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# **Breast Nurse Implementation at the Senological Center Mittelbaden, Location Baden-Baden**

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## 2. Introduction

Every year, more than 400,000 people fall ill from cancer in Germany, among them about 53,000 women with breast cancer. Breast cancer is the sentence of death for about 19,000 women, every eighth to tenth woman being affected with a slightly increasing tendency, mainly among younger women. The risk of falling ill with breast cancer nearly doubled within the last years.

Each single number of medical statistics represents a specific patient, each of these patients having her own life story and tale of woe. Deficiencies in the treatment of breast cancer are known for years. Especially some single elements of the supply chain are characterized by great flaws - starting with diagnostics, leading over to therapy, and ending with rehabilitation and aftercare. In Germany, this situation of women suffering from breast cancer strongly needs further optimization.

Nursing staff has the closest contact to patients. They have great faith, speak the patients' language, are present and act promptly. Consulting is one of the nursing staff's tasks; they inform patients about courses of disease, fostering, and ways to alleviate pain. It is the nurse, who introduces patients to the clinic's interests of organization and interprets medical technical terms. She instructs the patient, turns attentively to her, meets her with understanding, shares the patient's solicitudes, comforts her and buoys her up.

These resources have been availed by many countries; nursing experts look after sick patients in the form of "pilots". My own motivation to attend the advanced training "Breast Nurse" was perception of the patient in her wholeness, promoting her strengths, recognizing fears, allowing weaknesses, giving professional general and special care to the patient, consulting, and last but not least informing her.

## 2.1. Senological Center Mittelbaden

*“The Senological Center of the clinical center Mittelbaden gGmbH stands for quality, efficiency, and innovation in the treatment of women with breast diseases”<sup>2</sup>*

When it comes to women´s breast diseases in the region of Baden-Baden, the three headquarters Baden-Baden, Bühl, and Rastatt are closely cooperating. These three clinics of the clinical center Baden-Baden conjointly established the Breast Center Mittelbaden. The center operates according to the strict guidelines of the German Cancer Society as well as the German Senology Society and is furthermore certified by TÜV since March 2005.

The center is managed by the chief physicians of both Baden-Baden and Bühl/Rastatt. These two medics have no doubt that the future lies in certified centers; according to them, health policy will insist on a certification process much stronger in the future. The newly established breast center offers holistic accommodation - starting with provision and diagnostics, leading over to therapy, to the point of post-care in the context of studies.

One of the new center´s excellences is the short-term availability of all necessary experts, like gynecologists, radiologists, oncologists, pathologists, radiation therapists, and psychologists. All partners have to fulfill specified quality standards within their respective scopes. Case and tumor conferences are held on a weekly interdisciplinary basis, and regular advanced trainings are mandatory for all professional categories enlisted at the breast center. The quality of therapies at the new breast center is measurable and the respective information can be requested by patients. Our overall concepts, our quality policies, and quality goals (see attachments) are accessible for all patients, family members, and visitors. In view of an optimum consultation for women, many of the diagnostic procedures are anchored at the ambulant area. In case of an essential invasion, patients normally have to wait only 5 days. Only 3 days after a successful operation, subsequent treatments are determined, be they hormonal, chemo- or exposure therapies.

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<sup>2</sup> Cited from the overall concept breast center Mittelbaden

Our breast center guarantees accommodation through medical specialists, psychologists, physiologists, and social workers. However, there was hitherto **no** support and attendance in terms of professional competence, starting with diagnosis, leading over to therapy, to the point of custodial aftercare. This results in concrete need for action with respect to care.

Foreign countries, like USA, Australia, The Netherlands, Ireland, or Sweden, report many positive experiences regarding custodial support of breast cancer patients. Scientific studies prove direct connectivity between the survival rate and quality of life of operated breast cancer patients and regular support by specialized nursing staff.<sup>3</sup>

Corresponding requirements are recorded in the Eusoma position paper; for this purpose educated, specialized breast nurses have to be available, whose work widely exceeds the activities of nurses in German breast centers.

## **2.2 Description of the Situation at Station 4 C - Municipal Clinic Baden-Baden**

Station 4 C is a 30 bed gynecological station. The work is focused on oncological gynecology and surgical gynecology. Furthermore, patients with infectious diseases of sexual organs and patients with pregnancy problems are attended as well. Occasionally, we administer stationary chemotherapy. Since December 2004, we also care for patients from trauma surgery. 10 beds are available for the breast center.

## **2.3. My career**

Since October, 1<sup>st</sup>, 2001, I am working fulltime at the gynecological station as certified nurse. From July until November 2001 I attended a mentor course, and from November 2002 until November 2003 I attended an advanced training for custodial management of the municipal clinic's station or unit. I completed both courses successfully. Additionally, I joined in-house further educations for pain therapy in view of palliative aspects, I learnt to operate portcathetersystems as well as administration of cytostatic drugs, I attended advanced trainings for diagnostic procedures like sentinel node biopsy and perforate biopsy. I joined a 3 day seminar at Amoena, Bad Raubling, to get insights into external prosthesis supply and corresponding corsetry. In this regard I am the contact person of our station.

### 3. Diagnosis: Breast Cancer

“I am hoping

I am crying

I laugh in despair

Mourning, defiance, fear of death”<sup>4</sup>

“Somehow it is deadly silent inside my soul. No laughing, no panic, stunned silence. No jumping up, no screaming, no uproar”<sup>5</sup>

Diagnosed breast cancer means a deep incision of any woman´s life. Confronting the diagnosis causes fear, despair, fury, defense, insecurity, and feelings of guilt in the woman concerned. Women report on the chaos of their feelings, physically as well as emotionally. Cancer is the embodiment of destruction - of evil. One´s own life, as well as everything naturally belonging to this life, suddenly is challenged. Disputing cancer is a unique process for every woman concerned. As different as the disease´s points of departure - like age, living conditions, previous experiences with breast cancer as a disturbance of health - are the forms of accomplishment.

### 4. The Breast Nurse

#### 4.1. The Breast Nurse Abroad

In 2004, the Austrian town Linz awarded Linz hospital´s project “Breast Nurse - Mamma Surgery” with the annual health award, which honors outstanding achievements of health care. The main idea of this project is improvement of fosterage quality through breast nurses. The demand for breast nurses was determined in the context of interviewing stationary and ambulant patients. The project revealed that breast nurse integration has positive effects for all persons involved with major benefits for patients. The breast nurse is considered as psychological parent and confidant by patients and family members; patients feel better care of their diseases, which in turn increases their well-being.<sup>6</sup>

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<sup>4</sup> Herbert, Sibylle, 2005: 27

<sup>5</sup> Goldmann-Posch, Ursula, 2000: 9

<sup>6</sup> Allgemeines Krankenhaus der Stadt Linz, Österreich

The same result was reported by the pan-European initiative “Caring about women and Cancer” (CAWAC)<sup>7</sup>, who interviewed patients about their mental states. Women mainly criticized poor or hardly helpful information and missing opportunities for sufficient posing of questions. Most of the women would have liked to be part of the decision about their treatment, and information about side-effects to be expected was insufficient, too.

An interview in Sweden showed that breast cancer patients were unhappy with medical support in the post-care phase. Scientists demand more time for aftercare to optimize fulfillment of the patients´ needs. “Women, who filled in the questionnaire wish to have more time for discussions and would like to see the same person for each of their visits.”

I. Kössler thinks it should be possible to accomplish post-care by specially educated nursing staff.<sup>8</sup>

The multicenter study “An evidence-based specialist breast nurse role in practice: a multicenter implementation study”<sup>9</sup> accomplished in Australia during 12 months at 4 different breast centers showed that almost all patients had contact to their respective breast nurse. 5 dates scheduled in advance were administered. 67% of all patients had at least one more appointment. 89% of the women said that availability of a breast nurse played an important role in their choice of the hospital. 48% said they would only recommend a hospital with a breast nurse in charge.

The study concluded: the breast nurse increases continuity of care and enhances information and support for the women affected. The breast nurse´s service resulted in a more economic usage of time for the nursing staff, whereas the breast nurse in her role as specialized contact person was specifically questioned.

The article “Breast cancer patients´ satisfaction with a spontaneous system of check-up visits to a specialized nurse” reports the breast nurse´s influence at “scenting out” psychic diseases from breast cancer patients, which are often undiscovered or not treated. The existence of evaluated strategies to improve psychic/psychological outcome is encouraging, however, their integration into every day´s care procedures is questionable. The National Health and Medical Research Council (NHMRC) developed a specific guideline for breast nurses and initiated a study to test its implementation in different clinics and under various conditions.

<sup>7</sup> Deutsches Ärzteblatt 2000 <sup>8</sup> Brustkrebs-Patientinnen mit Nachsorge ganz zufrieden

<sup>9</sup> Eur Cancer Care (Engl.) 2003, Mar, 12(1): 91 - 97

Seven breast nurses at 4 Australian breast centers implemented this study to treat 196 women with freshly diagnosed breast cancer at different stages.

In a conversation between the institution “Europa Donna” and the breast nurse Sandra White, working at the Royal College of Nursing in Glasgow, Mrs. White said: “One of the breast nurse’s central tasks is acting for the patient’s interests and being responsive to her sorrows. It is in her hands to make sure that the patient really understands the information she gets.”<sup>10</sup> According to her view, the breast nurse is connector between the team of physicians, nursing staff, and patients.

This same result is given by the German study “Medical business treating women with breast cancer” initiated by Deutsche Krebshilfe. The study is based on interviews with 400 breast cancer patients and discussions with self-help groups, physicians, and hospitals. For the first time, accommodation procedures were critically analyzed in terms of patients’ viewpoints, and introduced in a press conference on 21<sup>st</sup> of July 2003.

Besides various structural flaws and burdening organizational interfaces, breast cancer patients consistently tell about physicians’ lacking empathy and insufficient time for conversations. The head of this study, Dr. Gerlinde Jänel, also stated that many patients had no time to inform themselves and were missing important information as a basis for their own decisions.

EUSOMA constitutes the following requirements for specialized senological centers: “Educated breast nurses have to be available for consultation and to offer practical, emotional and informal support for newly diagnosed breast cancer patients at the time of diagnosis as well as discussing treatment plans with these patients. Effective support should be available for aftercare as well as medical treatment of advanced cases subject to treatment. Specialized breast nurses have to be present for further consultation about the treatment options in line with the patient and for their emotional support. An appropriate room with sufficient privacy has to be available.”<sup>11</sup>

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<sup>10</sup> Europa Donna, Avanti IV/2004

<sup>11</sup> Requirements for specialized breast centers (breast units)

#### 4.2. Previously performed nursing care of Breast Cancer patients

Custodial care and consultation of breast cancer patients at our station to date was mainly “along the way”; there was no specially educated nurse, and aftercare was completely lacking.

I would like to show to date´s situation at our station with an example:

On 25<sup>th</sup> of September 2002, Mrs. M., 32 years, married, no children, came to our station because of a lump in her right breast she had palpated herself. Two weeks ago she had consulted her gynecologist, who had confirmed that everything was all right with her. Mrs. M. was operated 26<sup>th</sup> of September, i. e., 1 day after her diagnosis - her breast was maintained. A segmental ectomy and an axilladissection were conducted. She was suggested a 4 cycle chemotherapy, radiation of her remainder breast, and another radiation as follow-up therapy. Mrs. M. received the first cycles, however, she declined radiation a priori, no hormonal therapy was conducted. In the mornings, our nursing staff had to select the rooms the “chemo patients” had to be allocated these days. As a result of the station´s booking it happened by all means that “chemo patients” were in one room together with patients waiting for their OP or freshly operated patients. Often, the oncological patients were introduced as fifth patient in 4-bed-rooms. Later on, because of regressive booking from ambulant OP, we could “assign” one 4-bed-room, so that we could administer up to 7 chemotherapies in this room every day.

Back to Mrs. M.: She experienced administration of cytostatic drugs at our station this way as well, and she had to watch how wretched many patients were physically as well as psychologically due to chemotherapy. At the same time, patients, who had been treated for longer times, every now and then, gave “advices”. Mrs. M. did **not** continue her therapy. Several times, physicians were addressed about Mrs. M., but at this time nobody had information about her. Did she change the doctor? Does she visit another clinic for therapy? Does she feel so sick she cannot come any more? Or is she even dead?

One year upon her first diagnosis, Mrs. M. introduced herself to the chief physician, during breast consultation-hours. Now a recurrence was diagnosed. Her breast

could not be maintained during operation this time - a breast ablation was conducted. During the same OP, a biopsy from her left breast was extracted, the instantaneous section showed a carcinoma as well, so that a breast ablation was conducted left, too. **Only now** we found out why Mrs. M. hadn't come to therapy any more. She was afraid, afraid of further chemotherapies, afraid of being as badly off as she had heard from other patients.

“Every third breast cancer patient comes down with anxiety disorder or depression.”<sup>12</sup> Amongst others, causative risk factors are also problems arising from chemotherapy.

After 18 more exhausting months of therapy, amongst others with Chemoembolization (TACE) of her liver conducted outwards, Mrs. M. came back to our station with bad general condition and strong pains.

On 18<sup>th</sup> of April 2005, Mrs. M. died at the age of 34.

This sample of Mrs. M's medical records is not meant to claim that she'd still be alive with a breast nurse on the spot, however, the importance of a contact person or “advocate” would have been able to put some ignorance to perspective. The breast nurse, in her role as custodial consultant and member of nursing staff would have been able to give Mrs. M. basic information in this case, which would have been essential for some competent decision.

Since October 2004, administration of chemotherapy does not occur on our station any more; instead, we have an ambulant chemo-center at our clinic. We therefore see “our” patients during stationary treatment only. Seldom patients come for change of dressing or medical consultations, e. g. in the contexts of studies. Often we come into contact with patients again only in case of their stationary treatment due to weak immune systems or reduced general conditions or because of recurrences. Time and again, patients come to our station for their last path of life.

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<sup>12</sup> Ärzte Woche, Psychologische Medizin: Angst

### 4.3. The Tasks of a Breast Nurse

The breast nurse´s tasks are derived from experiences abroad as well as polls or statements from breast cancer patients, treating occupation groups, and patients´ requirements, respectively.

“How do other women manage their disease without an < Andrea > by their side?” This is asked by author Sybille Herbert, who is affected herself. Andrea is not only her friend, but a physician herself and thus has profound knowledge of medicine *with all the bells and whistles*. Andrea attends Sybille during diagnosis and therapy.

Andrea controls, organizes, plans, escorts Sybille to therapies, asks questions. “Andrea thinks, I feel. She decides, I let them do”.<sup>13</sup>

The breast nurse is meant to be the link between patients and physician, nursing staff, family members, psychologists, social services, self-help groups and anybody else involved in treatment, starting immediately upon diagnosis or operation, respectively. She contacts affected women and offers her help. The breast nurse is contact person for all questions directly and indirectly connected to cancer. These questions may concern the medical part of the disease as well as aspects of social justice and matters of healthy lifestyles.

The breast nurse shall be tutor, guide the patients, and make decisions on a common basis with patients. For that purpose it is important to inform the patient. An informed patient feels better once she´s got a notion not to be consigned, but joining a conversation autonomously, to be pro-active, and ultimately doing something for herself. This is confirmed by the statement of an affected patient: “I am a competent patient, when I do not only answer questions, but also ask questions and don´t stop doing so unless I understood virtually everything. After all, it´s all about me. Only if I know what will happen to me, I can cooperate actively.”<sup>14</sup>

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<sup>13</sup> Herbert, Sibylle, 2005: 41, 82

<sup>14</sup> Klinik für Tumorbiologie Freiburg

Also the president of the German Cancer Society, Professor Michael Bamberg, gave a lecture on the informed patients at the first open cancer conference (OKK) on 27<sup>th</sup> of February 2005 in Berlin<sup>15</sup>. He answered a question relating the “informed patient” in his own opinion primarily with information quality: “Yes, quality is very important. But the point also is to encourage the patient’s personal responsibility to take more responsibility for one’s own body. But the patient’s position should be enforced as well, to give him or her the courage to question things instead of being lead to the therapy corridor like a sacrificial lamb.”

Although the patient is encouraged to ask, many of her questions scare the physician, because he has to take his time and appeal to the patient.

Since affected women often need weeks to months to accept what they experienced, the breast nurse’s work does not end with the closure of stationary treatments. Patients experience longer-term attendance through a familiar person as help and support. Only later the mind is freed, and numerous questions emerge. Hilde Schulte, spokesperson of the federal board of directors of the German “Frauenselbsthilfe nach Krebs” (Women’s self-help upon cancer), who is affected herself, says: “I was overrun by the events, I was not asked, and I could not participate in the therapeutic decisions. This activated increased uncertainties, fears, and doubts weeks afterwards, when I was home again.”<sup>16</sup>

The breast nurse thus should offer consultation based on a schedule, on demand also individually agreeable, and she should be reachable by phone. Furthermore, it is favorable if she could attend house calls on demand, because patients can bring up their problems and sorrows more frankly in their familiar domestic surroundings and they can ask questions not asked during medical consultation hours. “To know that a contact person listening and looking after their problems can be reached quickly and on demand is very relieving”<sup>17</sup> The breast nurse’s engagement crucially contributes to an improved quality of life of the affected women.

The breast nurse supports the breast cancer patients in manifold ways; she acts as “pilot” or “advocate” on behalf of the women concerned, and she especially is:

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<sup>16</sup> Schulte, Hilde, 2002

<sup>17</sup> Claudia Hilger, 2004

<sup>15</sup> Interview with Prof. M. Bamberg

- Attendant/Consultant
- Interlocutor/Listener
- Instructor/Informant/Coordinator

There is no strict borderline between the individual “tasks of a breast nurse”; it is more of a *floating* from *one* task to the *other*.

#### 4.4. Attending the patient

The accomplishment of diagnosed breast cancer up to final stability can be categorized in 6 steps:

##### 1. Shock

This always is a phase of alarm, connected to mental blocks. Education does not make sense in this phase, because there has not been a phase of action and relaxation yet, an understanding on the part of the patient is not possible.

##### 2. Disavowal and Isolation

Patients ask themselves: Why me? Is there a mix-up of findings on hand? The patient especially reacts with this phase, if she is informed too early or abruptly - without her inner willingness - about the life-threatening disease. In this phase discussions are important, however, the patient herself should determine time and length of the conversation.

##### 3. Fury, Aggression, Rage

There must be someone to blame! She is furious about physicians and nursing staff, patients are dissatisfied with each kind of treatment, they correct doctors and most of all nurses, also family members aren't spared from their rage. These often react with feelings of guilt or shame, which even increases the patient's discomfort and grudge. If the patient finds understanding and someone gives her time and attention, she will soon get easier and demand less, because she knows that her wishes are noticed also without outbursts of fury.

#### 4. Negotiation

This often is a volatile phase; the patient utilizes the tactic of a child, who did not even with resistance get what it wanted to. We often find a subtle play-off of nurse against nurse or physician against physician initiated by the patient

#### 5. Depression

The patient retreats and doubts therapy.

This phase strongly develops with patients whose family does not recognize or understand her needs.

#### 6. Acceptance

This phase may also be called agreement; the threat is integrated/accepted. However, this is only accomplished if the patient had enough strength and time to undergo the former phases, to vocalize and act out all sentiments and emotions. This is the only way for the patient to reach a certain extent of peace and approval, helping her to accept her lot.

The breast nurse's task during these phases is attendance. She is **not** meant to solve the patient's problems. The patient may remain in a specific phase; **only she** decides how long this phase lasts. The skill consists of creating a frame to facilitate acting out during these phases.

#### 4.5. Informing the Patient

The breast nurse informs patients in all sections of their disease. Concrete information or education, respectively, is necessary regarding:

- Patients' rights  
Right to be informed and educated, transparency of medical activities, time to make decisions, right for qualified care and support, right to participate in therapeutic decisions
- Medical rehabilitation  
Chemotherapy/radiation/hormonal therapy

Always provided education is conducted by the physician! Information of breast nurse is supplementary

- Social rehabilitation

Subsequent therapy/rehabilitation

The breast nurse will connect the patient to the social worker, who is familiar with social rehabilitation

- Post-care

Medical post-care/support through breast nurse.

On scheduled chemotherapy, breast nurse will inform patient about supply with wigs and on operational activities like quadrant resection or breast ablation about supply with prosthesis in good time

- Hints to existing self-help groups

Breast nurse passes out handouts and reports on self-help groups, as not every patient matches any self-help group

#### 4.6 Consulting the patient

Even today hastiness and urgency are communicated with respect to breast cancer. It is important to know for any breast cancer patient that there is no exaggerated need to hurry upon diagnosis, but she always has enough time to gather extensive information, to discuss therapeutic methods, and to obtain additional opinions. **Breast cancer is not an emergency!**<sup>18</sup> For the first time, disease management programs anchor the obligation to give patients time for decision making prior to therapy after diagnosis and extensive consultation.

#### 4.7 Instructing the patient

One of the breast nurse´s tasks is highlighting various strategies of accomplishment to the patients. *Empowerment* means that the patient passes through the process of taking her affairs into her own hands, becoming aware of her capabilities and alternatives, developing her own strength and using social resources. The intention of *coping* is coping with reality: the patients review formerly successful strategies of their life. This process makes it clear to the patient that only she is **expert for her life**.

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<sup>18</sup> Guideline information for women

## **5. Breast Nurse Implementation at the Municipal Clinic**

I have already accomplished some first steps as “breast nurse”. I introduce myself to patients and family members as nurse, who is attending the advanced training as breast nurse, and I explain the concept of this further education as well as the corresponding objectives. I give patients and their family members the feeling, not to be left alone. I hand over the station’s phone number to each station upon her dismissal and encourage her to call me with questions and ambiguities. Some patients already availed this offer. I consult patients with operation or breast ablation with regard to initial treatment through the medical supplier and establish a connection.

Furthermore, I maintain close contact to the psychological oncologist, physical therapy and the social worker.

Many further tasks are necessary for full implementation of the breast nurse. I will approach these challenges step by step.

These tasks especially include:

### **Breast nurse introduction on open house at the breast center**

I have planned an information desk for the open house at the senology center Mittelbaden. I have already got some suggestions and recommendations from our psychological oncologist. I want to introduce my activities as breast nurse and I am open for first discussions. I want to introduce the breast nurse’s area of responsibility to office-based physicians as well. These are not to regard the breast nurse as “competition” to their medical post-care, but as meaningful amendment to the previous practice of post-care and as support of ambulant therapy.

### **Creating handouts and business cards**

To give breast cancer patients initially the feeling of not being “alone”, I want every woman concerned to receive a handout with the breast nurse’s contact address and her telephonic availability upon accommodation.

### **Introduction to self-help groups**

I will introduce myself as well as my areas of activity to the self-help groups. I think that exchanging experiences within self-help groups may essentially contribute to recovery of the patients' emotional balance.

### **Creation of rooms**

A suitable room has to be created to offer patients discussions and consultations within a protected context.

### **Establishment of consultation-hours**

I want to offer consultation-hours at our senological center; my projected schedule in the beginning is one hour fortnightly. This time may be extended or reduced, respectively, on demand. Consultation-hours are to be on Tuesdays, since this is the "chemo day" of breast cancer patients. I thus enable interested patients to visit my consultation-hours subsequent to their chemotherapy; extra approaches become obsolete.

### **Telephonic availability and Internet access for patients**

To be available for patients, I want to establish a telephonic hotline with connected answering machine to give patients the feeling that they "reached someone" even in my absence; I will call patients back as quickly as possible. Availability by email with corresponding email-address is meaningful, as many patients already obtain their knowledge from the "net"; this results in various questions, which may be asked by email on the spot.

### **Cross-professional team discussions**

Until certification of the senological center, we had cross-professional team discussions on a weekly basis. This cross-professional exchange is very important and should be reestablished at regular intervals (4 weeks).

### **Folder for findings**

Proposal to patients to create a special folder/file for their findings, photos, etc. and allude them to their right to get their findings.

### Consultation regarding sports/nutrition

Specialized diets or conversion of nutrition are not essential. Sportive activities may be conducted in the context of the patient´s potential.

### 6. Summary

The more arduous a disease, the more important is an efficient interaction between physicians and nursing staff on one hand and patients on the other hand. Only by this means success of treatments may be optimized. The most important objective in doing so is delivering any information necessary for a competent decision to the woman affected. This way the woman concerned can cooperate on a different level, the level of interactive/cooperative exchange, with her doctors and the nursing staff.

In association with breast cancer patients, great expectations and demands are often directed towards nursing staffs. The danger in doing so lies in their possible mental overload caused exactly by this means. This may lead to a nursing-care hyperactivity or sometimes resignation. “It is necessary to find the right balance between empathy on one hand and alienation on the other hand to avoid acting for the sake of acting or mental overload with the danger of emotional burn out connected to them.”<sup>19</sup>

The foremost in all areas of the breast nurse´s activities **always has to be the awareness that education about diagnostic findings, diagnosis, and therapy is due to physicians.** Education is mediation of information; the patient is educated about her disease and recommended therapy. In doing so, extent and depth of education should be orientated on urgency of invasion as well as the patients´ educational background and standard of knowledge.

In this regard a successful conversation between physician and patient is very important, leading to comprehensible and useful effects in the clinic´s everyday life.

Zelda Di Blasi and her colleagues from York University, Great Britain, could show in their 2001 study conducted with 3611 patients with mainly physical diseases that warm-hearted, friendly, and fear-reducing affection - irrespective of ulterior

treatments - could clearly reduce the temporal course of disease and quota of side-effects.<sup>20</sup>

Since education means an extreme situation for patients, they potentially tend to absorb totally different issues. I therefore consider the breast nurse´s presence during education necessary, as patients “reassure” themselves with members from nursing staff after every medical discussion. In doing so, they do not only ask once, but address the same question to various persons.

Especially the caring system changes constantly. However, this change appears rather casual, is experienced passively and seldom actively created or co-created. Solidified structures, confirmed by legal clauses, which are already out-dated by the time of their publication, as well as activities of practiced behavior, nip novel approaches in the bud.

**“There is nothing more continuous than change”**

(Heraklit)

Customer orientation and quality management will have even higher priority at each clinic for the future. To remain capable of competing, rethinking of association with patients is essential. In doing so, not always immense investment is necessary to change the clinic´s course of events, but often good will coupled with creativity will suffice.

I hereby certify that I created this thesis autonomously and only upon usage of the literature cited.

Date: 5<sup>th</sup> of June 2005

Signature:

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<sup>19</sup> Faber, H., 1998 : 73

<sup>20</sup> Di Blasi, Zelda, 2001