strated to affect the autonomy of the practitioner and restrict freedom to take responsibility. Political influence over healthcare provision and policy emanates from the medical, not nursing, profession. Failures of 'Interprofessional Communication' stem from differences in training and education. Elitism and dominance of doctors who are frequently from a higher social class is implicated.

While gender perceptions and management and power imbalances continue to adversely influence nursing, and doctors and nurses continue to communicate at different levels then nursing research, innovations and specialist knowledge will remain unrecognised.

1467 ORAL

A collaboration between hospital treatment and community health care systems for cancer patients

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Purpose: The paper represents a contribution to ensure that the different levels of the public health care system act coordinated, as a continuous value chain based on the patients needs.

Methods: During 1994 all cancer patients in two mid Norway communities, that had been in contact with the selected departments at The Regional Hospital in Trondheim, were involved in the project. A communication form was designed, naming both the primary nurse/doctor at the hospital and the general practitioner/homecare nurse in the community. At the day of departure from the hospital this form was telefaxed to the doctors office in the community. Within a week the homecare nurse would telephone the patient, offering a home visit. The homecare nurses had interviews with 19 patients in total. Focus groups were used as evaluation method.

Results: It has been confirmed that both patients and professionals experienced the health care system to be poorly coordinated. Without exception, the communication form and the homecare nurse service were regarded as a positive experience by all participants.

Conclusion: This experience emphasized that the cooperation has to be at a personal level and controlled by the patient. Today, much care and rehabilitation work is based upon individual agreements.

1468 ORAL

Consent to medical treatment. What are the implications for nurses?

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The common law has long recognised the principle that every person has a right to have his bodily integrity protected against invasion by others [1].

A patient's consent to medical treatment presents both an ethical and legal dilemma. How far can we take the doctrine of implied consent? What constitutes informed consent in law? How aware are we of the ethical issues surrounding informed consent?

Should we always obtain a patients consent to treatment, and how far can we respect the patients right to refuse treatment, especially if that treatment is potentially life saving?

Nursing staff are now becoming pivotal to the consent process, especially in the clinical research environment, and as nursing staff take on more specialised tasks previously undertaken by the doctor, how should we ensure that our patients are fully aware of the implications of consent? What exactly is the nurses role in clinical research and consent, and how protected are we as health care professionals?

Consent issues are bound up in ethics, moral rights and law. The rights of the patient are integral to our care, do we abuse and ignore those rights in our need to be seen to be doing what is best for them (as we see it)?

[1] Mason, J.K. & McCall Smith, R A. (1994) *Law and Medical Ethics.* Butterworths, London.

1469 ORAL

Lung cancer needs assessment

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Despite advances in lung cancer biology and in survival statistics for other types of cancer, mortality rates for patients with lung malignancies remain high, with a five year survival rate of less than 10% for males and females at all ages (OPCS 1989). Given the limitations of current therapeutic options the necessity for skilled symptom control and psychosocial care is great. Need has traditionally been defined by health economists and public health physicians as "an ability to benefit" from a given health care intervention. The responsibility for defining "benefit" however has remained within the domain of health care professionals. Little is known of patients' and families' perceptions of their need in relation to a diagnosis of lung cancer. Similarly, the views of professionals working outside lung cancer clinical trial studies, have remained largely unarticulated.

The mail questionnaire survey, accessing the views of patients, relatives and professionals from 36 randomly selected hospitals throughout the UK, aims to provide information to better enable health care purchasers and providers to contract for and demand, services responsive to the needs of patients with lung cancer and their families. Findings drawn from patient and nurse questionnaires will be presented and implications for the development of future services and new nursing roles will be discussed.

1470 ORAL

Accessing cancer care: The co-ordinating role and workload of cancer support nurses

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Cancer resources in North Lancashire and South Lakeland include chemotherapy units in Lancaster and Kendal, a psychosocial support organisation -Cancer Care, and a palliative care unit for a population of 250,000. Patients access these resources through cancer support nurses (CSNs) appointed in the ratio of 1: 50,000. The service role and working practices of the 3 CSNs in North Lancashire will be presented.

The cumulative case load at September 1996 was 604 of which 253 were patients with breast cancer. The number of new patients referred (397), the number treated with chemotherapy (98), and the number who died (267) were recorded over a 12 month period as an indication of work load.

The two most demanding issues were psychological morbidity and social isolation and the prevalence of each is given by the numbers referred to CancerCare (95) and Day Care (61) respectively. Comprehensive cancer care involves a range of services and CSNs with a co-ordination function ensure the best use of resources.

1471 POSTER

The application of ethical principles to the implementation of nursing research findings

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Morality and ethics lie at the heart of nursing. Every nursing action involves consideration of ethical principles. The implementation of nursing research findings requires application of the four accepted tenets of ethics: autonomy; justice; beneficence and non-maleficence; veracity.

Implementation of nursing innovation will affect patients, relatives and staff of many disciplines, therefore impinging on the 'autonomy' of many. Whilst maintaining their own rights innovators must also fulfill a duty to others. During the process of innovation conflict will arise and must be resolved for successful innovation. Mediation requires the application of the principle of 'justice and fairness'.

Consideration of the tenet of 'beneficence and non-maleficence' is complex. A change intended to result in benefit may cause harm to the working environment, staff morale and to patient care during the process of innovation. 'Veracity', an area well addressed in oncology patient care, underpins all other ethical principles. Staff of all disciplines have the right to truthfulness regarding the implications of an innovation for themselves, colleagues and patients. The implementation of nursing research findings creates ethical dilemmas which require the application of the four tenets of medical ethics to maintain patient care, good staff relationships and everyday moral standards.

1472 POSTER

Breast cancer: The nurse's role in genetic counselling

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Genetic counselling is the process by which patients or relatives at risk of a disorder that may be hereditary, are advised of consequences of the disorder, the probability of developing and transmitting it and the ways