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HEALTH CARE PROFESSIONALS ATTITUDES TOWARDS ELDERLY WOMEN WITH BREAST CANCER

C M MILLER

ONCOLOGY DIRECTORATE, GUY'S HOSPITAL, LONDON
SE1 9RT, UK

As the elderly are main consumers of health care services, it is important to establish their impact on health care provision. One of the great misconceptions of cancer is that it is more indolent in the elderly. Negative societal views of the elderly combine to reinforce these misconceptions in medical and nursing practice, hence the purpose of this study was to investigate the attitudes of health care professionals (including general practitioners, oncology specialists, nurse specialists) towards elderly women with breast cancer.

Research methods employed were qualitative in nature using postal questionnaires.

Results highlighted a varied response towards appropriateness of cancer treatments for elderly women with breast cancer. Also paternalistic practices from both primary and hospital personnel highlighted insufficient appreciation of each others specific roles in treatment programmes.

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HOME-CARE TREATMENT FOR SELECTED ACUTE LEUKEMIC ELDERLY PATIENTS BY LOW DOSE ARA-C

A Abbadessa, G Corazzelli*, R Muscherà*, S Giordano*, G Arcidiacone
Dipartimento di Internistica clinica e Sperimentale, 2° Ateneo;*Unità Operativa Ematologia Oncologia, Napoli ITALIA

New opportunities for nursing should be conceived for many leukemic elderly patients who are inelegible for aggressive or conventional chemotherapy. Continous Home-Care (median time 156 days, range 57-572) has been carried out for eight acute leukemic pts (6 AML: FAB M1=2, FAB M2=3, FAB M4=1; 2 CML myeloid blast crisis; M/F=5/3; median age 76,range 66-83), throughout the phases of active treatment, post-treatment monitoring and palliative care. Reasons for home-care option were different: severe cardiac disease, severe liver damage from prior intensive treatment, refusal of intensive chemotherapy and hospital facilities, dischargement from the wards with progressive disease. A nurse and a physician made regular home visits and could be reached 24 h a day through a calling system; samples for blood chemistry were collected at home and results available in few hours for drug scheduling adjustment; multidisciplinary consultants were available for problem-solving assistance. All the pts received subsequent courses(median 4,range 1-14) of Low Dose Ara-C (10 mg/m2 twice daily s.c. or by c.i. for 7-21 days); most of them experienced bone marrow aplasia and all required adequate transfusional and antimicrobial supports. Hickman lines, available in four pts, were safely handled at home. Three Complete Remissions were achieved (4,6,16 mos); all were FAB M2 AML. The CML-BC enjoyed a good PS for 3 and 5 mos. respectively.

In our experience home health care can be safe and medically appropiate for selected for selected leukemic elderly pts with the benefits of more intimacy of the caregiving of family and friends.

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"A CHILD WITH CANCER REMAINS A CHILD" NURSING EDUCATION SHOULD AIM AT CHILD-FRIENDLY CANCER NURSING.

ZOUDE P. BUSCARLET G.
NURSING SCHOOL
FREE UNIVERSITY OF BRUSSELS (ULB)

A child with cancer has to be considered first as a child with its own needs linked to its age. If hospitalisation is necessary, it is important to provide care in a unit which allows a "continuum" of its childhood living habits. This unit should be composed of a multidisciplinary team where the paediatric nurse should play a major role being a permanent referral person for the child and its family.

In Belgium, and particularly in the Nursing School of the Free University of Brussels (ULB), this approach was developed in the education of the paediatric nurse. Complementary to specific paediatric nursing techniques and scientific knowledge of medical drug use in paediatrics, concepts as quality of life, communication with the child and its parents and the solidarity of the nursing team, are key points to be inserted in this education.

This educational approach could be a model for development of child-friendly cancer nursing.

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THE EXPERIENCE OF BREAST CANCER: The Perceptions of Women Regarding the Decision-Making Process and the Role of Nurse Counselling

Kadmon I., Hadassah Medical Organization, Jerusalem, Israel.

What is the meaning the experience of breast cancer has for the women involved? What is the value of nursing counselling for women with breast cancer? The phenomenon of participation in the choice of treatment for primary breast cancer was explored, from the point of view of the women. The women's perceptions concerning the decision-making process and the role of nurse counselling formed the base for this work.

The research method used was qualitative, involving an in-depth exploration of experiences of women with breast cancer who have faced decisions regarding their treatment. Ten women were individually interviewed, and later a group meeting of all these women for a further discussion was held. Another group discussion with twelve women attending a 'Reach for Recovery' self help meeting took place. In these interviews the **lived experience**, in relation to the decision-making process of these women was explored.

Twelve themes have emerged during the analysis of the data relating to the decision-making experience. They were grouped under four categories: themes related to the inner personal world of the woman, referred to as SELF, themes related to the feelings towards the BREAST, themes related to the relationship with the DOCTOR and themes concerned with family, social, and peer group SUPPORT. In relation to nursing counselling, five major themes have been analysed: the timing of counselling; counselling as a source of information and advice; the place of the specialist breast-care-nurse-counsellor and finally, the limitations of nursing counselling.

In this presentation a description of the women's perceptions of each of these themes is given. Some practical implications for nursing counselling are suggested.

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NURSING ACTIVITY IN THE ONCOLOGIC DAY-HOSPITAL OF SANTA CHIARA HOSPITAL IN PISA, ITALY.

H. J. Limborgh Meyer, P. Rossi, A. Augugliaro. Dept. Medical Oncology, S. Chiara Hospital, Pisa, Italy.

The Department of Oncology has been established in Pisa in 8/1990. Initially run by only one nurse, it now has 4 nurses and 1 head-nurse. The Dept. is organized as follows: 3 patient rooms with rest-room; 3 outpatient examining rooms; 1 nursing station with hood and two reclining chairs; 2 physician offices; 1 office for the head of the Dept.; 1 office for the secretary; 1 office for the head-nurse, adjacent to a room where M.D.s interview pts before chemotherapy. We do not have a waiting room, and pts. wait in the hallway, where there are enough chairs. Our activity starts at 7 a.m. to end at 2 p.m. for five days a week. We do have Saturday clinic too, with reduced medical and nursing personnel. Two nurses rotate in preparing drugs under the hood, while two nurses assist pts; in the day-hospital. The head-nurse coordinates all activities and helps as needed. Pts. arrive at 8 a. m. , upon appointment, with the requested CBC and biochemistry. The physician responsible for the chemotherapy checks results and communicates chemo orders to the nurse, through written information in the pt.'s chart. Between 8 and 9.30 a.m. nine pts. needing long infusional therapy are brought to their rooms and beds. At 9.30 we start preparing and administering i.v. bolus therapy up until all pts. have received it. In the meantime, we prepare and apply the PACs for c.i. therapy.

When needed, we give assistance to M.D.s during procedures.

One nurse rotates in giving appointments to pts. for both visits and XRays. Twice a week we have p.m. meetings with the entire Staff concerning both clinical studies and new pts. entered. We all participate to continuous update trough courses, meetings and conferences which all improve our knowledge, so as to provide pts. with better care and better quality of life.

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DOES NURSING REALLY MAKE A DIFFERENCE?

Ensing H, Dubbelman R, Jongkind H, Batchelor D
The Netherlands Cancer Institute, Antoni van Leeuwenhoek Hospital
Amsterdam, The Netherlands.

Quality of life, as defined by Meeberg '93 has subjective and objective components. Objectively it has been proven that patients treated in clinical trials receive intensive support. Does this mean that subjectively the quality of life is also improved for these patients? This is a question that many nurses ask when they work on medical research departments.

As we all know, patients who take part in research protocols experience physical and psychological changes that have an effect on the quality of their lives. One of the goals that nurses work towards is optimal quality of life for their patients. Some of the nursing actions performed to achieve this goal are: patient education, supportive care and psychosocial support.

Therefore quality of life for patients treated in clinical trials is also dependant on quality nursing care, at least nurses who work on research departments believe this to be true. Is quality of life actually influenced by nursing care and if so how? To what degree can it be influenced when you consider that the average admission is 3-5 days in a research unit? Or are nurses just facilitating coping by providing comfort guidance and support. Does nursing really make the difference?