patients in different care phases). After treatment, this support became subjectively more important than that of the other groups of team professionals, i.e. the surgeons, the nurses at the outpatient clinic and the nurses in the surgical ward. Out of 49 patients who responded to the second questionnaire, 71−94% “completely agreed” that the supportive care given by the specialist nurse was satisfactory, and 90–100% deemed it “most important” or “important” to them. Whereas 10% had difficulty in understanding information given by the physicians, none had such problems regarding information given by the nurse. Contacts between the specialist nurse and 75 patients with esophageal or gastric cancer were most frequent during follow-up, and nutritional problems predominated.
Conclusion: Specialist nurses can be recommended as leader of the care pathway of patients with esophageal and other upper gastrointestinal cancers.

Workshop (Mon, 24 Sep, 13:45−15:45)
Telling the truth or not – information giving problems in cancer care

8010 INVITED

Nurses’ truth-telling with cancer patients

L. Hallila. *The Nursing Research Institute, Hämeenlinna, Finland*

Modern health care systems and advanced legislation in Europe have challenged nurses to exercise moral judgment in decision-making. One ethical issue is information-giving to cancer patients, how much, when and where it should happen. The most problematic information sharing situations are related to (a) breaking bad news, (b) informing patients of possible risks and complications caused by nursing or medical treatments, (c) informing patients about health care professionals’ malpractice. These situations may lead to the dilemma whether to tell the truth.
Truth-telling, truthfulness and honesty are related concepts. Truth-telling and honesty are important and basic cornerstones of morality. Communication between nurses and cancer patients is the crucial element in nursing care and patients may need the feeling of mutual trust that then actualizes in communication. Truth-telling and honesty may be the most difficult principles to try to live with because human beings are essentially vulnerable within relationships, and in order to protect this vulnerability may have built up defenses to avoid exposing themselves to others.
According to the nurses’ truth-telling literature there are several mechanisms which nurses may use when not telling the truth to their patients:

- postponing information-giving
- telling the partial truth
- giving evasive answers
- misleading
- silencing or concealing
- telling a lie
- deceiving the patient

The nurses may have expanded their awareness of ethical issues and realised that not being able to tell the truth to the patient is a problem. There may be different groups of nurses working in cancer care (1) some nurses may have always told the truth; (2) some nurses fail to see not telling the truth as an ethical problem; (3) nurses are afraid of confessing to having been dishonest to the patient. According to very resent studies the nurses experienced negative feelings of self-worth due to the problem they found themselves in, and they described how patients were undervalued in these situations when they were not told the truth.
Learning outcomes:

1. Nurses would see information-giving linking ethical theories, principles and legal aspects
2. Nurses are aware of information-giving’s impact to patients’ well-being
3. Nurses would recognize their roles as autonomous health care professionals when moral decision-making occur in information-giving situations
4. Nurses would gain assertiveness and be more empowered to raise the information-giving issues to general multi-disciplinary discussion in their organizations.

Meet the Manager (Mon, 24 Sep, 13:45−15:45)
Commercialism in the health sector: pros and cons of bringing private finance into cancer services

8011 INVITED

Commercialism in the health sector: pros and cons of bringing private finance into cancer services

S. O’Connor. *Buckinghamshire Chilterns University College, Faculty of Health Studies, Buckinghamshire, United Kingdom*

The introduction of private finance into healthcare has been hailed by many as the panacea to growing constraints upon public finances and the escalating cost of providing medical, social and nursing care to an increasingly ageing population. It also chimes with the consumerist ‘zeitgeist’ of the modern age, in which patients are no longer considered to be passive recipients of healthcare, but discerning consumers of healthcare ‘products’ whose expectations and preferences have increased in line with developments in medical technology and improvements in living standards across Europe as a whole. Private finance now provides the capital investment for many healthcare projects and in some cases, the operational management of entire healthcare systems, whilst commercial interest has long driven the development of new cancer therapies and the development of innovations such as private screening, treatment, rehabilitation and supportive care facilities. However; it has been argued that the short-term benefits of these schemes are offset by long-term demands upon the public purse, an increase in the total cost of such provision, and accusations that those embarking upon such initiatives are mortgaging future health care expenditure for immediate political and fiscal gain. Recent concerns about the quality, cost and affordability of capital programmes and services thus provided have caused some to revise their output specifications and review the payment mechanisms by which investors are rewarded for the ‘risks’ incurred in underwriting the costs of major public projects or developing new products and services. As a result, many healthcare professionals remain unconvinced about the benefits of such schemes, and this ‘Meet the Manager’ session will therefore consider the advantages and disadvantages of private investment, commercial interest and the profit motive in the development of cancer services. Expert speakers will provide a variety of international perspectives on the topic, and attendees will be asked to judge for themselves if commercial interests and private investment are helping or hindering the provision of cancer care in their own areas.

Proffered papers (Mon, 24 Sep, 16.00−17.30)
Ethical dilemmas, decision-making and advanced nursing roles

8012 ORAL

Cancer patients and critical care: technology to diagnose dying or an appropriate place for support?

N. Pattison. *Royal Marsden Hospital – NHS Trust, Critical Care, London, United Kingdom*

Background: As a result of disease, co-morbidities or iatrogenic causes, a proportion of cancer patients will become critically ill and subsequently require critical care support. Ideally decisions are made about levels of aggressiveness of care before admission; however this is often impossible in reality for a range of reasons. A significant proportion of those cancer patients will die in critical care units (CCU). This presentation focuses on provision of end-of-life care in CCU, exploring specifically: how cancer patients are cared for at the end of life in the high technology environment of CCU.
Method: This research study takes the novel approach of exploring all perspectives including those of cancer patients, cancer patients’ families, nurses, intensivists, consultants in palliative care, medicine and surgery. Experiences of receiving, witnessing, deciding to move to and providing end-of-life care are presented.
Using a qualitative phenomenological approach the research elicited in-depth descriptions of processes of decision-making for critically ill cancer patients, as well as phenomena around caring for such patients.
Results: 39 people were interviewed and the overarching themes included:

- perspectives on caring
- physical and psychological support
- the possibility of a good death in CCU
- prognostication in critical illness

– complexities of decision-making in cancer patients
– ethical difficulties: what is right, what is wrong?

This presentation will consider the findings in the context of current cancer care provision across the world and put forward suggestions and considerations for practice.

8013 ORAL

Disclosing/Informing the diagnosis of cancer to Turkish People and their close relatives: An Opinion Survey

A. Enaboifo[1], B. Yalcin[2], F. Icli[2], A. Demirkazik[2], H. Akbulut[2], F.C. Senler[2], A. Buyukcelik[2], M. Dogan[2], O. Sencan[2], S. Yalcin[3]. *[1]Ankara University Hospital, Department of Medical Oncology, Ankara, Turkey; [2]Ankara University Faculty of Medicine, Department of Medical Oncology, Ankara, Turkey; [3]Ministry of health Kayseri-Develi Goverment Hospital, Medical Oncology, Kayseri, Turkey*

The aim of the survey was to find out the opinion of the Turkish people about cancer and in case their close relatives were affected by the disease, what their attitude and reaction would be like for disclosing the diagnosis of cancer.

This survey study was conducted at nine hospitals (7 university, military and state hospitals) 7 different cities with the help of 27 colloborators. Data were collected via using questionnaire which includes demographics (age, gender, proffesion, education level, whether they have or had had a cancer-patient relative(s) if yes, whether they had disclosed the illness to them or not and WHEN during the period of the illness; whether the affected relative was still alive) and questions on their personal opinion about cancer:

1. If they would request that their patient be informed of their disease after the diagnosis.
2. Whether or not they would stand to be informed if they had the disease.
3. If their answer to the previous question is yes, WHEN would they prefer to be told.
4. If they don't want to disclose the bad news of the cancer to their relative but condition warrants them to do so what would their reaction be like.
5. Why they would feel unwilling to disclose the bad news to their relatives.

A total of 6566 people from different residential centers all over Turkey took part in the survey. The average age of the participants were 33 (18–100) with men and women percentage of 53.5 and 46.7 respectively. The result showed that 57.7% of the participants don't want their relatives to be informed of the cancer diagnosis. The survey also showed that 54.8% of the participants' relatives had frequent occurrence of cancer. Those whose relatives were diagnosed of cancer was ($N = 3597$) 69.9%; those who told their relatives of their cancer disease after the diagnosis were ($N = 2516$); 71.5% said they disclosed the bad news to their close ones immediately after they had been diagnosed; 16.9% said it after months and 9% said it at a time the patients were close to their death. Of them 62.8% responded said their relatives had died from cancer. It was also seen that when the participants in the survey were asked about cancer and its treatment approach, the optimistic ones and the pessimistic ones who don't believe medical medication ratio, was seen to be 76.5% and 16.3% respectively; only 2.9% of the participants in the survey were totally hopefull and at the same time hopeless. According to logistic regression analysis, it is interesting to note that the youth, the aged, the female sex group, the less educated, those who don't want to say they had relatives who had cancer, or those who proclaimed it late and those whose relatives had died of cancer and don't believe in cancer medication; all said at first they wouldn't want their relatives suffering from cancer to be told at all.

8014 ORAL

Truth telling to cancer patients

N. Schneider. *Chaim Sheba Medical Center, hematology, Tel Hashomer, Israel*

Breaking bad news to patients is a common occurrence in the hematology-oncology department. Yet, many healthcare providers tend to avoid these intimidated situations.

Purpose: To explore attitudes of physicians and nurses from the hematology-oncology departments and the general wards and cancer patients toward truth telling. To determine who should inform cancer patients of their diagnosis, optional treatments, side effects and prognosis. To examine differences between healthcare providers concerning truth telling.

Sample: 69 healthcare providers (23% physicians and 77% nurses) from hemato-oncology units and general departments and 35 cancer patients completed questionnaires dealing with attitudes and wishes regarding information given.

Results: 97% of the healthcare providers answered that if they had cancer they wished to receive more information regarding the diagnosis, prognosis and treatment comparing to cancer patients. Younger patients were more likely to share information regarding their illness with their relatives. The hematology-oncology staff had significant higher intention ($p < 0.05$) to share information with relatives than the general department staff. A nurse was found to be the most suitable caregiver to provide information regarding treatment side-effects ($p < 0.05$). Cancer patients would like to know less about their prognosis than healthcare providers. 80% of caregivers agreed to accept the patient's attitude not to be informed about their prognosis and 61% agreed that the healthcare provider can hide information if it can lead to desperation, depression or suicide attempt.

Conclusion: Training and education regarding this issue should be an ongoing process for healthcare providers which must adjust their attitudes and tailor intervention according to patients needs. This training should include clinical discussions, case studies and simulation exercises in order to improve the staff skills.

8015 ORAL

Stepwise implementation of an evidence-based specialist breast care nurse model in a Belgian breast cancer clinic: Impact on patient's satisfaction, a prospective study

G. Verheyden, H. Van der Mussele, A.M. Prove, L. Verkinderen, A. De Schepper, P.B. Vermeulen, G. Buelens, C. De Pooter, L.Y. Dirix, P. van Dam. *GH Sint-Augustinus, Breast Cancer Clinic, Antwerp, Belgium*

Background: To prospectively evaluate patient's satisfaction with primary operable breast cancer (POBC) prior to and following a stepwise implementation of an evidence-based SBN-model in a Belgian breast cancer clinic treating about 400 new patients with operable breast cancer (POBC) a year.

Methods. Patient's satisfaction was measured using a (validated) questionnaire (measuring 20 items) developed by the Belgian Dutch Clinical Pathway Network (BDCPN). Three groups of 60 consecutive POBC patients filled in the questionnaire: a first group prior to implementation, a second group after introducing a clinical path (from 1/1/2003 onwards) with scheduled consultations with a breast cancer specialist in the post-operative and follow-up phases of treatment, a third group after introducing a breast cancer nurse (from 1/2005 onwards) following patients systematically only postoperatively in the same setting and a fourth group having (from 1/2006) additional consultations of the breast nurse in the diagnostic and preoperative phase

Results. Introducing of a clinical pathway significantly improved patients satisfaction (group 1 versus group 2) regarding uniformity of information given on the disease and treatment ($p < 0.05$), reduced the waiting times during the stay in the hospital ($p < 0.01$), and beneficially influenced the information given upon discharge from hospital ($p < 0.01$). The amount of dissatisfaction higher then 10% among patients was reduced from 11/20 to 9/20 of the questioned items. Further introduction of the breast nurse in respectively the postoperative phase (group 3) en pre- and postoperative phase (group 4) further optimized the way patients appreciated the information given to them about the disease, investigations and treatment ($p < 0.\ 05$), the appreciation of the kindness of the treating personnel ($p < 0.05$). The level of dissatisfaction was further reduced having only 7/20 items in group 3 and only 1/20 items in group 4 ($p < 0.05$ versus group 1, 2 and 3) scoring higher then 10%.

Conclusion. Patient's satisfaction gradually improved following introduction of evidence based clinical pathway and breast cancer nurse model in our breast clinic. Particularly the role of breast nurse seems to be of major importance to guide patients through the pre- and postoperative phase of their treatment

8016 ORAL

A nurse led out-patient oral chemotherapy service for the delivery of capecitabine tp patients with colorectal cancer in North East Scotland: an audit of the first 3 years

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Background: A nurse led out-patient chemotherapy service for capecitabine monotherapy for adjuvant or palliative treatment for colorectal cancer (CRC) was started by the Anchor Unit, Aberdeen, in September 2003. The Unit serves a large geopgraphical area of North East Scotland including the remote Orkney & Shetland Islands. The aim was to improve the service for patients, particularly those living in remote areas and to reduce pressure on the hospital service, and intravenous chemotherapy service in particular.

Materials and Methods: An audit of the prospective database from September 2003 to November 2006. Data used included: patients diagnosis; performance status (PS); concurrent conditions; previous