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WORK REHABILITATION AND RESOCIALISATION OF CANCER PATIENTS REGARDING TRAFFIC

ABSTRACT

Incidence of cancer disease in Croatia is about 20,000 every year. In the same time, about 11,000 cancer patients die. If the average survival of cancer patients is five years, it is obvious that an enormous number of patients need rehabilitation and resocialisation, according to the stage of their disease. One of the best ways to achieve this goal is work rehabilitation, which contributes to the quality of living and to the desire of the patients themselves to participate in the treatment and curing process, especially in the second phase which often includes reconstructive surgery or use of rehabilitation devices. Work rehabilitation and resocialisation should be performed in assistance by the family doctor and the patients organised in the Club of Cancer Treated Persons which has already gained high recognition in the Croatian Cancer League.

KEY WORDS

cancer, rehabilitation, resocialisation

1. INTRODUCTION

According to the latest data of the Croatian cancer register[1], the total number of newly diagnosed cases of invasive cancer, excluding skin cancer, amounted in 1992 to 14,369, out of which 7,820 were diagnosed in men and 6,549 in women. At the same time, 10,157 cancer patients died, 5,960 men and 4,195 women. The incidence rate amounted to 300.3/100,000, i.e. 337.3 in men and 265.6 in women. The mortality was 212.3 - 257.0 for men and 170.2 for women per 100,000. (Figure 1)

According to the sites of origin, there are substantial differences between men and women. In men the dominating primary site of cancer are respiratory organs (smokers), and in women it is the breast cancer. (Figure 2)

Until the latest success in preventing, early discovery and treatment of malignant diseases, the cancer patients had been considered as lost regarding business and had been necessarily deprived of social and family life. Fortunately, this is not so any more, and more and more patients can expect to be cured, an even greater number survives over 5 years, and the number has been greatly reduced of those entering the long-term terminal phase when they need only palliative treatment in order to improve their quality of living.

The majority of treated patients can and should return to an adequate working and social environment, in which by contributing as much as they can according to their capabilities, they re-activate themselves in the respective social and working activities.

2. WORK REHABILITATION AND RESOCIALISATION

Advanced development of oncology has created conditions that now the success of treatment can be evaluated in the range from full recovery and satisfactory condition to the patient in the so-called terminal phase of the disease when no anticarcinogenic therapy can help, and suffering can be eased only by palliative treatment and symptomatic therapy, primarily concerning pain.

Regarding the number of cured cancer patients, the World Health Organization classifies malignant diseases into chronic diseases.[2] Therefore, these patients should not be left on their own, isolated, without hope of recovery and a more or less normal life. Depending on their condition, they should be provided with adequate quality of living, and this is best achieved through work rehabilitation and resocialisation. The very procedure of rehabilitation and resocialisation includes the entire psychosocial and somato-motoric area of life, and involving the family, social and working environment, as well as humanitarian societ-

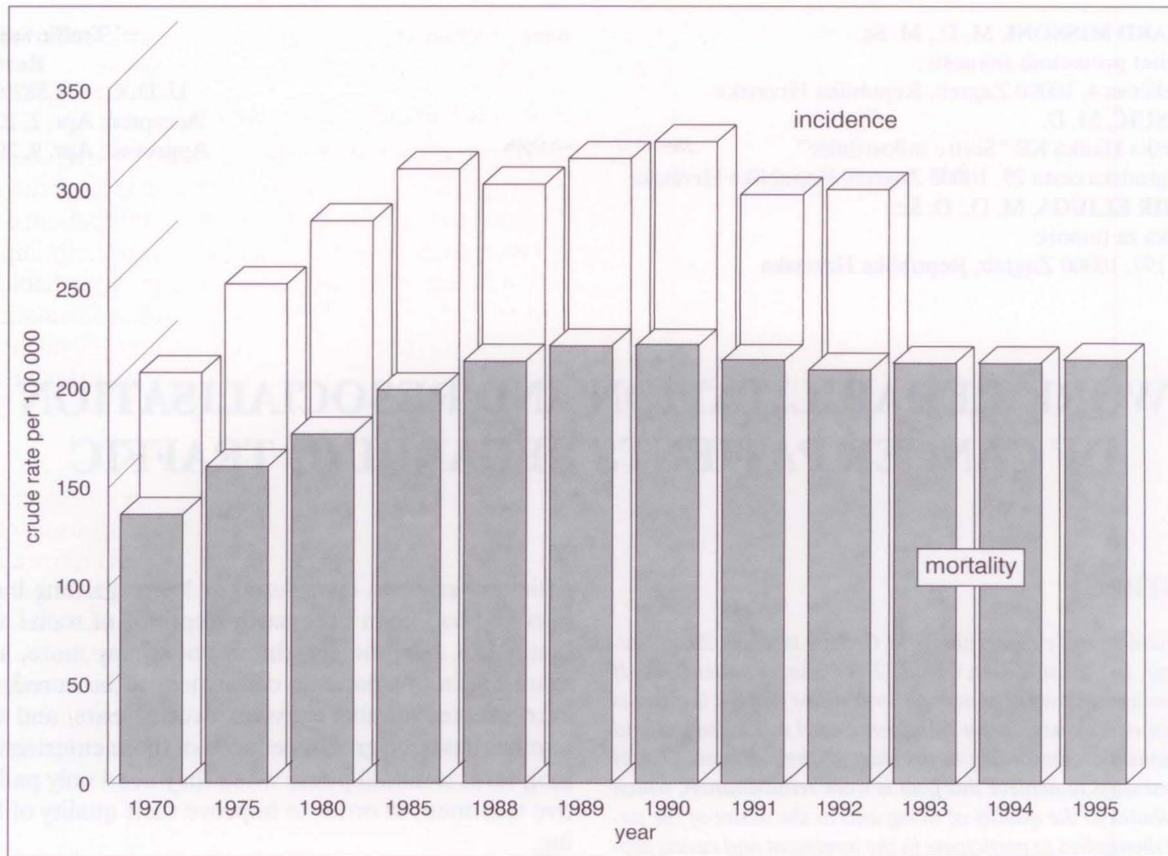

Figure 1 - Cancer incidence and mortality in Crotia 1970 - 95.

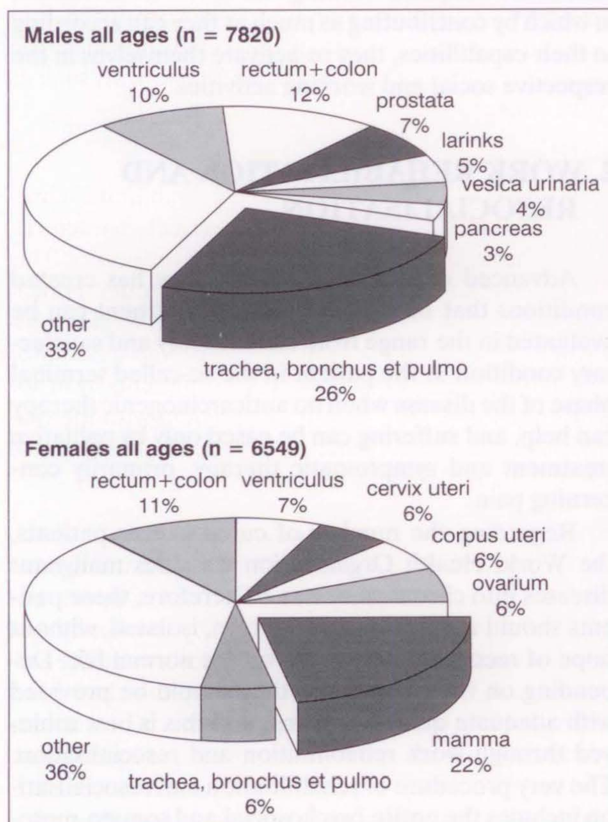

Figure 2 - New cancer cases and most commom cancer sites by sex in 1992

ies, such as those existing in Croatia: Croatian Cancer League with its clubs of cancer treated persons, and the Croatian Society for hospice and palliative treatment.

In starting rehabilitation one should take into consideration that some patients manage to offer resistance to their disease more easily and in a better way, thus remaining productive for a long time, whereas others, having the same patho-physiological condition, same treatment and similar prognostics succumb fast to the disease. The latter group of patients is classified by the oncologists into the so-called "C type personality" who are prone to disease.[3] The former group of patients has shown that they can relax more easily, thus releasing their nervous excitation, engaging in various social and working activities, therefore living longer, creating a kind of psychological resistance towards cancer.

Therefore, before starting rehabilitation the following should be determined:

- whether there are any psychological factors that may affect the treatment results and rehabilitation,
- whether these psychological factors can be influenced thus enabling patients to withstand more successfully their disease and adapt more easily to the social and working environment.

Great help in this can be obtained by engaging psychologists and therapists in the rehabilitation procedure.

In returning the cancer treated patients to their respective working and social activities and family life, the following should be attempted:

- to make the patient emotionally accept the disease for what it really is, without negative attitudes towards it and the suggested treatment,
- to allow the patient to adapt to the condition caused by the disease and to accept psychologically the possible disablement as result of the suggested treatment,
- to make the patient accept life with the disease, with the possibility of subsequent improvements by using adequate aids or by having reconstructive surgery to improve their appearance and working abilities.

As early as 1965 an Act was accepted in the USA providing for professional rehabilitation of oncologic patients.[5] The origins of rehabilitation in Croatia were set in 1956 by Dr. Jozo Budak at the KB "Dr. M. Stojanović", renamed today to "Sestre milosrdnice", and at the same time the practising of esophageal phonation in laryngectomized patients started at the Clinic for rhinolaryngology of the same hospital.[6]

The founding of the Croatian Cancer League in 1966 in Zagreb meant a step further to improving rehabilitation and resocialisation of the oncologic patients. Further step in this improvement was made by the Croatian Cancer League by founding the Central Institute for Tumours and similar diseases, today the Clinic for Tumours, in Zagreb, two years later, and a number of oncologic centres and out-patient clinics throughout Croatia.

Certainly, a significant year in the treatment of oncologic patients is 1979, when a Service for Rehabilitation of Cancer Patients was founded at the Clinic for Tumours in Zagreb, the work of which was directed to:

- medical rehabilitation,
- psychosocial rehabilitation, and
- scientific work.

It has been generally accepted that the rehabilitation procedure is performed based on the following six rehabilitation and pedagogical principles:

1) The principle of informing and explaining the aim

Candidates are explained the aim, need and method of rehabilitation, regardless of whether it is to be performed individually or in a group. It is important in the beginning to eliminate fear and lack of confidence in the suggested method of medical, working and social rehabilitation in patients. This requires engagement not only by physiatrists, but also by psychologists and therapists, and in those patients who will have problems with participating in traffic due to their disabilities, traffic medicine experts as well.

2) Principle of individual approach

In principle each of these patients should be approached individually, in order to gain trust of the patient and to get to know the problems this patient does not want to share with others. This is especially important in integrating the patient into group rehabilitation procedure. Possible details in this problematic, if not obtained from the patients themselves, might be obtained from the family, friends or the working environment.

3) Principle of a "demonstration" approach

The method of performing exercises and expected results is best shown to the patients visually using photos, films, but also by means of direct demonstration given by the already treated and rehabilitated patients. This means showing the way in which prostheses and protective devices should be used, as well as the advances of sophisticated reconstructive surgery with the aim of improving working capabilities and correcting malformations caused by previous therapeutical procedures.

4) Principle of motivation and activity

The patient should be made to understand the need to return to the family, society and working environment. The patient should be made aware of that during the whole process of rehabilitation, since the patient may break down if side effects appear, such as pain, nausea, vomiting, loss of hair, etc.

5) Principle of adequacy

Adequacy of method and of the rehabilitation procedure to the psychological and physical characteristics of the patient may contribute a lot to success. This approach has to be suitable to the age, gender, education, psychological profile and family and working environment surrounding the patient. The assistance here can be expected in case of labile patients by in advance prepared interviews of the patient with the visitors, friends, family and members of the clubs of treated oncologic patients.

6) Principle of socialisation

Regardless of the disease stage, the patient must not feel abandoned. The patient needs support, not only by the medical team, but also by the family and friends, regardless of the level of disability and the aesthetic defect. A significant role in this has been achieved by the Club of Laryngectomized Patients which is active within the Croatian Cancer League, and was founded in 1974, for a long time managed successfully by Mr. Sokolaj, B.Eng., who was the prototype of successfully trained esophageal phonation, so that many laryngectomized patients in Croatia and

elsewhere tried and managed to catch up with him. Later, such clubs were founded and continued working successfully in other big medical centres throughout Croatia. Encouraged by success of these clubs, soon clubs of mastectomised women and clubs of patients with stomas started to appear. Since the development of medical technology is advancing fast, it has become difficult to follow it, and the so-called "Application centres" started to be founded. The first one founded was the one that is till active in the Clinic for Tumours in Zagreb. Here, cancer patients and persons who take care of them can get all the necessary information about orthopaedic and other aids which can enable patients to integrate more easily and more successfully into the everyday way of living.

3. CONCLUSION

Rehabilitation and resocialisation of oncologic patients with the aim of their re-integration into the family life, social activities and working environment represent a complex procedure which depends on many factors. The procedure must be started as early as possible, since e.g. early logo-treatment in 50% of glossectomised patients causes just a minimal disturbance of speech. According to the current development of the rehabilitation procedure it should be expected that about 30% of laryngectomized patients will not manage to master the esophageal phonation, but this should not be the reason to break down, since in that case the patients can use electric larynx which will allow them to communicate successfully by speech. Reconstructive surgery can successfully correct the resulting defects caused by treatment, which is of special importance in case of younger persons sensitive to aesthetic appearance. Modern disposable plastic bags in patients with stoma allow almost normal movement among people and performing of very demanding tasks. However, along with all these advances in rehabilitation and resocialisation of the treated oncologic patients, the basic aim of oncology remains prevention and early discovery of cancer until possibilities for etiological treatment of malignant diseases are created.

SAŽETAK

RADNO I DRUŠTVENO OSPOSOBLJAVANJE ZA PROMET OSOBA OBOLJELIH OD RAKA

U Hrvatskoj se godišnje javlja oko 20000 novooboljelih od raka, odnosno zloćudnih bolesti. Istovremeno, oko 11000 bolesnika umire zbog istih bolesti. Ako je prosječno preživljavanje oko 5 godina, onda proizlazi da ogroman broj bolesnika treba rehabilitirati i resocijalizirati, ovisno o uznapredovalosti njihove bolesti. Jedan od najboljih načina za postizanje tog cilja je osposobljavanje za odgovarajući rad. Takav postupak znatno doprinosi poboljšanju kvalitete života i želji bolesnika da i sami doprinesu uspjehu liječenja, poglavito u fazi naknadnog liječenja, često povezanog uz izvođenje raznih rekonstruktivnih zahvata ili korištenje određenih pomagala. Sam postupak osposobljavanja za radni i društveni život ovih bolesnika ne može se silom nametnuti, pa bolesnike i njihove najbliže treba za to privoliti počevši od prvog kontakta bolesnik - liječnik. U tom procesu bitnu ulogu ima obiteljski liječnik, ali i klubovi osoba liječenih od raka, koji su se već dobro afirmirali u okviru Hrvatske lige protiv raka.

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