

Readers Clarify and Expand on Cancer-Related Patient Education

We read “Cancer-Related Patient Education: An Overview of the Last Decade of Evaluation and Research” (*Oncology Nursing Forum [ONF]*, Vol. 28, No. 7, pp. 1139–1147) by Jane Harper Chelf, MDiv, RN, and colleagues with great interest and found it to be an excellent synthesis. Both Dr. Joan Sullivan and I were pleased to be referenced in the article.

We would like to clarify and expand on several of our findings that perhaps were not clear in our cited article. These issues deal with points made by Chelf et al. concerning information needs/learning preferences and literacy/readability. First, the authors summarized their findings about information needs, indicating “Patients with cancer want as much information as possible . . .” (p. 1143). Although this was certainly true for the majority of our patients in both the study mentioned and in additional studies (Foltz & Sullivan, 1999; Miller, 1995; Sullivan & Foltz, 2000), we also identified a small percentage who found the information overwhelming. This finding supports the concept delineated by Miller, also referenced in the Chelf article, that some patients with cancer are “blunters.” These patients do not find information to be helpful to their coping process. We feel strongly that nurses must be attentive to this minority, both to protect their coping skills and to ensure that a patient caregiver is informed about crucial information.

Second, the authors’ indication of the importance of literacy and readability is strongly supported. However, attending to additional factors also is important. One element of readability that needs recognition is the familiarity of the concepts being discussed. In our sample, admittedly small, we found that some patients with college and graduate degrees did not understand or were unable to grasp some of the material written at readability levels consistent with their education. As one patient indicated, struggling to recall anatomical and physiologic concepts from early in her college career was difficult. This may be true for other well-educated people who did not choose careers based in the biological sciences.

A third related point is that treatment-related cancer information is, and must be, pro-

vided just before treatment is initiated. The ability to concentrate on complex information may be compromised during this period. Chelf and colleagues stated that “Although patients do not appear to resent easy-to-read materials, studies have not been conducted in populations that have high literacy” (p. 1143). In our small study, we found that well-educated patients appreciated having the limited literacy brochures on chemotherapy. They reported that processing that information was much easier and not offensive. This finding needs to be confirmed by other studies but, again, supports the issue mentioned by Chelf.

We congratulate Chelf and colleagues and hope their findings and suggestions will continue to be explored and implemented.

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Foltz, A., & Sullivan, J. (1999). Limited literacy revisited. *Cancer Practice*, 7(3), 145–150.
Miller, S.M. (1995). Monitoring versus blunting styles of coping with cancer influence the information patients want and need about their disease. *Cancer*, 76, 167–177.
Sullivan, J., & Foltz, A. (2000). Focus groups. Giving voice to people. *Outcomes Management for Nursing Practice*, 4(4), 177–181.

The Authors Respond

We very much appreciate Foltz and Sullivan’s kind words and welcome the opportunity to comment on their valid points. Our goal in this review was to summarize the big themes that research has identified; space limitations prevented us from attending to discreet groups of patients.

We certainly agree that “blunters” are an important subset of patients and should not be categorized as wanting the maximum amount of information. We hope that nurses’ learning needs assessments identify individuals who fall into this group and that information is provided appropriately.

We also agree with their comments regarding our literacy and readability section. However, we would like to point out that the issue they raise is only tangentially related to literacy. Even text written at a sixth grade reading level can be troublesome for college

graduates if prior knowledge is assumed and concepts are not well explained.

Finally, in response to their comments on the timing of treatment-related cancer information, although we agree that patients should be prepared for treatment before it begins, we also believe that nurses might be the best judges of when their patients are ready to learn. As we noted in the first paragraph under the subhead “Information Needs and Learning Preferences of Patients With Cancer,” “the desired timing and degree of information varies from person to person” (p. 1140). Again, we agree that it can be hard to concentrate on complex information when beginning cancer treatment and we would like to emphasize the need for ongoing assessment of learning needs. Repetition and reinforcement should be the norm rather than the exception.

We believe that Foltz and Sullivan’s letter helps draw attention to the complexity of providing patient education. We also hope that it will stimulate readers to approach their patients as unique individuals and take the time to review the many studies included in the tables available on ONS Online (www.ons.org/xp6/ONS/Library.xml/ONS_Publications.xml/ONF.xml/ONF2001.xml/August_2001.xml/Members_Only/Chelf_article.xml).

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What Are Potential Liability Issues of Conducting Sentinel Lymph Node Biopsy Off Study?

I recently read “Sentinel Lymph Node Biopsy in Breast Cancer: Scientific Rationale and Patient Care” by Eric Zack, RN, MSN, OCN® (*Oncology Nursing Forum [ONF]*, Vol. 28, No. 6, pp. 997–1005). I currently work at a large cancer center with 28 community hospitals that belong to our “cancer network.” We provide support and guidance for these community hospitals as they develop their cancer program services. Because sentinel lymph node biopsy (SNLB) has not