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Incorporating Supportive Care Into Routine Cancer Care: The Benefits and Challenges to Clinicians' Practice

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Patients with cancer experience significant symptom burden (Butt et al., 2008), unmet psychosocial needs (Boyes, Girgis, & Leca-thelinais, 2009; McIlmurray et al., 2001), and psychiatric morbidity (Strong et al., 2007; Zabora, BrintzenhofeSzoc, Curbow, Hooker, & Piantadosi, 2001). Current psychosocial guidelines recommend routine screening of all patients with cancer for distress and unmet psychosocial needs to prevent development of more significant disorders (National Comprehensive Cancer Network [NCCN], 2011) and improve patient physical and psychosocial outcomes (Boyes, Newell, Girgis, McElduff, & Sanson-Fisher, 2006; McLachlan et al., 2001).

The need for routine supportive care screening is supported by previous research indicating that clinician identification of patient physical and psychosocial needs is less than optimal (Fallowfield, 2001; Keller et al., 2004). Additional studies have indicated patient reluctance to raise supportive care concerns during clinic visits or to discuss them only at the initiative of the clinician. Clinicians also generally defer to the wishes of their patients when discussing emotional and psychosocial concerns (Detmar, Aaronson, Wever, Muller, & Schornagel, 2000) and note that issues patients most want assistance with are not necessarily those they feel most able to address (Snyder et al., 2007).

While acknowledging the need for supportive care screening, a range of barriers has been identified that are relevant to clinical implementation (Botti et al., 2006; Schofield, Carey, Bonevski, & Sanson-Fisher, 2006), including personal knowledge and perceived value of supportive care, practice (time, role-definition, resources), and organizational (feedback, rewards) barriers. Those barriers, alongside patient and clinician expectations for discussion of psychosocial issues, highlight the need for clinician training in supportive care provision in combination with appropriate clinical support.

Purpose/Objectives: To investigate clinicians' experiences with supportive care screening and referral, and identify perceived barriers and benefits associated with implementation into the clinical setting.

Design: Qualitative, exploratory approach based on interviews.

Setting: A large regional hospital in Victoria, Australia, that provides chemotherapy and radiotherapy services to patients with cancer.

Sample: 5 chemotherapy nurses and 1 radiation therapist.

Methods: Semistructured interviews were conducted, documented, and analyzed with qualitative techniques.

Main Research Variables: Clinical benefits of supportive care screening and referral, and barriers to clinical implementation.

Findings: Clinicians perceived that supportive care screening benefited their practice by improving communication and rapport with patients. Clinicians supported each other during screening implementation, and although they initially were hesitant about the process, they ultimately endorsed screening for wider implementation. Time constraints and scope of practice were identified as significant barriers.

Conclusions: Supportive care screening was endorsed as part of future clinical practice, but barriers to implementation need to be addressed.

Implications for Nursing: With current psychosocial guidelines recommending routine supportive care screening of patients with cancer and statewide mandatory screening targets set in Australia, healthcare organizations need to carefully consider implementation processes. Although nurses are ideally placed to complete screening, organizations need to ensure that appropriate training and support mechanisms have been developed, as well as adequate resources, to enable integration into routine practice.

In Australia, recommendations for routine supportive care screening of all patients with cancer have not been translated routinely into clinical practice. Victoria's Cancer Action Plan 2008–2011 seeks to