A study to determine the extent to which nurses recognize and believe they meet the needs of the radical mastectomy patient and the extent to which the patients think their needs are met.

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A STUDY TO DETERMINE THE EXTENT TO WHICH NURSES RECOGNIZE AND BELIEVE THEY MEET THE NEEDS OF THE RADICAL MASTECTOMY PATIENT AND THE EXTENT TO WHICH THE PATIENTS THINK THEIR NEEDS ARE MET

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CHAPTER ONE

INTRODUCTION

In the past decade much of the research in nursing has been concentrated on the role and role conflicts experienced by nurses in a changing pattern of both nursing practice and education. There has also been much written about what nursing is, and whether or not it has yet reached professional stature. As a result of this kind of research and philosophical study, it has become apparent that there is a need to precisely identify those components of patient care and patient needs which are not only the responsibility of nursing but which are so uniquely nursing that they quite properly are classified as integral parts of a science of nursing. It is with the desire that some small but hopefully significant information can be added to the science of nursing that this study of radical mastectomy patients was undertaken.

Statement of the Problem

This study proposed to answer the questions:

1. To what extent do nurses recognize the specific needs of patients following a radical mastectomy?

2. How well do nurses think they meet the needs?

3. How well do mastectomy patients think their needs were met?

Justification of the Problem

This problem was chosen for investigation because of the personal experience of the writer and the surprisingly large number of radical
mamectomy patients whom the writer has met in recent years who did not receive adequate support and concrete help from either doctors or nurses. These patients have frequently struggled through to a satisfactory rehabilitation but often this was accompanied by: a great deal of psychological stress in terms of adjustment to the actual physical deformity and its possible effect on the family, particularly a husband; varying degrees of physical incapacity due to lack of proper exercise; and much emotional frustration because of lack of knowledge of the different kinds of prosthetic devices available that would yield the best cosmetic result. In discussing the subject with nurses, it seems evident that many nurses understand the physical aspects of rehabilitative care for the radical mastectomy patient and have some knowledge of prosthetic devices. The awareness of what the psychological and emotional implications of this type of surgery are is not readily verbalized by the average nurse. There seems to be a reluctance to empathize with the patient which would perhaps give the patient an indication of freedom to talk out her fears and worries. The inability of the nurse to indicate, even in a subtle fashion, her understanding of the conflict that the patient is undergoing leads, it would seem, to the neglect of even the more easily handled teaching in order to also avoid that area in which she cannot feel comfortable or secure. If this is true then it must follow that another important area of teaching for this patient, as well as for other women, may be entirely omitted from a nurse's practice. The teaching of the importance of, and the technique for doing, breast self-examination should certainly be an accepted and practiced part of a nurse's responsibility in the area of preventive teaching. If she avoids meeting other overt needs of the patient, for whatever reasons, is it not possible that many excellent opportunities for this particular phase of positive health teaching are
It would appear that a more adequate program for the radical mastectomy patient might have two important results:

1. The patient herself would make a healthier adjustment in all respects to her disability.

2. By making a better adjustment, she is much more apt to become a very vocal advocate of regular medical examination and of breast self-examination, and an example to other women of the possibility of a normal, productive, and happy life in spite of the diagnosis of and surgery for cancer of the breast.

If these results are desirable, and they would seem to be, then it logically follows that an investigation of this type would point up areas in which a nurse will need additional instruction and experience in order that she may eventually implement all phases of a nursing care plan which will assure the total rehabilitation of the patient.

Scope and Limitations

In order to determine what needs nurses perceive the radical mastectomy patient to have and how well they think that they meet these needs, it appeared that two separate lines of investigation needed to be pursued. First, it was necessary to interview a group of patients who had undergone surgery for carcinoma of the breast. This was done in order to obtain information in relation to their perceived needs which were either completely met, partly met, or not met at all. To accomplish the first step in the collection of data, a total of eight women were interviewed. A set of criteria were first set up with the belief that patients who qualified within these criteria would yield the most valid results for this study. These criteria, as well as the reasons why they were chosen, will be discussed in the chapter on methodology.
The second line of investigation took the form of a two-part questionnaire administered to a group of graduate nurses who entered an undergraduate General Nursing Program in a university school of nursing in the fall of 1959. The questionnaire was administered to determine what they considered to be the needs of radical mastectomy patients and whether it was their usual practice to implement a nursing care plan that attempts to meet these needs. This group of nurses was selected because for the most part they had just completed either a senior nursing student experience or had come from a staff nurse position in a general hospital. They had not had any course, per se, in the principles of rehabilitative nursing, and it was therefore assumed that they would answer the questionnaire in terms of their own personal beliefs and attitudes as well as their knowledge and previous practice of the principles of comprehensive nursing care. This group numbered forty-two graduate nurse students.

The following limitations to the study were recognized by the writer:

1. The actual sample of patients available for interview was too small to yield statistically significant conclusions.

2. The interview guide for patients focused on only four specific needs.

3. The questionnaire for nurses focused on only four specific needs.

Preview of Methodology

The selection of the two samples and the procurement of the data for this study were accomplished in the following manner:

1. Four specific needs of the radical mastectomy patient were selected by the writer as those around which she wished to conduct her investigation.

2. Criteria for the selection of patients were established by the writer in the belief that patients who qualified under these criteria would yield the greatest amount of
information in relation to the pre-determined needs.

3. Letters were written to five doctors in two communities in the greater Boston area, giving the credentials of the writer, explaining the purpose of the study, and requesting the names of patients whom they considered would be not only suitable but willing participants in the study.

4. Upon receipt of the names of four patients which the doctors supplied, letters were sent to these women, again giving the credentials of the writer, explaining the purpose of the study, and requesting an interview. Postcards were enclosed which the patients were asked to mail back indicating whether or not they were willing to participate in the study.

5. An interview guide of thirty-six questions was developed. "Open-ended" questions interspersed with "fixed-alternative" questions were used for the most part to allow for a maximum amount of free expression. These questions were concerned with the areas of need decided upon by the writer. They were used following a warm-up period that varied from five to fifteen minutes.

6. Interviews were held with three patients obtained in the above manner. In each case the respondent was interviewed in her own home, following a telephone call from the writer setting a mutually agreeable time and date.

7. The names of three other patients were obtained from one of those interviewed in the first group and a seventh name from a patient in the second group. In each case the women supplying the additional names contacted their friends personally and explained the nature of the study. A follow-up call from the writer was in all instances warmly received and the date and time for an interview readily agreed upon. The eighth patient who was willing to participate in the study was one whom the writer had seen the previous summer after her operation.

8. A two-part questionnaire was administered to forty-two graduate nurse students in a General Nursing program in a university school of nursing. Permission to give this questionnaire had been previously obtained from the chairman of that department. The first part of the questionnaire asked the nurse to identify four specific needs of the patient who had had a radical mastectomy operation. The second part consisted of twenty-nine questions which could be answered for the most part by "yes" or "no". This latter questionnaire was designed to obtain information about attitudes and patterns of behavior, and specific factual knowledge that would be of assistance to patients who have had this operation.
Sequence of Presentation

The study of the outlined problem will be presented in four chapters according to the following sequence. Chapter Two will present the philosophical and theoretical framework of the study with a review of literature which relates to both the psychological implications of the diagnosis and the operation and to the rehabilitative care necessary to restore the patient to maximum health, both mentally and physically. The basis on which the hypothesis has been predicated will be discussed and substantiated.

A detailed discussion of methodology used in the study will be presented in Chapter Three, including the selection and description of the two samples as well as the tools which were devised for the procurement of data. In Chapter Four, the actual data collected will be presented, analysed, and discussed. Chapter Five is devoted to the summary, conclusions, and recommendations.
CHAPTER TWO

PHILOSOPHY UNDERLYING THE STUDY
BASED ON A
REVIEW OF THE LITERATURE

In surveying the literature for research studies and pertinent articles that would become a basis for validating the hypothesis of this study, it soon became apparent that it was necessary to confine the survey to that literature which had to do chiefly with the psychological implications of the diagnosis and treatment of cancer of the breast and to those aspects of nursing which related chiefly to the rehabilitation of the patient. There are many studies and articles that certainly have a bearing on all of the facets of care involved in the treatment of patients with serious, fear-provoking disease. One must assume that a study of this kind is based on a general knowledge and recognition of the needs of all patients and is focusing on those needs which are peculiar to the particular disease under study. To do otherwise would seem to distract from the main issue rather than to sharpen it.

The purpose and justification for this study have been explained from a rather personal point of view in the introduction to the study. The survey of literature has been undertaken to determine whether or not the authorities in the field of cancer surgery substantiate the hypothesis that women who must undergo radical surgery for carcinoma of the breast are subject, in varying degree, to psychological trauma that can be remarkably destructive if not recognized, understood, and treated by all members of the health team. They also substantiate that these patients have special
rehabilitative needs that must be recognized and met by nurse as well as doctor. To some people a study of radical mastectomy might appear of no greater import than any other kind of major surgery with its attendant trauma, and embodying patient needs specific to the disease. Perhaps a further justification, then, for this study might be found in the incidence of the disease and in the number of deaths that occur annually in the United States from cancer of the breast. As recorded by the National Office of Vital Statistics for 1957, this disease accounts for approximately 22,000 deaths annually.1 It is also "one of the commonest tumors of women, accounting for approximately one in every six deaths due to cancer among females. Levin has shown that there are approximately five patients living with the disease for every reported death."2 When one combines these facts regarding incidence with the empirical evidence that women undergoing this kind of surgery do not receive the kind of support and teaching that they require, it seems evident that there is need to evaluate our understanding of the disease and its treatment in terms of its effect on the patient, and to delineate ways in which the needs of these patients can more adequately be met. Not to do so seems to imply an unwillingness to examine our own attitudes and understandings and thereby give less than optimum care to a significantly large percent of our yearly hospital population.

One does not really have to look far afield to find the reason why there is so much psychological trauma attached to cancer surgery. Dr. Arthur

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Sutherland, attending physician and psychiatrist at the Memorial Hospital in New York city, suggests that while the tremendous advances made in cancer surgery in the past few years are making possible a higher rate of survival than formerly, these same advances are creating problems of their own, unknown before the newer techniques were possible. Extensive surgery results in major changes in form and function of various parts of the body. These changes are often disfiguring or mutilating and are not lightly borne by the average patient. In almost all instances they present challenges to the adaptive capacity of the patient and at times may appear overwhelming. Dr. Sutherland goes on to say:

The result is the therapeutic paradox of patients cured of Carcinoma and clinically well who are able to function in a very circumscribed way or not at all because the methods necessary for cure have resulted in psychological invalidism.4

One cannot read the literature in the medical journals and be unimpressed with the concern of many doctors for the poor handling of the psychological problems of the patient who has undergone surgery for cancer of the breast. Renneker and Cutler in their treatise on the subject deplore the inertia, caused by slow recognition, absorption, and integration of advances from widely scattered sources of research, that results in a lack of communication between, and use of knowledge of, other allied disciplines, as well as lack of utilization of new or even old knowledge.5


4Tbid., p.1139

Referring specifically to the problem of the radical mastectomy patient, they say:

We feel that such a state of inertia exists in the psychological handling of women with breast cancer and that here is a situation with potentially severe emotional trauma that is being sadly mismanaged and misunderstood by a good percentage of the medical profession. 6

What are the reasons, then, for the "potentially severe emotional trauma"? Is it a fear of the diagnosis of cancer, of the surgery itself, or the possibility of death? Most doctors seem to agree that none of these are the immediate fears of the patient who discovers or is told that she has a "lump" in her breast. Renneker and Cutler express this opinion:

[(the surgeon) must understand that the primary emotional reaction connected with disease of the breast is usually not a fear of cancer or death, but is rather the shocking feeling that the basic feminine role is in danger.] 7

They go on to say further that eventually the patient will think about the meaning of cancer and the possibility of death but that this does not usually occur until she has been able to make some kind of psychological adjustment to the prospect of mutilation and a change in her physical image.

Her first problem is that of protecting her breast; only later does she begin protecting her life. It is obvious that the surgeon . . . must bear in mind that the emotional focus is different in the preoperative and postoperative periods than in the later convalescent . . . phases when the threat to life becomes a struggle. 8

Both of the authors quoted above and Sutherland and Bard are in agreement that the chief psychological stress that occurs immediately is connected almost solely with the symbolic meaning of the breast for the individual. 9 Renneker and Cutler suggest this as a prime reason for not going to the

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6 Ibid., p.33. 7 Ibid., p.834. 8 Ibid., p.834.

doctor when a lump has been discovered: "Remove a woman's breasts and she has lost her badge of femininity." In addition, all of these authors suggest that the loss of "motherliness" is also an important factor in spite of the fact that the ability to breast feed is no longer a source of pride in our culture. Some women are more concerned with what the loss of a breast will mean in their marital relationship, or to men in general, than they are with either the personal feeling of loss or mutilation. Sutherland and Bard, in their article, report the following findings of anthropologist Margaret Mead:

After comparing the cultural values placed upon breast development in various primitive and civilized societies, Mead pointed out that the female breast has been so idealized in the United States that it has become the primary source of a woman's identification with the feminine role. One has only to look at the advertisements in any media, or go no further than his own television screen to realize that the above statement is not an exaggeration. One soon begins to understand the threat to femininity that this operation entails. Dr. Edward F. Lewison expresses the inherent danger that lies in this cultural phenomenon when he says:

It is a revealing commentary to note that throughout the annals of history women have never outlived their vanity. Cosmetic considerations and false modesty have hindered the early diagnosis and timely treatment of breast cancer from the dawn of humanity until today. Since the breast has always been an esthetic symbol of fertility and womanhood, amputation of the breast provoked mutilation of the mind as well as the body. . . . Thus, through the ages, vanity has always been the death-trap of reason in the struggle toward the early diagnosis and treatment of breast cancer.

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10 Renneker and Cutler, op. cit., p. 834.
11 Sutherland and Bard, op. cit., p. 656.
These are but a few of the psychological factors that make adjustment to the diagnosis and treatment of cancer of the breast one that taxes all of the adaptive mechanisms of the individual. A knowledge of these underlying currents of threat to the emotional and physical integrity of the individual must surely indicate to both doctors and nurses the need to develop insight into their own feelings and attitudes. This might enable them to develop an empathy with the patient that will be the basis for a sound therapeutic relationship.

Through the warm and understanding counsel of her physician, a patient may have been able to sufficiently verbalize her feelings about an impending operation before reaching the hospital. As all of the authorities cited in this study have agreed, however, this is too frequently a neglected part of the preparation of the patient. Many patients come to the hospital with no expressed knowledge of the possibility of a radical procedure, but rather with the more easily conceptualized notion that probably only a biopsy will be done at this time. All too often the word "cancer" has not passed the lips of either doctor or patient, in spite of the fact that there are research findings which indicate that a high percentage of patients have acknowledged that they would rather know than not. In a survey done by Kelly and Friesen at the University Hospitals in Minneapolis, 89 out of 100 patients with known cancer stated that they preferred to know about having cancer and 73 out of 100 thought that people, in general, should be told. In another group of non-cancer patients, being seen for other reasons in the outpatient departments of hospitals, 82 out of 100 indicated that they would want to be told if examinations disclosed that they had cancer. In another group

13William D. Kelly and Stanley Friesen, "Do Cancer Patients Want to be Told?", Surgery (XXVII, June, 1950), pp.822-826.
of patients who were over the age of 45 and being examined in the Cancer Detection Center at the University Hospitals, 729 out of 740 indicated that they wanted to know their diagnosis if cancer should ever be detected. In the series of 50 patients involved in the Renneker and Cutler study, almost all accepted the free use of the word by the psychiatric interviewer with welcome relief. Many expressed the opinion that failure to discuss the true nature of the diagnosis by their surgeons only served to convince them of impending doom.

This role of concealment on the part of the surgeon has the unfortunate consequence of removing him as a possible source of emotional aid. It also interferes seriously with the patient's cooperation in her postoperative treatment. She has a feeling of "What's the use?" and also of not completely trusting her doctor. The role of concealment on the part of the patient demands valuable energy for execution and represents an unnecessarily fatiguing and painful process.

Ideally the surgeon should ask in the very beginning of the first interview . . . whether or not the patient has been worried about the possibility of cancer. This touches on a common problem and at least brings the fear out into the open. The patient then finds it easier to relate herself to the physician and ventilate some of her anxiety.

These doctors go on to say, as do Lewison and Sutherland, that the patient should always be prepared for the possibility of a radical mastectomy. This gives the patient at least a brief interval before surgery to muster her adaptive forces before adding the burden of surgical recovery to a shocked and mourning mental state. For mourn the patient will. This is a natural counterpart of the loss of body image and is frequently as necessary as the process of repair.

The dictum, 'it's what's left that counts' is true as far as it goes, but it is at least equally true that the loss

14 Renneker and Cutler, op. cit. 15 Ibid., p.836.
of a significant body part . . . in the mind of the patient calls for a fundamental review of his ability to function normally.\textsuperscript{15}

As the patient enters the postoperative phase, she may, therefore, have been either more or less prepared for the results of her operation. The extent of preparation quite obviously is a significant determinant of the role which will be required of the nurse who cares for her. But of almost greater importance at this time are the attitudes and understandings of the nurse herself. She must be prepared to interpret the possible depression of her patient within its proper context. Above all she must not attempt the rehabilitation of the patient by trying to convince her that she has no problems. Her problems are not only real but very immediate, and they must be solved by her, alone or with the help of others. Sutherland believes that depression and dependence are a natural consequence of cancer surgery and that they must not be allowed to become chronic through lack of help.

To quote him:

\begin{quote}
Only too often (she) does not receive adequate help from professional sources and is left wholly on (her) own or receives from friends and family well-meaned but inappropriate advice. Kindness, acceptance, and support, especially from professional persons, have been proved over and over again to be of great significance to the patient.\textsuperscript{17}
\end{quote}

It is the conviction of this writer that the nurse does not have to enter the picture in the care of the radical mastectomy patient through the back door. She has her own professional skills and knowledge to supplement and complement the doctor's. If the opportunity has been given to her to examine her own feelings about cancer, about radical surgery, and about the possibility of a poor prognosis, she will be less apt to assume a

\begin{footnotes}
\item[15]Sutherland, op. cit., p.1140. \item[17]Ibid., p.1141.
\end{footnotes}
pseudo-cheerful, "Pollyanna" approach that is convincing neither to herself or to the patient. She will respect the period of mourning as a normal and inevitable aftermath, knowing that in most instances the ability to adjust is inherent in the healthy mind. Barckley asks nurses to recognize this when she says:

How, then, can we help our patients?
Not, certainly, by the false cheery assurances that many of us are wont to employ from kind but mistaken motives. 'You haven't a thing to worry about - you look just fine!' deceives only ourselves . . . Although we must not weep with our patients, we should let them know that we realize they are in a hard situation and that we feel for them.

Even the patient who has been well prepared by her doctor in a factual as well as psychological way needs continued reinforcement of this support in the short time that a nurse sees the patient before operation and in the early postoperative stage. She must empathize with the patient to a degree sufficient to interpret correctly the behavior of the patient which may appear to be demanding or in that meaningless category called "uncooperative". The nurse must understand the inherent resentment that is almost always harbored by patients against those who have been the instruments through whom their physical "wholeness" has been destroyed. Sutherland suggests that the patient may feel resentment toward the physician but not dare to openly attack him:

Resentment is often misdirected toward persons in the immediate environment - on nurses and social workers or on members of the family. Resentment is usually manifested by querulousness, a demanding attitude, complaints, and other manifestations of hostility . . . . Irritating as this state is to those who handle the patient, it should be regarded as a part of the normal

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process of repair, although at times a miscarried process. When the anger and resentment can be vented and worked through they do not persist as a permanent adaptive pattern.

The ability to recognize the emotional stress of the patient and to empathize with him is an art that Speroff says can be learned. But in addition to this skill the nurse who is prepared to aid the patient to meet her immediate rehabilitative goals is probably going to do more to establish a therapeutically sound relationship than will the nurse who does not anticipate the specific questions that patients will have and have specific information to give. Often the ability to adjust to the deep-seated problems becomes easier when the more easily recognized needs no longer present problems. It is in this area that a nurse may most successfully begin to establish rapport with her patient. It might be well for all nurses to keep in mind, too, that the patients also have a part in this as expressed by Leone when she said:

The attitudes accompanying simple comfort skills are needed for therapy, too, but in addition there is needed in therapy an important attitude of expectation—expectation that the patient will purposefully participate in his own recovery, will focus his own energy and spirit on the goals of therapy. ... For informed meeting of the doctor's and nurse's therapeutic expectation the patient is given more information than he was given in years gone by. Here, too, the nurse needs facts to impart, judgment as to what and when to inform, and the proper accompanying attitudes.

Certainly the question of how she is going to look and what she is

16Sutherland, op. cit., p.1142.


going to substitute for her lost breast must be uppermost in the patient's mind. Seligman says:

Each year more than 50,000 women in the United States face the problem of how to look and feel normal after a mastectomy. Surgeons have long recognized the importance of a comfortable, well-fitting prosthesis as necessary to the rehabilitation of these patients. The sooner these women resume their normal interests and activity, the more rapidly they recover, both physically and mentally. Nothing demoralizes these patients more than the thought of facing life knowing they look and feel 'different'.

Renneker and Cutler concur when they say:

Early in the postoperative phase the doctor should arrange for a woman to discuss prosthetics with the patient.

It would seem that there is no "woman" in a better position to discuss this with the patient than her nurse. But the latter must have a knowledge of the various devices that are available, their relative cost, and where they can be obtained. It rarely suffices to tell the patient that she should go to a surgical supply house or a corset shop. What, where, when, and how, need to be answered specifically. Although Dr. Lewison says that most patients feel that it is the obligation of the surgeon to supply this kind of information to his patient, experience tells us that this is too frequently a responsibility tacitly assumed by him to belong to someone else. The nurse who is interested in a well-adjusted patient ought to be sure that she is the "someone else".

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23 Renneker and Cutler, op. cit., p.635.

24 Lewison, op. cit., p.322.
Another area in which it would appear that the nurse might rightfully assume teaching responsibility is that of helping the patient to regain the use of her arm. Exercises for return of maximum function to the arm must be prescribed by the doctor before they can be taught and supervised by the nurse. Dr. Lewison feels that on the seventh to tenth day post-operatively patients should begin to use but not abuse their arm. Many doctors urge their patients to begin simple exercises as soon as forty-eight hours after operation in order to maintain as much range of motion of the shoulder joint as possible. There are numerous articles in both medical and nursing journals, as well as surgical and rehabilitative texts, which describe simple exercise routines that aid in restoring complete function to the affected arm. Almost without exception these have been based on the exercises described and pictured in the pamphlet Help Yourself To Recovery, written by three women, Bernhardt, Lasser, and Radler. This is an excellent visual aid for both physician and nurse to use in their teaching of the patient as well as to give to the patient for her own use. This little publication correlates the activities of daily living with the kind of purposeful exercise that will provide a particular kind of desirable motion. In addition it intersperses other pertinent material designed to create for the patient a wholesome and effective approach to her own rehabilitation.

Probably the most widely neglected area of health teaching for all women, to say nothing of the post mastectomy patients, is the technique of


breast self-examination. When one considers the incidence of breast cancer and the comparatively high rate of recovery for those whose disease was discovered and treated in the early stages, it seems incredible that most nurses rarely consider the teaching of breast self-examination a professional responsibility of major importance. In his preface to Haagensen's book Carcinoma of the Breast, Dr. Charles S. Cameron has this to say about the value of the practice:

Because most of the patients with breast cancer discover the lump themselves - accidentally - we firmly believe that at least half of these deaths would be preventable if the practice of self-examination of the breast (taught to women by their family physicians) became widespread. In the instance of each accidentally discovered lump, one cannot but wonder how much earlier it would have been found if the woman had deliberately examined her breasts regularly, systematically, and knowingly.

In his discussion of the same subject Haagensen presents this additional thought:

It is possible that, from the point of view of the greatest possible gain in early diagnosis, teaching women how to examine their own breasts is more important than teaching the technique of breast examination to physicians, for we must keep in mind the fact that at least 98 percent of the women who develop breast cancer discover their tumor themselves.

Although both of these doctors stress the importance of physicians teaching the patient, nowhere did this writer find any evidence that this was not a technique that could be safely taught to the patient by a nurse. The movie Breast Self-Examination, produced for the American Cancer Society, Inc., is one which all nurses should see and know about. Arrangements for the

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28Ibid., p.7.
showing of this to organizations can be made through a local chapter of the Cancer Society. As part of their community responsibility, this would seem to be a very worthwhile suggestion for nurses to make to lay groups. Certainly if part of a nurse's professional responsibility is that of health promotion, she must be aware of the materials at hand which describe more graphically than words the techniques and practices that help to promote health.

Frequently the patient who has undergone radical surgery for carcinoma of the breast wonders whether this might have resulted from breast feeding her children. Although there is little written about this aspect of the disease the following opinion is expressed by Jessiman and Moore:

> The establishment of lactation and the act of nursing a child reduce the likelihood of later development of cancer of the breast. Numerous statistical surveys of incidence have shown this disease is commoner in those who are less fertile. Nursing mothers have a lesser incidence than those who do not nurse; a nursing period of three to six months appears to be safest from this point of view.  

Another question which may be of deep concern and a source of real anxiety to the young woman who has had a radical mastectomy is that of the safety and advisability of future pregnancies. This is a subject about which there has been wide divergence of opinion in the past. Pollack summarizes the opinion to which many doctors now seem to subscribe:

> The key point in this group of patients is the extent of the breast cancer at the time surgery is performed. This, in general, is largely determined by a number of axillary lymph nodes (or internal mammary) involved. It has been shown that patients with cancers limited to the breast will do well despite pregnancy or nursing. However,

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those with axillary node involvement do very poorly. If, therefore, a patient has no axillary metastases (and one may say internal mammary node metastases on the basis of location of the lesion) at the time of her operation, future pregnancies would not be contraindicated. On the other hand, patients who did have axillary node involvement would be wisest to avoid pregnancy in the future, at least until an arbitrary interval of three to five years.

The writer has attempted to demonstrate in the foregoing pages her personal philosophy regarding the specific needs of patients who have had a radical mastectomy for cancer of the breast. The responsibility of the nurse for meeting these needs has also been considered. An effort has been made to substantiate this philosophy with the research and opinions of many who have had wide experience in this area of surgery. Perhaps this can be best summed up in the words of two authors: Bard, who expresses the needs of the patient, and Barckley, who indicates the satisfaction to the nurse who sincerely tries to meet the needs. Bard says:

We must be entirely realistic in appreciating the terrifying nature of surgical experiences, particularly when an organ of great psychic significance is involved. Radical mastectomy patients need warm support and understanding if they are to meet the threat of the situation. If this support can be routinely forthcoming to all patients, many women will be spared intense emotional reactions and limitations in living. The radical mastectomy patient can live a full life after cancer surgery but only if we accept our obligation to aid in the process of reducing trauma and restoring function.31

And Barckley leaves us with this thought:

Cancer nursing is often tiresome and discouraging. We find it irritating or even infuriating at times, for we are women and not angels. But it is deeply rewarding to give service to those who are suffering; it is a privilege


to be close to people who need us so desperately. There is both beauty and excitement in this work, and in the discovery of it we become worthy of man's great heart and brain; without this appreciation and response the spinal cord would be sufficient.32

Bases of Hypothesis

Throughout this chapter the writer has indicated the responsibilities that physicians and nurses have toward patients who must adjust to the psychological and physical trauma of radical surgery for cancer of the breast. It is the further purpose of this study to demonstrate that although both nurse and patient perceive the same needs, there is a lack of agreement between the two groups as to how well these needs are met. It is on this basis that the following hypothesis has been predicated:

Women who have had a radical mastectomy for carcinoma of the breast have specific psychosocial and rehabilitative needs, and although nurses have an intellectual understanding of these needs, they lack the necessary skills to assist patients to make an emotionally and physically desirable adjustment to their future lives.

32Virginia Barckley, op. cit., p.318.
CHAPTER THREE

METHODOLOGY

Development of Interview Guide
and Selection of Patient Sample

In order to fulfill the purpose of this study, namely to determine
the extent to which nurses recognize the specific needs of radical mastectomy
patients and how well they think that they meet them, it was necessary to
construct a study design which would yield data not only from nurses but also
from patients who had undergone this type of surgery. Accordingly two lines
of investigation were instituted.

The securing of data from former mastectomy patients proved to be
the more difficult of the two investigations. Before attempting to select
patients, criteria were established with the belief that patients who
qualified within these standards would yield the most valid results for this
study. It soon became evident, however, that less rigid qualifications would
have to be accepted if the data were to be collected within the time pre-
scribed for the study. Accordingly the following criteria were decided upon
with the knowledge that although more realistic they are not ideal.

No patient would be selected for the study who:

1. was over the age of fifty-five at the time of operation
2. was operated on more than six years ago
3. had received nursing care from a student nurse
4. was a graduate nurse.

The writer believed that for the purpose of this study it would be best to
limit the group to those not over fifty-five because there is evidence to
prove that women in the post-climacteric period experience less psychological trauma as a result of breast surgery than do younger women.33

Although the writer would have liked to interview patients operated on much more recently than six years ago, several pilot interviews indicated quite vivid recall of the specific points that were under investigation. To have gone beyond a six year period would seem to have put too great a burden upon the memory of the respondent and might possibly have resulted in hypothetical answers to the questions or none at all. If the patient had received nursing care from a student nurse, it seemed conceivable that there might have been considerable teacher-direction behind the application of principles of rehabilitative nursing. Lastly, to interview nurses would probably have led to some invalid answers inasmuch as one could assume that a professional nurse, through experience and education, would have had some basis at least for meeting her own needs. She would probably have relied less on either doctor or nurse for this. In addition to applying the foregoing criteria in the selection of patients, an effort was made to include both married and unmarried women in the study. This was successfully accomplished.

As a first step in finding patients for the study, letters were written to five doctors in two communities in the greater Boston area, giving the credentials of the writer, explaining the purpose of the study, and requesting the names of patients whom they considered would be not only suitable but willing participants in the study. A copy of this letter appears in Appendix A.

This method of trying to secure the names of patients was not too successful. One doctor responded immediately, submitting the names of four

33Renneker and Cutler, op. cit., p.835.
patients upon whom he had operated in the past. A second doctor sent the name of one patient. From the third surgeon came the request for a copy of the letter that would be sent to the patient. He did, however, indicate more than a casual interest in the study and wrote that he had three patients in mind whom he thought might fit in very well. Unfortunately, and in spite of a follow-up letter and a telephone conversation with his secretary, no patients were referred from this surgeon for the study. It is interesting to speculate on the reason why the other doctors did not respond. Was it really lack of time and interest? Or could it have been their own inherent feelings about cancer of the breast and radical mastectomy? There was some evidence of this when the writer had occasion to broach the subject quite casually to two doctors to whom she was talking in a non-professional capacity. They conveyed the distinct impression that this was a subject better left alone. On another occasion, when the writer was part of a panel, the purpose of which was to promote breast self-examination, there was a definite denial on the part of a participating surgeon of any belief that there was psychological trauma attached to this operation. One rather wonders, at times whether patients and nurses have a job to do in educating the doctors. Renneker and Cutler would seem to concur.34

To the patients whose names were submitted by the two cooperating physicians, a letter was sent by the writer, again giving her credentials, explaining the purpose of the study, and requesting an interview. A copy of this letter appears in Appendix B. A postal card was enclosed which the patient was asked to return to the writer stating whether or not she wished to participate in the study and indicating a convenient date and time for the

34Renneker and Cutler, op. cit., p.833.
interview. Cards were returned from three of the five patients, each agreeing to be interviewed. By telephone, interviews were arranged with the three respondents and then an interview guide was constructed.

Several decisions were made before the actual interview guide was constructed. Because the writer was interested primarily in discovering from the patients to what extent they felt that nurses had met their needs, it was arbitrarily decided by the writer to pre-identify four needs, specific to the patient who had had a radical mastectomy and omit the common needs of all patients who have had major surgery of any kind. The following needs, therefore, were those around which the interview guide was built:

1. recognition of the multiplicity of psychological and emotional problems involved
2. demonstrations, discussion, and supervision of the exercises and activities which would help to restore maximum function to the arm and shoulder
3. information about prosthetic devices
4. information, demonstration, and teaching of breast self-examination.

Since the writer wanted this very definite kind of information, a focused interview using chiefly "open-ended" questions, interspaced with some "fixed-alternative" questions, was the technique decided upon for the interviews. As Selitiz et al have said:

The interview is the more appropriate technique for revealing information about complex, emotionally laden subjects or for probing the sentiments that may underlie an expressed opinion.35

In regard to "open-ended" questions, the same authors have this to say:

The "open-ended" question is designed to permit a free response from the subject rather than one limited to stated alternatives. The distinguishing characteristic of open-ended questions is that they merely raise an issue but do not provide or suggest any structure for the respondent's reply; the respondent is given the opportunity to answer in his own terms and in his own frame of reference.36

In all cases the respondents knew that the writer, too, had undergone a radical mastectomy. Because of this, it was decided that to open the interview with a discussion of a common problem, namely that of a suitable prosthesis, would perhaps create a degree of rapport that would result in freer expression of feeling and opinion in the subsequent areas of questioning.

A copy of the interview guide is contained in Appendix C. Thirty-six questions were decided upon: ten of these referring to the selection of a prosthesis, sixteen to the psychological factors involved, six referring to exercises and the return of function to the arm, and four to the subject of breast self-examination.

As has been previously indicated, the names of three patients willing to participate in the study were obtained through two cooperating physicians. Through the interest of one of these patients, interviews were granted by three additional women, acquaintances of this patient whom she knew only because of their common problem. Again from one of this latter group came the name of the one person in the study who seemed best able to verbalize many of the problems which so frequently beset women who have undergone radical mastectomy for cancer of the breast. To this group of seven was added a patient whom the writer had been asked to see by a friend.

36 Ibid., p.257.
the previous summer, three weeks after her surgery had been performed. These eight patients, then, made up the group who were interviewed in order to obtain information about what they perceived as their needs and the extent to which they felt that nurses met these needs. A brief vignette of each patient will be given in the following chapter. With the exception of one, all interviews took place at the homes of the patients. The eighth patient came to the house of the writer because ten months after the operation the patient's mother was still not aware of her daughter's operation. The average time for each interview was approximately one hour and a half. The writer took notes during the interview with the respondent's permission.

Development of Questionnaire for Nurses, Selection of Sample, and Procurement of Data

The second set of data for this study was collected from a group of graduate nurse students currently enrolled in a University General Nursing Program. A two-part questionnaire was developed with two purposes in mind. It was assumed that most of these nurses had had some instruction in the comprehensive care of radical mastectomy patients. Therefore the first part of the questionnaire was designed to test the nurse's ability to draw upon past experience and education by identifying and listing four specific needs which she felt all radical mastectomy patients had. It was thought that the results of this kind of questioning might give some indication of whether these needs would be recognized by the graduate nurse without specific reminders from someone else within the nursing hierarchy. Since it was also assumed that there would probably be a range of ages represented in the group, it was thought that it might be possible to find some correlation between the ability to identify these specific needs and the number of years
that had intervened since graduation from nursing school. Since there has been a much greater emphasis on the rehabilitative aspects of nursing as well as the psychological implications of cancer surgery in the past few years, it was felt that the years in which nursing education was obtained might be a factor in the teaching and understanding of the radical mastectomy patient.

The purpose of the second part of the questionnaire was to obtain factual, easily standardized information in regard to attitudes and understandings, knowledge of teaching content, and some indication of what is done in the actual nursing situation. There were twenty-nine questions involved in this tool. The first nine were developed to give information about the nurse herself in relation to age, education, and previous experience with radical mastectomy patients. There were eight questions, one with three parts, which were designed to ascertain understandings and attitudes about the psychological implications of both the operation itself and the diagnosis of cancer. The next ten questions involved both knowledge and attitudes in relation to exercises and prostheses. The last two questions, of which the first had eight parts, was structured to determine the nurses' knowledge of breast self-examination, and the responsibility they assume for performing this technique themselves and teaching it to radical mastectomy patients as well as to other women. A copy of this questionnaire appears in Appendix D.

It has been previously indicated that the nurses to whom this questionnaire was submitted were graduate nurses enrolled in an undergraduate General Nursing program at a university. The students were in the first year of this program at the time of the study. The permission of both the chairman of the General Nursing program and the instructor of one of the nursing courses was obtained prior to the administration of the question-
naire during a session of one of the nursing classes. In the interest of getting as free a response as possible, the students were asked to identify their papers only by number, this in order for the writer to be able to compare the identification of the free response portion of the questionnaire with the fixed-alternative questions on the longer questionnaire. The students seemed to be willing participants in the study and appeared to consider their answers thoughtfully.
CHAPTER FOUR

PRESENTATION, ANALYSIS, AND DISCUSSION OF DATA

Introduction

This chapter is concerned with the presentation, analysis, and discussion of the data obtained from the interviews with eight former radical mastectomy patients and from the questionnaire administered to forty-two graduate nurses. These data collected from each sample will be first analysed separately and discussed within the framework of the four needs pre-identified by the writer before constructing the interview guide and the questionnaire. Then it will be possible to compare the data from each group in terms of mutually perceived needs and the extent to which each group believed that the needs were met.

It was satisfying but, in retrospect, rather disheartening to the writer to be so warmly received by the eight patients who granted interviews for this study: satisfying, because in each case it was possible to establish a degree of rapport that made the interview successful; disheartening, because many of the patients, in spite of the time lapse since their operation, still had a need to verbalize some of their fears and problems. There is no question in the mind of the writer that the mutual experience shared by both patients and writer was a very potent factor in the ease with which the interviews proceeded. As noted in the previous chapter, all patients with the exception of one were interviewed in their own homes. The patients received the writer most graciously and in most cases had coffee or
a cool drink ready to serve. All had attractive homes so that it proved very easy to get into a warm-up period of conversation about preference for different periods of furniture and decor. In some instances this warm-up was terminated by the patient herself saying, "But this isn't what you came for," or the writer hazarding a guess as to which side was the affected one. Almost invariably the question of prostheses arose immediately, and following a usually lengthy discussion of this subject, it was possible to pursue the interview according to the plan of the guide. Because no two patients' experience and problems were exactly the same, each will be presented in a short vignette in order to better indicate the differences in their perception of their needs and the extent to which they considered these to have been met by nurses. The patients have been coded from A through H for easier identification throughout the rest of the chapter.

Presentation and Discussion of Data from Patients

Patient A was a fifty-three year old woman operated on for cancer of the right breast in March, 1959. Mrs. A is married, the mother of two married children, and an "avid gardener and fanatical golfer," to use her own description. Although Mrs. A seems to be well adjusted to both her operation and her diagnosis, she admitted that it had not always been true. From the time that she discovered the lump until several weeks after the operation she was convinced that her days were numbered. She at first decided not to go to the doctor at all: "I was going to live it up and die quickly," were her words. It was her husband that convinced her of the foolishness of this decision when she finally confided her worries to him. The patient went to the hospital with the knowledge that she might have more than a biopsy, but her doctor never discussed with her the possibility of
extensive surgery. Postoperatively Mrs. A had a special nurse and then was taken care of by staff nurses. There was no indication on the part of any of the nurses that she had anything to worry about. There was no discussion or advice given on any phase of her rehabilitation. The patient believed that this was partly her fault in that she thought that nothing but time would serve to allay or confirm her fears, so she asked no questions. In retrospect she realized that the nurses should have anticipated some of her more "practical" concerns and given her some information about the kinds of prostheses that were available and where they could be obtained. This would have saved a great deal of frustrating trial and error and a considerable amount of unnecessary expense. She would also have appreciated suggestions about how to most effectively exercise her arm, the sooner to be able to play golf. Actually, because of her own persistence, she was able to resume play about the middle of July, three and one half months after her operation. At the time of the interview she was looking forward to a full season of golf and gardening.

Patient B was a forty-four year old married woman with two school aged children. Both she and her husband lead an extremely busy life, active in their church, the P. T. A., and the Scouts. Mrs. B was operated on in March, 1958 for cancer of the breast. She was the only patient interviewed who was prepared for her operation not only by her doctor but through previous acquaintance with a well adjusted mastectomy patient. Her physician had been watching a "lump" for several months, finally decided that it should be biopsied, and prepared Mrs. B completely for not only extensive surgery but for the diagnosis of cancer. The patient believed that his frank but sympathetic attitude would have been sufficient to start
her well along the road to acceptance of the operation. The fact that her mother-in-law, now dead, had had a radical mastectomy a number of years before, and had made a remarkable adjustment, was a source of encouragement to Mrs. B and gave her the determination to do likewise. In addition, there was not enough that the patient could say about the sympathy and understanding afforded her by her husband. Mr. B seemed to be a very extroverted individual who quite willingly (and at the request of his wife, not the writer) participated in the latter part of the interview. He readily admitted that the contemplation of this kind of operation for one's wife was a threat to the husband as well. It filled him with fear for her welfare and the welfare of their children as well as raising doubts about his own ability to accept the disfigurement. However, Mr. B said that these worries were transient and that "any man who let this kind of thing interfere with a happy marital relationship needed a psychiatrist worse than his wife needed a surgeon." So with such an auspicious beginning to the ordeal of a radical mastectomy, it was unfortunate that there was anything to mar a completely successful adjustment to the operation.

The question of an adequate prosthetic device was the one area in which Mrs. B had a great deal of frustration and needless expense. Her doctor had merely told her to go to a good corset shop and that she would be told what to buy. Unhappily, Mrs. B had to do a great deal of experimenting before she found a surgical corsetiere who recommended Identical Form. The patient is a large breasted woman for whom this particular prosthesis is most suitable. Not to have had this need recognized by the nurses in the hospital, and the necessary information given to her, caused this patient a great deal of unnecessary worry and expense. It almost
undid all the very excellent support given by her physician. Fortunately, at the end of a year of experimentation, she heard about Identical Form and is very satisfied with it. Now she appears to be a very happy woman, confident that she has not only a probable cure but that outwardly she presents a perfectly normal, feminine appearance.

Mrs. B was a very sensitive, intelligent woman who, without bitterness, decried the lack of empathy that nurses seemed to have with a patient who has undergone a radical mastectomy for cancer. This has bothered her to the extent that she has "advertised", as she said, all over town the fact that she has had this operation, has survived, and is an active, happy participant in a very full life. She discusses breast self-examination "at the drop of a hat" and urges one and all not only to develop this habit but to have regular medical examinations. She feels so strongly about the needless worry that so many patients have experienced that she has volunteered to visit future patients of her physician in order to allow them to benefit from her experiences. In fact, it was this patient through whom it was possible for the writer to eventually reach four of the patients interviewed for the study. She did all the telephoning for the writer and called several times to be sure that nothing had happened to prevent the interviews from taking place.

Mrs. B is a remarkable woman, but the writer wonders how this patient might have reacted if she did not have the particularly thorough preparation provided by the doctor and the example of her mother-in-law to give her courage. The writer is well acquainted with the more frequent reaction of this particular ethnic group to serious illness. The writer can only regret that the patient could not credit a single nurse with any part
in her successful rehabilitation.

The third patient whom the writer interviewed was a most attractive, unmarried woman who belied her fifty-two years. She was operated on for cancer of the breast six years ago, in 1954. Miss C's rather startling comment when we began the interview was "I began to live when I knew that I was going to die." And she quite literally meant this, as her story proved in the telling. Quite accidentally Miss C discovered that she had an extensive pathological condition in her breast. Upon hearing a business acquaintance tell of the recent radical mastectomy that a friend had undergone, the patient decided that she should have a medical check-up. She did, and was utterly horrified at not only the discovery of a pathological condition but one of such evident seriousness that the doctor wanted her to go to the hospital that day. His whole implication, Miss C said, was that probably ten years ago would not have been soon enough. When she arrived at the hospital several days later, the question was asked of her by three nurses, "Why did you wait so long?" From that day to this she has never heard the word "cancer" mentioned by the surgeon, who is also her family doctor, but he never fails to almost audibly gasp each successive time that she walks into his office for a check-up.

Miss C attributes her very slow convalescence to the "dismal" attitude displayed by all the personnel with whom she came into contact at the hospital. No one talked to her about anything because, she supposed, "everyone thought I was going to die and obviously they couldn't talk about that." The nurses did, however, institute a regular exercise regime for her arm and urged her to continue the exercises at home. As a result she has never had any loss of function. She was convinced, though, when she left
the hospital that she was going home to die and "she acted the part." She lost weight because she did not eat - but attributed it to the ravages of cancer. She became anemic and pale - and blamed it on the "cancer look." She had no interest in anything because she had no way of knowing if she would even have time to "finish a book." This was obviously an intolerable existence, particularly when in her heart she knew that she did not feel as ill as she should. After a little more than a year, when she had made several futile attempts to return to work, Miss C accepted the invitation of some friends to go to Florida. Strangely enough, she had a good time. She ate, she gained weight, her color was better, and she returned in a month to her position in the telephone company - but still not convinced that she did not have incurable cancer that would soon make its presence known again. When, in the late spring, there seemed to be no slowing down in her apparent return to health, she decided that she might as well "die happy." She had always wanted to go to Europe and so she went. She was planning her fourth trip when the writer interviewed her, as happy and healthy a person as one could hope to see. But at what a tremendous cost to her! and all for the lack of insight and empathy that would have made it possible for this patient to talk out her fears. She really interpreted the complete silence regarding her condition and probable prognosis to mean utter hopelessness. To have discussed this with the nurses or the doctor, the patient thought, would have caused them pain and embarrassment--so she refrained. Remarkably, though, Miss C has no bitterness toward anyone. She has a very deep faith and firmly believes that she is a better person now than formerly, is giving more of herself to others through charitable work, and is receiving much more than she gives.
A suitable prosthesis has never been a problem to Miss C. She is a very slim woman with small breasts so that a "falsie" has always been adequate. But never since her operation has she worn an evening dress or cocktail dress that was low-cut. It has been only in the last two years that she has been able to bring herself to wear a bathing suit, although swimming has always been her favorite sport. Miss C does do breast examination fairly regularly. She never advocates this to friends or acquaintances, however, because she never talks about her operation.

The fourth patient whom the writer interviewed described herself as a "stoical Presbyterian" whose religious philosophy made it incumbent to accept life as it came and to try to make the best of it. Mrs. D was a fifty-four year old woman with several grown-up children. She was operated on in 1956. Mrs. D discovered a drawn-in area on her breast one day and, accompanied by her husband, went almost immediately to the doctor. Her family physician was an elderly man; kindly and sympathetic, who discussed with husband and wife the possible implications of the abnormal area on her breast. He frankly admitted that it was probably malignant but felt that it was localized and that her chances of cure were good. His diagnosis proved to be correct when a biopsy was done and a radical mastectomy was therefore performed immediately.

Mrs. D was the second patient who attributed her rapid recovery, mentally and physically, to the excellent preparation given to her by her doctor and his continued support and encouragement during the postoperative period. It was he who suggested the use of an Identical Form which has proven very satisfactory. Although this patient admitted to some temporary depression following the operation, - "after all no one really likes to lose
part of herself" - her real concern was whether she would have full use of her arm. Mrs. D is a pianist and supplements her husband's income by teaching piano to a rather large group of students. Obviously, not to have full range of motion on her affected side would have been a tragic situation for this patient. Although she did not recall a definite set of exercises, Mrs. D remembered both the doctor and nurses in the hospital telling her how she could exercise while doing her housework. And as she said, "I played the piano even when it 'killed' me, so determined was I to play well again." This kind of perseverance was rewarding because the patient does have full use of her arm and plays beautifully.

When asked about breast self-examination, Mrs. D said that the doctor watched her closely for a year and suggested that she watch her other breast closely. Shortly after her physician's death, the patient saw the movie "Breast Self-examination" and said that she now regularly examines her breast using that technique.

Patient E was a young woman thirty-seven years old who had her first mastectomy four years ago in another state. She was told at the time that a "pre-malignant" condition existed which did not require as radical an operation as some. She was told that all her breast tissue and the glands under her arm were removed. Shortly after moving to Massachusetts she decided, following a regularly performed self-examination of her remaining breast, that there were changes that might be danger signals. Subsequent examination by a doctor indicated chronic cystic mastitis and simple mastectomy was recommended. There was correspondence between the first surgeon and the second. It is possible, the writer presumes, that the patient may not have been told the true extent of her disease at the
time of her first mastectomy. However, one could not guess, from looking at her, how radical the first operation was. At any rate the patient was extremely casual about the entire procedure and did not reveal any residual fear of a recurrence, nor did she apparently ever believe that there had been much about which to worry. Mrs. E felt that she had been extremely fortunate to have learned the technique of breast self-examination through watching the Cancer Society movie and happy that she had been faithful in examining herself.

As Mrs. E said, "As soon as my second breast was removed I had no further problem with a prosthesis." This patient, too, is small and has found that a padded brassiere with sponge rubber forms is both adequate and comfortable. She did not have any appreciable difficulty in regaining the full use of her arm after the first operation and, of course, none after the second. However, she does feel that her right arm is weaker than the left - the right side being the site of the more extensive surgery. She did not recall that anyone specifically mentioned doing exercises following the operation. Her doctor told her to gradually resume her household chores and not to favor her arm.

It was interesting to note that Mrs. E, regardless of what she said she believes about her diagnosis, is a very vocal disciple of breast self-examination and frequently urges her friends to be faithful to their examination. She has taught several of her friends the technique and rounded up a large contingent of friends to view the movie "Breast Self-examination" when it was shown several years ago in the local theatre.

The sixth patient whom the writer interviewed had apparently given the prospective interview considerable thought ahead of time. Mrs. F was a
former social worker and obviously had considerable knowledge of the psychological and emotional implications of this type of surgery. After a very brief introductory conversation, the patient herself said, "I suppose you are chiefly interested in how well I adjusted to this operation emotionally." She then went on to say that she was a very stable personality with a most understanding and sympathetic husband and that there "just were not any real problems." And the writer felt that this was probably quite true. In the subsequent conversation, as the patient talked about the contrasting problems that she was experiencing with her two 'teen-age' sons, one could detect a very insightful personality accustomed to looking deeply for the reasons behind a particular kind of behavior. To be able to analyze one's own reactions to threatening and traumatic experiences so that they do not cause emotional disturbances is indeed an asset, but Mrs. F was capable of this and adjusted easily, therefore, to the trauma of radical surgery.

Mrs. F had known for some years that she had chronic cystic mastitis and had regularly examined her breasts for any overt changes. During a regular medical check-up her doctor decided that there had been sufficient change in the feeling of one gland to warrant a biopsy. He indicated at the time that if this proved to be malignant, or even "suspicious," a radical procedure would be the safest course to pursue. This proved to be the case, and as was true with another patient, the diagnosis was "pre-malignancy."

There was no planned teaching, Mrs. F said, on the part of the nurses in regard to exercises nor did they give her any information about prostheses. However, she felt that her ability to talk about her diagnosis, her evident acceptance of the disfigurement from the start, and her lack of
questions perhaps gave the nurses the impression that she needed no help. She did believe, though, that the nurses ought to definitely anticipate the patient's need for information about the different kinds of prosthetic devices and where they could be obtained. Mrs. F happened to know, but as she said, "The nurses couldn't be sure that I knew."

At the time of the interview Mrs. F confessed that she had been feeling a "lump" in her other breast for several weeks and just had not gone to the doctor due to a busy schedule. Apparently the prolonged discussion of the former operation provided a sense of urgency because Mrs. F said she was going to call the doctor as soon as the writer left. The patient said she had always urged her friends to practice breast self-examination and she, too, had brought many of her acquaintances to see the film "Breast Self-examination" when it was shown in the local theatre several years ago.

Patient G was a thirty-eight year old, unmarried woman, an attractive blonde, very smartly attired. This was the one patient whom the writer saw in her own home, and Miss G drove to the interview in a large, heavy car which she managed with apparent ease. This young woman is a teacher of remedial reading in a large city school system and appears to be a very well-educated person with a vital interest in her work as well as in her social and cultural activities. Miss G was operated on at the close of the school year in June, 1959, at a small community hospital near her home. About three weeks after the operation a mutual friend asked the writer to visit the patient because she was depressed and bewildered and seemed in need of some concrete advice and help. At that time the writer demonstrated to the patient the usual exercise regime devised to get as complete a return of function to the arm as possible. The question of a suitable
A prosthesis was of real concern to the patient. The various kinds of devices were discussed as well as their relative cost and where they might be obtained. One kind of prosthesis was demonstrated to the patient as one that might be suitable for her rather small figure. The patient had a number of personal problems that were discussed and since the fear of recurrence was one of those verbalized, breast self-examination was explained, but demonstrated only in a superficial manner. The writer suggested that the patient might ask her doctor to demonstrate this technique more fully.

When Miss G was seen ten months later for purposes of this study, she was quite a different woman - confident, happy, and apparently well adjusted to her operation and diagnosis. The word "apparently" is used because one problem had still not been resolved and that had been the patient's chief postoperative concern. Because the patient's mother had a severe heart condition she was not told about her daughter's operation or diagnosis. During Miss G's hospitalization and convalescence at a sister's home (where the writer first saw her), her mother thought that she was visiting another sister in a distant city. At the time of the interview, almost a year later, the mother was still unaware of what had happened. The patient hoped that she would never have to know. The writer wondered whether or not Miss G, herself, had more than the normal impatience for the three year "presumptive cure" period to pass. This is obviously a normal worry of considerable proportion to any post-mastectomy patient. Presumably, however, it could become an ingrown, gnawing fear that would make life a sort of day-to-day search for a new "lump." The fact that her incision had not completely healed ten months after the operation was also
a source of worry to the patient. "Did this represent 'unhealthy' tissue which wouldn't heal?" was perhaps the patient's unasked question.

In all other aspects Miss G seemed to have made an excellent recovery. She had full use of her arm and was delighted that she could write on the blackboard at any height. As mentioned before she managed a heavy car with ease, she looked well and said that she had never felt better in her life. Although she had bought the kind of prosthesis that the writer had shown to her originally, and liked it, her doctor had advised her to go back to a soft cotton padding until her incision was entirely healed. Miss G said that since she visited the doctor so frequently, breast self-examination had not been necessary. She did promise, however, that this would become a regular habit when she no longer needed such constant medical care.

The eighth and last patient to be interviewed was one who either represented a woman much more emotionally disturbed by both her operation and diagnosis or one who could more readily verbalize the tremendous psychological impact of this operation for her. Mrs. H is a thirty-three year old woman operated on in November, 1957. She is the mother of three children whose ages now are thirteen, ten, and five. The patient is very active in all kinds of community affairs and has been able to resume full participation in these activities.

Only because it seems indicative of the depth of Mrs. H's inability to accept her disfigurement will the writer describe briefly the effort involved in securing the interview. Another woman who had been seen previously in connection with the study made the original contact with Mrs. H. She seemed not only willing but rather anxious to be interviewed by a
nurse. When the writer called to arrange a date and time, the patient pleaded a busy schedule and asked the writer to call again on a specific day. For six weeks this went on, and each time the answer was the same. However, the writer persisted not only because the referring respondent had indicated that the patient needed help but because Mrs. H, herself, never gave any indication that she really did not want to be bothered. The situation was interpreted by the writer to mean that the patient wanted to talk but could not bring herself to do so. When the interview finally took place, the reason for the prolonged delay was almost immediately apparent. After some preliminary conversation, the writer made a comparison between the patient's shoulder and her own. As though night had turned into day, the patient's expression changed completely and she almost gasped, "Have you had this operation, too?" The thought had not occurred to the writer that the respondent had not communicated this information to Mrs. H and that the latter had only interpreted the interview in terms of talking about something which was painful, to a person who could not possibly understand her feelings. Once the fact of the mutual experience had been established, the flood gates came down. Mrs. H really had problems and fears that none of the other respondents revealed. Whether they had them or not is still their secret.

Mrs. H is a member of an ethnic group whom, she said, have an inordinate pride in their feminine appearance and a real desire to wear "high-style" clothes - particularly at cocktail or dinner parties or other festive occasions. In her circle of friends this means low-cut, strapless dresses for social occasions and the briefest of bathing suits for beach wear. According to her present belief it is no longer possible to even
approximate the glamor of her friends' clothes and this is indeed a very real tragedy. The patient demonstrated the degree of this feeling when she told the writer that just the day before, while attending a wedding, she had gone to her car and cried bitterly because she felt that she looked "old and matronly" in the kind of dress she felt forced to wear. She considered this to be unfair and degrading, at the same time realizing the unreasonableness of such an opinion. In some respects Mrs. H's problem did center around a prosthesis that would give her the cosmetic result that she desired. Unhappily the high, uplift effect that she coveted probably could not be achieved with the available devices. The patient had experimented enough to know that this was so but the truth did not make her happy.

The patient also had a tremendous amount of feeling about her husband's reaction to her disfigurement. This was purely subjective on the part of Mrs. H. In two years she had never undressed in the same room with her husband and said that he would never view this "horrible and ugly scar" in the light of day. She said that she felt like half a woman and asked how he could in his heart really feel differently. The patient admitted that she had not been able to discuss this with her husband, even though she said, "I knew that I didn't have to worry about my husband. He only thanked God that I discovered the lump when it was so small." When asked if she had thought of discussing this with a nurse, her answer was that the nurses in the hospital were either too young and unmarried or too old to understand. And "besides, none of them had a warm personality that you could confide something like this to, anyway." (The writer is not attempting to equate her personality with the patient's concept of a "warm personality." The parallel situation of both writer and patient in terms of a common experi-
ence at approximately the same age was very apparently the factor that contributed to the degree of rapport that was established.)

Mrs. H also verbalized other fears that she had at the time of operation, and still has to a certain extent. She confessed to being so uncertain about how long she would live that she cancelled the order for a new washing machine on the basis that she had no idea what plans her husband would make for himself and the children. The fact that her doctor never mentioned the word "cancer" added to her fears. As one other patient did, she also equated this silence with hopelessness. All her doctor ever said was that he did what he had to do and he was sorry.

As far as instruction about exercising her arm, Mrs. H said that no specific regime was either described or demonstrated to her. However, one nurse did tell her that it was important to start using her arm and that gradual resumption of her household work was as good exercise as she could get. Fortunately the patient has complete use of her arm although she still finds that her arm becomes very tired when she does too much heavy work.

Mrs. H was operated on in November, 1957 and in the spring of that year she had seen the film "Breast Self-examination." Each month after that she did examine her breasts very carefully and regularly. In October she felt no lump. In November she did. Although "shaking as though she had a chill," she went to the doctor the next day and her worst fears were confirmed. Since her operation Mrs. H said that she has never missed examining her breast regularly. She said that her friends get tired of hearing her tell them to do likewise.

Although the eight patients interviewed for this study, with the exception of the last patient presented, now represent a well adjusted
group, it is apparent from a study of their histories that each one had some particular problem which might have been solved more readily had either doctor or nurses anticipated the needs. It was proven through the interviews that psychological and emotional problems were present in varying degrees but were not verbalized by the patients while they were in the hospital - largely because nurses gave no indication that they realized these worries and fears were present. Teaching in relation to exercises and breast self-examination was almost entirely lacking. In no case did the patients learn anything about prostheses from the nurses. In some instances considerable support and some information about prostheses was given by the doctors but even this seemed woefully inadequate. In spite of this, however, the writer did not find that the patients were bitter toward either doctors or nurses for not giving them more help in solving their problems. All patients agreed that they would have appreciated information about prostheses from the nurses. They were of the opinion that this was one area in which nurses should assume the initiative in giving information, whether the patient asked for it or not. They should have a full knowledge of the various devices available, their cost, where they could be obtained, and their advantages and disadvantages. The interview seemed to point up for many of the patients that if a nurse had shown a more empathic attitude and encouraged the patient to ask questions, they probably would not have felt so alone in solving their problems and would have been less reticent about seeking advice when problems arose after leaving the hospital.
Presentation and Discussion of Data from Nurses

Questionnaire for Nurses: Part I

Part I of the questionnaire administered to forty-two graduate nurses elicited free responses from the nurses in terms of what they considered to be four specific needs of radical mastectomy patients. The results were interesting and will be discussed according to the four needs pre-identified by the writer as those she considered to be the outstanding and obvious needs of the patients who have had surgery for cancer of the breast.

Psychological Needs.---In the area of psychological and emotional needs of the radical mastectomy patient there was one hundred percent agreement on the part of the nurses that this was a very important aspect of nursing care. However, there was a considerable spread in the ability to verbalize the specific psychological problems that might be implied. Fifty-eight percent of the nurses questioned were able to identify a particular aspect of the total experience that might be of concern to the patient. As might be expected, the question of the effect that this operation might have on the patient herself, in relation to her future appearance and her feeling of loss of femininity, was the most frequently identified worry that the radical mastectomy patient probably had. Second to this, and mentioned almost as frequently, was the patient's fear of her husband's reaction to her disfigurement. In many instances the respondents coupled this latter fear with acceptance of the operation by other members of the family. In no case, however, were children mentioned specifically as members of the family for whom this operation might be a source of anxiety. The fear of cancer
itself, with its insidious and all-too-frequent incidence of recurrence, was another area of adjustment in which nurses realized that patients needed an opportunity to "talk-out" their fears. This was sometimes expressed as a need to know more about cancer in general but might have implied that nurses realize that the lay person really has heard most frequently about the unsuccessfully treated cancer patient and needs facts and reassurance about the many who have been cured. Several nurses were of the opinion that patients might be overly concerned about their ability to lead useful lives following their operation. Whether this was meant in terms of unrestricted activity, partial invalidism as a result of progressive disease, or just what, was not determinable.

The other forty-three percent of the group merely stated in general terms that the patient needed psychological or emotional support, without specifying what underlying needs made this particular kind of nursing therapy important. They expressed this need of the patients in such statements as:

"Psychological approach to patient's anxieties."
"The need for emotional support after the patient's physical trauma."
"Need for a 'sounding board' to relieve their anxieties."
"Need great deal of understanding and emotional support."
"Psychological needs - patient and family."
"Need for deep understanding by nurses and doctor."

Although it is not possible or fair to guess from what frame of reference these nurses would operate in giving psychological support, the writer wonders if such generalized statements are truly indicative of a deep understanding of the basic needs of the radical mastectomy patient as they have been documented and confirmed by research. Conversely, the question might be asked whether the needs are intellectually understood but unable to
be verbalized by the nurses.

Need for Exercise.-----When one considers the tragic phenomenon of complete or even partial disfunction of a joint or limb due solely to neglect of exercise, the fact that of forty-two nurses only seventeen, or forty percent, could freely identify the need for exercising the arm post-operatively may be cause for some concern. Such was the case, however. Again this may not be indicative of actual practice. Nonetheless, with the emphasis that is being placed currently on the concept of range of motion exercises for all patients, one wonders if this is a theoretical concept only or an accepted part of a professional nurse's responsibility. Although it is true that exercises for the radical mastectomy patient must be prescribed by the doctor, one might hope that nurses would consider exercises to be such an essential part of the post-operative care that they would be easily identified as a major need.

Need for Information about Prostheses.-----Thirty-one percent, or thirteen of the forty-two nurse respondents, indicated in the free response questionnaire that patients needed information about prosthetic devices. There were a number of general statements made about the fear of disfigurement and worry about cosmetic effect that were not included in the thirty-one percent. It may well be that the respondents in question would attempt to allay such expressed fears by a discussion about prosthetic devices. It may be, too, that these respondents who merely said that the patient needed "rehabilitation" may have assumed that giving information about forms and brassieres would be an obvious part of rehabilitation. Since nurses are women first, one can only speculate as to why this would not almost automatically be the
first specific, tangible need that would come to the mind of a woman. It may be that nurses feel that a knowledge of the kinds of prosthetic devices available and where they may be obtained is common knowledge to any woman who has been patronizing lingerie departments for many years. That this is far from the truth can be ascertained by asking the question of any random sample of women.

Breast Self-examination.-----There was one hundred percent failure to mention the technique of breast self-examination in the free response questionnaire. In the light of data to be presented later, it would seem fair to presume that such a preventive aspect of health teaching was not considered by the respondents to be a specific need of the radical mastectomy patient. Since nurses should assume responsibility for giving information about the value of this technique to all women, it is perhaps more properly classified with the generalized needs of all female patients.

Table one gives a composite picture of the number and percent of nurses who identified the four specific needs as defined by the writer. Tables two and three compare the groups: 1) in terms of age level and period of nursing education, and 2) in terms of the last held position in nursing. It is interesting to note that it is the younger, more recently educated nurse who seems to have a more internalized concept of rehabilitation than does the older nurse. As suggested earlier in the study, this result was anticipated by the writer in view of the greater emphasis, in the past decade, not only on the rehabilitative aspects of nursing care but also on the more specific definition of the psychological implications of illness. It was somewhat disconcerting, however, that the head nurses and
supervisors who, combined, made up only fifty-eight percent of the older group were still in the very lowest percentage group for identification of all needs. Although this very limited sample cannot provide statistically valid conclusions, the results might well raise a question about the factors which determine progress upward in the nursing hierarchy. Is progress determined by a demonstrated ability to perform nursing at a professional level or is it more likely to be achieved by those demonstrating administrative skills?

Although nursing education was represented by only three nurses in the total sample, it seemed a promising sign for the future that these nurses could more readily identify the specific needs of the patient. Of the three, two were among the youngest of the respondents and the third was slightly below the median age of the older group.

**Questionnaire for Nurses: Part II**

The second part of the questionnaire attempted to assess attitudes as well as factual knowledge and actual practice. This yielded data that tended to confirm the hypothesis that nurses have an intellectual understanding of the problems and needs of the radical mastectomy patient but that in actuality they do not demonstrate a high degree of correlation between their intellectualized knowledge and their practice. They seem to have a self-concept of empathic ability that is contradicted by the evidence that they do not, in fact, do what they say should be done. This was certainly confirmed by the patients who were interviewed.

It may be interesting to note here a few additional statistics about the respondents:
TABLE 1. - Number and percentage of nurses mentioning the pre-identified needs of radical mastectomy patients in Part I of the Questionnaire for Nurses

<table>
<thead>
<tr>
<th>Pre-identified needs of the radical mastectomy patient</th>
<th>Total no. of nurses</th>
<th>No. of nurses</th>
<th>Percentage of nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for psychological support</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific needs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specific needs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for exercises</td>
<td>42</td>
<td>17</td>
<td>40</td>
</tr>
<tr>
<td>Need for information about prostheses</td>
<td>42</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Need for information about breast self-examination</td>
<td>42</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
TABLE 2.--Percentage of nurses mentioning the pre-identified needs of radical mastectomy patients; the nurses grouped by age and period of nursing education

<table>
<thead>
<tr>
<th>Pre-identified needs of the radical mastectomy patient</th>
<th>Age 21-30 Education 1953-1959 (N=30)</th>
<th>Age 31-52 Education 1927-1952 (N=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for psychological support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific needs:</td>
<td>67</td>
<td>42</td>
</tr>
<tr>
<td>Non-specific needs:</td>
<td>37</td>
<td>58</td>
</tr>
<tr>
<td>Need for exercises</td>
<td>53</td>
<td>8</td>
</tr>
<tr>
<td>Need for information about prostheses</td>
<td>33</td>
<td>25</td>
</tr>
<tr>
<td>Need for information about breast self-examination</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
TABLE 3.--Percentage of nursing personnel mentioning the pre-identified needs of radical mastectomy patients in Part I of the Questionnaire for Nurses

<table>
<thead>
<tr>
<th>Pre-identified needs of the radical mastectomy patient</th>
<th>Nursing Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Student nurse (N 9)</td>
</tr>
<tr>
<td>Need for psychological support</td>
<td></td>
</tr>
<tr>
<td>Specific needs:</td>
<td></td>
</tr>
<tr>
<td>Need for exercise</td>
<td>78</td>
</tr>
<tr>
<td>Need for information about prostheses</td>
<td>22</td>
</tr>
<tr>
<td>Need for information about breast self-examination</td>
<td>0</td>
</tr>
</tbody>
</table>
1. ninety percent of the group were single

2. ninety-five percent had taken care of a patient who had had a radical mastectomy

3. fifty-five percent knew someone very well who had had a radical mastectomy

4. the nurses credited forty-eight of their friends with being self-responsible for a satisfactory adjustment to the operation.

Again the major portion of the data obtained from this questionnaire will be presented in relation to the pre-identified needs.

**Psychological Needs.**——A substantial percentage of nurses indicated that they understood the psychological phenomena underlying the possible depression that follows a radical mastectomy operation. Seventy-six percent of the respondents indicated that they believed a period of "mourning" was necessary and natural following the loss of an integral part of the body structure; eighty-one percent said that they understood the phrase "destroying body image" and even higher percentages realized that usually greater trauma is experienced by younger women than older, and married women more than unmarried. Although eighty-six percent of the sample said that they did not feel uncomfortable in talking to patients about disfigurement, thirty-six percent admitted that they could not empathize enough with a patient to understand her worries about her husband's possible reaction to the disfigurement. This fairly high percentage of negative responses to the latter question might be on the basis of the high percentage of unmarried nurses in the group. However, of the four married or divorced nurses, two said that they could understand this worry, two could not.

The nurses were overwhelmingly in favor of patients with a diagnosis of cancer knowing it. This traditionally seems to be the conviction of nurses,
many of whom have observed the more traumatizing result of the patient discovering later the truth about his diagnosis, accidentally or otherwise.

Need for Exercises.-----Inasmuch as only forty percent of the respondents on the free response questionnaire identified exercises as a specific need of the post-operative mastectomy patient, it was rather surprising to the writer to have eighty-one percent of the group indicate familiarity with the exercise routine and sixty-four percent say that they had actually demonstrated and/or helped a patient with them. There was strong evidence, too, that the nurses considered it a definite responsibility to discuss with the doctor his failure to prescribe exercises, ninety-three percent agreeing that this should be done. Eighty-three percent of the respondents also thought it within their professional perogative to discuss this phase of rehabilitative care with the patient in the event that the doctor did not prescribe a definite exercise regime. In view of the availability of the very excellent, and rather widely publicized, booklet, Help Yourself To Recovery, it was again rather surprising that only fifty-two percent of the nurses knew where this pamphlet might be obtained.37

Need for Information about Prostheses.-----In contrast to the very low percentage of nurses (thirty-one percent) who recognized, in part one of the questionnaire, the need for information about prosthetic devices, eighty-three percent of the respondents indicated in the second question-naire that they should have considerable information about prostheses. This would be presumably to advise patients, although the latter was not a specified part of the question as it probably should have been. The nurses

37Bernhardt, Lasser, Radler, op. cit.
did in fact seem to know that there were several kinds of devices available, ninety-three percent claiming knowledge of one to four varieties, and eighty-one percent indicating that they had seen at least one variety. There were considerably less than half the group who knew the relative costs and a few less than fifty percent who knew a store that sold these devices. Considering the amount of knowledge displayed about prostheses, it is difficult to determine why this very feminine need would not be immediately thought of by a group of nurses whether in a free response situation or not. It again raises the question in the mind of the writer as to whether there is really a true understanding and appreciation of the traumatic experience that a radical mastectomy operation presents to the majority of patients. If nurses do understand, then it would seem to logically follow that they would provide the patient immediately with some tangible evidence that a very satisfactory method is available to restore at least an outward appearance of normalcy and femininity. One might then assume that this evidence of interest and sympathy on the part of the nurse would be an indication to the patient that here was a woman - nurse, too - who did realize what the operation implied and was trying to ease the shock, and help with the acceptance of what had to be lived with. Conceivably this could then lead to the verbalization of some of the other fears, which are so often minimized or even forgotten once they are "talked out."

Breast Self-examination.-----The answers to the section of the questionnaire having to do with the technique of breast self-examination revealed high agreement among the respondents that this was not only an important preventive measure but also an area of professional responsibility in terms of health education for patients as well as self and friends. All of the
nurses had heard of the technique. Ninety-three percent considered it important that radical mastectomy patients be taught the technique before leaving the hospital and ninety percent believed that they should suggest the desirability of doing breast self-examination to their friends. Again there was a very low correlation between the intellectual concept and performance. Although eighty-eight percent of the nurses said that they could teach a patient how to do breast self-examination, only thirty-one percent had ever done this. The respondents said that they should tell friends about the technique; only twenty-nine percent have ever discussed or demonstrated it to friends. And as revealing as any statistic is the fact that only fifty-seven percent of the nurses themselves do breast examination. Of those, only twelve percent do it regularly. The latter fact may be accounted for by the relatively low median age of the entire group.

However, there were one third of the nurses in the over thirty age group who did not do breast self-examination, and of the two thirds who did, considerably more than half of the group did not carry out the technique regularly.
CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study proposed to answer the questions:

1. To what extent do nurses recognize the specific needs of patients following a radical mastectomy?

2. How well do nurses think that they meet the needs?

3. How well do mastectomy patients think their needs are met?

The questions evolved from the following hypothesis:

Women who have had a radical mastectomy for carcinoma of the breast have specific psychosocial and rehabilitative needs, and although nurses have an intellectual understanding of these needs, they lack the necessary skills to assist patients to make an emotionally and physically desirable adjustment to their future lives.

As a basis for determining those needs of the mastectomy patient that seemed to be most specifically concerned with the kind of surgery performed - involving as it does, both a diagnosis of cancer and disfigurement - a review of the literature was carried out in order to substantiate the validity of the four specific needs identified by the writer.

Data were obtained from two sources: 1) interviews were conducted with eight patients who qualified for the study according to criteria established to obtain the most valid results for this study; 2) a two-part questionnaire was administered to forty-two graduate nurses, currently enrolled in a University General Nursing Program. Both sets of data have been presented in terms of the pre-identified needs and with the purpose of
drawing conclusions that would answer the proposed questions as well as to determine whether the hypothesis of the writer was proven or disproven.

Conclusions

The conclusions that may be drawn from this study may be divided into two parts: 1) those based on information from the patients in relation to their self-identified needs and their perception of how well they were met, and 2) those based on the nurse's intellectual convictions about the patient's needs and the professional responsibility of the nurse to meet them in contrast to the actual practice of the nurse.

Conclusions drawn from patient data.

1. Patients do give evidence of a considerable variety of psychological and emotional problems. They are convinced that nurses are unaware of their problems as evidenced by their casual and superficial reaction to the depressive state that usually follows surgery.

2. Patients do indicate that they cannot verbalize their fears and worries unless a nurse gives overt evidence of empathy.

3. Patients do not have knowledge about prosthetic devices and believe that it is the professional responsibility of the nurse to give detailed information about the advantages and disadvantages of various kinds of prostheses, the cost, and the place where they may be obtained.

4. Patients do worry about regaining the full use of their arm and would appreciate information about an exercise regime that would effectively accomplish this.

5. Although many patients do know about breast self-examination as a result of hearing about the technique from doctors or friends, or seeing the film "Breast Self-examination", this fact was not ascertained by the nurses caring for this group of patients and no effort was made to review the technique to be sure that it was being correctly performed.

6. Therefore, the overall conclusion is drawn that the group of patients who were interviewed for this study did have needs that correlated closely with those pre-identified by the writer and that they did not believe that they were adequately met by a professional nurse.
Conclusions drawn from the questionnaire.

1. Nurses can freely identify the fact that surgery for carcinoma of the breast does have many psychological and emotional implications.

2. Nurses think that they have no difficulty in empathizing with patients. Actual practice would seem to indicate the inability of nurses to convey this empathy to patients to a degree that makes it possible to discuss with the patient her fears and worries about the operation and diagnosis.

3. Nurses do not freely identify the need for giving information to patients about prostheses and, in fact, do not do so. However, they indicate considerable knowledge about the kinds of prosthetic devices available, some idea of cost and availability, and a definite intellectual conviction that they should have this information, presumably to pass on to patients.

4. Nurses indicate a wide knowledge of the exercise regime that should be taught to patients following their surgery and an overwhelming conviction that they should assume responsibility for the patient's knowledge of this therapy. Although all the nurses had taken care of one or more patients following radical mastectomy, less than half had ever taught these exercises to a patient.

5. Nurses are convinced that breast self-examination is not only an effective diagnostic measure but that it is their professional responsibility to disseminate this information to patients, family, and friends. In actual practice they not only neglect to do this for others, but only twelve percent of the nurses questioned do breast self-examination regularly, forty-five percent only occasionally, and forty-three percent not at all.

6. An overall conclusion that may also be drawn from this study is that, in general, nurses who have received their nursing education in the last decade seem to have a better knowledge of the principles of rehabilitation, as they affect the radical mastectomy patient, than do nurses of older generations.

The writer believes that the findings of the study indicate quite clearly that her hypothesis has been proven. The evidence from the patients substantiates the fact that they do not believe nurses adequately meet their needs. The evidence from the nurses indicates that they do have
an intellectual understanding of the needs but do not have the skills necessary for meeting them.

Recommendations

As a result of the conclusions that have been drawn from this study, the following recommendations are made:

1. It would appear that the surgical nursing instructors need to strengthen their teaching in the following areas:
   a) greater emphasis on the need to give patients positive evidence that nurses understand the psychological trauma which usually accompanies radical mastectomy
   b) greater emphasis on the need for nurses to be sure that patients have a detailed knowledge about exercises and prostheses before leaving the hospital
   c) greater emphasis on the technique of breast self-examination not only for radical mastectomy patients but for other women patients and for nurses themselves. The professional responsibility to promote this kind of health teaching in the community should also be emphasized.

2. Following a theoretical presentation of the needs of the radical mastectomy patient, the instructor should endeavor to select appropriate learning experiences for the student in order to give practical reinforcement to the teaching. This area of patient teaching is not easy for young nurses and they need practice in the skills required in order that learning does not remain just on the intellectual level.

3. Inasmuch as the older nurses were the least able to identify the needs of the mastectomy patient, it would seem that an in-service program for staff nurses, head nurses and supervisors would be indicated for nurses in the older age group. A major portion of such a program should be oriented toward the rehabilitative needs of patients, to the psychological implications of a diagnosis of cancer and to disfiguring surgery.
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Dear Doctor ________,

May I introduce myself to you before explaining the reason for my letter?

I am at present a student at the Boston University School of Nursing studying for my Master of Science degree. I am also a graduate of Pembroke College and the Yale University School of Nursing. In the past I have been primarily occupied in nursing education, but have also done considerable part-time work at the ________ Hospital. In connection with my graduate work I must do a field study on some phase of nursing and it is for that reason that I am writing.

Some years ago I had a radical mastectomy and since then have been interested in the number of patients who have come to me for advice in regard to prosthetic devices, adjustment to the disfigurement, and psychological problems. In 1957 I appeared on a television program for the Cancer Society in their promotion of the film "Breast Self-Examination." The number of letters that I received afterwards in regard to handling the problems involved were quite amazing to me. Over the years I have come to the conclusion that nurses do not do their part in helping patients to begin a healthy rehabilitation, and I would like to find out from some recently treated patients whether they received or would have liked more help from the nursing staff. I will also attempt to determine from a group of recent graduates what they perceive as the needs of the patients.

In order to carry out such a study I obviously need to interview some patients who have had a recent mastectomy. I have discussed this with Miss ________ and she suggested writing to you to see whether you had any patients whom you think would consent to an interview of this kind. I have no intention of trying to determine their reaction to a diagnosis of malignancy so the subject will not be broached by me and, if mentioned by the patient, will be tactfully treated as an "unknown variable" as far as my knowledge is concerned and referred back to the physician.

If you feel that there are any of your patients whose names you could submit to me, I would of course first send a copy of the letter requesting the interview to you for your approval. In the case that a patient was referred to you for
surgery and is under the care of another physician I would also secure permission from him before proceeding.

It is my feeling that as nurses we need to identify some of the components of nursing care that are the responsibility of the professional nurse so that all patients can benefit from what a "good" nurse does intuitively. I think this is an important area to investigate.

Thank you for whatever assistance you may be able to give me.

Sincerely yours,

Eleanor K. Gill
APPENDIX B
February 22, 1960

Mrs.  
Jones Street  
_______, Massachusetts

My dear Mrs.  

Your physician, Doctor ______ has given me permission to write to you. May I introduce myself to you before explaining the purpose of my letter? I am a graduate nurse studying for a degree in nursing at the Boston University School of Nursing. In addition I had the same operation, a number of years ago, that you have had - a mastectomy. Because I am a nurse and also a former mastectomy patient, I have had many women referred to me for advice on "what do you do about this problem?" Several years ago I appeared on the Louise Morgan program in an effort to prove to women that it was quite possible to live a normal, happy life even though this had happened. The number of letters I received following this appearance, asking for specific information, was most surprising to me. It was then that I came to the conclusion that nurses were not helping patients as much as they might in answering some of the questions that women hesitate to ask their doctors - questions about devices to use, about bathing suits, evening clothes, strapless bras, etc. We know that this kind of "know-how" may seem unimportant to others but it is all-important to the patient; to have to get it by the trial and error method is most disturbing at the time.

And so when I had to decide on the subject of a small nursing research project to be done during this year of study, I thought that I would like to investigate whether most patients did leave the hospital perplexed about what to do and hesitant about where to turn for help. It has always seemed to me that if nurses would anticipate some of the questions that might be bothering patients and make a point of knowing the answers, it would go a long way toward lessening the psychological impact of the operation. In order to find out if my hunch is right, I need to interview some former patients to find out how they actually did solve any problems they might have had.

Doctor ______ feels that this project is a worthwhile one and has suggested the possibility that you would be willing to grant an interview. Needless to say the information which
I gather will be reported on a completely impersonal basis and will be considered to be strictly confidential, just as any information about you, known to a nurse in the hospital, has been considered.

For your convenience I am enclosing a card on which you can indicate your preference in this matter. If you are willing, perhaps you would also give me several dates and hours when it would be convenient for me to see you. For your information I am free on almost any Tuesday morning or Friday afternoon, or any evening except Monday or Thursday.

Thank you very much for your patience in reading this lengthy letter. I will be most appreciative if you feel that you would like to be part of the study. I hope that it will help others to make an easier adjustment.

Sincerely yours,

Eleanor K. Gill
(Mrs. Harry W. Gill)
INTERVIEW GUIDE

1. May I ask what kind of bras and form you have found most suitable?
2. Who suggested this particular prosthesis to you?
3. What information did you receive from nurses in the hospital in regard to suitable bras and forms?
4. Did you have any idea at first about where to obtain a suitable prosthesis?
5. What did you think about the probable cost?
6. Did you do a good deal of experimenting before finding a prosthesis that was right for you?
7. Was this expensive?
8. Did you wonder about going swimming and wearing sun dresses or evening gowns?
9. Did you specifically ask a nurse any questions about what to wear?
10. Did she have helpful information?
11. What indication, if any, did the nurses give that they felt you needed emotional support and encouragement in order to make your adjustment to this operation easier?
12. How was the "lump" in your breast discovered?
13. How soon after discovering the "lump" did you go to the doctor? (if pertinent) Why did you delay?
14. Did your doctor discuss frankly with you the possibility of cancer or malignancy before the operation and prepare you for radical surgery?
15. Did you discuss this with your family and/or husband?
16. Did the prospect of losing a breast frighten you in any way?
17. How did you feel after your operation?
18. Did you worry about how your family would react to this operation?
19. Did you worry specifically about your husband's reaction?
20. To your knowledge did the doctor talk to your husband about the possible emotional implications of this operation or the physical appearance of your scar?

21. How do you think that the nurses who took care of you felt about your reactions to the operation?

22. Did you worry then about a recurrence? (This was asked only when the patient had indicated that she understood her diagnosis well and had mentioned a possible recurrence in a general way.)

23. Would you have liked the opportunity to discuss fully, with a nurse, problems that might have been bothering you?

24. Did you have the feeling that the nurses assumed you knew the answers to all your questions?

25. Did you know anyone before your operation who had a radical mastectomy?

26. If yes - did you discuss the subject with her?

27. Do you have any limitations in the use of your arm?

28. What did your doctor tell you about using your arm?

29. Did he prescribe definite exercises?

30. Did a nurse help you in regaining the use of your arm?

31. Did anyone give you any literature which pictures and describes the exercises?

32. Did a nurse in the hospital suggest how you might exercise correctly while doing your household chores?

33. What instructions did you receive about checking your other breast?

34. Was breast self-examination discussed and demonstrated to you? If yes, by whom?

35. How often do you do breast self-examination?

36. Do you talk about your operation and breast self-examination to other women?
APPENDIX D
Questionnaire for Graduate Nurses

Part I

Student Number

List four specific needs that you feel all radical mastectomy patients have which you as a professional nurse need to anticipate, and have information about, in order to formulate an effective nursing care plan.

1.

2.

3.

4.
Questionnaire for Graduate Nurses

Part II

Please circle whichever answer is appropriate for you.

1. Your age
2. Year of graduation from nursing school
3. Marital status
   S  M  D  W  Engaged
4. Last position in nursing
   Student  SN  RN  Sup  Instr
5. Have you ever taken care of a patient who has had a radical mastectomy?
   Yes  No
6. Do you know anyone very well who has had a radical mastectomy?
   Yes  No
7. If yes, how did she adjust to her operation?
   Well  Poorly  Do not know
8. If well, whom do you think helped her in her adjustment?
   MD  Nurse  Self  You  Do not know
9. Have you ever had a course in rehabilitative nursing?
   Yes  No
10. Do you believe that a period of "mourning" for a lost part is natural and necessary?
   Yes  No
11. Do you think you understand the phrase "destroying body image?"
    Yes  No
12. Do you feel uncomfortable in talking to patients about disfigurement?
    Yes  No
13. Do you feel that you empathize enough with a patient to understand her worries about how her husband may feel about this disfigurement?
    Yes  No
14. a) Do you yourself believe that a woman who has had a radical mastectomy should be restricted in relation to pregnancy?
    Yes  No
14. b) Do doctors who are actively engaged in research to find the cause of breast cancer consider it safe to undergo a pregnancy following a radical mastectomy? Yes No

OR Sometimes at a later date

c) Is a discussion of this with a patient within the scope of nursing responsibility? Yes No

15. In general do you feel that patients with a diagnosis of cancer should know it? Yes No

16. Do you feel that younger women (25-40) probably have a more difficult adjustment than older women? Yes No

17. Do you feel that married younger women (25-40) probably have a more difficult adjustment than older women? Yes No

18. Are you familiar with the exercise routine usually prescribed for these patients? Yes No

19. Have you ever demonstrated these exercises to a patient and/or helped her with them? Yes No

20. If the doctor does not prescribe exercises or specifically encourage motion, do you feel that it is your responsibility to discuss this with him? Yes No

21. If the doctor does not prescribe definite exercises, do you feel it is within your prerogative as a professional nurse to at least discuss with the patient the need for exercise and the ways to accomplish this, in the hope that effective exercise will take place at home? Yes No

22. Do you know where you can obtain pamphlets that describe and picture these exercises? Yes No

Where?

23. How many kinds of prosthetic devices do you know about? 1 2 3 4

24. Do you know about their relative cost? Yes No

25. Have you ever seen any of these devices? Yes No
26. Do you know one store relatively close to your locality where these devices are fitted and sold?  
   Yes  No

27. Do you feel that you should have considerable information about various prosthese?  
   Yes  No

28. a) Have you ever heard of "breast self-examination?"  
   Yes  No

   b) Do you think that you could teach a patient to do this?  
      Yes  No

   c) Have you ever taught any patients to do this?  
      Yes  No

   d) Do you believe it important that a patient with a radical mastectomy be taught this before leaving the hospital?  
      Yes  No

   e) Do you do breast self-examination?  
      Yes  No

   Regularly?  
      Yes  No

   f) Have you ever suggested to friends that this is a good preventive measure and volunteered to teach them the technique?  
      Yes  No

   g) Do you know where you can obtain pamphlets that describe and picture this technique?  
      Yes  No

29. Do you feel that suggesting breast self-examination to other patients and/or friends is part of your responsibility in the field of health education?  
   Yes  No