

**Psy 02**

PROBLEMS AND POSSIBILITIES IN THE COOPERATION BETWEEN MEDICAL ONCOLOGISTS AND A DEPARTMENT FOR PSYCHOSOMATIC MEDICINE  
W. Pontzen

This paper deals with problems and results of a four year period of cooperation between a department of medical oncology (5. Med. Klinik, Klinikum Nürnberg, head: Prof. Dr. W. M. Gallmeier) and a department of psychosomatic medicine (Klinikum Nürnberg, head: Prof. Dr. W. Pontzen). Two prerequisites have to be met for such a cooperation: the chief of oncology has to be openminded for psychosomatic problems, members of the department of psychosomatic medicine have to be continuously or at least at certain hours available on the ward. The member of the department of psychosomatic medicine has to be careful not to work with the patient against his own doctor from medical oncology nor with the medical oncologist against the patient. It has been shown that this critical balance has to be worked out again and again in every days collaboration and has to be established in a more stable way as time goes on. The member of the psychosomatic department has to try to elucidate the unconscious process underlying the communication between the patient and his medical oncologist. He thus has to bring into scope the pathology of personal interaction of psychosomatics in addition to the classical view of modern organ pathology when dealing with cancer patients. The aim is to leave the treatment and guidance of the patient as a whole with in the responsibility of the medical oncologists in charge. The main job of the member of the department of psychosomatic medicine is the counselling of the members of the oncological ward and not the direct care of the cancer patients.  
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**Psy 03**

PREVALENCES OF MEDICAL INFORMATION METHODS FOR CANCER PATIENTS - A COMPARISON BETWEEN KIEL AND MALMÖ  
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Within the scope of 2 empirical pilot studies carried out on Kiel and Malmö cancer patients, doctors, nurses as well as clinical social workers were asked their opinions on how medical information can be satisfactorily given. A complete standardized questionnaire was used to enable exactly the same questions to be given to all groups. According to Thurstone's "Law of comparative judgement" the probands from both countries were asked to rate the 10 items in the order of importance to allow a comparison to be made on an organized interval scale. By means of this method one does not only obtain details about the order of precedence (relative importance), but in addition information about differences shown on the scale by the items under consideration. In assessing the medical information methods (doctor's role) in the country comparison there are clearly larger differences in the self-assessment by the doctors than in the idealized doctor-image of the Swedish and German patients. In the overall view the doctor-patient relationship in Sweden appears - also from the isolated view of the doctor's role - to harmonize, i.e. to be less conflict-stricken. In spite of all methodological doubts about a country comparison there seem to be differences, as shown by the results of the project, over and above the stereotype and mentality problems.

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**Psy 04**

CHILDHOOD CANCER: FIVE COPING STRATEGIES - A RETROSPECTIVE STUDY  
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A retrospective study on coping behavior was performed in 30 families with children with cancer. All patients had been treated at the children's university hospital, Bonn. 15 of the patients had died of their disease, 15 were in long-term remission and may be called "cured". The study intended to evaluate the "normal" coping behavior of families with cancer-sick children, i.e. without psychological intervention. In semistructured interviews 42 aspects of possible coping styles were questioned. According to the stress coping model by LAZARUS five different coping styles could be differentiated. The families experienced the disease as a) challenge, b) probation, c) misfortune, d) punishment, or e) fate. The characteristics and the differences of these styles are described and their positive effect on the course of the disease are evaluated. A mutual influence of all family members and the sick child was demonstrated. It is assumed that the individual's confidence in his possibility to change the course of the disease is the most favorable coping behavior. Such behavior is free of exaggerated fear and mistrust toward the physician, the treatment and the hospital situation. An important factor for positive coping behavior is the family's status of knowledge about the disease. Uninformed families tend to create their own fantasies about the possible cause of their child's cancer. Often they feel guilty and thus punished by the disease. A relationship between the kind of childhood cancer, its clinical prognosis and the form of coping can be observed.

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**Psy 05**

IMPROVEMENT OF CANCER PATIENTS POST-CLINICAL CARE BY CANCER REGISTRIES  
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Following primary therapy, cancer patients must be considered risk patients, since therapy success can be endangered by relapses, metastases, and secondary tumors. Regular, well-timed follow-up examinations are therefore extremely necessary, but they are often not realized. Since 1982, the after-care registry of the Tumor Center Kiel has been built up in order to confront this problem.

This evaluation concentrates on whether or not an after-care registry can remove existing information deficits, and can insure that patients will undergo the necessary follow-up examinations. More than 200 patients who had been treated for a gynaecological tumor were included in the study. All patients did not observe a fixed examination appointment in the clinic by more than 6 weeks. In cooperation with local authorities, physicians in private practice, and the patients themselves it was discovered that about one fourth of the patients had died in the meantime. About 10 % of the patients had been taken out of follow-up examinations because of tumor progression, and were again receiving intensive treatment. For 30 % of the patients listed the follow-up examinations had been done by physicians in private practice; however, no information had been exchanged with the clinic. Most of the remaining patients (about 25 %) came to the clinic or went to a physician in private practice to have their follow-up examinations.

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