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BRIEF REPORT

THE PSYCHO-ONCOLOGY SERVICE IN PADOVA: OUR EXPERIENCE OVER THE LAST DECADE

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Historically, before 1980, we only occasionally applied for psychiatric consultations for our patients, within or outside the Hospital.

Since 1981, when the first psychologist obtained a grant for support work *within* the Medical Oncology Department, an integrated approach which combines support for patients, with continuous training for the staff has been developed:

- first came the acknowledgment that there were psycho-emotional problems needing to be confronted, in surroundings primarily installed for 'physical' problems;
- next came the attempt to optimize efficient use of personal, organizational and professional resources of all the medical and ancillary staff, through improved communication, among themselves and with patients;
- then we made an effort to recognize, exploit and improve the new psychological conditions created by a more human and conscious communication.

The Psycho-Oncological (PO) intervention applied in our unit includes the following:

A form for PO and social data collection, named SAPOS, is completed for new patients. We have developed this form with the aim of facilitating the beginning of communication between psychologist and patient, in patients usually 'blocked' in their capacity to share emotions and problems.

A shorter form (SPOR), which summarizes the data from SAPOS is used to enable other non-mental-health professionals to use the information. Only SPOR is inserted into the medical notes. It provides the basis for case discussions, and considers the different causes of distress linked directly to the disease, as well as the treatments, the patient's relatives and the possibility of (or obstacles to) a good relationship between the patient and the various attending professionals.

Formal and informal discussions on the problems of patients particularly at risk of psychological distress (with one weekly meeting regarding the in-patients) are regularly operating.

The PO Working Unit, since 1985 provides psycho-therapy for patients and relatives; organizes meetings in order to update knowledge of scientific PO, often inviting outsiders to report their own new-and-personal experiences, and provides training courses.

The psychologists of this Unit are responsible—according to the Integrated Psychological Approach (IPA or in Italian API)—for guaranteeing the liaison between staff, such as the head of medical oncology, the medical assistants and observers, the psychologists and grant recipients, nurses and other auxiliary and secretarial personnel: they are requested to:

1. ensure that emotional distress does not lead to tensions
2. that there is evaluation and treatment of the individual patients.
3. that there is cooperation with physicians in coping with problems of information, compliance, rehabilitation, response to treatment, and friendly relationships and availability towards the patient's relatives.

The emphasis since 1985 has been brought on developing a method that allows everybody to potentiate psychosocial skills, through the skilled

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and active mediation of the psychologist and within an environment where emotional conflicts are accepted as inevitable.

A mix of medical knowledge and psychological awareness is the outcome of this API approach.

Further support is provided by a non profit private organization (ASDOM) founded in 1989, consisting of the department personnel plus Volunteers, and providing a community home-care service.

When this kind of home care is requested by the community physician two specialists (one psychologist and one physician) first visit the patient together. They will provide a weekly report in a special meeting on the causes of distress affecting the newly-enrolled patient, and a care plan is discussed with other members and with the head of department.

Appropriate psychological and medical care is then provided in close cooperation with the community physician, and progress will again be reported at subsequent weekly plenary sessions.

We recognized that very different forms of assistance are needed for in-patients and patients treated at home. In-patients are entrusted to the medical team, and their relatives in this situation have only minimal involvement. At home the family involvement is uppermost. One should further consider that in hospital the patient and the medical personnel have very little time to spend with the psychologists, so that quick tests and quick decisions and interventions are needed; at home, on the contrary, a full psychological interplay is possible and usually needed.

Two physicians and 2 psychologists easily provide home care for approximately two hundred new patients per year. The mean survival of 3 months found in these patients indicates the type of patient followed.

Just to summarize what has been described above as an historical development, we can define the actual status reached by our PO activity in 1993, under separate headings:

1. the PO team is now based on 1 full time + 2 part-time and 2 volunteer psychologists, plus an external reviewer; the team activities include:
2. integration with non-mental-health dedicated personnel, through:
   (a) the weekly ward meeting, based on the SPOR chart, parallel to the medical ward round, but discussing only the psychosocial aspects of the *admitted* patients
   (b) the weekly meeting on home care, where physical as well as psycho-social aspects of the *terminally ill* patients are discussed: these meetings are examples of multidisciplinary approach.
3. The hospital based service that, beside approaching all admitted new patients with the SAPOS and SPOR assessment forms, provides more in depth individual assistance when these instruments reveal a psycho-social distress;
4. the community based service as described above;
5. training courses open to psychologists, physicians and nurses;
6. research activity mainly dedicated to certain categories of patients and/or problems, like Quality of life, Diagnostic communication, Elderly patients, Ovarian Cancer, Vomiting, and the Burn-out syndrome in the personnel.

We do not feel that our organization (both inside the hospital and in the community) is a definitive model, without room for improvements. We reported it here, simply to provide an idea of the needs we have been faced with, and of the provisional means adopted in order to cope with them; we trust that at least some of the readers, especially the beginners, will find our personal experience of some value.