OPINION OF NURSES ON CANCER, ITS TREATMENT AND CURABILITY

A SURVEY AMONG NURSES IN PUBLIC HEALTH SERVICE

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The support of doctors and nurses in their professional and social contacts with laymen is vital to the success of any attempt to foster in the public mind a less fatalistic attitude to those cancers of accessible sites that are potentially curable, and to promote more confidence in the value of early treatment. Moreover, it is important both that the information imparted by doctors and nurses should be of a positive kind likely to relieve needless anxieties, and that their demeanour should reflect their own confidence in the truth of what they say.

By virtue of their numbers and their day-to-day duties, nurses in the public health service are in direct contact with a large cross-section of the general public. What they say on matters of health and disease cannot but have a wide influence, and their beliefs and opinions about cancer are consequently of profound importance. In the course of routine in-service and initial-training lectures to health visitors, district nurses, and midwives, lecturers from the Manchester Committee on Cancer gained a subjective impression that many nurses were dissatisfied with the care available to the patient with terminal cancer who is nursed at home, doubtful about the value of much hospital treatment, and despondent about the prognosis even for those cancers of accessible sites that respond well to early treatment. If this impression is well founded, it denotes a serious barrier to any attempt to improve public attitudes to cancer, since such unduly pessimistic views are likely to be passed on to members of the general public. This paper describes the results of an inquiry to test the validity of our impressions of the beliefs and opinions about cancer held by nurses in the public health service.

METHOD

A questionnaire was given to 783 health visitors, district nurses, and midwives. It was impracticable to conduct the survey among so large a sample by personal interview. We thus sought the co-operation

of medical officers of health, who asked their nurses to read a letter explaining the purpose of the inquiry and immediately afterwards to complete a questionnaire, as far as possible in circumstances that would minimize the possibility of collusion between respondents. By giving the nurse no time for reflection or discussion with her colleagues, we hoped to achieve a clearer picture of what she thought—rather than what she felt she ought to think as a professional—about the subject. Nurses were assured that complete anonymity would be preserved. One medical officer of health went so far as to display an envelope into which completed questionnaires would be sealed, lest any of his nursing staff should fear that their handwriting would be recognized.

SAMPLE

Since we were primarily concerned with those nurses most likely to be drawn into conversation about cancer in the normal course of their duties, we concentrated on health visitors (394) and district nurses (312), but included a smaller sample of midwives (77). Nurses who fill the dual role of district nurse and district midwife were treated throughout as district nurses. Of the total sample, 576 questionnaires were completed by nurses in the densely-populated Manchester conurbation, and a further 207 by nurses in North Lancashire, South Cheshire, and the City of Sheffield, and by others attending a week-end training course in Sussex. With the exception of Sheffield (25 replies) and Sussex (49 replies), questionnaires were completed by nearly 100 per cent. of health visitors and district nurses in the county boroughs and medical divisions that co-operated in the survey.

RESULTS

The results of the survey are divided into three main sections:

(1) Opinion on the care of the cancer patient.

(2) Opinion on the causes of, and reasons for, delay in the treatment of the cancer patient.

(3) Opinion on the curability of early cancer of certain sites.

In each section the results are presented in tabular form (Tables I–VI).

(1) OPINION ON THE CARE OF THE CANCER PATIENT

(a) Do you think hospitals *frequently* give treatment that is really not worth while?

TABLE I
OPINION ON HOSPITAL TREATMENT

Treatment	No.	Per cent.
Worth while	578	73·2
<i>Frequently</i> not worth while	158	20·0
Don't know	47	6·8
Sample	783	100

(b) (i) Is home care for the patient with terminal cancer on the whole adequate?

TABLE II
OPINION ON HOME CARE

Home Care	No.	Per cent.
Adequate	352	45
Not adequate	431	55
Sample	783	100

(ii) If you think home care is not adequate, what more could be done?

Of the 431 who said that home care is not adequate, most offered more than one suggestion for improving this service. Percentages are those of the sample of 431 and total more than 100 per cent. because multiple answers were possible.

TABLE III
SUGGESTIONS FOR IMPROVEMENT IN HOME CARE

Suggested Improvement	No.	Per cent.
More nurses, nursing homes	167	38·7
Nursing help at night	158	36·8
Improved "home help" service	145	33·2
More attention from G.P.	57	13·4
Patients' and relatives' emotional well-being	46	10·7
More financial assistance	37	8·6
Sample	431	

(2) OPINION ON CAUSES OF, AND REASONS FOR, DELAY IN TREATMENT

(a) What are the two or three most frequent causes of the delay when a patient who has known about her symptoms for a long time does not reach hospital until her cancer is well advanced?

Only 277 nurses drew a distinction between "causes" and "reasons". Answers to this question relating to patients' "reasons" for delay are included in Table V.

TABLE IV
OPINION ON CAUSES OF DELAY IN ADMISSION TO HOSPITAL

Cause of Delay	No.	Per cent.
General practitioner delay	188	67·9
Long hospital waiting-lists	120	43·3
Sample	277	

(b) Why do you think so many patients delay reporting their symptoms to a doctor? Name two or three reasons.

Every nurse answered this question. Most gave more than one reason.

TABLE V
OPINION ON PATIENTS' REASONS FOR DELAY

Reason for Delay	No.	Per cent.
Fear	744	95·0
Ignorance	429	54·8
Family responsibilities	248	31·7
Fear of ridicule by G.P.	109	13·9
Modesty	81	8·7
Sample	783	

(3) OPINION ON CURABILITY

Of 100 middle-aged people with *early* cancer of each of the following sites, how many would you expect to be cured? (Ring the number you think most likely for each.)

Posing the question in this way admittedly leaves little room for estimation between the points named, but we thought the advantage of speed and ease of completion outweighed this disadvantage (Table VI, overleaf).

Some nurses with only a vague idea that early cancer of the first three sites is fairly curable may have tended to predict 50 per cent. However, although such a guess may reflect a genuine lack of confidence, it is with those nurses who predicted a 0–25 per cent. cure for early cancers of the breast, mouth, and

TABLE VI
OPINION ON CURABILITY OF EARLY CANCER, BY SITE

Site of Cancer		No. expected to be cured out of 100 Early Cases						Total
		0	25	50	75	100	Don't know	
No. of Respondents (Per cent. in brackets)	Breast . . .	9 (1.1)	116 (14.8)	247 (31.6)	344 (44.0)	46 (5.8)	21 (2.7)	783 (100)
	Mouth . . .	53 (6.8)	272 (34.8)	209 (26.7)	167 (21.2)	35 (4.5)	47 (6.0)	783 (100)
	Cervix uteri . .	15 (1.9)	176 (22.5)	277 (35.3)	244 (31.2)	43 (5.5)	28 (3.6)	783 (100)
	Lung . . .	151 (19.3)	414 (52.7)	142 (18.2)	37 (4.8)	4 (0.5)	35 (4.5)	783 (100)

cervix uteri that we are concerned here. This group, which may fairly be described as grossly despondent, is discussed in more detail later.

DISCUSSION

(1) OPINION ON THE CARE OF THE CANCER PATIENT

Of the whole sample, 20 per cent. thought that hospital treatment is frequently a waste of time, and the 6.8 per cent. who said "don't know" were evidently unwilling to express full confidence in its value. This supports our subjective impression that many nurses may not be aware of the limited aim of purely palliative treatment, and that they tend to regard subsequent deaths as failures of treatment intended to cure.

Inadequacies in the domiciliary care of the cancer patient were mentioned by 60 per cent. of health visitors, 53.2 per cent. of midwives, and 48.1 per cent. of district nurses.

Many of the criticisms and suggestions offered concerned the burden that falls on the patient's relatives, and the need for the provision of a more comprehensive nursing service was often qualified by remarks, such as "to ease the relatives' burden", and "to allow the relatives to get some sleep". Comments about the inadequacy of provision for nursing help at night cropped up so frequently (158) that we gave this item special mention in Table III. [It would be interesting to know how much this situation has improved since the 1952 Joint National Cancer Survey Committee found that, of patients requiring night nursing, only 4 per cent. were attended by a trained nurse.] The group expressing concern about the emotional state of patients and their relatives, though relatively small (46), expressed itself strongly. Patients, or their relatives, were left too much in the dark and did not know what to expect. *Someone* in authority—variously, consultant, general practitioner, or hospital almoner—should visit the home with the object of explaining to relatives what course the condition might be expected to take, how best to nurse the patient, and so on. It would be a mistake to dismiss these remarks as mere carping. They are

extremely important when considered in the light of the findings of Cobb, Clark, Lee, McGuire, and Howe (1954), who discovered that, irrespective of whether a patient has died, his relatives tend to delay less in seeking treatment for themselves if a physician has previously explained to them the nature of the disease and the purpose of treatment.

Some nurses, who expressed satisfaction with the quality of the care available, qualified their answers by remarks such as "provided full use is made of existing services"; and we wonder whether full advantage is always taken of the assistance offered by voluntary agencies such as the Marie Curie Memorial Foundation and the National Society for Cancer Relief.

(2) OPINION ON CAUSES OF, AND REASONS FOR, DELAY IN TREATMENT

Only 35.4 per cent. of replies made any distinction between "causes" and "reasons" in answering the question about delay in admission to hospital. We recognized this as a potential difficulty when formulating the questionnaire, but decided to leave in open-ended form both this question and the question relating to patients' "reasons" for putting off a visit to a doctor, the better to elicit what feelings about causes of delay were uppermost in nurses' minds.

Every nurse had something to say about patients' "reasons" for delay. Of those who said "fear", the majority felt no need for qualification, as though the underlying cause of the fear were self-evident. We suspected that some answers were no more than a reflection of the nurse's own feelings. Typical of these was the nurse whose three reasons were: "Fear, fear, fear; 1, 2, and 3, fear". Another, who said "fear of cancer, no other real reasons", recognized the attitude observed by Aitken-Swan and Paterson (1955) that: "fear . . . is often a kind of cultural fear, a herd instinct rooted in prejudice and ignorance. The fear of cancer is vague and is therefore usually expressed in some more . . . rationalized basis. 'Reasons' for delay include fear of doctoring, of hospitals . . . leaving home, losing a job, leaving a young family or a sick husband." A sufficiently large

number of nurses (109) said "fear of ridicule by doctor", or "fear doctor will think them neurotic", to justify this "reason" being given a place of its own.

(3) OPINION ON CURABILITY

The first three sites—breast, mouth, and cervix uteri—were chosen because they yield a high rate of cure (75, 60–65, and 75 per cent. respectively) when treated early, and because cancers of the breast and cervix at least are likely to be within the day-to-day experience of most nurses in the public health service. Lung cancer, notoriously difficult to treat successfully, is also familiar to them, and we thought it would be interesting to compare their predictions for this site with those for breast and cervix. In fact, many more nurses gave "accurate" predictions for early lung cancer (72 per cent. selected 0–25 per cent. cure) than predicted the actual cure-rate of 75 per cent. for breast and cervix (only 44 per cent. and 31·2 per cent. respectively did so), and this confirms our impression that nurses are less well informed about the prognosis for curable forms of the disease than they are about those cancers that give little grounds for optimism. However, in view of the tendency for some breast cancers to recur years after apparently successful treatment, we were surprised to find that this is the "curable" site about which nurses feel least despondent, only 15·9 per cent. estimating a 0–25 per cent. cure-rate for this condition as against 41·6 per cent. for early mouth cancer and 24·4 per cent. for early cancer of the cervix.

We analysed the data to see what factors seemed to be associated with pessimistic or optimistic opinions about curability, and the results are given in Tables VII–X.

(a) *Length of Service.*—The hypothesis that long service, involving greater experience of distressing terminal illness, would tend to make a nurse more despondent, and that recently recruited nurses, with more up-to-date experience of modern therapeutic procedures, would tend to be less despondent, was not borne out by the survey. A comparison between

the estimates by health visitors with more than 15 years' service and those with less than 3 years' service showed no statistically significant differences. The same applied to district nurses.

When testing significance, the "don't know" columns of the tables were excluded because they gave no reliable indication of whether nurses were optimistic or pessimistic about curability. In Tables VIII (cervix) and X, where numbers in some cells were small, the columns for estimates of 75 per cent. and 100 per cent. were aggregated.

(b) *Occupation.*—District nurses were slightly more despondent than health visitors about breast cancer, and considerably more despondent about cancer of the cervix (Table VII).

(c) *Experience of Cure.*—Nurses with relatives who had been cured of cancer were less despondent about prognosis than those with relatives who had died of the disease (Table VIII, overleaf).

Similarly, nurses who said they knew of more than five patients cured were less despondent than those knowing fewer than five patients who had been cured (Table IX, overleaf).

Since nurses were not given time for long consideration when completing the questionnaire, it may be argued that a nurse's estimate of how many cured patients she knew may reflect her powers of memory rather than her actual experience. Which-ever interpretation is put on these figures, however, it is interesting to note that only 299 (38 per cent.) were able to recall more than five patients cured, and that predictions of cure tended to be related to what nurses believed was their actual experience.

(d) *Opinion on Hospital Treatment.*—The biggest differences were revealed when answers were analysed according to the nurse's opinion of the value of hospital treatment (Table X, overleaf).

CONCLUSIONS

The impression that many nurses in public health service have a despondent attitude to cancer and to the existing hospital treatment and care at home of the

TABLES VII
COMPARISON BETWEEN ESTIMATES OF CURABILITY BY HEALTH VISITORS AND DISTRICT NURSES

Site of Cancer		Type of Nurse	No. expected to be cured out of 100 Early Cases					Total
			0–25	50	75	100	Don't know	
No. of Respondents (Per cent. in brackets)	Breast*	Health Visitors	56 (14·3)	115 (29·2)	183 (46·4)	27 (6·8)	13 (3·3)	394 (100)
		District Nurses	60 (19·2)	100 (32·0)	137 (44·1)	10 (3·2)	5 (1·5)	312 (100)
	Cervix†	Health Visitors	76 (19·3)	141 (35·8)	136 (34·5)	23 (5·8)	18 (4·6)	394 (100)
		District Nurses	91 (29·2)	119 (38·1)	83 (26·6)	15 (4·8)	4 (1·3)	312 (100)

* $\chi^2_1 = 7·807$

P < 0·05

† $\chi^2_1 = 11·569$

P < 0·01

TABLE VIII
COMPARISON BETWEEN ESTIMATES OF CURABILITY BY NURSES WITH RELATIVES CURED OF CANCER,
AND THOSE WHOSE RELATIVES HAD DIED

Site of Cancer		Fate of Relative	No. expected to be cured out of 100 Early Cases					Total
			0-25	50	75	100	Don't know	
No. of Respondents (Per cent. in brackets)	Breast*	Cured	11 (12.1)	21 (23.0)	44 (48.4)	11 (12.1)	4 (4.4)	91 (100)
		Died	44 (18.0)	84 (34.5)	99 (40.5)	11 (4.5)	6 (2.5)	244 (100)
	Cervix†	Cured	18 (19.7)	31 (34.1)	31 (34.1)	4 (4.4)	7 (7.7)	91 (100)
		Died	63 (25.9)	87 (35.6)	75 (30.7)	8 (3.3)	11 (4.5)	244 (100)

* $\chi^2_3 = 10.940$ $P < 0.02$ † $\chi^2_3 = 13.175$ $P < 0.01$

TABLE IX
COMPARISON BETWEEN ESTIMATES OF CURABILITY
BY NURSES KNOWING OF MORE THAN FIVE, AND LESS THAN FIVE, PATIENTS CURED

Site of Cancer		Patients known to be cured	No. expected to be cured out of 100 Early Cases					Total
			0-25	50	75	100	Don't know	
No. of Respondents (Per cent. in brackets)	Breast*	More than 5 ..	33 (11.0)	93 (31.1)	152 (51.0)	19 (6.3)	2 (0.6)	299 (100)
		Less than 5 ..	92 (19.1)	154 (31.9)	192 (39.8)	27 (5.6)	19 (3.6)	484 (100)
	Cervix†	More than 5 ..	57 (19.1)	110 (36.8)	109 (36.5)	16 (5.3)	7 (2.3)	299 (100)
		Less than 5 ..	134 (27.8)	167 (34.5)	135 (27.8)	27 (5.6)	21 (4.3)	484 (100)

* $\chi^2_3 = 12.560$ $P < 0.01$ † $\chi^2_3 = 10.249$ $P < 0.02$

TABLE X
COMPARISON BETWEEN ESTIMATES OF CURABILITY
BY NURSES THINKING HOSPITAL TREATMENT WORTH WHILE OR NOT

Site of Cancer		Value of Treatment	No. expected to be cured out of 100 Early Cases					Total
			0-25	50	75	100	Don't know	
No. of Respondents (Per cent. in brackets)	Breast*	Not worth while	37 (23.4)	51 (32.3)	63 (40.0)	5 (3.2)	2 (1.1)	158 (100)
		Worth while ..	90 (14.1)	196 (31.3)	281 (45.0)	41 (6.5)	19 (3.1)	625 (100)
	Cervix†	Not worth while	59 (37.3)	53 (33.5)	37 (23.4)	2 (1.3)	7 (4.5)	158 (100)
		Worth while ..	132 (21.1)	224 (35.6)	207 (33.3)	41 (6.5)	21 (3.5)	625 (100)

* $\chi^2_3 = 10.61$ $P < 0.02$ † $\chi^2_3 = 24.184$ $P < 0.01$

cancer patient, has been confirmed by this survey. There is a strong case for more or better instruction in initial and in-service training programmes.

Whether or not criticisms of the care of the cancer patient nursed at home are valid, it was not the purpose of this inquiry to answer; but we feel these merit further investigation—perhaps on the lines of the National Survey Report in 1952 by the Marie Curie Memorial Foundation and the Queen's Institute of District Nursing. However, over half this large sample of nurses does believe that there are grounds for serious criticism, and it would not be surprising if such opinions contributed to feelings of frustration and pessimism about cancer in general. Perhaps the Ministry of Health's plan to recruit more nurses for the public health service will eventually answer some of these criticisms. In the meantime it may be profitable, when planning training programmes, to take note of the suggestion that all the

sources of assistance, from both voluntary and statutory bodies, are not so well known to nurses as they might be.

Substantial minorities think hospitals *frequently* give treatment that is really not worth while (20 per cent.); blame general practitioners or hospitals for long delays in establishing a diagnosis, or in the admission of patients for treatment (24 per cent. and 15.7 per cent.); and blame general practitioners for the reluctance of patients to seek advice about very early symptoms because they fear exposure to ridicule (13.9 per cent.). Where provision is not already made, lectures by hospital specialists and general practitioners might be introduced into training courses. This would do much to foster among nurses a greater understanding of the purposes of different types of treatment, and of the problems and difficulties that beset the family doctor. The benefit of such lectures need not be in one direction only.

Hospital staffs and family doctors alike may well profit by hearing the nurses' opinions. The latter often become close confidantes of patients and their relatives, and know how people who have cancer—or who fear they may have it—react to the way in which their anxieties are dealt with by the doctor.

Because of their daily contacts with the public, and because health visitors in particular are charged with health education, it is clearly undesirable that large numbers of public health nurses should hold negative views about curability. They may pass on these views to laymen who are already prey to those feelings of hopelessness and apprehension about cancer that so often contribute to avoidable delay. While it is obviously important that nurses should have a good general idea of the results of treatment, at least for the common forms of the disease they are likely to encounter, it is as well to bear in mind that statistics alone are seldom convincing to those whose experience is at variance with the overall picture. The evidence from this survey shows that a nurse's personal experience of cure, either in her family or in her professional life, has a bearing on her beliefs about curability in general, and also that her opinions on the value of hospital treatment are reflected in her tendency to forecast a high or low cure-rate. This suggests that a strong emphasis on successful case histories and more instruction about hospital treatment may help to change the attitude of many nurses to cancer.

SUMMARY

An inquiry has been conducted among 783 nurses in the public health service to test the validity of a subjective impression that many nurses are unduly despondent about cancer and about the management of the cancer patient.

One-fifth (20 per cent.) believe that hospitals frequently give treatment that is not worth while. Over half (55 per cent.) criticize the quality of the care available to the patient with terminal cancer nursed at home. Their suggestions for improving this service include more nurses, a more comprehensive night-nursing service, and more consideration, by general practitioners and hospital staffs, of the emotional state of patients and their relatives.

Over one-third (35·5 per cent.) blame general practitioners or hospitals for delay in the treatment of the cancer patient. All offer opinions why patients themselves delay; as well as "fear",

"ignorance", and "family responsibilities", mentioned by large numbers of nurses, a substantial minority (13·9 per cent.) name "fear of ridicule by general practitioner".

Gross despondency exists about the curability of some early cancers of accessible sites. Early breast cancer is believed to be 0–25 per cent. curable by 15·9 per cent., early mouth cancer is believed to be 0–25 per cent. curable by 41·6 per cent., and early cancer of the cervix uteri is believed to be 0–25 per cent. curable by 24·4 per cent.

Factors that seem to be associated with a nurse's tendency to estimate a high or low cure-rate are discussed.

It is concluded that many public health nurses experience feelings of frustration and despondency about cancer and that these may be passed on to laymen. Suggestions are made for adjusting training programmes to ensure that communications about cancer by such nurses to members of the general public are more likely to be positive and reassuring.

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