Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 112; No. 7; P969

Exploring the Interface of Oncology and Palliative Care in Ireland

K. Coleman [1], C. Brady [2], S. O'Reilly [2], T. O' Brien [3]

1. School of Medicine, University College Cork
2. Department of Medical Oncology, Cork University Hospital
3. Marymount University Hospital and Hospice, Co Cork

Abstract

Aims
To explore the integration and delivery of oncology led referrals to palliative care (PC) by examining physician attitudes and referral practices.
Methods
An online survey was circulated to oncologists and PC physicians in Ireland.
Results
The study (N = 100) comprised sixty-nine oncologists (69%) and thirty-one PC physicians (31%). Ninety-two(92%) believe patients with advanced cancer should receive concurrent treatment, however only 53% of oncologists(N = 37) routinely refer. Regarding end-of-life (EOL) care: 81% of oncologists (N = 55) are directly involved in its administration, despite 84% (N = 53) agreeing patients benefit when PC specialists coordinate EOL care.
Conclusion
The gulf between positive attitudes and limited implementation suggests the need for interdisciplinary changes to facilitate integration of PC in clinical practice in Ireland.

Introduction

Research confirms the integration of PC for patients with advanced disease, which is delivered concurrently with oncology treatment intended to prolong life, has the potential to improve clinical outcomes [1, 2]. Most notably Temel et al. illustrated that introducing PC at diagnosis of advanced cancer led to longer median survival rates, less symptom burden, better quality of life, better understanding of prognosis, less anxiety and depression, and less aggressive end-of-life care [2.] This practice changing study resulted in revision of oncology guidelines to recommend the early incorporation of PC input [3].

Studies on oncologist perceptions and referral practices have demonstrated the majority of oncologists describe their view of PC as favourable. Realising the benefits most oncologists would prefer an integrated care approach, yet continue to refer most of their patients only when no further oncologic treatment is possible, or at the end of life [4]. Despite positive attitudes towards PC, barriers co-exist, and the late introduction of PC is concerning and discordant with current evidence which indicates a combined model of care needs to be integrated earlier in the trajectory of disease for PC to have meaningful influence on patients' quality of life and medical care [5].

There is little research exploring the interface of oncology and PC and no study has investigated referral practices in Ireland [6]. The primary aim of this research was to obtain insight and accurate descriptive data regarding oncologist attitudes and clinical practice regarding the management of patients with advanced cancer. Our objective was to identify obstacles which may delay or prevent the appropriate referral of patients with advanced cancer to PC. This information will facilitate the optimal integration of PC in Irish cancer care, ensuring a comprehensive and robust care model exists to match patient needs.

Methods

This was a quantitative cross-sectional design that looked at a study population of doctors practicing in four medical specialties: medical oncology, radiation oncology, haemato-oncology and palliative medicine in the Republic of Ireland. Inclusion criteria included training at registrar, specialist registrar and consultant level. Different surveys were circulated to oncologists and PC physicians.

The questionnaires were devised based on a validated survey tool conducted by the European Society of Medical Oncology (ESMO) Taskforce on Palliative and Supportive Care and included items adapted from Bradley's Caring for Terminally Ill Patients: Physician Survey [7, 8]. An online and anonymous 85-item questionnaire collected demographics and data on participants' referral practice, direct involvement and collaboration in PC including attitudinal and perceptual items regarding potential barriers and triggers surrounding PC referral.

Ethical approval was received from the Research Ethics Committee of Cork Teaching Hospitals (CREC). Consent was implicit by participation. Data was analysed using the statistical program SPSS.

Results

The study (N = 100) comprised of 69% oncologist (43 medical oncologists, 15 radiation oncologists and 11 haemato-oncologists) and 31% (N = 31) PC participants. The umbrella term of oncologist will herein include medical oncologists, radiation oncologists and haemato-oncologists.

Ninety-five (95%) respondents practice in a regional cancer centre or hospice. The largest portion of our participants identified as consultant (57%). Most of the responding palliative medicine physicians were female (68% N = 21) while there was greater gender balance in oncology participants (female: 51% N = 35 and male: 49% N = 33). The median respondent age was 40 - 44 years. Overall most oncologist respondents were very involved in the care of patients with advanced cancer: 58% of oncologists reported that the management of patients with advanced cancer represented a substantial portion (> 50%) of their practice, while few (9%) reported that patients with advanced disease represented < 25% of their practice.

Collaboration

To gain insight into current oncology clinical practice and the degree to which oncologists collaborate with PC services participants were asked "In your dealings with patients with advanced cancer, how often do you collaborate with" on a 5-point Likert-type scale.

Table 1: Frequency (percent) of oncologist collaboration with other professionals when managing patients with advanced cancer ordered from highest mean (most collaboration) to lowest mean (least collaboration).

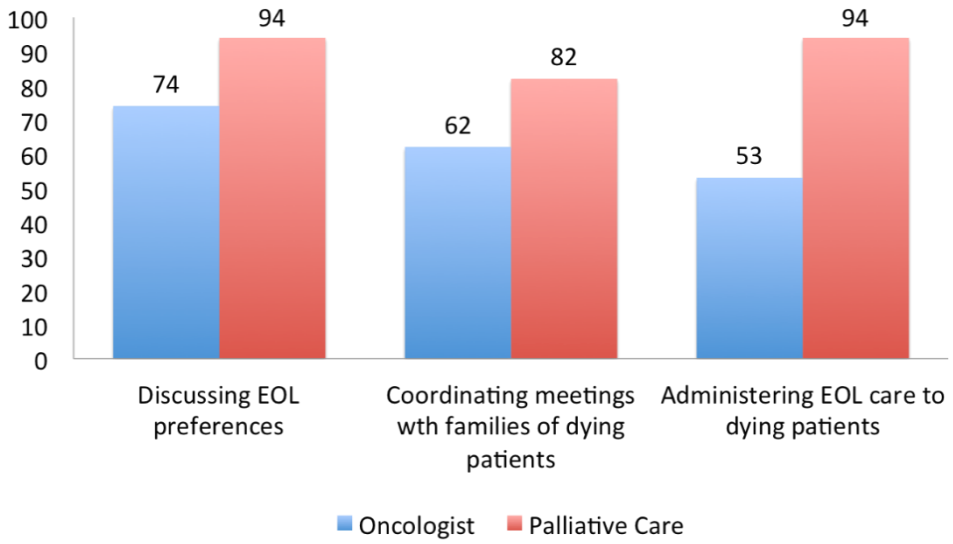
Profession	No. of responses % (n)	Daily (score = 3) % (n)	Weekly (score = 2) % (n)	Monthly (score =1) % (n)	Rarely/Never (score = 0) % (n)	Mean
PC nurse	**100 (69)**	46 (31)	38 (26)	13 (9)	3 (2)	2.2
PC doctor	**100 (69)**	36 (25)	46 (32)	16 (11)	1 (1)	2.3
Social worker	**100 (69)**	13 (9)	55 (38)	16 (11)	16 (11)	1.1
Psych-oncology	**100 (69)**	3 (2)	46 (32)	20 (14)	30 (21)	1.2
Home care team	**100 (69)**	3 (2)	33 (23)	30 (21)	33 (23)	1.7
Inpatient hospice	**100 (69)**	1 (1)	20 (14)	33 (23)	45 (31)	0.8

Direct Involvement

To evaluate oncologist's direct involvement in managing patients with advanced cancer we explored their clinical practice activities. For comparison, we asked the PC physicians the same questions (15 items).

Noteworthy findings include 61% of PC physicians reported direct involvement in managing the complications of chemotherapy every day - indicating that a large proportion of their patients are concurrently on active disease modifying treatment. In contrast 12% of oncologists describe directly administering end-of-life (EOL) care on a daily basis, denoting a high level of oncologist involvement in end-stage disease management for their actively dying cancer patients.

Figure 1: Comparison of frequency (percent) of daily/weekly administration of end-of-life (EOL) care between oncologist and palliative care physicians.



Questions surrounding daily activities and the concordance in responses displayed in figure two highlights the enormous clinical overlap and shared care goals which may go unrecognised in clinical practice. Both specialties are dealing with the same patient symptoms: the complex care needs of patients with advanced cancer are not the exclusive domain of oncology or PC.

Figure 2: Frequency (percent) of daily direct administration of care for patients with advanced cancer: a comparison between oncology and palliative care five most common daily activities.

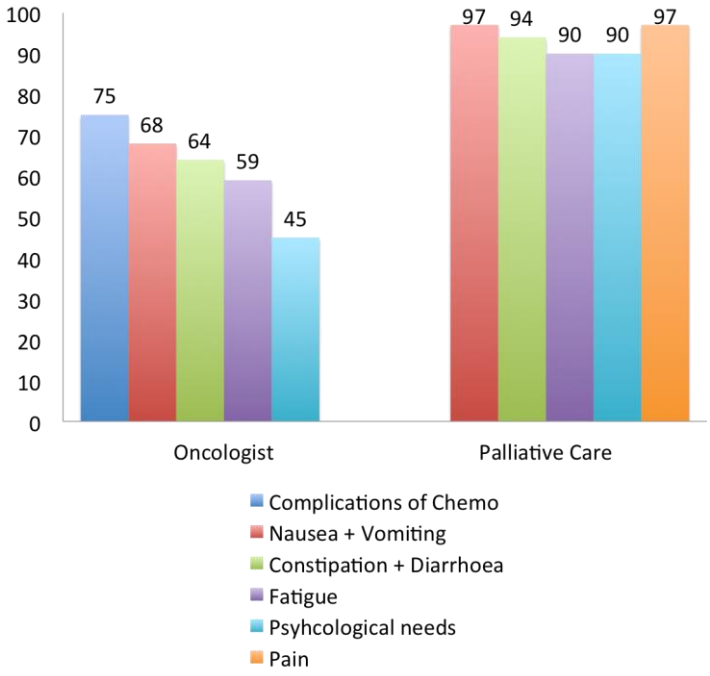


Table 2: Greater than 75% of responding oncologists agreed (agree or agree strongly) to each of the following statements:

Statement	% agreed
All cancer centres should have a palliative care service	99
I derive satisfaction from managing the physical symptoms of my patients	97
I have a close working relationship with the PC services in my region	96
All advanced cancer patients should receive concurrent PC, even if they are receiving anti-tumour therapies	90
A PC specialist is the best person to co-ordinate PC for advanced cancer patient.	87
I derive satisfaction from managing advanced cancer and dying patients	84
Oncologists should be expert in the management of physical and psychological symptoms of advanced cancer	83
I am interested in participating in research in PC treatment of advanced cancer	81
I am usually successful in managing my patient's pain	77

Discussion

To our knowledge this is the first study assessing aspects surrounding the referral of oncology patients to PC services in Ireland. Our research examined the degree to which oncologists are directly involved in the management of patients with advanced cancer, the level of cross-specialty collaboration, oncologist attitudes of palliative care and explored barriers that might delay or prevent the timely and appropriate referral of oncology patients with PC needs to the relevant services.

Several clinically relevant themes emerged providing accurate descriptive data and insight into referral practice and attitudes in relation to management of cancer: oncologists agreed that patients' and families' needs are better met with access to PC services, patients can benefit from simultaneous oncologic treatment and PC, and that early referral to PC services is optimal. Oncologists recognised the role of PC services, especially PC nurses supporting them in the care of cancer patients and as a valued connection to PC doctors.

While oncologists reported being satisfied with PC services, clinicians with a positive attitude toward the role of the PC are much more likely to refer patients, incorporate care and collaborate with PC services. However, we found that acknowledged benefits of early PC referrals were at times inconsistent with practice: oncologists endorsed the belief that advanced cancer patients should receive concurrent treatment, however referral rates on diagnosis are suboptimal and oncologists regularly administer end-of-life care despite agreeing PC specialists should coordinate palliation.
This mismatch in accepted benefit versus actual practice must also be attributed to the existing structure and capacity of the healthcare system. The current healthcare system is not configured for coordinated care: The National Doctors Training and Planning review of the palliative medicine workforce in Ireland highlighted that there are not enough PC doctors working in acute hospitals. Oncologists recognise that the strained PC services cannot cope, and they intercede to fulfil the role [9].
Low levels of oncologists reporting daily direct involvement in managing psychological complications of cancer (depression and anxiety) compared to PC physicians may also indicate a psychology service-need for patients.

It will be essential to address these factors in order to ensure the successful implementation the National Cancer Control Programme (NCCP) established in 2007 to formulate a whole population, integrated and cohesive approach to cancer [10]. All of these developments have delivered continuing improvements in outcomes for Irish patients with cancer. Recommendation 31 of the NCCP Cancer Strategy 2017-2026:

Designated cancer centres will have a sufficient complement of specialist palliative care professionals, including psycho-oncologists, to meet the needs of patients and families (such services will be developed on a phased basis to be available over seven days a week) [10].

This was a novel study on physician perspective building upon previous peer led and IMJ published research which examined patient attitudes - patients deemed PC beneficial but a significant relationship exists between familiarity with PC and thinking it's only offered "when nothing more can be done" [6]. Extrapolating this to our research it is possible that even patients who agree with their oncologist to a PC referral may not ultimately allow the PC team access, for whatever reason, and this may explain some discrepancies in oncologist positive attitudes towards to PC yet their level of involvement in end of life care.

We estimate the overall our survey response rate was approximately 70%. This is higher than comparable research for a national survey of these professional groups, yet it raises the possibility of responder bias. If we assume that responders had a positive bias towards palliative care compared to non-responders, then real referral practices are likely to be less than our results suggest, and positive attitudes overstated.

95% of respondents practice in a regional cancer centre or hospice and a total of 12 counties from each province in the Republic of Ireland were represented, however there may be geographic, regional or administrative impediments to early referral. The role of the GP may be very significant in some regions - this was not examined in our work and warrants further exploration.

Regarding survey design, the PC consultant group highlighted an inadequate feedback mechanism which limited their opportunity to provide extra information. A text box after each question could perhaps have generated a deeper understanding of physician attitudes.
An inherent strength of this study was the collaborative effort between oncology and PC: research co-operation leads to mutual understanding, better clinical teamwork and ultimately comprehensive care for patients. Other strengths include: the pilot of our surveys, a response rate representative of the population and high level of consultant participation.

Our study demonstrated the willingness between oncologists and PC teams to work together to meet the needs of patients. We highlighted the shared desire to provide PC in the acute hospital setting. The gulf between widely expressed positive attitudes and limited implementation suggests the need for better structured specialist training schemes, more PC doctors, and infrastructural changes to facilitate better actualisation of PC in clinical practice in Ireland.

The findings suggest that service development is needed to make room in our current system to adopt initiatives such as those used in the Temel trial and in achieving the actualisation of the vision of the National Cancer Strategy by 2026. Multiple models of PC integration in oncology, such as co-ordinated clinics, have been proposed: while no one model exists as a paradigm for all, collaborative oncology and palliative care is a clinically meaningful and feasible care model with established evidence that it positively impacts patient outcomes and improves quality of life [1 - 3].

Oncology and PC are not mutually exclusive: the availability of and successful integration of early PC into cancer care could prove significant in defining further treatment guidelines for cancer care in Ireland.

Declaration of Conflict of Interest:
There are no conflicts of interest to declare.

Corresponding Author:
Dr. Kate Coleman
Department of Medical Oncology
St Vincent's University Hospital
Elm Park
Dublin 4
Email: katemariacoleman@gmail.com

References:

1. Kwon J, Hui D, Chisholm G, Ha C, Yennurajalingam S, Kang J, Bruera E. Clinical Characteristics of cancer patients referred early to supportive and palliative care.
   J Palliat Med 2013;16(2):148-155.
2. Temel J, Greer J, Muzikansky A, Gallagher E, Admane S, Jackson V, Constance M, Blinderman C, Jacobsen J, Pril W, Billings J, Lynch T. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010; 363:733-742.
3. Kelley AS, Meier DE. Palliative Care - A Shifting Paradigm. *N Engl J Med* 2010;363 (8): 781-782
4. Ward AM, Agar M, Koczwara B. Collaborating or Co-existing: a survey of attitudes of medical oncologists toward specialist palliative care. *Palliat Med* 2009; 23(8): 698-707
5. Brickner L, Scannell K, Marquet S, Ackerson L. Barriers to hospice care and referrals: survey of physicians' knowledge, attitudes, and perceptions in a health maintenance organization. *J Palliat Med* 2004 Jun;7(3):411-418.
6. Docherty C, Lester L, O'Reilly S. Attitudes toward Palliative Care and End of Life Issues: A Prospective Survey in Patients with Metastatic Cancer. *Irish Medical Journal* 2016;109(4)
7. Johnson CE, Girgis A, Paul CL, Currow DC. Cancer specialists' palliative care referral practices and perceptions: results of a national survey. *Palliat Med* 2008; 22(1):51-57
8. Cherny NI, Catane R, European Society of Medical Oncology Taskforce on Palliative and Supportive Care. Attitudes of Medical Oncologist Toward Palliative Care for Patients with Advanced and Incurable Cancer. *Cancer*. 2003 Dec 1;98(11):2502-10.
9. National Doctors Training and Planning: *Review of the Palliative Care Workforce in Ireland 2017* https://www.hse.ie/eng/staff/leadership-education-development/met/plan/specialty-specific-reviews/palliative-medicine-review-for-web.pdf
10. Department of Heath. *National Cancer Strategy 2017-2026* https://health.gov.ie/wp-content/uploads/2017/07/National-Cancer-Strategy-2017-2026.pdf
11. Ogle K, Mavis B, Wyatt G. physicians and hospice care: attitudes, knowledge, and referrals. J Palliat Med 2002;5(1):85-92.
12. Davis MP, Strasser F, Cherny N. How well is palliative care integrated into cancer care? A MASCC, ESMO, and EAPC Project. *Supportive Care in Cancer* 2015; 23(9): 2677–2685.
13. Wentlandt K, Krzyzanowska MK, Swami N, Rodin GM, Le LW, Zimmermann C. Referral practices of oncologists to specialised palliative care. *Journal of Clinical Oncology* 2012; 30(35):4380-6.
14. Schenker Y, Crowley-Matoka M, Dohan D, Rabow MW, Smith CB, White DB, et al. Oncologist Factors That Influence Referrals to Palliative Care. *Journal of Oncology Practice* 2014; 10(2): 37-44