Anita Smith, PhD, RN

Ovarian cancer is described as being a whisper because it is challenging to diagnose at an early stage. Women need the voice to respond to the whisperings and nurses need to listen and acknowledge these voices. The purpose of this descriptive qualitative study is to examine personal stories of ovarian cancer within the framework of Women’s Ways of Knowing (WWK) to understand how women voice their “whisperings of ovarian cancer” and their interactions with healthcare providers. The importance of listening and acknowledging a woman’s voice is illustrated by the five categories of knowing delineated by WWK. The categories of knowing are silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. Listening for a woman’s voice, acknowledging her voice, and being an advocate for her voice are key components of holistic care. Listening may play an instrumental role in the early diagnosis of ovarian cancer.

At a Glance

- Listening is fundamental to nursing.
- Women’s Ways of Knowing is a theoretical model that can be used to emphasize listening to women as they are screened for ovarian cancer.
- Women are at various stages of knowing when they encounter the healthcare system.

Literature Review

A review of the literature was conducted using the CINHAL® database. To begin the search, the key words, ovarian cancer, cancer screening, female, and early detection, resulted in 116 articles. The literature included discussions of evidence-based screening practices, recommended diagnostic tests, and the
Ovarian Cancer Symptom Index (Fields & Chevlen, 2006; Goff et al., 2004, 2007; Koldjeski, Kirkpatrick, Swanson, Everett, & Brown, 2005; O’Rourke & Mahon, 2005; Tiffen & Mahon, 2005). Because WWK is the guiding framework for the study, the key words, ovarian cancer and women’s ways of knowing and ovarian cancer and intuition were used to guide the literature search. The combination of those key terms had no results.

For early detection of breast and cervical cancer, established screening tools are used on an annual basis in the general population. Ovarian cancer still is elusive because no useful diagnostic test for the general population is available. The need to focus on screening women for this deadly cancer is a high priority because diagnosis of the disease at an early stage makes survival more likely (Goff & Muntz, 2008). The hope is for the use of biomarkers that can assist with early identification, but more research is needed before using them in the clinical arena (Tiffen & Mahon, 2005). To date, no diagnostic test is available that is definitive and catches the cancer at an early stage like the mammogram does for breast cancer or the Pap smear does for cervical cancer. Rather a combination of diagnostic tools are used to screen for ovarian cancer, but they are not used to screen all women. Because no equivalent to the mammogram or Pap smear currently exists for detecting ovarian cancer, it is essential that all healthcare providers listen to the voices of women.

Current screening activities include identifying risk factors, yearly bimanual pelvic examinations, ultrasound, and the CA 125 blood test (Fields & Chevlen, 2006; O’Rourke & Mahon, 2003). The accuracy of those modalities is limited and has not proven to be effective in identifying ovarian cancer in the early stages (Koldjeski et al., 2005). In addition, the costs related to annual screening using ultrasound and the CA-125 in the general population is prohibitive. The American Academy of Family Physicians and the U.S. Prevention Services Task Force (USPSTF) do not recommend screening the modalities (Calonge, 2004; USPSTF, 2005). USPSTF listed a D recommendation for routine ovarian cancer screening, which means that screening of asymptomatic women is ineffective or the harms outweigh the risks. Population-based screening for ovarian cancer is not recommended by the American College of Obstetricians and Gynecologists (Goff et al., 2007; Goff & Muntz, 2008).

The Ovarian Cancer Symptom Index developed by Goff et al. (2007) could prove to be an inexpensive screening and educational tool (Black, Butler, Goldman, & Scroggins, 2007). The symptom index may provide possibilities for early detection of ovarian cancer based on the frequency of symptoms the woman is experiencing and can be used in various primary and specialty care settings (Goff et al., 2007). Goff et al. (2004) used a prospective case control design to compare the frequency, severity, and duration of symptoms of women presenting to a primary care clinic for general checkups, mammograms, or a specific problem already diagnosed with ovarian cancer. A sample of 1,709 women who were visiting primary care clinics completed the survey that listed 20 symptoms associated with ovarian cancer. One hundred and twenty-eight preoperative women with pelvic masses completed the same survey. The findings indicated that women with malignant masses experienced more severe and frequent symptoms, which were 20–30 times per month. Bloating, urinary symptoms, and increased abdominal size were more common in participants diagnosed with cancer. Further diagnostic investigation is warranted if the symptoms are more frequent, severe, and of recent onset because they are associated with ovarian masses (Goff et al., 2004).

Goff et al. (2007) used a survey of symptoms to identify specific symptoms related to ovarian cancer and their frequency and duration. Pelvic or abdominal pain, urinary urgency and frequency, increased abdominal size and bloating, and difficulty in eating or feeling full were symptoms that were associated with an ovarian cancer diagnosis. The symptoms needed to be present for less than a year and be experienced more than 12 days per month. The findings are hopeful because, although screening asymptomatic women for ovarian cancer has not been effective, having symptoms to use as a guide or trigger for use of diagnostic tools and further evaluation may help in early diagnosis. The symptom index is being tested prospectively in a primary care setting (Goff et al., 2007).

Use of the symptom index with other screening tools is being studied. Andersen et al. (2008) used a prospective case control design to examine the use of the symptom index in combination with CA 125 to determine whether ovarian cancer screening has improved sensitivity or specificity. The sample included 254 healthy women at high risk for ovarian cancer and 75 women with ovarian cancer. The findings indicate that using the symptom index with CA 125 as a first-line screening tool results in an increased identification of ovarian cancer. More than 80% of women were identified with early-stage disease. Using the symptom index and CA 125 provide greater sensitivity to early-stage cancer. The results of this study cannot be generalized because the sample of women either had ovarian cancer or were at high risk and were more knowledgeable about symptoms. Future study needs to be prospective in nature and include diverse samples of women. Research focused on diagnosis of early-stage ovarian cancer continues and includes the use of multimodal and multistep screening using CA 125 (Anderson et al., 2008).

Identifying early symptoms is essential for early diagnosis. Koldjeski et al. (2005) reviewed the literature to propose a conceptualization of why diagnostic delays occur with ovarian cancer. Three phases of diagnosis seeking were identified and include the self-care phase, the primary provider care phase, and the specialist care phase. The self-care phase was when women interpreted their symptoms and self-managed them. The primary provider care phase was linked to misdiagnosis and poor symptom management, and the specialist phase used specialized diagnostic tools for actual diagnosis. To alter ovarian outcomes, early diagnosis of ovarian cancer should shift to the self-care phase and primary provider care phase. To facilitate this, women and primary care providers need to be educated on the presentation of early symptoms. Understanding women’s ways of knowing...
and their use of voice are essential in the self-care phase. Women may not report the bloating or urinary problems because they are embarrassed, think it is part of going through menopause, or feel that the doctor is the one to tell them what is wrong.

The Ovarian Symptom Index (Goff et al., 2007) and the conceptualization of diagnostic delays (Koldjeski et al., 2005) provide evidence that “recognizing early symptoms of ovarian cancer does make a difference” (Goff & Muntz, 2008, p. 26). The index is a tool that lists early symptoms of ovarian cancer and the conceptualization of the three phases of diagnosis demonstrates how the delay of an ovarian cancer diagnosis can occur. Women experiencing the identified symptoms need to voice them to their healthcare providers. The theoretical framework, WWK (Belenky et al., 1997), addresses the development of voice in women. This framework is used as the theoretical framework for the current study.

**Women’s Ways of Knowing: The Guiding Framework**

Belenky et al. (1997) developed WWK, a theoretical framework, which describes women’s ways of knowing and the development of self, voice, and mind. The model is grounded in the analysis of interviews with 135 women from universities and human service agencies. The sample was made of students and mothers raising families. Career women were not included in the interviews, which may be a limitation. Using a phenomenologic approach, the interview questions focused on women’s points of view on life and learning. From the data, the authors identified five major perspectives or categories by which women know the world: silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. A description for each category is found in Table 1. The perspectives or categories are not described as having stage-like qualities in that women progress from one category to the next. More research is necessary to investigate whether a stage-like progression occurs through the categories.

Within the framework of WWK, “voice” is a point of view and became a metaphor for many aspects of women’s experiences and development. “Voice depicts intellectual and ethical development; and that the development of a sense of voice, mind, and self were intricately intertwined” (Belenky et al., 1997, p. 18). In the silence category, women are voiceless, and in the received knowledge category, women listen to external voices over their own. The inner voice or intuitions are valued in the category of subjective knowledge, and listening to voices of reason is important in the procedural knowledge category. Finally, in the category of constructed knowledge, women integrate all the voices, their inner voice, and the external voices of others, such as healthcare providers. Therefore, if a woman is in the category of silence, she may not speak up about the pelvic and urinary symptoms she is having at her annual healthcare visit. Nurses need to consider the development of the women’s voice when they question women about their symptoms.

### Women’s Collective Voice

A review the literature found that women with ovarian cancer have used their collective voice to bring about changes within the healthcare community. Women have shared their personal stories of ovarian cancer on the Internet; using those stories to learn about the experience of ovarian cancer is essential. Most of the stories shared include an explanation of the early symptoms the women experienced prior to diagnosis. Stories related to ovarian cancer are data to consider when exploring how to provide the best nursing care for women prior to and after a diagnosis of ovarian cancer. The themes and feelings that emerge when reading the online stories represent the voices of the women.

### Purpose

The purpose of this descriptive qualitative study was to explore the personal stories of women with ovarian cancer using the WWK theoretical framework to gain an understanding of how women “voice” the whisperings of ovarian cancer and the resulting interactions with healthcare providers.

### Methodology

A descriptive, qualitative research study using content analysis was conducted. Content analysis is used to identify themes and patterns (Polit & Beck, 2003; Sandelowski, 2000). University institutional review board approval was obtained for the purposes of

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**Table 1. The Five Categories of Women’s Ways of Knowing**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>Silence</td>
<td>Without a voice and subject to external authority</td>
</tr>
<tr>
<td>Received knowledge</td>
<td>Listening to voices of others; capable of receiving knowledge from authorities but not generating new knowledge on own; listens to others over own voice</td>
</tr>
<tr>
<td>Subjective knowledge</td>
<td>The inner voice: truth and knowledge come from within the person; women’s intuition; external authority is mistrusted.</td>
</tr>
<tr>
<td>Procedural knowledge</td>
<td>Voice of reason; invested in learning and applying knowledge in an objective fashion</td>
</tr>
<tr>
<td>Constructed knowledge</td>
<td>Integrating many voices; values objective and subjective strategies for learning; listens to own voice as well as others</td>
</tr>
</tbody>
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*Note. Based on information from Belenky et al., 1997.*
using the personal stories of ovarian cancer located on Web sites. The posted personal stories on the public domain of two Web sites were used for the data collection. One Web page was sponsored by a U.S. cancer organization and the other Web page was sponsored by a Canadian cancer organization. A total of 379 posted stories (253 from the U.S. organization and 26 from the Canadian organization) were analyzed using qualitative content analysis.

The personal stories of women with ovarian cancer posted on the Internet were analyzed and coded within the framework of WWK. Preexisting codes representing the five perspectives or categories of WWK (silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge) were developed. The women with ovarian cancer and their husbands, sisters, daughters, sons, nieces, brothers, nephews, and friends posted the stories. A limitation of using the personal stories is that they are based on self-report and recall of information during a stressful situation. In addition, the difference between women who do and do not post stories is unknown.

Findings

Most of the stories focused on the symptoms experienced prior to the diagnosis of ovarian cancer. Distress over the symptoms experienced prior to diagnosis was noted whether it was the women with ovarian cancer or the children of women who were frustrated with the symptoms their mothers or grandmothers were experiencing, such as increased abdomen girth, loss of appetite, or extreme fatigue. Another frequent theme was women with cancer stating the need “to look for a MD that listens and, if you think something is wrong, keep insisting.” Several women were frustrated because they felt the physicians treated them like they “were crazy” because they frequented the doctor's office with symptoms, whereas others were told repeatedly their symptoms were the result of being pregnant.

Themes from the personal stories were found for each of the five categories of knowing. Using WWK as a framework for the themes illustrated how women dealt with the whispers. Some women did not use their voices to call attention to their symptoms (whispersing), some listened to the physician's voice rather than their own voices, some ignored their own feelings and knowledge, and some failed to speak up to an external authority. Others learned from the diagnosis experience and used their personal stories to tell other women to learn about ovarian cancer, trust their feelings and knowledge, and seek a healthcare provider who would listen to them. Finally, some women pushed the medical system to call attention to their symptoms and did not give up using their voices within the healthcare system. Each of the five categories of WWK are illustrated by excerpts from the personal stories with direct quotes (names and specific Web sites purposefully omitted to protect patient identities.)

Silence

The silence category portrays women as not having a voice and as only listening to voices of external authority (Belenky et al., 1997). Women did not trust their own experience as knowledge and are not able to express their opinions. They are not aware of their intellectual abilities and are voiceless. In Belenky et al.'s sample of women, few women were in this category but they were more likely to be young and socially, educationally, and economically deprived. For these women, the external voice, such as a healthcare provider, has more importance over the woman's voice and knowledge.

In truth, my mother should have been more proactive in terms of her care. She should have demanded to see a gynecologist. But she was from a generation of women that was raised to think of doctors as all-knowing and that gynecologists are only necessary for women who are trying to have children.

Received Knowledge

In the received knowledge category, women listen to the voices of others to learn. The external voice has authority over the women's voice. Women receive knowledge from authority figures and will not generate ideas on their own (Belenky et al., 1997). In the case of women experiencing symptoms of ovarian cancer, the women listened to their providers and accepted their recommendations as the truth.

I'd been back and forth to the doctor only to be told “lose weight, exercise, take Mylanta” [Merck Consumer Pharmaceuticals Co.,] and change your diet.” I reluctantly accepted that advice and continued to suffer.

Don’t JUST listen to your body (we all know or have heard ovarian cancer whispers) make sure the doctor is listening too. Don’t get lulled into the “great, the doctor says I’m OK” mode like I did.

Subjective Knowledge

The subjective knowledge category includes the inner voice and the concept of intuition. Knowledge and truth come from within the women from direct sensory experiences or involvement and external authority often is mistrusted (Belenky et al., 1997). Women have a sense of “private authority” and “usually feel strongly that they ‘know’ but have few tools for expressing themselves or persuading others to listen” (Belenky et al., p. 134). Substantial comments were made by women, daughters, cancer survivors, and girlfriends that emphasized women's feelings, intuitions, and knowledge of body. Belenky et al. alluded to the disadvantage that women may have if they rely solely on intuitive and experiential knowledge in a rational and objective society. Women seek care when something is not right, but they may not be able to describe the problems in objective medical terms or the symptoms are not significant within a medical model. The following are examples of the inner feelings or intuitions described in the personal stories as well as the demand that women should actively find a doctor that they can trust.

Like others have said before, know your body and be your own advocate, if you think something is wrong and don't get the answer that seems right, try another doctor and another doctor.

To end my story, I want to say to all women everywhere, “listen to your body. Do not ignore aches and pains, bloating, unexplained weight gain, gas, inability to eat much at a time, going to the bathroom constantly, and...
low backaches. Go to your OBGYN and ask, demand the tests that can rule in or rule out cancer.” I ignored what my body was saying, and now I am very, very sorry I didn’t “listen” and do something much sooner!

Finally, don’t take “no” for an answer if you feel that there is something wrong. You know your own body better than anyone else. Listen to it!

My girlfriend and I had many intimate talks while she was fighting to live. The one talk that stands out the most is when she said to me, “Girlfriend, get to know your body. Be aware of changes, follow your instincts, and if something does not feel quite right, do not hesitate to go see your doctor. Ask questions, demand tests. Be a ‘thorn’ in your doctor’s side.”

Listen to your body. Listen to your instincts. If you feel uncomfortable, respect it and keep pushing even if you are told there is nothing to worry about.

My advice to all women is to listen to your body and heed its warning signals. Let no one dismiss your concerns. Be tenacious in being heard and in getting help. It could make a difference in being diagnosed at an early stage, if cancer is present.

**Procedural Knowledge**

Women who are in the procedural knowledge category of knowing listen to voices of reason and are invested in learning and applying their new knowledge in an objective fashion. This category encompasses the voice of reason, separate knowing, and connected knowing. Separate knowing involves examining ideas, thinking critically, and using more impersonal methods of establishing truth. Connected knowing involves relationships and truth that emerge through caring and collaboration (Belenky et al., 1997). The voice of reason is demonstrated by the following excerpt.

Being proactive about my healthcare did the trick. I’m doing something about my cancer risks and the cancer risks of my family. I am no longer a victim. I am a survivor.

Educate yourself. It will help you get the best possible care.

**Constructed Knowledge**

In the constructed knowledge category, a woman integrates many voices in addition to her own voice. This includes integration of intuition with external knowledge, separate and connected approaches to knowledge, and valuing objective and subjective strategies for learning. Knowledge is considered within the context of the situation (Belenky et al., 1997).

Just keep your faith, keep building your relationship with God, listen to your body, listen to your physician (if you don’t have a good feeling about your doc, it is your right to seek other medical opinions), and keep up-to-date about the new chemos.

We are not immortal. Things do happen and can happen to each one of us, so we need to be vigilant about our bodies and how they are feeling. Our intuition is so powerful, don’t ever ignore it. If you feel something is wrong, see a doctor. If you are not happy with what you are told, see another. Don’t take no for an answer and don’t let doctors flick you off as a complaining woman. And don’t put symptoms down to your busy life as a wife/mother, all too often we look after others before ourselves, put yourself first for a change.

The category of constructed knowledge also is illustrated by a personal story published in a medical journal. Feelings and dreams of having ovarian and uterine cancer led a physician to seek the care of her gynecologist before taking a year sabbatical in a foreign country (Scannell, 2000). She listened to her intuitions and used her medical knowledge to push for diagnostic testing, which was positive for cancer.

**Discussion**

Women cared for within the healthcare system are in the various categories of knowing described by WWK. Some women are comfortable with their knowledge and voice to challenge the medical authority and others lack the voice to speak out about what they know. Nurses need to consider the voices that women are willing to use and, if women are silent, nurses need to be an advocate for them. WWK can be used as a model for assessment and education related to ovarian cancer as well as in the consideration of women being collaborators in their care.

The WWK theory and the use of the theory to frame the themes found in the personal stories posted on the Internet have limitations. The WWK theory was developed in the 1980s and has not been tested using women who were in the patient role or further developed using other samples of women. A limitation of the current study is using the personal stories taken from the public domain of the Internet. Speaking directly with the women about their experiences or their use of voice could elicit more information. As noted earlier, whether a stage-like progression occurs through the five categories of knowing is not known.

The WWK framework was used in a nursing research study that examined mothers with chronically ill children (Gibson, 1999). Gibson examined the process of critical reflection among 12 women who had children with a variety of neurologic conditions. Through in-depth interviews, critical reflection was seen to assist women who originally had felt powerless by the medical condition of their children to becoming empowered with ability to navigate the healthcare system and collaborate with the healthcare team. Gibson links critical reflection experienced by the mothers in the study to the five perspectives of WWK. The mothers moved from the silence perspective to the constructed knowledge perspective in which the mother integrates all types of knowledge and develops her own voice that comes from intuitive and learned knowledge.

The excerpts provided for each category of knowing illustrate how women looked back at the experience and learned from it and then shared with others but do not provide the information on whether the women progressed through the five categories during their cancer experience.

The themes of trusting one’s intuitions and speaking out to authority are evident in the various categories of knowing but prominently in the category of subjective knowing. An analysis of the themes also supports Koldjeski’s et al. (2005) conceptualization of why diagnostic delays occur with ovarian...
cancer. The women sought care from many providers based on the symptoms they experienced and their intuitions but experienced misdiagnosis or delays in the diagnosis. Frequently, a diagnosis was not made until the woman received specialist care. Knowledge gained from the Ovarian Cancer Symptom Index, the conceptualization of why diagnostic delays occur, and women’s use of voice will help nurses provide holistic care and possible early detection.

The collective voice of women already has led to changes in how early detection of ovarian cancer is viewed by the medical discipline. The Ovarian Cancer Symptom Index is the result of ovarian cancer survivors speaking out at the Allied Support Group of the Gynecologic Cancer Foundation. These survivors challenged a medical doctor who said ovarian cancer does not have early symptoms (Black et al., 2006). Ironically, the international newsletter for those fighting ovarian cancer is called CONVERSATIONS and the symptom survey initially was distributed through it (Black et al.). The voices of women challenging a physician led to research related to early diagnosis based on common symptomology.

Ovarian cancer survivors also are are educating medical personnel and the public on the ovarian symptoms (Black et al., 2006). These brave women are lobbying in Congress for more research dollars, providing education to medical students, and creating awareness campaigns for women. An example of the collective voice of women is Survivors Teaching Students: Saving Women’s Lives, which is an education program provided to future healthcare providers (doctors, nurse practitioners, and physician assistants) (Black et al., 2006). The survivors share their stories with students so they are aware of the early symptoms of ovarian cancer. Through the voice of the ovarian cancer survivor, community awareness of symptoms is conveyed.

Implications for Nursing Practice

The purpose of the current descriptive study was to explore the personal stories of ovarian cancer within the framework of WWK and to provide practical information based on a theoretical framework for nurses caring for precancerous patients and those along the continuum of cancer care. In screening for ovarian cancer, listening for the voice of the women and the volume is essential. Although this advice may be simplistic, it is considered fundamental to basic nursing care. In addition, understanding how women perceive knowledge, the truth, and authority are essential as nurses educate and care for women and advocate for them to be collaborators in their own care.

Understanding the development of women’s voices will help nurses better understand how they can be advocates for women. WWK demonstrates the need to listen for women’s voices and probe for their voices if necessary. Women are at various stages of knowing when they encounter the healthcare system. WWK provides the theoretical framework for the importance of listening and, by combining with the Ovarian Cancer Symptom Index, could help with early detection of this evasive cancer. Nurses should consider the lack of voice in some women and become advocates for their health.

Nurses have an important role in acknowledging the whisperings of ovarian cancer and generating the voice for all women. Some women are silent, some defer to authority figures, some solely value their intuitions, some value a logical presentation of information, and some integrate their intuitions with external authorities. Figure 1 provides nursing interventions for each category of WWK. In the silence, received knowledge, and subjective knowledge categories of knowing, nurses need to probe and assess for the voice of women, listen carefully, and be an advocate for women’s intuitions or inner voices. Without a voice, strict trust of authority, or mistrust of authorities makes it difficult to educate and collaborate with women in the healthcare setting. In the procedural and constructive knowing categories, nurses can focus on providing education, empowering, and collaborating with the women because women in these categories listen to various voices in addition to their own.

Assessment includes listening to women’s perspectives and voices. To probe, nurses can ask, “List the symptoms you have been experiencing in the last three months that are troubling to you.” “What is your body telling you?” “Do you feel your healthcare providers have addressed your concerns?” “Have provided treatments and education addressed the symptoms you have been experiencing?” and “What do you feel is wrong with you?” Statements or questions that foster collaboration include “What do you think should be done next?” “Your input is important when planning your care.” “What do you think is wrong?” or “Is there anything you would like to share?” These questions or statements need to be said or asked in a nonthreatening, nonjudgmental environment that provides privacy and trust. Women should feel comfortable in speaking up about their symptoms, concerns, or intuitions.

The need to listen to women’s intuitions and embrace them as collaborators in the continuum of cancer care is needed, especially in the screening or early detection phase or self-care phase outlined by Koldijksi et al. (2005). Groopman (2001), in his book Second Opinions: Stories of Intuition and Choice in the Changing World of Medicine voiced the need to listen to patients’ intuitions and embrace patients as collaborators. Listening and respecting women’s intuitions is essential in building a collaborative relationship between women and healthcare teams. The ultimate goal is to have women using constructed knowledge and working in a collaborative relationship within the healthcare system in the prediagnosis or self-care phase. The following excerpt from a personal story illustrates a collaborative relationship. The woman used her voice and her doctor listened to her.

Over the past seven years, I have heard many of the stories of misdiagnosis that have occurred to so many women, and I’m sure that, had my internist not listened to everything I said, I would have been one of those cases. Time and again, when I tell my story, doctors tell me how lucky I was. With all the medical tests available, the thing that made the difference in my case was my telling the doctor everything and her listening to me.

Providing education related to women’s ways of knowing and the implications of this knowledge during the screening and early detection process for ovarian cancer is another nursing responsibility. Nurses working in outpatient, inpatient, education, and community settings should be aware of women’s ways of knowing and their use of voice. In addition, sharing this theo-
retical framework and the findings from the current study with other disciplines that provide direct care in the primary care or specialty care settings is a necessary step in being advocates for women's voices. Education of women and the lay public on the early signs and symptoms of ovarian cancer is essential as "recognizing early symptoms makes a difference" (Goff & Muntz, 2008, p. 26). Educating the lay public on the symptoms and need to listen to women who voice their concerns is vital, as it will be a spouse, partner, friend, or family member who will hear women's voices first. Finally, the ovarian support organizations, the collective voice, can be key players in disseminating the information and working to be advocates for the individual voices of all women.

Future Research

Qualitative content analysis is the least interpretive, quantitative research method in that data is presented in its own terms rather than being represented using different terminology (Sandelowski, 2000). Future nursing research can use more interpretive methods, like phenomenology. A focus on the lived experience of women being evaluated for and diagnosed with ovarian cancer can provide vital information that can foster supportive and holistic nursing care. Qualitative studies can complement the biomedical research that is examining biomarkers, proteins, and diagnostic tools for early diagnosis of ovarian cancer.

Although discovering the best diagnostic tool to detect ovarian cancer at an early phase is a priority, other priorities are evident in cancer research by grant announcements, which include examining decision making and feelings experienced by patients with cancer in the continuum of the cancer experience from screening to end-of-life issues (McCaul, Peters, Nelson, & Stefanek, 2005). McCaul et al. provided a summary of the six themes that are important to linking decision-making research to cancer prevention and control. One of the themes is that the decision maker relies on feelings. Because intuition was a frequent theme in the personal stories, nursing research can focus on the feelings and intuitions of women and how they relate to women seeking screening and being aggressive in their care. Use of the WWK theory in examining the decision making of women seeking cancer screening or early detection is another option to explore.

Conclusions

Nurses need to consider women's ways of knowing when providing care and education to women. Listening for women's voices and being an advocate for their voices is a key component can be instrumental in the earlier diagnosis of ovarian cancer. Listening especially is important when type, frequency, and duration of symptoms are described. The Ovarian Cancer Symptom Index is a tool that can be used now to assist in screening women in the primary care setting, but listening and understanding the voices of women will complement the usefulness of the symptom index.

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