Screening for distress and supportive care needs during the initial phase of the care process: a qualitative description of a clinical pilot experiment in a French cancer center

Sylvie Dolbeault, Béatrice Boistard, Jocelyne Meuric, Laure Copel and Anne Brédart

Abstract

Objective: To provide a qualitative description of a clinical pilot experiment in a French cancer center, conducted by a nurse after the treatment decision consultation attended by new cancer patients during the initial phase of the care process.

Methods: The Psychological Distress Thermometer (PDS) and a problem checklist were administered to 255 patients before nurse consultation, helping her to manage the clinical interview, explore patient’s distress and supportive care needs, and finally refer the patients in need to the required Supportive Care units.

Results: Patients were primarily referred to the social service unit (35% patients), followed by the physiotherapy unit (23.9%) and the psycho-oncology unit (19.6% of patients). In cases of significant distress (43% patients with PDS ≥3), the percentage of patients referred to the psychosocial units increased (44% referred to the Social Unit, 35% to the Psycho-Oncology Unit). However, the main interest of our screening procedure resides in its qualitative and didactic dimension, based on clinical training and cooperation with healthcare professionals during the process of investigating patients’ distress and their supportive care needs. Difficulties and limitations are also described.

Conclusions: This first clinical experiment conducted among dedicated nurses involved in a Therapeutic Decision Consultation in a French cancer center has provided evidence in support of the idea that non-specialist professionals are able to identify patients’ distress and their Supportive Care needs (particularly in the psychosocial field) provided that they have received appropriate training.

Keywords: cancer–oncology; screening; patients’ needs; distress; supportive care; routine nursing practice

Introduction

Cancer and its associated conditions may significantly damage patients’ quality of life. Serving as a complement to cancer therapy, the care provided in oncology must include the management of disease symptoms, treatment of side effects and sequelae, psychosocial distress and the needs that arise in this context [1].

One dimension of quality of life is psychological well-being, which may be considerably affected by the diagnosis of cancer and the therapeutic process. Psychological suffering may be perceived as a ‘normal’ reaction to the traumatic event that a cancer diagnosis represents. However, a significant number of cancer patients may develop persistent psychological disorders which require professional attention. About one-third of patients newly diagnosed with cancer experience psychological distress [2].

Studies suggest that clinicians fail to identify patients with high levels of anxiety or depression [3–5] and those requiring psychosocial counseling [5].

Interventions have been designed to facilitate the detection of physical and psychological problems through the use of patient-reported outcomes (PRO) in clinical practice [6]. The integration of standardized health-related quality of life (HRQL) in daily clinical practice has been tested in both daily oncology consultations [7] and oncology-related nursing practice [8], thus facilitating the discussion of HRQL issues and, according to Velikova et al. [7], also
improving emotional well-being. Various instruments have been tested [9] and specific experiments reported [10] on the basis of recommendations for routine screening for psychological distress.

Patients’ and physicians’ views concerning the clinical value of these approaches emphasize the need for standard measures, for flexible measurement adapted to treatment and follow-up, for a clear interpretation of scores and for decision guidelines [11].

Of the PRO questionnaires in use in clinical practice, patients seem to prefer needs assessments, both because of the significance to them for the items they contain and their desire for help in dealing with the issues addressed [12].

A recent systematic review of instruments used to screen for emotional distress in cancer patients makes it clear that many of these scales reach a fairly high-quality threshold in terms of their psychometric properties and generality [13].

In the United States, the National Comprehensive Cancer Network (NCCN) (www.nccn.org) has been involved in the testing of specific tools and procedures designed to trigger referral by oncology staff to the psychosocial services. In a way similar to the pain management guidelines, patients in an outpatient setting are administered a rapid psychological screening measure, the Distress Thermometer (DT), and complete a Problem checklist in order to identify sources of distress (psychological, family, social, spiritual, practical, physical), identify those patients at risk of psychosocial problems and facilitate the appropriate interventions. The DT has been translated and validated in French, and has been seen to achieve a cut-off score of 3, sensitivity of 76% and specificity of 82% [14].

Using psychometric judgment criteria, Vodermaier [13] qualifies the DT as fair in terms of psychometric performance and suggests that modifications such as the inclusion of additional mood domains as in the Emotion Thermometers might help to improve the original scale [15,16].

The use of computer-adaptive tests [17] may prove to be the best way to increase the utility of PRO assessment in clinical practice [12]. Using this approach, the questions can be efficiently tailored to the issues relevant to any given patient, thus addressing the problems of content relevance and respondent burden. The initial results relating to the development [18] and validation of an item bank and the assessment and screening of psychological distress [19] make it clear that there is still room for improvement. It is also important to provide clinically significant difference scores for these instruments in order to ensure their clinical usefulness for the monitoring of patients over time [20].

At present, evidence relating to the effectiveness of screening for anxiety or depression in non-psychiatric patients suggests that the observation of high scores indicating a considerable risk of psychopathology does indeed increase the detection of these problems by clinicians, but does not improve the level of intervention intended to address them [21].

The purpose of this paper is to provide a qualitative description of a pilot experiment in a French cancer center, conducted by a nurse administering the Psychological Distress Thermometer (PDS) and the Problem checklist [14,22–23] after the treatment decision consultation attended by new cancer patients during the initial phase of the care process.

Context

Since 2003, the organization of oncology care in France has benefited from an extremely extensive national program, the ‘Plan Cancer’. One of its many aims is to improve the conditions under which the diagnostic disclosure is made and patients enter into the care process through the development of a ‘Diagnostic Disclosure Mechanism’ (item 40 of the Plan Cancer) [24]. This defines the roles of each professional and the way they coordinate in caring for the patient, improves the way information is communicated and provides for the early evaluation of the difficulties exhibited by patients, thus theoretically making it possible to direct patients toward the available supportive care services. Whereas in many countries, these supportive care services are integrated in the oncology department (http://www.mascc.org) and underpinned by the concepts of multidisciplinary work, coordination and cooperation between professionals [25] in a way that is reminiscent of the consultation–liaison psychiatry model [26–28], this organizational model has as yet made little headway in the French professional care context [29].

Our experiment was conducted during the Therapeutic Decision Phase. During the 7–10 days following the surgeon’s post-surgical final diagnosis, the patients were asked to attend a multidisciplinary consultation where, on the same day, they were seen by both a chemotherapist and a radiotherapist who, in turn, presented the envisaged treatment and explained the expected benefits, the advantages and drawbacks and care administration procedure. Each patient was then seen by a nurse specifically dedicated to the conduct of the corresponding consultation. During a clinical interview, the nurse went back over the information presented by the doctors, checked that this had been understood correctly and answered any additional questions raised by the patient. However, this interview also represented an opportunity to perform an initial assessment of the patients’ needs and, if necessary, direct them to other professionals in the supportive care field working in close cooperation with, and as a complement to, the specialists in the specific
treatment to be administered. This procedure was conducted with the help of assessment tools and served as the basis for the initial training and subsequent follow-up of the dedicated nursing staff.

During the course of the following days, this stage was complemented by meetings with other doctors and nurses who provided the patients with additional information, in particular during the reception interview at the chemotherapy clinic and then subsequently at the radiotherapy reception interview (Figure 1).

Aims
The study consisted of a clinical experiment designed to evaluate the implementation of a systematic screening procedure for distress and supportive care needs and was organized within the framework of a Therapeutic Decision Consultation (TDC) made available to recently diagnosed patients who were attending the Institut Curie. The experiment was conducted under the control of the responsible staff in the Supportive Care Department (doctor, managing nurse and assistant) in cooperation with the doctor and organizational staff responsible for the correct conduct of the TDC.

The main aim was to study the feasibility of this approach being adopted by the relevant professionals, in this case the nurses responsible for the dedicated consultation. The secondary aims were to gather descriptive information concerning distress levels, the number and type of difficulties encountered, the frequency of referrals to one or more of the Supportive Care resources available at the hospital and, finally, to examine the differences in terms of both encountered difficulties and orientation as a function of the expressed level of distress.

Data collection procedure
All new patients with a breast cancer, gynecological cancer or lung cancer who attended this TDC and met the dedicated nurse were asked to take part in the study. Immediately after the medical consultations, the patients met the dedicated nurse who handed them a pencil-and-paper questionnaire containing a self-evaluated distress scale and problem checklist, which they were able to complete in just a few minutes in the waiting room. The consulting nurse used the data to conduct the interview and to systematically explore the various areas addressed, and in particular those in which the patients had reported difficulties. At the end of this interview, the nurse was in a position to complete the Supportive Care Referral Criteria and orientate the patients to the required unit or units (Figure 2).

Finally and in all cases, she sent both documents to the Supportive Care team, whether or not the patient was actually referred to the Supportive Care Department manager, in order to be analyzed. Data were also inserted in the medical chart, giving a possibility of later reviews.
Assessment tools

The following tools were used:

- The French Psychological Distress Scale (PDS) [14] is derived from the ‘DT’ [22,23]. When translated literally into French, the term ‘distress’ does not have the same connotations as in English. In French, the word ‘déstresse’ may mean ‘distress’, ‘suffering’, ‘confusion’ or even ‘in difficulty’ with or without the accompanying adjective ‘psychological’. Although the word ‘déstresse’ includes ideas of severe suffering, danger, fear of death and need for help (while in English a subject can also feel ‘distress’ about relatively trivial things), discussions between clinicians specializing in psycho-oncology finally led to the selection of this word, but coupled with a reference to a psychological state (‘déstresse psychologique’).
- The NCCN Simplified Problem List, in combination with the French PDS whose aim is to identify the causes of the expressed distress.
- The Supportive Care Referral Criteria scale: This was completed by a professional which made it possible to identify the clinical criteria requiring the systematic referral of a patient to one or more Units in the Supportive Care Department: Psycho-Oncology Unit, Social Service Unit, Physiotherapy Unit, Nutrition Unit, Wounds Unit or exceptionally at this stage, ‘Palliative Care Unit’. In the case of Psycho-Oncology, for example, four base criteria were identified by a group of specialists: identified suicidal ideas, speech, behavior; known severe psychiatric antecedents; major behavioral disorders; refusal of treatment or poor compliance with regard to the cancer treatment. The various criteria were then adapted to the specific characteristics associated with the relevant tumor types in order to make them suitable for use in the different Therapeutic Decision Consultations (here for senology, gynecology, and pneumology) in accordance with the recommendations set out in the Diagnostic Disclosure Mechanism.

Results

Population

During a pilot phase conducted between September 2007 and September 2008, we collected completed protocols from 255 patients who had participated in the TDC conducted within the framework of the Diagnostic Disclosure Mechanism. Our population represented approximately 45% of the patients intended to benefit from the TDC.

The mean age was 57.5 years and the median value 59 years [26–85]. Ninety-two percent of the sample consisted of women (234 women). The subjects presented three tumor locations: 209 had breast cancer (82%), 41 lung cancer (16%) and 5 gynaecological cancer (2). The tumor was locoregional in 92% of cases (235 patients) and metastatic in 8% of cases (20 patients). These figures reflect the usual distribution of new patients receiving care at the Institut Curie and referred to attend the TDC (Table 1).

Distress level, problems reported and referral

Forty-three percent of the patients in our population (110 patients) had to be considered as exhibiting significant distress since they had a PDS >3. Of these, 96.4% were women and 91.8% were at a locoregional stage (Table 2).

The self-evaluation of the problems stage made it possible to identify the number of problems reported by each patient: one practical problem for 16% of patients and two or more for 7.5%; one physical problem for 27% of the patients, two for 29% and three or more for 14%; a family problem in 14% of the population; one psychological problem for 34% of the patients and two such problems for 20%; finally, other types of problems were reported by 14% of the patients.

In total, 23.6% of our population reported practical problems (one or more), 69.8% physical problems, 15.7% family problems, 65.8% psychological problems and, finally, 10.2% reported one or more problems of a different type.

Referrals to the Units in the Supportive Care Department following a hetero-evaluation by the nurse were distributed as follows: 35.6% of the

<table>
<thead>
<tr>
<th>Table 1. Characteristics of the population (N = 255)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>Median [range]</td>
</tr>
<tr>
<td>Female 234 (91.8)</td>
</tr>
<tr>
<td>Male 21 (8.2)</td>
</tr>
<tr>
<td><strong>Gender, N (%)</strong></td>
</tr>
<tr>
<td><strong>Cancer diagnosis, N (%)</strong></td>
</tr>
<tr>
<td>Breast 209 (82)</td>
</tr>
<tr>
<td>Lung 41 (16.1)</td>
</tr>
<tr>
<td>Gynaecology 5 (2)</td>
</tr>
<tr>
<td><strong>Stage, N (%)</strong></td>
</tr>
<tr>
<td>Locoregional 235 (92.2)</td>
</tr>
<tr>
<td>Metastatic 20 (7.8)</td>
</tr>
<tr>
<td><strong>Table 2. Distress level</strong></td>
</tr>
<tr>
<td>PDS score N = 255</td>
</tr>
<tr>
<td>Median [range] 2.7 [0–10]</td>
</tr>
<tr>
<td>PDS score &gt;3 N (%)</td>
</tr>
<tr>
<td>By gender, N (%)</td>
</tr>
<tr>
<td>Female 106 (96.4)</td>
</tr>
<tr>
<td>Male 4 (3.6)</td>
</tr>
<tr>
<td>By stage, N (%)</td>
</tr>
<tr>
<td>Locoregional 101 (9.1)</td>
</tr>
<tr>
<td>Metastatic 9 (8.2)</td>
</tr>
</tbody>
</table>
patients were referred to the Social Service Unit (28% for one reason, 6% for two reasons and 1.6% for three reasons; 23% were sent to the Physiotherapy Unit; 19.6% to the Psycho-Oncology Unit including 18% for one reason and 1.6% for two reasons. The other referrals were marginal. Overall, 35.3% of the patients in our population were referred to the Social Service Unit, 19.6% to the Psycho-Oncology Unit, 23.9% to the Physiotherapy Unit; 1.6% to the Nutrition Unit. None of the patients in our population was referred to the Palliative Care Unit or to the Wounds Unit.

In cases where patients were referred to several different units from the very start, the most common combinations were: social and psycho-oncology units (86 patients), followed by social and physiotherapy units (38 patients), psycho-oncology and physiotherapy units (22 patients), social and nutrition units (11 patients), physiotherapy and nutrition units (10 patients), psycho-oncology and nutrition units (6 patients).

Among the 110 patients in the sub-sample characterized by a significant level of expressed distress (PDS > 3): 26.4% reported practical problems (one or more), 76.4% physical problems, 20% family problems, 80% psychological problems and, finally, 27% one or more problems of another type.

Concerning referrals to the Units of the Supportive Care Department, 44.6% of the patients in our population were referred to the Social Service Unit, 35.4% to the Psycho-Oncology Unit, 29.1% to the Physiotherapy unit and, finally, 1.8% to the Nutrition Unit.

In cases where patients were referred to several different units from the very start, the most common combinations were: social and psycho-oncology units (45 patients), followed by social and physiotherapy units (21 patients), psycho-oncology and physiotherapy units (18 patients), psycho-oncological and nutrition units (five patients), physiotherapy and nutrition units (four patients), social and nutrition units (three patients; Table 3).

Among the 255 patients participating in the TDC, 50 were referred by the dedicated nurse to the Psycho-Oncology Unit. Among them, 21 patients received a psycho-oncology consultation, including 16 patients after the Therapeutic Decision Consultation and five other patients before the Therapeutic Consultation, probably either self-referred or referred by another clinician.

### Discussion

This screening procedure enabled us to measure the prevalence of distress among patients who had recently been diagnosed as having cancer and were starting their treatment. Most of our 255 patients were female (92%) and presented a cancer at a locoregional stage (92%), including 82% with breast cancer. These figures reflect the clinical activity characterizing the DTC at the Institut Curie. Forty-three percent had to be considered as exhibiting significant distress, with 96% of these being women. Given the preponderance in our population of breast cancers in locoregional phase, this level must be viewed in the light of the composition of the population. It is higher than the mean level of prevalence observed in cancer patients questioned at different times during their healthcare trajectories (http://www.ipos-society.org/professionals/meetings-ed/ed-online-lectures.htm), a fact which may be due to the particularly high level of anxiety associated with the recent diagnosis and the period of great uncertainty and cognitive confusion during which the responses were recorded, i.e. while the patients were finding out about the healthcare trajectory.

The problems mentioned by the patients we questioned were primarily physical (70%) and psychological (66%) in nature. Among the patients exhibiting a significant level of distress, these percentages increased to 76 and 80%, respectively.

The needs identified within this context of care strategy communication resulted in the nurse who participated in the Therapeutic Decision Consultation initially referring the patients to the social service unit (35% patients), followed by the physiotherapy unit (23.9%) and the psycho-oncology unit (19.6% of patients). The high percentage of referrals to the Physiotherapy Unit was due to the fact that the vast majority of the patients in our population were women with breast cancer who had undergone surgery and had to be seen by a physiotherapist at least once for the communication of practical information together with documents relating to the arm rehabilitation program to be adopted.

In cases of significant distress (PDS > 3), an even higher percentage of patients were referred to the psychosocial units, with 44% being referred to the Social Unit and 35% to the Psycho-Oncology Unit. In the case of this latter unit, the number of

<table>
<thead>
<tr>
<th>Table 3. Problems reported and referral to supportive care units</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (N = 255)</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Patients reporting ≥ 1 problem(s), N (%)</td>
</tr>
<tr>
<td>Practical</td>
</tr>
<tr>
<td>Physical</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Psychological</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td>Referral to supportive care units, N (%)</td>
</tr>
<tr>
<td>Social Service Unit</td>
</tr>
<tr>
<td>Psycho-Oncology Unit</td>
</tr>
<tr>
<td>Physiotherapy Unit</td>
</tr>
<tr>
<td>Nutrition Unit</td>
</tr>
<tr>
<td>Wounds Unit</td>
</tr>
<tr>
<td>Palliative Care Unit</td>
</tr>
</tbody>
</table>
referrals was practically twice as high as for the overall population. This observed difference between the overall groups of patients and the group with a PDS > 3 is all the more worthy of attention given that, in this experiment, the distress expressed by patients in response to the PDS was not used as a direct criterion for referral to the Psycho-Oncology Unit. Indeed, it simply constituted one of a range of components involved in the assessment of the patient’s overall state used by the nurse who relied on her own clinical judgment during the final stage of the hetero-evaluation and the decision to trigger or omit referral to the Supportive Care Department. This is because we thought that it would be more valuable to use the PDS distress score in a more ‘distanced’ way given the fact that the TDC was conducted at a time which was both emotionally intense and charged with context-induced anxiety.

However, it is important, at this point, to stress another key aspect of the implementation of this systematic procedure. The success of this endeavor largely rests on the development of specific psychosocial knowledge and skills among nurses or non-cancer specialist health professionals [6–8]. This is based on clinical training and cooperation with healthcare professionals during the process of investigating patients’ distress and their supportive care needs. In practice, monthly clinical meetings are organized with dedicated nurses in order to check that they are adhering to the procedure and to discuss the clinical situations that have caused them difficulties. The participants at these meeting analyze all the observed ‘divergences’ between the expression of difficulties by a patient and a decision not to refer him or her to the Supportive Care Department—first by analyzing the patient’s medical record and then by discussing the case with the relevant nurse. In some cases, the nurse may, after this discussion, contact the patient again in order to check that the expressed but unaddressed needs have been met if, indeed, they are still present. This operation ensures that nurses benefit from valuable ongoing training and guidelines.

Thus, in addition to our primary aim of implementing a mechanism which makes it possible to identify patients’ needs and respond to these as appropriately as possible, the case analyses underpin discussions concerning interview practices and enable carers to explore more delicate areas which they do not always dare to address.

In addition to the clinical meetings, a corresponding document describing the screening procedure for the identification of supportive care needs has been drafted and is available to all caregivers on our institute’s intranet site.

We did not collect quantitative data in this first screening procedure phase about its impact on nurses and their practise. Nevertheless, we obtained qualitative data from the report of their personal experiences. Indeed, through regular supervision meetings, nurses had opportunities to provide their feedback about the procedure as well as about their personal feelings and ease at performing this task. Nurses who have been trained for this new screening process underlined two main points. First, they expressed being much more comfortable to explore psychosocial areas they were not used to before, being helped by the Problem Checklist which was giving them the legitimacy to look for troubles in such areas. On the other hand, they were interested to learn about the way to conduct such a psychosocial and supportive care needs exploration, thanks to the training they received. Receiving legitimacy in this role seemed to be perceived as a strong practice improvement, as well as collecting the patients’ (and caregiver, when present) expression of a high satisfaction with the procedure. In this pilot study, the educational process applied to the nurses is a main point to reach, showing them their responsibility as well as their capacity to raise patient’ psychosocial and supportive care needs, to better explore and contextualize it.

However, at this first step of the procedure, we did not work on the physician’s communication but we encouraged them to systematically refer the patient to the dedicated nurse. Indeed, we did not look for physician behavior changes, knowing their heavy level of constraints and preferring to give priority to training the nurses in charge.

However, it is important here to emphasize a certain number of difficulties associated with the implementation of this clinical experiment.

First of all, our population represented only approximately 45% of the patients who are supposed to benefit from the TDC. In effect, despite the highly protocol-based nature of the procedure, many of the patients did not complete the TDC: new patients not enrolled for the TDC by the surgeon; patients seen by the doctor but not referred to the dedicated nurse or who did not accept to be seen by her. In contrast, the vast majority of the patients seen by the nurse agreed to take part in our study. It is essential for all the professionals involved in the healthcare cycle to agree to participate and this is only possible if information and explanations concerning the value of the operation are constantly reiterated. [10–11,30].

Another limitation relates to the absence of information concerning the patients’ actual demands for assistance from the institution. In effect, our experiment shows that a certain number of patients express problems relating to the supportive care field but do not necessarily expect these problems to be addressed by the institution they are attending. An increasing number of published studies have addressed the question of unmet needs both during and after treatment [31–34]. It might be possible to clarify this issue by adding an item relating to the help expected from the institution and possibly also
a question concerning the assistance actually received by the problem checklist.

We were not able to compare data from the previous distress screening process with the one described in this paper. Indeed, such data are registered in the medical chart only since recently. Implementation of this formalized screening process gave us the opportunity to organize the recording of such information in the medical chart. This allowed performing descriptive analyses of the process. For this reason, it is not possible at this first step of our screening procedure to conclude whether there has been an improvement in the referral process, and this point is clearly a limitation of our qualitative study.

Furthermore, it is important to note that there was a certain amount of initial resistance, with the professionals who were involved not necessarily recognizing the value-added achieved thanks to the systematic nature of the procedure and, even less, the use of the assessment tools. It should also be noted that many of them had already made use of ‘individual referral criteria’ based, to a large extent, on their personal intuitions, with the result that their examination of their patients’ needs was highly dependent on their natural ability to explore the areas in question and therefore extremely personal in nature. It is also important to point out a problem relating to ‘care culture’ which often tends to perceive a simplistic dichotomy between qualitative clinical interviews and structured quantitative evaluations. The result of this is that acceptance of the principle that the two approaches are complementary will take some time to be agreed on and implemented in practice. Finally, the type of change of approach involved here will require significant effort before the corresponding proposals are adopted and individuals will often need to take the time to step back and reflect on this new experience. This is why the adoption of a systematic approach such as the one implemented here is a long-term goal which will demand regular contact and continuous liaison with caregivers in practical clinical environments [11,35].

However, an approach involving this type of systematic exploration only makes sense if a certain number of conditions are met, in particular: it is important to use it and then do something with the results from the consultation; do not think that it can replace dialogue; agree to share tasks with other actors whose assistance may be called on following the assessment [36].

Finally, this type of procedure cannot be conducted in isolation and other activities will have to be performed in parallel, for example:

- coordination of the different interventions in order to ensure the correct distribution of tasks among the various professionals;
- inclusion of communication training programs in medical and paramedical courses.

While this type of training is at a fairly advanced level in some countries, it is still far from being systematically practiced in France [37–39];

- development of cancer patients’ education programs (in particular at the start of the healthcare trajectory) [40,41].

Overall, this clinical experiment has enabled us to confirm the feasibility of the adoption of a screening procedure for distress and supportive care needs conducted by the nurses involved in the TDC. It has resulted in the drafting of a screening procedure for supportive care needs that is accessible to all carers. It represents an opportunity to set up an ongoing training for all nurses which will be conducted with a number of objectives in mind: to make them aware of and encourage them to internalize the importance of their own role in screening for patients’ distress and needs; to reinforce their skills in this field; to help them conduct such investigations on a systematic basis while adapting them to each patient’s individual characteristics; to show them that screening tools can be quite naturally incorporated in the consultation and to be useful during their clinical interviews.

It also provides us with an insight into the prevalence of distress and the types of difficulties expressed by patients at the very start of the healthcare trajectory and improves the quality of referrals to the appropriate specialists in the Supportive Care Department. Nevertheless, at this stage, the data are specific to the time of collection and do not enable us to track changes in patients’ distress and needs over time.

For our institution, the next step will consist of replicating the same procedure at different times during therapy. We have already implemented the procedure at the time of patient admission to the chemotherapy clinic which occurs, on average, 2–3 weeks later for the sub-sample of the population which receives this type of treatment. We are also introducing this approach in a hospital department in which the medical and care team have shown themselves to be motivated and interested in the implementation of this procedure. In effect, the mobilization of the team operating in the practical clinical environment and the establishment of an effective partnership with it are crucial if this type of protocol is to be conducted successfully.

However, this is the starting point for an entire quality chain. In effect, the assessment of patients’ difficulties followed by that of their needs will undoubtedly lead to further questions: what impact does the response to the expressed needs have in terms of quality of life? what is the level of satisfaction with the received care? How suitable are the resources that are made available?
Conclusions

This clinical experiment conducted among nurses involved in a Therapeutic Decision Consultation has provided evidence in support of the idea that non-specialist professionals are able to identify patients’ distress and their Supportive Care needs provided that they have received appropriate training. The initial resistance observed may have been due to a lack of knowledge concerning the existence of structured screening methods and the benefits they confer in terms of facilitating communication with the patient. Provided that professionals receive ongoing support and the necessary time is taken to establish a trust-based relationship, we consider that the results of our experiment are encouraging and provide us with the motivation to pursue and extend the procedure.

By improving the stage during which distress and needs are evaluated, by making use of simple, complementary self-evaluation questionnaires whenever any new patient is received, by making carers more sensitive to this type of systematic evaluation, it should be possible to improve the early support offered to patients who express distress or the need for supportive care. We consider this didactic approach to be of fundamental importance if we accept the principle that distress and supportive care needs should be screened for and taken into consideration in healthcare practices at an institutional level.

References