



A grounded theory exploration of the first visit to a cancer clinic—strategies for achieving acceptance

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KEYWORDS

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Cancer patients;
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Summary The purpose of this study was to investigate cancer patients' experiences of their first visit to a cancer clinic. Nine patients with various cancer diagnoses about to receive curative cancer treatment were interviewed after their first visit to the clinic. A qualitative research approach based on Grounded Theory was used throughout the research process. The data analysis gave rise to a process leading to a core category which showed how patients can reach acceptance of the impact cancer has on their lives. Five different categories were identified as being important for reaching acceptance, namely action, knowledge, respect, continuity and confidence. The patients expressed the need for receiving treatment for their cancer without delay, and for continuity in their care. They needed to be given individualized, relevant information about their illness and to be treated with respect. If these needs were met a feeling of confidence resulted. Meeting all of these needs helped patients accept the impact cancer had on their lives, as did confidence in the care being given. Acceptance was reached when patients felt they could actively participate in treatment decisions, when they knew what to expect and when they felt they were being treated as individuals. Health care professionals should be aware of these needs, and should try to treat their patients as individuals and thus help them to achieve acceptance.

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Zusammenfassung Diese Studie untersucht die Erfahrungen von Krebspatienten während ihres ersten Besuchs einer Krebsklinik. Neun Patienten mit verschiedenen Krebsdiagnosen, die eine kurative Krebsbehandlung antraten, wurden nach ihrem ersten Besuch der Klinik befragt. Ein qualitativer wissenschaftlicher Ansatz nach der Methode der „Grounded Theory“ wurde während der gesamten Untersuchung

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angewandt. Die Analyse der Daten deckte wichtige Kategorien zu der Frage auf, wie Patienten die Auswirkungen von Krebs auf ihr Leben akzeptieren können. Fünf verschiedene Kategorien wurden als wichtig für die Akzeptanzfindung unterschieden: Handeln, Wissen, Respekt, Kontinuität und Zuversicht. Nach Aussage der Patienten waren die unverzügliche Behandlung ihrer Krebskrankheit, wie auch Kontinuität bei der Behandlung notwendig. Die Patienten benötigten individuelle, relevante Informationen über ihre Krankheit und wollten mit Respekt behandelt werden. Wenn das Krankenpersonal diesen Bedürfnissen entsprach, stellte sich bei den Patienten ein Gefühl der Zuversicht ein. Wenn alle Bedürfnisse erfüllt wurden, konnten die Patienten die Auswirkungen des Krebses auf ihr Leben besser akzeptieren, und sie hatten größeres Vertrauen in die ihnen dargebrachte Pflege. Eine Akzeptanz trat ein, wenn Patienten der Ansicht waren, dass sie aktiv bei den Behandlungsentscheidungen beteiligt waren, wenn ihnen die weitere Entwicklung bewusst war, und wenn sie das Gefühl hatten, als Individuen behandelt zu werden. Das professionelle Pflegepersonal sollte diese Bedürfnisse kennen und versuchen, die Patienten als Individuen zu behandeln, um ihnen auf diese Weise bei der Akzeptanzfindung zu helfen.

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Introduction

Information provided about serious illness such as cancer often places patients in crises of varying degrees (Birgegård and Glimelius, 1998). Avoidance and denial are subconscious defence mechanisms for handling a trying situation and defending the patient's "self" (Cullberg, 1992). These mechanisms may complicate the processing of information and patients may find it difficult to take in and comprehend the information given to them (Quirt et al., 1997). To give relevant information to the patient in this situation is fraught with many difficulties. It places great demands on the person giving the information to win the patient's confidence, feel empathy and try to judge the acceptability of what has been said.

Several studies have shown that a large percentage of patients want all the information surrounding their illness regardless of whether the information is good or bad (Meredith et al., 1996; Templeton and Coates, 2001). To seek and obtain information has been highlighted as a strategy for coping with and reducing stress (Van der Molen, 1999). The majority of patients want to participate in the decisions surrounding their care (Protière et al., 2000). Nevertheless it has been shown that even though patients wish to receive all the information relating to their illness most patients choose to hand over the final decision about treatment (Sutherland et al., 1989). Well-informed patients are more secure, experience less anxiety and depression and experience a greater amount of involvement (Van der Molen, 1999). Hinds et al. (1995) identified three main categories of patients' information needs, namely participation, prepara-

tion and anxiety reduction. Other studies likewise suggest that involvement in treatment decisions lessens the trauma of the cancer experience (Luker et al., 1996). However, several investigations have shown that patients interviewed were dissatisfied with the areas about which they had received information, as well as about how the information had been given and who had given it (Friedrichsen et al., 2000). The Swedish Hälso- o Sjukvårdslagen Act of 1982, which is based on respect for the autonomy of the individual, stipulates that patients should have individualized, relevant information and should participate in the decisions surrounding their illness and treatment (Wilow, 2003). It is important, however, to keep in mind that people from many other cultures and countries do not always believe that it is in the patient's best interests to receive detailed information about his or her disease.

Cancer patients experience great changes in their lives. One investigation of cancer patients' quality of life (QoL) reports that patients are affected in four different ways by having cancer: psychologically, socially, physically and spiritually (MacDonald, 2001). Cancer patients' needs have been described by Levy (1994) to include the need for physical and psychological support, the need for information and spiritual needs. Elsewhere cancer patients' needs have been described to include a good relationship with the health care professional, together with practical needs and needs relating to the patient's identity (Soothill et al., 2001; McIlmurray et al., 2001). The ability to take care of the home and maintain good contact with family and friends is another need described by Whelan et al. (1997).

Increased specialization and demands for efficiency have resulted in patients moving faster from one health care facility to another, which has led to a shorter time in which to establish a good relationship with the health care provider. We all follow guidelines specifying the length of time to be spent on different types of consultations but this is not always in relation to the amount of information that should be given or the needs of the patient.

Much of the research in cancer patients has dealt with predefined issues such as living with cancer, QoL, psychological reactions and the patients' needs, with breast cancer patients being a well-investigated group in contrast to testicular and prostate cancer patients. Many researchers have used standardized questionnaires (Rustoen and Begnum, 2000). However, the literature provides little information on patients' expectations and experiences during an appointment at a cancer clinic when they are newly diagnosed with cancer and are to begin their curative cancer treatment. Awareness of cancer patients' experiences at this specific time in their illness helps us to understand and thereby determine how best to support and help them.

Aim of the study

The aim of this study was to investigate how newly diagnosed cancer patients experience their first appointment at a cancer clinic.

Research methods

Grounded theory

This interview study with a descriptive qualitative design was based on Grounded Theory. Grounded Theory was first described by Glaser and Strauss in their book titled *The Discovery of Grounded Theory: Strategies for Qualitative Research* (1967). It has its roots in symbolic interactionism (Blumer, 1969), in terms of which the perspective of the actor should be in focus and single cases rather than a patient population as a group should be studied (Alvesson and Sköldbberg, 1994). Of particular importance is the meaning that events have for the individual and the symbols that convey this meaning. Humans are affected by the social world and the meaning is continuously modified by experiences and interactions with others (Baker et al., 1992; Crooks, 2001). Grounded Theory aims to

generate theories through establishing different concepts from the data that have been collected. The theories are generated from the context in which they will later be applied (Glaser and Strauss, 1967).

Respondents

This study was performed in nine patients newly diagnosed with cancer. The patients were all waiting for their planned chemotherapy or radiation therapy. All had been referred by their surgeon from another clinic, which had also informed them about the diagnosis. The patients were meeting with their treating doctor for the first time and the aim of their visit was for them to receive information about their cancer and the planned treatment. The planned cancer treatment was curative in nature, which the patients were aware of. As we wanted to include both sexes and different ages, the patients who were asked to participate had various cancer diagnoses (see Table 1). All patients spoke Swedish.

Eight patients declined to participate in the study. The non-respondents differed from the respondent by age and diagnosis (see Table 1).

Setting

The study took place at the Department of Oncology, Sahlgrenska University Hospital, Gothenburg, Sweden. Cancer patients are referred to this department from the western Swedish region.

Table 1 Demographic characteristics.

	Respondents (n = 9)	Non-respondents (n = 8)
Sex		
Male	4	4
Female	5	4
Diagnosis		
Breast cancer	5	4
Prostate cancer	3	1
Testicular cancer	1	3
Age (years)		
20–40	0	4
41–60	6	1
61–80	3	3

Procedure

The study protocol was approved by the ethics committee of Göteborg University, Gothenburg, Sweden. Thereafter, a letter inviting them to participate in the study as well as written information about the study was sent to all patients eligible for the study. The first author (S.J.) contacted the patients by telephone 2 days before their visit. This was an opportunity to more thoroughly explain the purpose of the study. The patient's right to decline participation or later withdraw from the study was also explained and it was emphasized that the data would be used only for the stated scientific purpose. Informed consent was obtained verbally. In consultation with the patient a date was set for an interview within 1 week of the visit. Before the interview written informed consent was obtained.

Data collection

Data were collected through semi-structured interviews. All interviews were tape-recorded and performed by the first author who also transcribed the interviews verbatim. Each interview was opened with the question, "What was your experience of your first visit?" This allowed the patients to tell about their experience in their own words. As we also wanted to study patients' specific needs for the content in the information given we included a few questions with that theme unless the patients themselves volunteered information on their needs. Data from previous interviews were highlighted in subsequent interviews to confirm and/or modify findings. Data collection stopped when no new information could be gained from the interviews.

Following each interview field notes were taken. These included brief data on the patient interviewed and observations made during the interview.

Data analysis

Data from the interviews were analysed and categorized according to the constant comparative method of data analysis (Strauss, 1987). Data collected during the interviews were summarized into different themes, which were confirmed and modified throughout the analyses. The data analysis started directly after the first interview and consisted of open, axial and selective coding. Open coding included repeated readings of the interviews and an in-depth, line-by-line analysis of the data. By means of open coding, data were coded under various headings according to their content with the purpose of opening up data as well as achieving a constant comparison of incidents and categories that emerged from subsequent interviews. In the axial coding, categories were linked together, with sub-categories describing the specific category. In the final, selective coding the categories were linked together, which resulted in a core category (Strauss, 1987).

Research findings

The data analysis gave rise to a process leading to a core category which showed how patients can reach acceptance of the impact cancer has on their lives. Five different categories were identified as being important for reaching acceptance, namely action, knowledge, respect, continuity and confidence. By "action" is meant having immediate action taken against their cancer while "knowledge" implies receiving individualized, relevant knowledge. Patients must furthermore experience respect and continuity in their cancer care. If all these conditions are met patients feel confident. These categories mentioned were understood as being strategies for patients to reach the acceptance (see Fig. 1).

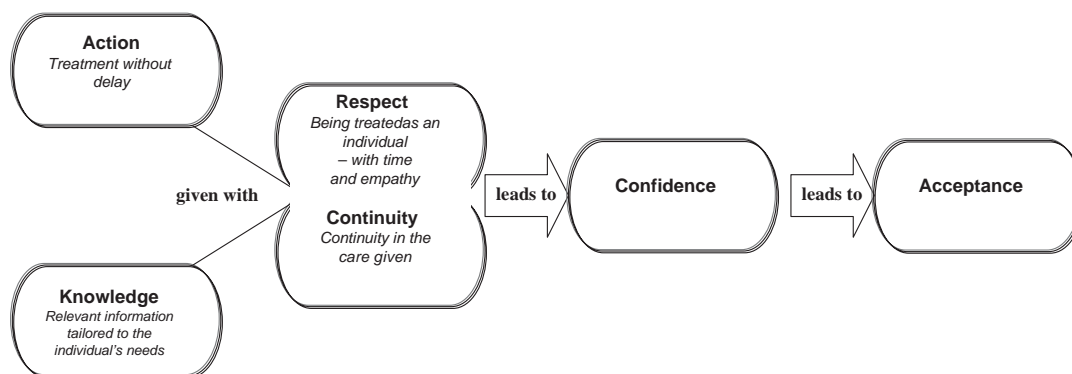


Figure 1 Strategies in cancer patients for achieving acceptance.

Core category—acceptance

Acceptance may be understood as a state of mind the patient reaches if he or she is confident that he or she is involved in planning the cancer treatment and knows what to expect and, further, if he or she has been and is being treated as an individual. The above mentioned categories, which are necessary for the patient to reach acceptance, should interact. Participation in decision-making (i.e. in planning the treatment) makes the patient feel that he or she is part of the process and can to some extent influence the impact the cancer has on his or her life. This feeling of “being in control” is important for accepting the impact of the illness on the patient’s life and therefore for carrying on. The patients who had experiences of participation in decision-making in this way said they were willing to take the consequences of their decisions.

Action

The “action” category includes the dimension of receiving cancer treatment without delay. The patients expressed the need for something to be done about their cancer. In fact, it emerged that for the patients, the most important action was that their cancer treatment should begin. The time the patients had waited from their operation or diagnosis to this visit varied from 3 weeks to 4.5 months. Many experienced this time of waiting as very trying. They expressed a feeling of loneliness and frustration about nothing being done about their cancer:

Otherwise, that’s been the hardest thing, the waiting for answers; you go around thinking about it, wondering all the time.

What makes them think I can wait? My tumour developed in 2 months.

All of the patients wanted to start their treatment without delay. Many had been under the impression that their treatment would start immediately and expressed disappointment and hopelessness over the fact that they had another waiting period ahead of them.

I’m supposed to get radiation and I want it fast and I don’t want to wait any longer. Or else I’ll just refuse it. I knew it wouldn’t start the same day, but I definitely thought it would be faster than this.

I won’t be able to work through it all until I’ve had the radiation; once that’s done, maybe I’ll be able to deal with it again.

One patient who had waited for her treatment for a long time, though anxious for it to start and to get it over with, experienced the waiting time as something positive:

But I’m happy I had to wait 4 weeks, because that means it isn’t that serious.

Another who did not have to wait so long said, “When I got called in so soon, I thought okay, she must have found something that wasn’t good.”

The interviews showed that while waiting for their treatment patients want to be contacted by a health care professional:

I think somebody should have called me, a counsellor or someone, once a week while I was waiting, just to say hello, we’re thinking about you and how are you feeling?

Knowledge

The “knowledge” category included the importance of receiving relevant information tailored to the individual patient’s needs. By “relevant information” is meant information that is relevant from the patient’s perspective.

It emerged from the interviews that the patients were not interested in information that was not essential to them at this moment in their disease process. Most patients did not wish to hear how the cancer might develop and what kind of effect this could have on them.

I don’t think they need to tell you there are a bunch of different stages and how serious it might be, but they should tell you what’s going on.

Speculation doesn’t help, you need to be told what your situation is.

The patients, who had received information about their cancer and the prognosis from their surgeon, considered information about their upcoming treatment to be of interest. This information was to include the kind of treatment they were about to receive together with possible side effects. Some of the patients said they wanted information about their cancer. They felt that they had not received any straight information before this visit. Some had come to the clinic hoping to get information about their blood samples and X-ray results. Those patients who had to choose between different treatments alternatives wanted detailed information about the differences. The information was to be presented in an honest and straightforward way:

They should tell you the unvarnished truth.

They didn't beat around the bush, and I think that's the best approach.

Patients also wanted the information in writing, especially information pertaining directly to themselves. The patients said they appreciated it when the doctor drew and wrote down information during the visit. This was information they could take home and would be able to study at home:

When I left, it all just disappeared out of my head, but then I had it all down on paper and that was a tremendous help.

When you're listening, you're totally on edge; you try to concentrate, but it was really helpful to have a sketch that I could take home, study, and think about.

Written information in the form of brochures was also appreciated though it was expressed, "...if you've read one, you've read them all".

The patients found that brochures often are too general. It is hard for patients to sift through all the information and know which parts of the written material concern them.

The patients expressed a need to read and find out facts about their cancer in connection with the operation and diagnosis. This need decreased over time. At the time of the interviews the patients did not feel this need any more. The patients had mostly used their friends and colleagues at work to discuss, find out more and obtain advice about their cancer. A few had also used medical literature but only to the extent of answering certain questions since they had found it hard to sift through the literature and do research on the Internet with regard to their illness:

It almost feels like you can get cancer from reading too much.

Some patients said they wanted "...no professional literature, because it might describe situations that are more serious than what you have and it might make you feel more lost and more worried."

Most of the interviewees were still following any information concerning their illness in the newspapers and on television and continued discussing their illness with their friends; however, most did not actively seek information.

Opinions differed about the importance of having relatives present at the visit to the clinic. The patients said they wanted to be able to choose whether to have a relative accompany them or not:

I couldn't choose to have someone with me because I didn't know what it (the consultation) was going to involve.

She told me beforehand that I could bring someone with me if I wanted. I thought it was good that she said so and that it was a good idea to bring someone.

Those patients who had a relative accompany them said they had wanted another set of ears and to have someone present who could ask the right questions.

In this case [it felt good to have someone with me] because she can ask better questions than I can.

Those patients who had chosen to come alone either did not want to burden their relatives or had non-Swedish-speaking relatives:

I feel this is going to be okay. I feel inside that this is nothing to go and worry people about unnecessarily.

Respect

There were three dimensions to respect, namely being treated as an individual, being given time during the consultation and being treated with empathy.

With regard to the importance of being respectfully treated as an individual the patients highlighted different aspects in the meeting as signifying being treated with respect. These included using language understandable to them ("...they didn't use all those Latin words, because that is just insane"), and greeting the patient with respect and looking him or her in the eyes and shaking hands.

You don't want someone questioning your personal feelings, you want to be treated as an individual, accepted for who you are.

There was a relation between being given time and being treated with respect. Those patients whose appointments had been delayed expressed irritation but said they understood that there are other patients who are sick and who are perhaps in greater need of attention. The experiences with regard to time concerned not only the amount of time given but also, the importance of quality in the time being given.

They need to give you a chance to calm down. They have to make time.

They don't have to sit with me for hours and talk about things—as long as I get information about the big questions, the things I want to know. She was really good and took plenty of time to explain, so I felt pretty secure.

The patients expressed the need to be treated with empathy.

The capacity to take the time to understand—I think that means a lot more than how knowledgeable they are.

I felt like she had incredible empathy.

Continuity

The “continuity” category had two dimensions: firstly, patients said they needed information concerning the continuous care and secondly, they wanted continuing contact with one health care professional. The dimension of information concerning the continuous care included taking part in planning the treatment, finding out about practical issues and knowing what to expect with regard to the treatment:

I needed to know what was happening and what they were planning.

All the patients said they wanted continuing contact with a health care professional after the visit. They wanted to know that it was in order to contact their health care professional with questions and thoughts after the visit. They needed to know which person they could turn to:

I want to know whom I can call with questions. I was invited to call back if I needed to, and I did actually call back once.

This need to have continuity in the contact with one's health care professional is related to the fact that many patients found it hard to comprehend and/or remember what was being/had been said at the visit:

You listen so selectively, you focus on the good news and hold on to it.

You don't know what to ask—it comes to you later, gradually.

However, wanting to return for another consultation or to contact their health care professional depended on the patients' feeling confident.

Confidence

During the interviews it was expressed in different ways that feeling confident in the care was

dependent on the conditions, which are described under the different categories, being met. The patients felt confident if they were given straight answers, time, continuity and respect and if they were treated as individuals with individual needs.

The important thing is to see someone you feel you can genuinely trust; where there's no side-stepping the issue, just straightforward information.

It was that he took the time to tell me, to describe my situation, so to speak. I felt I could trust him, mainly because he really took a lot of time with me.

Because if they lack empathy, it doesn't matter.

Discussion

The aim of this study was to investigate how cancer patients experience their first visit to a cancer clinic. The results show that the patients not only want knowledge about their cancer and their upcoming treatment but other aspects in the care are also important. These include having something done about the illness without delay and being treated with respect and continuity, which in turn leads to confidence in the care being given.

The five categories discussed under “Research Findings” are seen to be important for patients to reach acceptance of the impact cancer has and will have on their lives. Reviews of the literature show acceptance to be a coping strategy (Payne, 1990; Fortune et al., 2002; Stanton et al., 2002; Wasteson et al., 2002). Coping has been defined by Lazarus and Folkman (1984) as a set of responses to stressful or negative events, which function to attenuate distressing psychological outcomes and modulate the individual's psychological reactions. According to Stanton et al. (2002), acceptance as a coping strategy at diagnosis predicts a more positive adjustment and decreased distress over time. The authors also highlight that acceptance is correlated to optimism, which could indicate that expecting the outcome to be positive facilitates acceptance. However, Payne (1990) reports acceptance as an approach in women who received palliative chemotherapy. Acceptance has been described by Wasteson et al. (2002) as a coping strategy used in handling physical and psychological aspects in daily life in patients with gastrointestinal cancer. Fortune et al. (2002) investigating the coping strategies of patients with psoriasis discuss similarities between psoriasis patients and patients with breast cancer using acceptance as a coping strategy. These studies endorse the findings

of the present study on how to help patients achieve acceptance. To achieve acceptance can also be linked to the patient's feeling of being in control. In agreement with our findings [Marlow et al. \(2003\)](#), who investigated breast cancer patients' psychosocial needs, state that a sense of control is dependent on accessible relevant information tailored to individual requirements and on involvement in decisions about treatment.

Many studies have concentrated on the needs of cancer patients at different stages of their illness. Many report findings similar to ours. Confidence, information and help in maintaining a sense of control are highlighted in [McIllmurray et al. \(2001\)](#). [Leydon et al. \(2000\)](#) conclude, however, that not all patients want extensive information about their disease.

Although our findings are in agreement with those of previous studies it is important to point to differences between these studies and the findings presented in this paper. For instance, practical and emotional needs have been shown to be of importance ([McIllmurray et al., 2001](#)). These needs were not been seen in our study population. This difference can be explained by the fact that the focus of the present study was the patients' experience of their first visit and not their overall needs. Another explanation could be that the patients investigated by [McIllmurray et al. \(2001\)](#) were patients who were, according to their own definition, at a critical moment in their disease such as at the time of diagnosis, at the end of their first treatment, at first recurrence or at the point of switching from curative to palliative treatment. Also, the fact that the patients in our study were affected by the waiting time and felt a strong need to start their treatment may show some overlap with the expression of supportive, practical and emotional needs. The time that is spent waiting for treatment was a major issue for the patients in our study. Almost all the patients had difficulty focusing on the interview question when all they wanted to do was to relate their experiences of waiting. Once they had got those off their chest they were able to focus on the interview.

Not knowing in detail what would happen was what frustrated our patients about the long waiting time. Patients who had had surgery said it had taken about 14 days to recover from the operation. After that they had wanted to know the results of the operation and to start their treatment. In this study the action that the patients wanted was their follow-up cancer care. However, the question still remains whether actions such as telephone calls or a visit to a cancer clinic at an earlier time point to receive more information decreases the anxiety

associated with a long waiting time. In other words, is it the treatment as such or action (such as contact with a health care professional) of any kind that is of importance?

Time was one of the dimensions involved in treating the patients with respect. Enough time and quality of time being given played a major role in the way each patient experienced relevant information, respect, and continuity of care and, as a result, confidence in the care received.

Straightforward answers and information are important elements of patients' needs to be informed about, and participate in, treatment decisions. The patients we interviewed wanted to take part in planning their treatment but were to some extent willing to leave the choice of plan and treatment to the professionals. In an extensive randomized study on the experience of women with cancer [Veronesi et al. \(1999\)](#) showed that opinions about involvement in treatment decisions were evenly split between the participating patients. Mostly patients who wanted to be involved were under 60 years of age, or were patients who had suffered a relapse, were highly educated or were being treated at a university hospital. However, the cited study did not investigate or show to what extent the patients wished to be involved in the decision process. We assume that what was meant was that to be involved and to achieve full information is not the same as deciding what treatment is best for you.

The present study suggests that it is very important for patients to be treated as individuals and to be given individualized care with continuity. Knowing whom to turn to for more information is an important element in this continuity since, as the study shows, patients often find it hard to concentrate during a first health consultation and know what questions to ask.

Limitations

This study has some limitations which need to be considered. The material is small and the findings must be interpreted in relation to this fact. Nevertheless the study provides knowledge of the needs of cancer patients on curative treatment through investigating their experiences. Also, the fact that the findings in this study are similar to some of the findings of other studies (e.g. [McIllmurray et al., 2001](#); [Leydon et al., 2000](#)) suggests that this study has merit.

[Glaser \(1978\)](#) describes specific criteria for identifying a good Grounded Theory study: the

theory must fit and thus account for all the data and it must work, meaning it must be able to explain what happens and predict what may occur. In the present study these criteria were striven for through openness, thoroughness in collecting data and consideration of all data in the theory development phase.

Nine patients with three different cancer diagnoses and a wide age range were interviewed while eight patients declined to participate in the study. Many patients in the region have a long way to travel to the clinic and some of the patients who declined participation said that they did not have the strength to come for an additional visit for the interview. We do not know whether these patients would have considered participating had the interviews taken place at their home. Two patients said they were not interested in participating in the study. It is possible that the findings of the study would have been different if the 20–40-year age group had also been represented. Because of this fact it is important to more thoroughly investigate patients' experiences during their first visit to the cancer clinic. It must also be taken into consideration that one inclusion criterion of the study was the ability to speak Swedish, which excluded the non-Swedish-speaking members of our community.

The patients expressed relief about the fact that their cancer had not spread. With regard to this fact it should be emphasized that the results of this study are not applicable to patients in palliative care as their experiences can be different.

All patients were interviewed within a few days to 1 week of their appointment at the cancer clinic. We attempted to keep the interval between the appointment and the interview as short as possible because some facts that affect the experience can be forgotten and the information given may be repressed and denied.

Implications

Awareness of cancer patients' experiences is vital in supporting these patients in their process of coping. In this study we have shown important issues in the care of cancer patients about to receive curative treatment and suggested how best to care for such patients. More studies must be performed highlighting the importance of acceptance as a coping strategy and how we as health care professionals can help these patients to achieve acceptance.

Soothill et al. (2001) propose that multi-professional care should be striven for and introduced at

an early stage in the care of the cancer patient. Many factors in this study, such as providing knowledge and continuity in care, as well as making sure that the patient feels confident, emphasize the importance of the nurse's involvement. Developments within cancer care, resulting from an older patient population and increased ambulatory care, have led to the development of nurse-led clinics (Loftus and Weston, 2001). We should investigate whether these cancer patients could have been seen by a nurse and whether they would have benefited from seeing a nurse. Patients often feel that nurses are more easily accessible and have more time than other health care professionals do. Studies have also shown that cancer nurses can improve cancer patients' QoL by providing the patients with a feeling of security and by treating them with respect, as individuals (MacDonald, 2001). Further studies could provide an answer to the question whether it is important to have a health care professional, preferably a nurse, keep in touch with the patients while they are awaiting treatment, providing a sense of continuity that could be maintained even after the initial visit to the cancer clinic. It is important for patients to know who has the responsibility for their care when they are referred between different institutions. Better organization is therefore needed in order to decrease the waiting time and improve the care for cancer patients waiting for treatment.

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