as the core way of knowing in practice, informed by the empirical, the personal, and the ethical dimensions of practice. It has been recognized that individual patient and family responses to a cancer diagnosis cannot always be described from a theoretical or scientific perspective. Patient responses and reactions to living with cancer are frequently complex and are related to the meaning that an individual attaches to his/her life and experience of living with cancer (Howell, 1998). These situations can be understood only by listening to and actually hearing the patient’s story. The nurse-person process is not data-based; it is human-based. This kind of dialogue is unscripted and through this relationship nurses demonstrate a commitment to be with patients to listen, respect, provide, and be involved as directed by patients (Mitchell, 1999).

A sixth way of knowing was added to the conceptual model used to guide reflective practice, namely that of unknowing. Unknowing has been described as an awareness that the nurse does not and cannot know fully the client’s perspective (Munhall, 1993). Adopting the element of unknowing into the model was important for Interlink nurses to describe the humanistic element of their

| Table Two: Interlink Community Cancer Nurses’ framework for reflection |
|--------------------------|-------------------------|
| **Ways of knowing** | **Questions for reflection** |
| Aesthetics | Art of nursing care |
| | What was I trying to achieve? |
| | What feelings were described to me by the patient? |
| | Why did I respond as I did? What were the consequences? |
| Personal | How did I feel in this situation? |
| | What internal factors, belief systems or values were influencing me? |
| Ethics | How did my actions match with my beliefs? |
| | What ethical principles were involved? |
| Empirics | What knowledge should have informed me? |
| | What theory might have helped describe the situation? |
| | What evidence exists for the interventions utilized? |
| Sociopolitical (White, 1995) | Where and how can my voice be heard? |
| | What change action is needed to respond to these patient needs? |
| Unknowing (Munhall, 1993) | What is unable to be explained in the patient situation and is just the person’s way of being in the world? |

*Adapted with permission from Johns (1995).*
practice as a particular way of caring that goes beyond the medical domain and to ensure that patient situations are not merely reduced to an analysis of the empirical. Interlink nurses recognize that there is an element of unknowing in providing humanistic care. This element requires that the nurse listens to herself and is open to learning about the interaction between patient and self in order to enhance care and support. Professional practice demands a comfort with the unknown in light of a broad knowledge base and understanding of the lived experience of the person with cancer. The model for reflection adopted by Interlink Community Cancer Nurses which incorporates the six ways of knowing and the questions that are used to guide reflection are described in Table Two.

**Using the framework for reflection**

In using the framework for reflection, the Interlink nurse chooses a patient who has been cared for in her practice and reflects upon care provided. Nurses may choose to focus on only one or all of the elements within the reflective framework, as some nurse-patient situations demand attention to particular elements. Nurses who are just embarking on a self-reflective process will find the use of all of the elements in the framework more helpful.

The reflective process for the Interlink nurse involves presentation of a case situation to the Interlink nursing team followed by a reflection on the care provided using the framework. The nurse prepares the presentation prior to the team review and, consequently, may have already reviewed the literature for additional information that might have informed her practice. Reflecting on the empirical way of knowing in nursing may lead the Interlink nurse to further explore what is known about a particular concept or theoretical construct which could be used to advance her practice. For example, one of the Interlink nurses reviewed the literature on coping to empirically inform her practice with a woman experiencing significant distress as a result of her breast cancer diagnosis. Following the nurse’s reflective presentation, the team and a facilitator (Practice Development Leader) discuss the nurse’s presentation and provide feedback on the nurse’s practice giving guidance on additional knowledge or practical advice that may have informed her practice and may be helpful in future patient and nurse interactions. The following is an excerpt from one of the reflective practice presentations.

**Reflecting on a patient situation**

The nurse tells the story of Sally, a woman in her late 70s who is fiercely and proudly independent. For months, Sally had complained to her family physician about constipation and general abdominal fullness. Eventually she ended up in the emergency department with vaginal bleeding and abdominal obstruction. Immediate surgery revealed a diagnosis of Stage III, ovarian cancer. She spent several weeks in hospital, most of them in the intensive care unit. She was seriously ill and almost died. She has little clear memory of that time except she remembers hearing the surgeon tell her that he had, “got it all.” Sally was anxious to return home, but became worried and frustrated when she did not regain her former health and energy within a week of discharge. Within a month she was having nightmares of her time in hospital. However, she did not want further assistance from a psychiatrist. At this time she did not believe that she was disease-free and she felt the doctors were not telling her everything and were minimizing her concerns. Her focus was on regaining her strength and the use of her scooter, which was the symbol of her independence. The assistance of a community mental health occupational therapist was sought. This did not help. During this time, she continued to believe that she still had cancer because she continued to be constipated (x-rays and scans were negative).

**The nurse reflects**

**Aesthetics.** I had many wants for Sally. I wanted her frightening dreams and memories resolved. I wanted her to feel less impatient and frightened by her fatigue, to feel confident in the use of her scooter, and to be able to independently leave her apartment. I wanted her to get back to socializing. These were the things that Sally told me she wanted. I heard the anguish of her most telling statement, “I never thought getting sick and dying would happen to me…” I felt connected with her and wanted to reduce her anguish. I wanted Sally to know that I believed her and wanted to help her. I believed that my feelings of connection with Sally, and my intention to help her, rendered me open to her. I need to, intend to, be still, to listen, to empty my thoughts of my agenda. Johns (1995) tells us that the aesthetic way of knowing is the core way of knowing in practice informed by the empirical, the personal, and the ethical dimensions of practice. My aesthetic way of knowing in working with Sally was my comprehension of her anguish in realizing and admitting her vulnerability and her mortality.

**Personal.** Instead of really listening, and being with Sally in her anguish, I got busy doing “fix it” things. I left Sally alone in her anguish, which increased as my “fix-it” actions did not help. The goal or “outcome” I envisioned - that of as much independence as possible - was also Sally’s goal. If, however, I had grasped what I knew - that Sally did not want this anguish and that she was used to taking care of herself - I would have engaged with Sally as another person with many of the same questions and worries about vulnerability and mortality. We each would have learned about self and the other (Parse, 1998). Sally might - or might not - be riding her scooter these days. It doesn’t seem to matter what she is doing. She is doing and being with less anguish, more confidence and hope (despite the “fix-it” nurse). And she continues to enable me to learn and discover in relationship with her.

**Ethics.** Also with reflection, I realize it is the questions about ethical knowing that have helped me to realize I could have been there with Sally in terms of respecting Sally as the expert in her own life and in terms of sharing myself with Sally as a person, and as a person without all the answers. My actions did not match my beliefs. I became more focused on “fixing things” for Sally according to my perspective. It took me a long time to hear Sally’s perspective; the scooter was not her issue. The facts that she had been very ill, had almost died, and that she still did not have full control of her living - these are her issues. An ethical approach to care allows the nurse to be fully present with people and to hear their perspective and ways of managing the illness that confronts them.

**Empirics.** I need to enable myself to be guided by a theoretical perspective more consistent with a humanistic way of caring for Sally. I reviewed the literature regarding humanistic nursing responses to complex patient reactions, including Parse’s Human - Becoming Theory (Parse, 1998). I have learned from Sally that I can heed the pushes and pulls - the ambiguities and contradictions - in conversations. Coping theory also helped me to understand Sally’s early traumatic reactions to the diagnosis such as the nightmairres and the turmoil they created for her.

**Sociopolitical knowing.** In this practice situation, reflection did not include sociopolitical knowing. However, in other situations the nurse might reflect upon the system change or advocacy that may be necessary to support persons living with cancer in the community. As an advocate, the nurse might help others to hear and understand the patient’s perspective.

**Unknowing.** I realized that I do not fully know the other person’s experience of living with cancer and recognize the need to be open to the other and hear that person’s story and perspective. To really listen. I wanted Sally to know that her physicians and I were paying attention to her so that she would believe she was well and would be able to focus on living. While setting goals with Sally to be well, I experienced inner turmoil knowing that her cancer will likely recur. I
wanted to help her get on with her living. In helping her to find her way to living, and to understand her perspective, I asked a number of assessment questions such as: “What do you hope will happen for you? What help do you need for that to happen?” These questions caused great anxiety in Sally. She would ask for help or direction, then reject ideas. She would express her feelings and frustrations, but would respond to any problem-solving suggestions with, “I don’t want to talk about it.” I was feeling frustrated with Sally’s push-pull presentations. I began to listen more and ask fewer questions. However, I was not articulating - or even consciously acknowledging - this frustration. I lost focus. I wanted to be there for Sally on her terms, and according to her perspective and feel that I am open to this way of practice. I believe that I practise in this way. However, unknowingly, I was listening to my own agenda and developed a stance of wanting to fix things in this situation.

The nurse’s ability to reflect on her practise in this situation provides insight into the ways in which she was practising and provides an opportunity to explore more effective ways of practising and caring for others.

**Becoming a self-reflective practitioner**

Personal knowing and self-reflection by the nurse has been one of the most challenging elements to incorporate within reflective practice sessions which are presented to all members of the Interlink nursing team. Yet, personal knowing and self-reflection can be one of the most positive ways of enhancing relationships with colleagues and patients. Personal knowing concerns the inner experience of becoming a whole, aware self and it is through knowing the self that one is able to know another human being (Chinn & Kramer, 1995).

Self-reflection is a powerful tool to increase self-understanding and reveal reasons for the nurse’s behaviour and potential barriers to the therapeutic relationship. The outcomes of nursing action are clearly dependent on the sort of person the practitioner is and the nurse must be aware of who he/she is so that personal concerns do not interfere with the patient’s exploration of his/her concerns (Johns, 1995). Yet, to embark on a process of self-reflection, to reveal personal knowing in a patient situation can be intimidating for the nurse.

Reflective practice provides nurses with the opportunity to articulate the underlying behavioural strategies that accompany interactions and inform them about their own individual patterns of interpersonal behaviour. Perception of personal feelings in order to understand and accept the patient or relative without prejudice, particularly in an environment of cultural diversity, is critically important. However, it must be recognized that the process of self-reflection creates a sense of vulnerability within the nurse as professional role barriers are let go and the ways in which the nurse practices are revealed to both self and colleagues. It is only through a process of self-reflection that differences between professional barriers and personal boundaries can be worked through in each nurse-patient relationship.

**Shaping a reflective practice environment**

Promoting and shaping a reflective environment enables learning to occur from the lived experiences of nurses. Interlink nurses are poised to engage more deeply in self-reflection and peer reviewed reflection. The use of reflective practice in monthly nursing team meetings has been a slow process for Interlink nurses as trust and the development of relationships between team members evolved. An experienced facilitator who is not a practising Interlink nurse has been critical in guiding the process. The facilitator provides feedback and guidance to the individual
nurse using the reflective framework, as well as to team members to encourage them to provide honest, constructive feedback to their colleague. During the first few months, colleagues tended to provide only positive feedback, but now they feel more comfortable to discuss other interventions that may have been helpful. Gradually, the milieu was created within the Interlink nursing team and they have evolved from timidly reflecting on their practice with each other to being able to make suggestions for alternate interventions. Interlink nurses experienced varying degrees of discomfort and excitement. An environment of trust has been critically important in order to be able to move from merely supporting interventions of colleagues to truly reflecting on practice decisions and actions and to exploring potentially new ways of practising.

Reflective practice demands that long-held beliefs about professional roles and attitudes must be questioned. Professional role barriers may complicate our ability to create a humanistic, personal connection with patients. The nurse-patient relationship is another person-to-person relationship, but it is more complex and requires an awareness by the nurse of personal boundaries in order to practise therapeutically. For example, we are very much present with the grieving patient, may even cry with him/her, but we are not available to him/her during off-duty time. Feeling emotional connections with patients, which is not the same as emotional involvement, leaves the nurse vulnerable to experiencing grief when cancer recurs or when the patient dies. Admitting to these emotional connections with patients to colleagues during a reflective practice session may leave many nurses feeling open to criticism as an ineffective nurse.

Reflective practice must not be perceived as a way of identifying deficiencies in practice, but as advancing our understanding of the art and knowledge embedded in the care of patients and their families and the ways in which care might be enhanced. Nurse leaders and colleagues must help to create an atmosphere of mutual respect that promotes a feeling of trust and safety in order to lessen the feeling of vulnerability inherent in revealing one’s ways of working with patients.

The power of reflection
One of the most challenging aspects of developing structured reflection is preventing self-reflection from becoming purely an academic exercise. Reflective practice has the potential to uncover and articulate the essential knowledge embedded in nursing practice and to assist in articulating the art of care. Self-realization has been described as both exciting and awesome. Fay (1987) describes the process of reflection as one of enlightenment, empowerment, and emancipation. Enlightenment is to understand oneself in the context of defining and understanding practice; empowerment is having the courage and the commitment to take the necessary action to change oneself; and emancipation is to liberate oneself from previous ways of being, to become who you need to be in order to achieve desirable practice. Interlink nurses are feeling enlightened through the practice of self-reflection and are striving to achieve empowerment and emancipation.

Conclusion
The nurse of the future is described as a knowledge worker, able to articulate the knowledge that guides decision-making. Interlink nurses find that a conceptual framework helps to guide them on the path to adopting reflective practice. At times it has been challenging to explore patient situations more deeply. However, the process has been an important one for the development of the quality of the Interlink nurse’s practice and has contributed to individual development, and growth within the team. Nurses may need time to develop the skills of reflection, and considerable practice in order to internalize reflective cues as a way of viewing practice. Nurses without guidance and mentorship may experience difficulty in accessing contemplative thinking and in their ability to think through the situation deeply, considering reasons for thoughts, feelings, and actions. Reflective practice is fostered through environments that provide mentorship and guidance to the nurse as he or she journeys along the path to becoming a self-reflective practitioner. Interlink nurses are committed to using reflection in order to continually advance the quality of caregiving and to articulate their role in positively influencing the cancer person’s experience of living with cancer.

References