

Effectiveness of Planned Teaching Programme on Knowledge Regarding Non-Curative Care of Terminally ILL Cancer Patients among Care Takers

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Abstract: *The purpose of this study was to assess the effectiveness of planned teaching programme on knowledge regarding non-curative care of terminally ill cancer patients among care takers. Objectives- To assess the knowledge among care takers on non-curative care of terminally ill cancer patients before and after structure teaching. To find the association between knowledge with selected socio demographic variables. Methods An evaluative research approach with quasi experimental design with 40 cares takers and convenient sampling technique. Results the highest proportion of care takers (32.5%) were from the age group of 40-49 years, (50%) males and 20 (50%) of them females, majority of the samples (42.5%) were graduates, around 13 (32.5%) of samples were taking care of terminally ill cancer patient. The Mean posttest knowledge 29.65 was higher than Mean pre-test knowledge score 15.75. The computed 't' value 33.944 (P< 0.05) .Conclusion The findings of the study concluded that care takers had inadequate knowledge regarding non-curative care of terminally ill cancer patients. The planned teaching programme on non-curative care of terminally ill cancer patients was highly effective in improving the knowledge of care takers regarding non-curative care of terminally ill cancer patients.*

Keywords: Non-curative care, terminally ill cancer patients, care takers, Knowledge

1. Introduction

One of the very common types of diseases nowadays is cancer. Cancer has already gained the respect of almost all doctors all over the world because of its serious and hazardous effects towards its victims.[1] Another complicated idea about cancer is that its exact cure has not been discovered yet by the medical world. However the positive thing left for this type of disease is that it has specific stages where in you can vary your way or method of treating it. [29] Cancer' is a term used for diseases in which abnormal cells divide without control and are able to invade other tissues. Cancer cells can spread to other parts of the body through blood and lymph system. [3] 'Terminal illness is a medical term popularized in the 20th century to describe an active and malignant disease that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient. [14] Non-curative care is any form of treatment that concentrates on reducing a patient's symptoms, improving quality of life, and supporting patients and their families. [5] Non-curative care is given as early as possible in the cancer treatment process and continues through all stages of illness, regardless of whether a cure is the expected outcome. In Non-curative care, cure is no longer possible; it aims to control symptoms and quality of remaining life by maintaining comfort and function. If you decide to stop disease-directed treatment, non-curative care focuses on managing the symptoms caused by cancer. [6] A family caretaker/ institutional caretaker concern that has been reported consistently in the literature is the need for information about the dimensions of care to be provided,

such as information and assistance regarding the disease; physical care; comfort measures; what symptoms to expect, their causes, and how to manage them; treatment regimens; expectations for future care; patients' emotional responses; household management procedures; finances; and community resources. Caregivers also seek information on strategies for reassuring patients with decreased energy, as well as about managing other symptoms. [27]

2. Justification of the Study

Cases of cancer doubled globally between 1975 and 2000, will double again by 2020, and will nearly triple by 2030," Indian Council of Medical Research (ICMR) Director General Viswamohan Katoch said at a seminar on 'New Frontiers in Hematology and Oncology'. [6] There were an estimated 12 million new cancer diagnoses and more than 7 million deaths worldwide this year, approximately 0.8 million occur in India. In India one in 10 deaths is related to cancer and a sizeable section of this huge population die in unrelieved pain and suffering. The projected numbers for 2030 are 20 to 26 million new diagnoses and 13 to 17 million deaths. [6] To simplify further, in India, about 10 lakh persons suffer from cancer every year, about 4.5 lakh die, about 6 lakh undergo painful treatment processes, about 4.3 lakh are terminally ill advanced cancer patients every year. [9]

Vision 2015 for India is to offer affordable and accessible diagnostic, therapeutic and palliative care services in the country. The goal is to improve the quality of life of

advanced cancer patients and their families. [10] Only 5% of persons in Maharashtra undergo screening for cancer, while 95% refrain from getting screened. [11].

Demands on caregivers escalate as treatment plans shift, the disease progresses, and the patient's functional capacity deteriorates. Thus, continued guidance and support from health care professionals will assist caregivers in coping with these aspects of care, which, in turn, will help to alleviate some of the stress, burden, and depression that caregivers experience. [12] The complexity of care giving is influenced by the quantity of required tasks, many of which are not predictable. These tasks may require insights and abilities that caretakers do not possess, adding to caretakers' anxiety and frustration. Information thus becomes a key resource for caretakers. [13]

3. Review of Literature

Review of literature is a broad, comprehensive in depth, systematic and critical review of scholarly publications, unpublished scholarly print materials, audiovisual materials and personal communications. [4]

International comparison study was concluded that differences among the primary concerns from the Short-Term Life Reviews, arguing that we can improve the spiritual well-being of terminally ill cancer patients by focusing on the primary concerns within each country. [15]

The evidence was strongest in relation to pain management, where inadequacies in caregiver knowledge and the importance of education were emphasized. The significance of effective communication and information sharing between patient, caregiver and service provider was also emphasized [16]. Study suggest that professionals who are in a position of assisting families should be aware of the phases of care giving development so that culturally and spiritually sensitive interventions can be designed to address individual needs they change along a patient's illness trajectory [17].

3.1 Literature related to terminal cancer stage symptoms and its non-curative management

Pain, dyspnea, and fatigue were the only symptoms measured in all 22 studies. It is difficult to draw conclusions about the relationships among multiple symptoms, predictors, and outcomes due to the heterogeneity of these studies [18]. At baseline, the day care group was (non-significantly) worse than the comparison group in the MQOL support domain. The comparison group had marginally more severe pain at baseline and more severe symptoms at second assessment. Both patient groups maintained overall health-related quality of life during the three months of the study. Palliative day care was not found to improve overall health-related quality of life. [19]

There is evidence for high satisfaction among patients selected into day-care, but not yet sufficient to judge whether this improves symptom control or health-related

quality of life [20]. This study provides evidence for a strong need for symptom assessment and spiritual assessment, development of plans of care inclusive of symptom control and spiritual care, and implementation and evaluation of those plans utilizing quality of life as an indicator for the outcome of care provided by nurses. [21]

A Participant reported reduced ambulation, inability to perform hobbies or housework, and the need for occasional assistance in self-care QoL was fair. Multiple regression analysis showed that patients who were older, female, had ever been married, or had higher physical functioning tended to have better QoL [22]. The main issues arising from the findings for nurses are the early detection and management of both physical and psychological symptoms, particularly fatigue, pain, anxiety and depression, and the need to use strategies that will empower patients to have a greater sense of control over their illness and treatment. [23]

A correlational study was done by Marjorie Acierno, University of South Florida to study the relationship between sleep- wake disturbance and pain in cancer patients admitted to hospice in the year 2007. There is evidence of a relationship between sleep-wake disturbances and pain variables in cancer patients. It is hypothesized that pain affects all aspects of sleep patterns. Pain has been known to affect sleep disturbances; however there are different facets of sleep-disturbances and pain that can be evaluated. These variables include pain distress, pain intensity, pain at its worst, relief from pain, sleep distress, how well the patient sleeps, how tired one feels, and drowsiness distress. There were no significant relationships found between sleep distress and relief from pain, pain distress and how well the patient sleeps, pain distress and how tired one feels, and pain distress and drowsiness distress. Sleep-wake disturbances and pain have been studied in cancer patients, but there is little known concerning pain and its correlation to sleep disturbances of cancer patients admitted to hospice home care. This study provides data to support the necessity to provide complete and accurate assessments of sleep and pain symptoms on admission to hospice home care and throughout the patient's care to aid in improved quality of life. [24]

Fatigue is the most prevalent and distressing symptom experienced by patients with advanced lung cancer and especially among those patients undergoing therapy. Advanced cancer and its associated symptoms can significantly impact the quality of life (QOL) of those who have the disease. The primary purpose of this study was to measure fatigue levels, characterize the fatigue experience, and assess for gender differences in perceptions of fatigue and QOL in patients with advanced lung cancer receiving chemotherapy. The study results also failed to confirm gender differences in QOL measures. The chart audit did reveal that the providers in this study did not consistently assess and document fatigue levels, with the nurses documenting less frequently than the physicians. The results of this study did suggest that fatigue levels and QOL are problematic for patients treated for lung cancer. In an effort to better assist patients and tailor plans of care, it is vital that

practitioners, especially care takers assess for fatigue in advanced lung cancer patients[25]

A statistically significant correlation was noted between cancer-related fatigue and depression these study results support findings from previous studies indicating a moderate correlation between cancer-related fatigue and depression. This study addresses the correlation between cancer-related fatigue and depression in chemotherapy patients which may improve nursing assessment of fatigue and depression in this population. Findings suggest the need for ongoing research focusing on cancer-related fatigue and depression as well as appropriate pharmacological and non-pharmacological interventions to improve the quality of life of

3.2 Literature related to effectiveness of planned teaching programme

Literatures available on various educational methods and media for practice in nursing [7]. Planned teaching programme was found to be effective in improving the knowledge, attitude and knowledge on practice of mothers regarding ARIs as shown by the post-test scores of experimental group. The findings revealed that there was increase in the knowledge level of staff after structured education trials. [28]

A study concluded that demonstration regarding feeding of hemiplegic patient among caregivers was effective in increasing the skill of the caregivers regarding feeding of hemiplegic patient. [2]

4. Problem Statement

A study to assess effectiveness of planned teaching programme on knowledge regarding non-curative care of terminally ill cancer patients among caretakers at a selected oncology institution

4.1 Objectives

1. To assess the knowledge among care takers on non-curative care of terminally ill cancer patients before and after planned teaching programme.
2. To find the association between knowledge with selected socio demographic variables.

4.2 Assumptions

1. The caretakers of terminally ill cancer patients may have some knowledge regarding non-curative care
2. The caretakers may cooperate and attend the teaching programme by their own interest and will, hence updating their knowledge is an important learning need in such sensitive scenario
3. The planned teaching programme may be beneficial to the caretakers working with terminally ill cancer patients at the institution.
4. The result of the study may help the caretakers to know more about the non-curative care of terminally ill cancer

patients which will help them to apply the same in future endeavors.

4.3 Hypothesis

H₀: There will be no significant difference in the pre-test and post-test knowledge score.

H₁: There will be significant difference in the pre-test and post-test knowledge score.

4.4 Research Methodology

The study was conducted in three phases

Phase I: It includes assessing the existing knowledge of care takers regarding non-curative care of terminally ill cancer patients.

Phase II: In this phase, planned teaching programme on non-curative care of terminally ill cancer patients was developed and administered to the care takers.

Phase III: This included determination of effectiveness of planned teaching programme

4.4.1 Research approach

In the present study, evaluative research approach was taken.

4.4.2 Research Design

The research design selected for the study was a quasi-experimental one group pretest posttest design. The design used is depicted below.

4.4.3 Population

The population of the present study comprises caretakers.

4.4.4 Study subjects-

The tarstudy subjects were caretakers from selected institutions.

4.4.5 Accessible population

Accessible population in the present study was caretakers of terminally ill cancer patients in selected oncology institutions.

4.4.6 Independent variable

In this study, the independent variable is the planned teaching programme on non-curative care of terminally ill cancer patients.

4.4.7 Dependent variable

The dependent variable in the study is knowledge of caretakers.

4.4.8 Setting of the Study

The study was conducted at in patient setting in the selected institutions.

4.4.9 Sample Size

The sample of the study consisted of 40 caretakers of terminally ill cancer patients in selected oncology institutions available at the time of data collection. The caretakers who fulfilled the criteria were selected as the subjects for the study.

4.4.10 Sampling Technique

In view of the objectives of the study convenient sampling technique was used.

0-12 - Poor knowledge
13-24 - Average knowledge
25-36 - Good knowledge

5. Criteria for Selection of Sample

5.1 Inclusion Criteria

- The caretakers working in selected oncology institutions
- Those caretakers who are willing to participate in the study.
- Those caretakers who are available at the time of data collection.
- Those care takers who can read and write English and Hindi languages.
- Caretakers who have not attended seminar or workshop on non-curative care of terminally ill cancer patients within last 1 year.

5.2 Exclusion Criteria

- The caretakers who are not willing to participate in the study.
- The caretakers who are not available during data collection.
- The caretakers who have attended any workshop or seminar in the topic of non-curative management or end of life services within last 1 year.

5.3 Data Collection Instrument

A structured questionnaire was selected for the Study to assess the knowledge of caretakers.

6. Description of the Tool

The structured questionnaire was designed with two sections.

Section 1

Section 1 consisted of 6 items pertaining to the demographic variables of the respondents, such as age, gender, educational qualification, and duration of taking care of terminally ill cancer patients, any previous experience of taking care of terminally ill cancer patients in the family and any workshop or training on non-curative care of terminally ill cancer patients.

Section 2

Section 2 consisted of 36 items pertaining to Non-curative care of terminally ill cancer patients. These 36 items were distributed under the following 2 components.

- Cancer and terminal stage cancer.
- Terminal cancer symptoms and its non-curative care.

Each score of correct response was given a score of one and incorrect response a score of zero. The maximum scoring possible was 36 and minimum 0. The scoring was categorized as:

6.1 Content Validity of Tool

The five experts were from the field of nursing in medical and surgical nursing specialty. One expert was an oncologist and other expert is a statistician from an epidemiological unit. They also approved the items prepared in terms of its content.

The modifications suggested by the experts were carried out before final preparation of the tools. The tool was prepared in English and Hindi.

6.2 Reliability of the Tool

The Reliability of the validated tool was established by application of the split half technique, which measures the co-efficient of internal consistency. The reliability of the half test was found by using Karl Pearson's correlation by raw score method. The coefficient of correlation of knowledge test was found to be **0.77**. Since the computed correlation of knowledge score was high, the tool was found to be reliable.

6.3 Data Collection Method

The data collection process involves the precise, systematic gathering of information relevant to the research purpose questions, or hypothesis of a study. The investigator personally contacted each selected subjects and their informed written consent was obtained after explaining the purposes of the study. Questionnaire was administered to each sample who was asked to fill it then and there. After pre-test, planned teaching programme was provided to the subjects. The posttest was conducted on seventh day.

6.4 Plan for data analysis and interpretation

The data analysis was planned to include descriptive and inferential statistics. The following plan of analysis was developed with the opinion of experts. The analysis was done based on the objectives and hypothesis to be tested.

6.5 Ethical Aspects

The research synopsis was presented in front of the ethical committee and it was approved by all the members of the committee. The feasibility of the tool and planned teaching programme was discussed and approved of. The confidentiality of the subjects were maintained. The written consent was obtained before each sample was involved in the research process. Control was maintained over the subjects throughout the study.

7. Findings

Table 1: Frequency and percentage distribution of sample characteristics

S.No	Sample characteristics (n= 40)	Frequency (%)
1	Age of the care taker	
	a. 20- 29 years	11(27.5%)
	b. 30- 39 years	9(32.5%)
	c. 40- 49 years	13(17.5%)
2	d. 50- 59 years	7(%)
	Gender of the care taker	
3	a. Male	20(50%)
	b. Female	20(50%)
4	Educational qualification	
	a. Primary education	8(20%)
	b. Secondary education	14(35%)
	c. Graduation	17(42.5%)
5	d. Any other	1(2.5%)
	Duration of taking care of terminally ill cancer patient	
	a. 1- 3 months	11(27.5%)
	b. 3- 6 months	6(15%)
6	c. 6- 9 months	10(25%)
	d. More than 9 months	13(32.5%)
7	Any previous experience of taking care of cancer patient in the family	
	a. Yes	14(35%)
8	b. No	26(65%)
	Attended any training/ workshop on non-curative care of terminally ill cancer patient	
9	a. Yes	12(30%)
	b. No	28(70%)

The study reveals that majority 11 (27.5%) of the samples were from age 21- 29 years, 9 (22.5%) of them were from 30-39 years, 13 (32.5%) from 40-49 years, and 7 (17.5%) were from the age group of 50- 59 years. while 20 (50%) of them were males and 20 (50%) of them were females out of them were 8 (20.0%) primary educated, 14 (35.0%) of them were secondary educated, 17 (42.5%) of them were graduates and 1 (2.5%) belonged to other, which was a post graduate. The result showed that 11(27.5%)of the samples were taking care of terminally ill cancer patient since 1- 3 months, 6(15.0%) of them were taking care since 3-9 months, 10 (25.0%) took care since 6-9 months and 13 (32.5%) were taking care for more than 9 months. majority 14 (35.0%) of the samples had previous experience in taking care of terminally ill cancer patient, whereas 26 (65.0%) of them had no previous experience in taking care of terminally ill cancer patient while 12 (30.0%) of them have attended workshop on non-curative care of terminally ill cancer patients, 28 (70.0%) of them have never attended any workshop/ training on non-curative care of terminally ill cancer patients.

Table 2: Pre-test knowledge scores about non-curative care of terminally ill cancer patients (N = 40)

Level of Knowledge score	Pretest	Posttest
	Frequency%	Frequency%
Poor Knowledge: (scores 0-12)	6(15%)	0(0%)
Average knowledge:(scores 13-	33(82.5%)	2(5%)
Good knowledge :(scores 25-36)	1(2.5%)	38(95%)

The above table shows that in pretest, 6(15.0%) of samples in pre -test were having poor knowledge (scores 0-12),

33(82.5%) of samples in pre-test were having average knowledge (scores 13-24) and only 1(2.5%) of sample in pre-test were having good knowledge (scores 25-36) and majority 38(95.0%) of sample in pre-test were having good knowledge (scores 25-36).

The findings showed that only 1 sample had good knowledge in pretest whereas 38 of them had good knowledge in posttest. A paired t- test was used to calculate the effect of planned teaching programme on knowledge of care takers about non-curative care of terminally ill cancer patients. Since p-value is 0.000 (<0.05), the planned teaching is statistically significantly effective in improving knowledge of caretakers regarding non-curative care of terminally ill cancer patient. Hence the hypothesis H_0 is rejected and the hypothesis H_1 is accepted. Average knowledge of caretakers regarding non-curative care of terminally ill cancer patients is improved after administration of planned teaching. With respect to age, the calculated p value is more than 0.05 ($p > 0.05$), that means there is no significant association of demographic variables with pre – test knowledge regarding non-curative care of terminally ill cancer patients.

8. Discussion of Findings

8.1 Discussion in relation with description of demographic variables

The demographic data distribution of Subjects who participated in the Study has been presented from Tables 1- 6. The age-wise distribution pattern reveals that the highest proportion, 11 (27.5%) of the samples were from age 21- 29 years, 9 (22.5%) of them were from 30-39 years, 13 (32.5%) from 40-49 years, and 7 (17.5%) were from the age group of 50- 59 years. Co- incidentally, 20 (50%) of them were males and 20 (50%) of them were females. Among the samples, 8 (20.0%) of them were primary educated, 14 (35.0%) of them were secondary educated, 17 (42.5%) of them were graduates and 1 (2.5%) belonged to other, which was a post graduate.

The data shows that 11(27.5%)of the samples were taking care of terminally ill cancer patient since 1- 3 months, 6(15.0%) of them were taking care since 3-9 months, 10 (25.0%) took care since 6-9 months and 13 (32.5%) were taking care for more than 9 months. Only 14 (35.0%) of the samples had previous experience in taking care of terminally ill cancer patient, whereas 26 (65.0%) of them had no previous experience in taking care of terminally ill cancer patient. 12 (30.0%) of them have attended workshop on non-curative care of terminally ill cancer patients, 28 (70.0%) of them have never attended any workshop/ training on non-curative care of terminally ill cancer patients.

8.2 Discussion in relation with aspect / component wise statistical analysis of Pre-test and Post-test mean knowledge score of respondents

The present findings revealed that the overall mean pre-test knowledge score of the subjects was less (15.75) with the individual component mean knowledge values being as follows: As regards to cancer and its terminal stage, the

Mean score in pretest was 2.95; and as regards to knowledge regarding terminal stage symptoms and its non-curative care, the Mean score in pretest was 12.625.

In posttest, with regards to cancer and terminal stage of cancer, the mean posttest knowledge score was 6.075, with respect to terminal stage symptoms and its non-curative care, the mean posttest knowledge score was 22.875. Thus in the study, there is a significant increase in the mean knowledge score of each component in the Post-test when compared to the Pre-test mean knowledge score. Thus, in the study, in all the components, there is a good increase in the posttest knowledge score of the respondents with significant enhancement of knowledge in each component indicating that the planned teaching programme was effective in improving the knowledge level.

8.3 Discussion in relation with findings related to effectiveness of planned teaching programme

In the present Study, there is a significant increase in the mean knowledge score from 15.75 in pretest to 29.65 in posttest. In pretest 33 samples had average knowledge, 6 samples had poor knowledge and only 1 sample had good knowledge. In posttest, only 2 samples had average knowledge and 38 samples had good knowledge. The computed 't' value is 33.944 and $P < 0.05$ showed that there is significant difference between the pre-test and post-test mean knowledge scores. This indicates that the planned teaching programme was effective in increasing the knowledge score of care takers regarding non-curative care of terminally ill cancer patients.

8.4 Discussion in relation with Findings of Association between knowledge score with selected demographic variables

In terms of association of the knowledge score with demographic variables, it was found that the variable educational qualification had significant association with the knowledge score of the respondents whereas the age, gender, duration of taking care of terminally ill cancer patients, previous experience in taking care of terminally ill cancer patients and whether attended any workshop or training on non-curative care of terminally ill cancer patients had no significant association with the knowledge score of the respondents.

8.5 Discussion in relation with the hypothesis of the Study

H0: There will be no significant difference between the pretest and posttest knowledge scores on non-curative care of terminally ill cancer patients in patients undergoing chemotherapy.

H1: There will be significant difference between the pretest and posttest knowledge scores on non-curative care of terminally ill cancer patients in patients undergoing chemotherapy.

The Mean posttest knowledge 29.65 was higher than Mean pre-test knowledge score 15.75. The computed 't' value is

33.944 and $p = 0.000$ ($P < 0.05$) showed that there is significant difference between the pre-test and post-test mean knowledge scores. Thus the results of t test show that the improvement of the mean value of knowledge scores of Post-test when compared to the lesser values of Pre-test are not by chance but due to the gain in knowledge because of Planned Teaching Program.

9. Conclusion

On the basis of the findings of the study the following conclusions were made.

- Distribution of samples according to level of knowledge shows that majority had average knowledge regarding non-curative care of terminally ill cancer patients.
- Present study shows that there was need to impart knowledge regarding non-curative care and planned teaching programme is highly effective in doing so.
- The Total Mean percentage of knowledge score of the care takers during pre- test was 60.8 percent and SD 8.1 percent and in the posttest was 80.5 percent and SD 6.1 percent. Very high significance was found between pre and posttest knowledge scores of the samples in all areas regarding non-curative care of terminally ill cancer patients.

10. Scope of the Study

The findings of the study will be useful for all who render care to the terminally ill cancer patients. The care takers will be able to apply the acquired knowledge of planned teaching in their practice and will be able to identify the patient's symptoms and carry out the necessary interventions. The researcher aims to improve the quality of services at the end of life period of terminally ill cancer patients. As every human being has the right to a dignified death, so is this study important to enable to reward each one of the same, despite any kind of illness.

a) Nursing Implications

The findings of the study will be useful in the field of nursing education, nursing practice, nursing administration and nursing research.

b) Nursing Education

The study has shown that involving subject of non-curative care in the medical surgical nursing subject for GNM, BSC Nursing as well as MSC Nursing will equip the future nurses to impart the knowledge to their students in college as well as clinical areas. The nursing personnel should be given in-service education to update their knowledge and abilities to identify the learning needs and impart education to those who care for terminally ill cancer patients, thereby improving the Quality of life of the terminally ill patient.

c) Nursing practice

The oncology nurse should be able to use the acquired knowledge to give health education to the care takers in the clinical area and will be able to supervise the symptomatic care measures adopted by the care takers for the relief of the symptoms in terminal stage of cancer. Different A.V. Aids

can be used in imparting knowledge. This facilitates a dignified death for the patient and to make the end of life days better.

d) Nursing Administration

Having thorough knowledge regarding non-curative care of terminally ill cancer patients can prevent suffering of terminally ill cancer patient. Nurse administrator should arrange continuing educational programme for nursing personnel regarding non-curative care. Nurse administrator should prepare adequate learning material for giving health education. The administrator should emphasize the need for implementing planned educational strategies for improving the knowledge of the care takers. As a nurse administrator, one should encourage a specific association of care takers who can then carry out periodic meetings and programmes so as to be of help for the new care takers.

e) Nursing research

Study reveals that there is a deficit in the knowledge of the care takers regarding non-curative care and there is a need for extended Nursing research into different aspects of terminal stage of cancer. Even today, there are no much study done on end of life issues and care. Future nurse researchers should take up various aspects and conduct interventional studies. Nursing research will emphasize to increase the knowledge regarding non-curative care in terminal stage of cancer. Nursing research will help to implement in nursing practice for prevention of suffering in terminal stage of cancer.

11. Limitations of the Study

- The study is limited to caretakers working with terminally ill cancer patients.
- The study is limited to caretakers associated with selected oncology institutions.
- The study is limited to care takers who will be available at the time of Data collection.

12. Suggestions

- An association should be formed which will include care takers of terminally ill cancer patients.
- There should be an appropriate bereavement support group for the loved ones of the terminally ill cancer patients.
- Government should set up palliative care centers in Mumbai, which is presently very few. There are very few hospices in Mumbai, and the incidences of terminal cancers are alarmingly high.
- Some helpline facility for care takers should be set up which will assist them in times of crisis
- An information booklet can be prepared and used as a teaching aid in hospitals and outpatient clinics.

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