

Medical oncologist's perception of palliative care programs and the impact of name change to supportive care on communication with patients during the referral process. A qualitative study

Presented by: Serena Rix, V, January 16th, 2013

Reference: Rhondali W, Burt S, Wittenberg-Lyles E, Bruera E, Dalal S., Palliative & supportive care. E-published ahead of print: Jan 2013

Abstract

Objective: In a simultaneous care model, patients have concurrent access to both cancer-directed therapies and palliative care. As oncologist play a a critical role in determining the need/timing of referral to palliative care programs, their understanding of the service and their ability to communicate this to the patient is of paramount importance. Our study aimed to examine the oncologists' perceptions of the supportive care program at M. D. Anderson Cancer Center, and to determine whether renaming "palliative care" to "supportive care" influenced communication regarding referrals.

Method: This qualitative study used semi-directed interviews, and we analyzed data using the grounded theory and qualitative methods.

Results: We interviewed 17 oncologists. Supportive care was perceived as an important time-saving application, and symptom control, transitioning to end-of-life care, family counseling and improving patients' ability to tolerate cancer therapies were cited as important functions. Although most claimed early referrals to the service are preferable, oncologists identified several challenges, relating to timing and communication with the patients regarding the referral, as well as with the supportive care team after the referral was made. Whereas oncologists stated that the name change had no impact on their referral patterns, the majority supported it, as they perceived their patients preferred it.

Significance of results: Although the majority of oncologists favorably viewed supportive care, communication barriers were identified, which need further confirmation. Simultaneous care models that effectively incorporate palliative care with cancer treatment need further development.

Themes identified:

Role of palliative care is primarily supportive (symptom control) or transition to end of life care.

Symptom control is better managed by the holistic approach of the palliative care team. [Note: must remember that management may differ when treating toxicities due to chemotherapies.]

Transitioning to end-of-life care easier when there has been a long-term relationship between the palliative care team and the patient and family.

Palliative team is better equipped to provide support to care givers, and young children of cancer patients

Palliative care can decrease to workload on the oncologist.

Improved supportive care may extend chemo treatments and may prolong life.

Communications

Most concede earlier intervention is better, but not all oncologists follow this rule, waiting until there are no further cancer treatment options or the transition to end-of-life-care.

Triggers and barriers to referral include lack of a reference point (sentinel event) and not knowing when they may no longer be providing optimal care (admitting failure). Communicating the need for referral to palliative care is frequently difficult for oncologists. [Loss of income?]

Occasionally patients or their agents will ask for the referral. [Not only oncologists refer to palliative care]

The change of name from palliative to supportive care made no difference to referral patterns.

Strengths of study: Prospective. Sample size deemed sufficient for study design and statistical analysis methodology.

Weaknesses of study: One center (US) may not be generalizable. Authors agree recruitment process may introduce bias. Only oncologists were interviewed, but there are other services referring to palliative care. Patient/family point-of-view was not considered.

Relevance to palliative care: As early consultation to palliative care and the simultaneous care model become the expected norm, it is important to understand the barriers to early referral, so these may be recognized and addressed. We should also anticipate the increased resources required, including necessary infrastructure and sufficient appropriately trained personnel to accommodate these needs. It also must be determined if this simultaneous model of care is cost-effective and sustainable for our health-care system.