

## To refer or not? Oncology and palliative care

### INTRODUCTION

Palliative care is an integral component of oncology care. Despite medical breakthroughs, many patients still face the risk of relapse and may be unsuitable for further oncological intervention. Therefore, it is important to integrate palliative care into oncology care. There is growing evidence that early integration of palliative care results in better outcomes, including improved quality of life, decreased depression, increased satisfaction, reduced chemotherapy use at the end of life and may even improve survival.<sup>1-3</sup> In such a dynamic treatment landscape, the optimum timeframe for referral to palliative care remains one of the greatest challenges today.

Referral practices from oncology to palliative care vary widely. In developed countries, the main obstacles to integrating palliative care in oncology include inaccurate perception of palliative care, lack of knowledge of palliative care and lack of uniform criteria for timely and accurate referral.<sup>4</sup> In developing countries, the main challenges revolve around inadequate access to palliative care resources and negative perception of palliative care or that palliative care is not a priority in the treatment landscape.<sup>5</sup>

Palliative care service in Sarawak, Malaysia, is still in its infancy. Sarawak General Hospital is the only hospital within the state with specialist-run oncology and palliative care. Cancer care, including palliative care outside Kuching and its surroundings, is usually provided by the local general surgical or general medicine department. Palliative care service in the state's capital, Kuching, is divided into inpatient palliative

care service, consult service and outpatient home care service.

### METHODS

#### Study design

This study is an exploratory, descriptive, cross-sectional and quantitative study conducted in Oncology Unit, Sarawak General Hospital, Kuching. A 12-item closed-ended questionnaire on Google Forms was developed between palliative care and oncology to explore the attitudes and beliefs of oncology practitioners within the state regarding palliative care. The survey had an extra item (13 questions total) if the practitioner discloses that he/she never or infrequently refers to palliative care. Acceptance to answer the questionnaire was taken as consent to participate.

#### Inclusion and exclusion criteria

The oncology unit in Sarawak General Hospital was consulted regarding participation in the survey. It included all oncology practitioners working in Sarawak (oncology consultants, specialists, trainees and medical officers), including public and private practitioners. Oncology practitioners that did not respond after three contact attempts were excluded from recruitment.

#### Data collection

Survey participants were invited to fill in a Google Form containing the questionnaire in May 2023. The primary outcomes explored were referral habits of oncology practitioners and reasons for palliative care referrals. Secondary outcomes included exploring reasons for the lack of engagement with palliative care services and palliative care knowledge and competency among oncology practitioners. The study also examined the association between oncology practitioner demographics and their attitudes and beliefs towards palliative care.

Participants were asked about demographics, attitudes and beliefs towards palliative care. For oncology practitioners who answered never or infrequently in the question 'How often do you think you refer to palliative care?' the Google Form leads the participant to a separate section with an additional question exploring medical practitioners' attitudes and beliefs on perceived lack of engagement with palliative care.

Participants were asked to choose three options about what they think is the optimum moment for referral to palliative care. The final item in the questionnaire explores the beliefs of the oncology practitioner and asks which component of the WHO's definition of palliative care they consider the most important. Options are listed in [table 1](#).

#### Data analysis

Descriptive statistics using frequency and proportions summarised all demographic and referral practice responses. Each participant's data was analysed and divided into medical practitioners with formal oncology training (oncology trainees, specialists and consultants) and non-oncology trainees (medical officers). These groups of participants were then analysed regarding previous palliative care training and perceived top three optimum moments for referral to palliative care.

### RESULTS

In total, 38 oncology practitioners (86% response rate) completed the survey. Demographics and oncology practitioner characteristics are shown in [table 1](#). Most oncology practitioners are medical officers in the public sector (71%) and new to oncology (52.6%).

Most participants claimed they had formal palliative care

**Table 1** Demographics and oncology practitioner characteristics

	Number (38)	Percentage
Age (years)		
25–29	12	31.6
30–34	11	28.9
35–39	11	28.9
40–44	0	0
45–49	3	7.9
50–54	0	0
55–59	0	0
60 and above	1	2.6
Gender		
Male	15	39.5
Female	23	60.5
Role in oncology		
Medical officer	27	71.1
Oncology trainee	2	5.3
Oncology specialist	5	13.2
Oncology consultant	4	10.5
Number of years in oncology		
0–2	20	52.6
3–5	5	13.2
6–10	6	15.8
11–15	5	13.2
More than 15	2	5.3
Years since graduation from medical school		
0–5	22	57.9
6–10	8	21.1
11–15	4	10.5
16–20	1	2.6
21–25	2	5.3
26–30	0	0
More than 30	1	2.6
Previous training in palliative care		
Yes	21	55.3
No	17	44.7
Self-perceived level of understanding about palliative care		
None	0	0
Poorly informed	1	2.6
Moderately informed	26	68.4
Sufficiently informed	11	28.9
Accessibility of palliative care services		
No	0	0
Yes—palliative care specialist service	30	78.9
Yes—palliative care resident-led service	7	18.4
Yes—palliative nurse-led service	1	2.6
Collaboration with palliative care		
Yes	38	100
No—lack of time	0	0
No—lack of manpower/medical personnel/ no available palliative service	0	0

Continued

training. Only one participant felt ‘poorly informed’ about palliative care, with the vast majority (97.3%) of respondents answering ‘moderately informed’ or ‘sufficiently informed’. All participants agreed that they had access to palliative care service and collaboration with palliative care, with more than 75% of participants (78.9%) having access to palliative care specialist service, with the remaining participants having palliative care resident-led service or palliative care nurse-led service.

When asked about the frequency of referrals to palliative care, only 8% of participants responded ‘infrequently’ and most (92%) practitioners responded ‘often’. For practitioners who responded ‘infrequently’, a follow-up question was asked on their top reason for perceived minimal engagement with palliative care. Patient’s logistics/socioeconomical circumstance appeared as the top reason for perceived minimal engagement with palliative care.

All participants were asked about their top three reasons for referral to palliative care. More than 75% of participants (76.3%) named ‘advanced disease with poor functional status (ECOG (Eastern Cooperative Oncology Group)>2)’ as their top reason for referrals, followed by ‘presence of uncontrolled pain’ (55.3%) and ‘no more oncological intervention/best supportive care’ (55.3%). Non-oncology trainees were more likely to refer for communication difficulties. Many oncology specialists recognise uncontrolled symptoms as the optimum referral timeframe. In contrast, younger oncology practitioners are more likely to consider advanced disease with good functional status (ECOG 0–2) as the optimum timeframe for palliative care referral. Overall, oncology trainees and specialists were more likely to refer later when the disease is symptomatic or when all

Table 1 Continued

	Number (38)	Percentage
No—palliative care referral is not necessary	0	0
No—disagreement with palliative care	0	0
How often do you think you refer to palliative care?		
Never	0	0
Infrequently	3	7.9
Often	35	92.1
What do you think is the optimum moment for referral to palliative care?		
Limited survival	13	34.2
Advanced disease with good functional status (ECOG 0–2)	7	18.4
Advanced disease with poor functional status (ECOG>2)	29	76.3
Presence of uncontrolled pain	21	55.3
Presence of uncontrolled symptoms other than pain	18	47.4
No more oncological intervention/best supportive care	21	55.3
Communication difficulties with patient and/or family members	5	13.2
Which component of the WHO definition of palliative care that you consider the most important?		
Palliative care provides pain and other distressing symptoms relief	2	5.3
It affirms life and regards dying as a normal process	3	7.9
It intends neither to hasten or postpone death	0	0
It integrates the psychological and spiritual aspects of patient care	3	7.9
It offers a support system to help patients live as actively as possible until death	3	7.9
It offers a support system to help the family cope during the patient's illness and in their own bereavement	4	10.5
It provides an interdisciplinary approach	0	0
It enhances quality of life and may also positively influence the course of illness	17	44.7
It is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life	6	15.8

ECOG, Eastern Cooperative Oncology Group.

oncological options have been exhausted.

## CONCLUSION

This study has shown that most oncology practitioners are aware of and have access to palliative care services. However, most

oncology specialists/trainees are more likely to refer patients later during the disease. Oncology practitioners with palliative care training were less likely to refer for complex communication issues and more likely to refer earlier. If this trend is consistent

nationwide, it would suggest an urgent need for formal integration of palliative care training in oncology training.

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