

**Results:** At six weeks parents with repressive coping had significantly lower depression scores than those without (6.65 vs 11.83, two sided t-test  $p = 0.011$ ) but at 40 weeks the difference was non-significant. This was because the mean scores of those with repressive coping had increased (from 6.65 to 8.84) but those of the remainder had decreased (from 11.83 to 6.65). However there was a marked gender difference. Among mothers with repressive coping there was a mean increase in depression scores of 4.13 from 6 to 40 weeks, whilst in the remainder there was a decrease of 4.24. These mean differences were significantly different from each other (two sided t-test,  $p = 0.027$ ). Among fathers the depression scores of those without repressive coping increased somewhat (by 2.2), and in those with repressive coping there was little change (by 0.2). Exploration using categorical variables was limited by low numbers. Those who worsened by 0.3 s.d. or more, or improved by 0.3 s.d. or more, and those who stayed within 0.3 s.d. of zero change were compared. Within the repressive coping group 3/8 worsened by 0.3 s.d. or more contrasted with 2/25 of those without repressive coping (OR 6.90, 95% CI 0.90-52.7), and 2/8 improved compared to 15/25 in the remainder (OR 0.22, 95% CI 0.04-1.3).

**Conclusions:** These preliminary data suggest that in mothers of children with cancer a coping strategy that puts an emphasis on denial of emotions may be associated subsequently with a greater level of depression. In fathers, by contrast repressive coping appeared to be effective, at least up to 40 weeks following diagnosis.

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POSTER

### Bad news from the patient's perspective: an analysis of the written narratives of newly diagnosed cancer patients

P. Salander. *Umeå University, Department of Radiation Sciences - Oncology, Umeå, Sweden*

**Purpose:** Advice papers in medicine dealing with how to tell patients bad news rely almost exclusively on the opinion of the physician. What is lacking is empirical studies from the perspective of the patient. The purpose of the present study was to analyse how patients with recently diagnosed cancer narrate the manner in which they received their diagnosis, and to discuss this in relation to bad-news papers and related research.

**Methods:** A consecutive series of 187 patients who had received their cancer diagnosis 2-8 months prior to the outset of this study were asked to describe the manner in which they learned of their diagnosis in writing. The contents of the 138 submitted written narratives were sorted according to experiences of the Setting, Care and Disease Information.

**Results:** A crucial finding was that the participants often described experiences from the first contact with hospital staff to the end of their treatment, rather than as a single instance of diagnosis communication. The relational meaning of these experiences was obvious. Information on treatment was of the utmost significance. No one required more prognostic information.

**Conclusion:** From the perspective of the physicians, bad-news focuses on how to provide information about diagnosis and prognosis in the course of a single diagnostic consultation. From the patient's perspective, bad news reflects the process of being diseased by cancer, and how medical services are available when one is in need of establishing a helping relationship. In this relationship information about diagnosis and treatment is more a means than an end. Further conceptualisation of the patient-physician relationship from the perspective of the patient would benefit greatly from interdisciplinary collaboration with the social sciences.

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POSTER

### Euthanasia – Emotional and juridical aspects of euthanasia. Experiences from the last five years

M. Feenstra. *Daniel den Hoed Clinic, Oncology Department of the University Hospital of Rotterdam, Netherlands*

To be able to perform euthanasia in the incurable diseased patient with cancer you have to comply with a lot of juridical criteria to obey the law in the Netherlands.

Interesting is that the emotional steps a patient usually has to take to come to such a grave decision are in my experience in harmony with the law.

People are very much attached to life and when they feel life slips away they become more and more conscious of the small things that make them happy and they move their borders.

As a doctor you go with the patient through this emotional process which takes a lot of your time and empathy and in the end of the process you fulfil also the requirements of the law.

The written statement, obligatory in the law, forces the patient to clarify his/her thoughts about the situation that will make life unbearable in the end.

Once there is complete clarity about what the patient experiences as unbearable suffering and once there is an agreement with the doctor there comes almost always a peaceful state of mind.

The knowledge that if you can't bear anymore you don't have to together with good palliative care makes euthanasia sometimes unnecessary in the very end.

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POSTER

### Oesophageal cancer: perceptions and informed consent in an African population

L. Schoeman, C.F. Slabber. *University of Pretoria, Department of Medical Oncology, Pretoria, South Africa*

**Purpose:** To evaluate the perceptions of patients with oesophageal cancer about their illness and treatment, and to determine the role, if any, of the informed consent process in a South African population.

**Methods:** Two hundred black patients with advanced squamous cell carcinoma of the oesophagus were interviewed. The median age was 54 and the male to female ratio was 3:1. Most of the patients were from a low socio-economic status with an income of R500 or less per month (72%), often unemployed (47.5%), and with only primary school education (75.5%). They completed a perception of illness questionnaire, where after they were informed about their illness, the possible treatment options, the benefits it may have, the possible side effects, as well as that they could withdraw at any time without affecting the standard of care. Within 48 hours, the perception questionnaire was once again completed.

**Results:** Before the informed consent process, 92% of the patients did not know what was wrong with them or what the available treatment options were. However, almost all the patients (95%) indicated that they wanted information about their illness and treatment. After the informed consent process, 96% knew that they had cancer, while 91% of the patients indicated that they preferred receiving information (albeit of a negative nature) because it removed uncertainty. Most of the patients (75%) indicated that they used the information as a coping mechanism. Overall, the informed consent process significantly improved the knowledge as well as the perception scores ( $p < 0.0001$ ).

**Conclusion:** The informed consent process is a valuable tool in our population to provide patients with information they need, to alter their perceptions for the better, and to help them cope with this life threatening disease.

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POSTER

### Recurrence: the emotional challenges and opportunities for patients & providers

J. Thompson. *Park Nicollet Clinic, Oncology, Minneapolis, MN, USA*

In this presentation we will draw upon the lessons learned in clinical practice as well as hear the words of patients as we examine our work with those facing recurrence. The emotional challenges of advanced cancer are enormous and yet, there are many straightforward, simple ways to support and enhance coping.

Through lecture and discussion, we will look at the following:

- Nourishing hope as an illness progresses.
- The benefits of clinician self-disclosure.
- Placing the locus of control with the patient.
- The four things that patients report they most want to hear from their health care providers when facing recurrence.

Attention will be given throughout this presentation to some of the accompanying emotional challenges for us as clinicians when we work with those facing cancer's return.

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POSTER

### Walking in the shadow: examining a model for group psychotherapy with patients facing advanced cancer

J. Thompson. *Park Nicollet Clinic, Oncology, Minneapolis, MN, US*

This presentation will introduce a group therapy model for individuals challenged with metastasis or recurrence. Through the example of one group now embarking on its ninth year, the following elements of the group experience will be highlighted: