

treatment should seek to avoid doctor and patient bias and both may be compromised when assessing AM! Physical methods of AM can be assessed by prospective randomised controlled trials, ideally testing one method versus placebo but given the self-selecting patient population more realistically comparing one method of AM with another. Psychological methods are best assessed by established quality of life instruments but careful study design is essential to try and control addition (non-declared) supportive therapies, and of course the effect of concomitant CT may adversely affect quality of life but increase survival. Patients motivation for using AM is usually a hope that survival will be increased and therefore the ultimate end-points in assessing AM should include quality of life studies and overall effects on survival.

1005

The role of the nurse in palliative care

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The role of the nurse in health care can be described based on their professional domain: the consequences of disease and treatment. It doesn't give us a very specific description of tasks, qualifications and responsibilities, but it is directive to come up to the different requirements for nurses.

Patients in palliative care are confronted very much with the consequences of disease and treatment, so is their family and the professional support team.

The role of the nurse in palliative care is not easy to describe because of the variety in organisational models dealing with palliative care problems. Nevertheless, there are similarities in the different settings in all our countries. In this presentation the similarities will be discussed in order to come to a common understanding.

The roles that will be discussed are:

- (a) the nurse as the analyst of (nursing) problems
- (b) the nurse as the co-ordinator of hostilic care
- (c) the nurse as the advocate of the patient and the family
- (d) the nurse as the teacher for patient, family and the health care professionals
- (e) the nurse as the team-leader of the palliative support team.

Specific attention will be paid on the necessary use of measuring-instruments, communication skills and ways and means to obtain expert knowledge.

Central themes guiding the discussion about the nurses role in the interdisciplinary support team in palliative care are the 5 C's of:

- (a) Co-ordination
- (b) Communication
- (c) Complementation
- (d) Creativity
- (e) Continuity.

1006

How far should we go in treating cancer patients?

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At least 50% of the patients with cancer will not be cured by our current therapeutic efforts. It does not mean however that, in those incurable patients, there is not a place for palliative chemotherapy and radiotherapy. As a matter of facts, with the use of supportive care techniques, relatively aggressive palliative therapy of neoplasia, and even experimental therapy, can be given to patients with advanced tumors.

However, such a therapy may not be reasonable beyond certain limits; this is the case when the performance status is low, the life expectancy is short or when treatment is declined by the patient. Under these circumstances, it is often appropriate to decide that cardio-pulmonary resuscitation will not be performed. However, this does not necessarily imply that all supportive care interventions should be automatically withdrawn and that these "not to be resuscitated" patients should only receive treatments which make them comfortable. Many of these patients can benefit from adjusted palliative therapies in combination with supportive care techniques.

Nevertheless, to avoid overtreatment which can occasionally lead to a significant reduction of the quality of life in these patients, a try and evaluate approach is proposed; this implies that interventions will be discontinued as soon as their inconvenience outweighs the benefit, rather than to palliate these adverse symptoms with new interventions.

It is clear that this comprehensive approach needs to take into account

the patient's will and the medical possibilities. It would be unacceptable to treat an unwilling patient or to administer futile therapies.

1007

Patient needs as analysed through national "helplines"

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Purpose: In order to improve patients-physicians relationship, ECL (European Cancer Leagues) has asked for a survey on this theme.

Methods: A questionnaire was handed out at the Helpline Conference in Granada, Spain, 2-4 May 96 to receive information on the types of problems the conference-delegates, who answer the helplines, have been running into regarding this special matter while speaking with patients or family members.

Results: 33 helpline-delegates from 23 European countries answered the twelve questions. I will present the results of this questionnaire. Other problems, not mentioned in the questionnaire, will be added.

Conclusion: There is a problem identified: Lack of good communication: it has to be taken seriously.

1008

Nordic cancer union: Programs in communication a way to increase patients satisfaction

Steinar Hagen. *Dept. of Oncology, Ullevål Hospital, Oslo, Norway*

Purpose: How to increase doctors skill in communication?

Method: A standard teaching program has been tested in 5 Scandinavian countries. One teacher and 6 doctors in each courses has been fulfilled.

Result: All course attending doctors has been evaluated. There is a high scar (increase) in the ability to communicate. 20 items are tested and the results will be revised.

Conclusion: The result is inspiring The Norwegian Cancer Society (one member of NCU) has put the program on their main agenda for the coming years.

1009

What's up doc? - A patient's perspective on Doctor/patient communication

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The presenter is a former patient, treated successfully for testicular teratoma. He is a lawyer by occupation.

Arising from my personal experience as a patient, the following issues seem to be the most important:

- (1) Prior consideration of the personality, background, intelligence, social circumstances and state of knowledge of the patient.
- (2) The need for training and self-knowledge in the Doctor as to his ability to communicate effectively.
- (3) The need to listen and really hear the patient's response - the importance of body language, tone, the undercurrents of questions and "the questions not asked".
- (4) Often, patients do not hear or interpret properly what is said to them. There is likely to be a need for continuous reinforcement.
- (5) The need to have the whole caring team will briefed on the patient's understanding of his condition, his attitude to it and his concerns.
- (6) The need for appropriate optimism, reassurance, warmth, humour and "small talk."
- (7) The only golden rule is that there is no golden rules.

1010

Informed consent & cancer clinical trials

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All agree that the randomised controlled trial is the gold standard for evidence based medicine. All agree on the ethical imperative for informed consent prior to recruiting patients into such trials. Most agree that the informed consent charade is the major rate limiting factor in improving statistical power of these clinical trials yet few are prepared to confront head on this dilemma. It is my view that the time for individuals to be informed

about cancer and clinical trials is when they are well, in anticipation of the fact that a third may develop cancer in the future. In other words it is time the lay public woke up to their responsibility that if they want to enjoy the benefits from clinical trials of the past they also have a responsibility to enter clinical trials in the future. In return the profession must be prepared to work alongside lay groups in the design of the clinical trials because we are all stake holders in these ventures as well. As describing these underlying principles, I also wish to describe the pioneering work of the Consumer's Advisory Group for clinical trials which has risen to this challenge.

1011

Structured patient information in radiotherapy departments in Europe

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Purpose: With the help of ESTRO, we performed a survey to evaluate the present status and means of information given to patients treated by radiotherapy. A short questionnaire was sent to 746 European heads of department with a request to send specific documents used for informing the patient. Within 2 months (March and April 1996), we received 290 answers (39%) and 97 centres sent 298 documents.

Methods: Analysis of the questionnaire and the documents was performed quantitatively with usual statistical methods and qualitatively with a socio-anthropological method of content analysis.

Results: Analysis of the questionnaire shows the major role of the radiation oncologist in giving information and writing documents. The 298 different samples sent from 97 centres represent a wide panel with a booklet of general information (59 booklets/57 centres), practical advice and specific explanations (177 documents/49 centres) and informed consent (36 documents/28 centres). The anthropological study was centred on the way information was given, evaluation of the patient's understanding and qualitative analysis of documents sent.

Conclusion: The high rate of response (40%) of this survey shows the general interest for radiation therapy staffs on patient information. However, this preliminary survey needs to be completed by a study, including the patient's point of view and needs, about the information given.

1012

Training oncologists in communication

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Purpose: To develop, run and evaluate communication skills courses for clinicians in cancer medicine.

Methods: 178 senior clinicians from all medical specialties that deal with cancer patients attended 1½ or 3 day residential courses. The teaching model utilised an experiential learner-centred approach. Emphasis was placed on video-taped role-play with trained actors and structured feedback from facilitators working with small groups of 4.

Results: Few participants had received any communication skills training during their medical education. Giving complex information and informed consent were the primary problem areas for the majority of doctors. Confidence ratings in most communication areas improved significantly post-course ($p < 0.01$). At 3 months post-course, 95% of doctors reported significant changes in their practice of medicine, due to their increased awareness of specific new skills and techniques. 78% of participants had already embarked on new teaching initiatives in communication for junior staff. 97% said that they would 'definitely' recommend the course to colleagues.

Conclusion: Doctors recognised that they were hampered by the lack of adequate communication skills training and will, if the format is acceptable, attend courses. Subjective improvements were reported immediately post-course and were maintained at 3 months. Resources for such educational initiatives are important to help both patients with cancer and their doctors.

1013

Cytoplasmic transduction mechanisms of mitogenic signals

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Two fundamental steps in the cytoplasmic transduction of mitogenic signals are: i) activation of tyrosine kinases and ii) membrane recruitment of cytoplasmic proteins with function of signal transducers.

The transducers are usually substrates of activated tyrosine kinases and transmit their signals to members of the Ras family of small GTPases. Ras proteins regulate fundamental cell functions such as growth and survival (ras), cytoskeleton organization (rho and rac). On their turn, Ras proteins activate a number of serine/threonine kinases.

The mechanism through which the signals are transmitted from the membrane to the nucleus involve a chain of protein-protein interactions which are mediated by protein modules with specific binding properties: the SH2 and PTB domain, which interact with phosphorylated tyrosine residues; SH3 and WW domains which interact with polyproline regions; the EH domain, which interacts with the NPF motif. Structural alteration of proteins involved in signal transduction may confer proliferative advantages and in fact are frequently found in tumours.

Signal transduction pathways in hematopoietic cells and their activation in leukemias will be discussed.

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Growth factor activated MAP kinases: Mechanism of nuclear translocation and role in growth control

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Many extracellular signals are transduced via the activation of a conserved and specific MAP kinase module: MKKK > MKK > MAPK. Growth factors promote nuclear translocation and persistent activation of p42/p44 MAP kinases during the entire G0/G1 period. Whereas the two upstream kinases of the module, RAF and MKK are exclusively cytoplasmic. MAPKs nuclear translocation is controlled by the strict activation of the MAPK cascade indicating that MAPKs are retained in the cytoplasm via a MAPK-sensitive 'anchor'. Relocation of MKK in the nucleus by expression of an NLS::MKK is sufficient to re-address MAPKs in the nucleus in the absence of mitogenic stimulation. This finding, together with the co-immunoprecipitation of the MKK/p42-44MAPK complex, strongly suggests that MKK serves as a regulatable MAPK cytoplasmic anchor. Finally, we conclude that MAPK nuclear translocation is crucial for the growth factor response since preventing p42/p44MAPK nuclear translocation blunts S-phase entry.

1015

Growth factors and ErbB/HER tyrosine kinases: How do they contribute to malignancy?

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ErbB-2 (also called Neu and HER2) is a cell surface molecule that attracted attention of oncologists because a significant fraction of several types of human adenocarcinomas overexpresses this marker protein. Overexpression was correlated in certain types of solid tumors with poor patient survival and resistance to chemotherapy. Since ErbB-2 has structural characteristics of a transmembrane receptor/enzyme, whose catalytic function is stimutable by growth factors, initial work aimed at isolating a ligand for this putative receptor. Indeed, by using kinase activation as an assay, we and others isolated a family of novel growth factors, termed neuregulins. However, later studies revealed that ErbB-2 becomes activated by neuregulins only indirectly: these ligands first bind to either ErbB-3 or to ErbB-4, two related tyrosine kinase receptors, which then form heterodimers with ErbB-2. Over the last two years we learned that these inter-receptor interactions are part of an interactive network of signal transduction, that funnels intercellular signalling not only by neuregulins, but also by a large group of EGF-like growth factors. ErbB-2 plays a major coordinatory role in the network, amplifying and diversifying biochemical signals that control cell fate. Our more recent work resolved the molecular mechanism underlying ErbB-2 function: it turned out that all growth factors of ErbB proteins are bivalent; their high affinity arm selects the primary receptor, but the low affinity arm is more promiscuous. Nevertheless, ErbB-2 is the preferred target of the second binding site. Thus, by acting as a low affinity receptor of a group of