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Consultation in palliative care: The relevance of clarification of problems

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ABSTRACT

This study aims to determine the extent and nature of problems in palliative care that are newly identified in the consultation process and the factors influencing their identification. The consultation process includes clarification of problems mentioned by professionals requesting advice. Data are derived from the standard registration forms of Palliative Care Consultation teams. Multilevel logistic regression analysis was carried out with newly identified problem as dependent variable. Fifty seven percent of problems (n = 7854) were newly identified. Most newly identified problems were related to physical and pharmacological problems. If psychosocial/spiritual problems were identified, this occurred in most cases through clarification (70%). Newly identified problems were more likely to be identified in the domain of spiritual and psychosocial problems, in bedside consultations, in requests from clinical physicians, and for patients accommodated in a hospice or hospital. Explicit clarification of problems facilitates the identification and addressing of a more comprehensive and specific scope of problems.

1. Introduction

Palliative care requires professionals to address patients' physical, psychosocial, and spiritual needs.[1] Fulfilling specialist requirements is difficult for a professional when palliative care is not the main focus of daily activity. General practitioners for example lack specialist knowledge and skills on symptom treatment. Furthermore, they are unacquainted with the activities of other health care professionals.[2] As a result, important available resources and expertise are underused. The formation of Palliative Care Consultation (PCC) teams was stimulated within a national programme to improve palliative care. In such a team, experts from several disciplines and settings (hospital and primary care) work

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together to provide consultation for other professionals with less experience.[3] With a few exceptions, these teams are multidisciplinary. The exceptions are teams consisting solely of general practitioners or nurses specialised in palliative care.

The teams override the usual boundaries between healthcare disciplines in a joint attempt to address the problems of a specific patient. The agenda is set by the problems related to a specific patient rather than to the rules and structure of the disciplines and organisations involved. The teams cross the boundaries between settings and disciplines, thus providing transmural or integrated care.[4] In doing so and in being meticulous about leaving the responsibility for care in the professional requesting advice, the teams present an example of how transmural collaboration at the interface of different disciplines can be used to improve the quality of care.

The quality of support and advice given to professionals in palliative care depends not only on the palliative care expertise of the consultant, but also on the quality of the professionals' interaction. Consultation refers to the process of one professional requesting advice from another more experienced professional. Without a clear expression or identification of the problem, inappropriate actions might be proposed.[5] Adequate clarification of the questions and problems posed and exploration of the problem context offer the opportunity to identify the scope of problems related to the palliative phase of a disease. A more specific and comprehensive overview of problems would lead to a better understanding of the problems that should be addressed and the priorities that should be set in addressing these problems. A previous 1-year study of the PCC teams revealed that more than 50% of all the advices they gave were based on problems identified through clarification and exploration; these problems were not mentioned in the initial request for consultation.[3] In this study, we focus on these newly identified problems. They include (a) those identified in the clarification and exploration of the problems initially mentioned by professionals requesting advice and also (b) addressed in the advices given. The aim of this study is the identification of the nature and extent of problems derived from explicit clarification in palliative care consultations and to investigate the factors influencing whether or not such new problems are identified. It is hypothesised that newly identified problems arise most often in the domain of psychosocial and spiritual problems, since the primary reason for requesting medical consultation is the patient's physical problems[6] and professionals might hesitate to ask consultation for non-medical problems.

Consultation: the process of a professional requesting advice from another more experienced professional.

Request for consultation: a less experienced professional requesting advice and support from a Palliative Care consultation Team. One request can contain several (initial) problems.

Initial problem: a patient-related problem posed by the professional requesting consultation.

Newly identified problem: (a) problems identified through the clarification and exploration of the problems initially mentioned by the professional requesting advice and also (b) addressed in the advices given.

Clarification: retrieving more explicit information on problems mentioned by the professional requesting consultation.

Exploration: investigation of the context of problems (other domains of palliative care, for example).

2. Patients and methods

2.1. Respondents and design

Respondents were PCC teams registering their consultations. A national prospective study was conducted, registering all consultations of the PCC teams throughout a period of 2 years. In the period 1st March 2001–1st March 2003, PCC teams participated in this descriptive study by systematically recording the requests they received for consultation.[6] Some teams are based in hospitals, some in a primary care setting. Most teams are multidisciplinary and support professional caregivers working within as well as outside healthcare institutions. The teams consist of professionals from several disciplines, including general practitioners (GPs), nurses, clinical physicians, and nursing home physicians. Clinical physicians are specialised physicians like neurologists, they are often referred to as consultant physicians, but the term would be confusing in the context of this article. All team members have at their disposal their own expertise gained through training and experience and the expertise of fellow team members. The PCC teams conduct two sorts of consultations: (1) telephone consultations with the consulting professional and no contact at all with the patient and (2) bedside consultations in which the expert sees and speaks with both the consulting professional and the patient. All PCC expert teams are accessible during office hours; a few teams can be reached 24 h a day, 7 d a week.

PCC teams were specially trained in the clarification and exploration of problems and in sharing decisions on treatment with other professionals.

2.2. Data collection

Each consultation was registered with the aid of a common registration form developed by a national multidisciplinary group of researchers on the basis of previous pilot studies undertaken by the different PCC teams and a literature study. The form contained questions on the characteristics of the requesting caregiver and the patients involved.[3] In addition, the initial problems posed by the professional requesting consultation (initial problems), and the newly identified problems were registered by the consultant. All data were entered into a national computerised database. To prevent selective non-response, missing items were systematically checked with the consultant and the form completed as far as possible. Registration forms were entered into a Microsoft Access database.

2.3. Instruments

The following data were collected on the determinants of the presentation of newly identified problems: