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Original Article

Professionals' perspectives on caring for cancer patients with pre-existing severe mental disorders

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ABSTRACT

INTRODUCTION. Cancer trajectories among patients with pre-existing severe mental disorders (SMD) are challenging and these pateints' prognosis is poor. This study aimed at exploring barriers in cancer trajectories among patients with pre-existing SMD as experienced by Danish healthcare professionals.

METHODS. Semi-structured interviews were conducted with healthcare professionals who were sampled by purposive sampling. Data were analysed using inductive qualitative content analysis.

RESULTS. The participants wanted to optimise treatment, but several barriers were reported, including lack of knowledge of supportive social systems. Oncological participants experienced a lack of knowledge of psychiatric disorders and a reluctance to deal with patients with SMD among some colleagues. Furthermore, participants expressed a lack of time and continuity.

CONCLUSIONS. Concerns about how to create optimal cancer care trajectories for people with pre-existing SMD exist among healthcare professionals. Even so, stigmatisation, lack of knowledge and system barriers such as a lack of time and continuity must be addressed to optimise care for this population.

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TRIAL REGISTRATION. This study is registered in the internal register of research projects of the Central Denmark Region (R. no. 1-16-02-227-21).

A cancer trajectory is burdensome and patients with cancer and pre-existing severe mental disorders (SMD) may experience extra difficulties [1]. SMD include schizophrenia, bipolar disorder and moderate-to-severe depression. The prevalence of SMD has been estimated to approximately 5.6% [2]. People with SMD comprise a vulnerable group and are more likely to experience excess mortality, less screening for cancer, socio-economic and social disadvantages as well as stigmatisation, which makes it more difficult to navigate healthcare systems [1, 3]. Even in a fully tax-financed healthcare system like the Danish, a mean reduction of life expectancy exceeding 11 years was found among people with SMD compared with the general population [4]. Also, Danish

women with schizophrenia have been found to be less likely to receive guideline breast cancer treatment, and their mortality is increased [5].

Studies have reported that healthcare professionals working with this patient population experience multiple care provision challenges, including a lack of knowledge about patients with both psychiatric and somatic conditions [6-8].

Only few studies have been conducted on experiences of healthcare professionals caring for patients with cancer and pre-existing SMD [6-8]. Furthermore, research conducted in a fully tax-financed healthcare system is lacking. This article therefore aims to explore healthcare professionals' experiences in providing cancer care for people with pre-existing SMD in Danish hospitals, focusing on healthcare professionals from the oncology department.

Methods

This was a qualitative interview study and is a part of the Danish research initiative CASEMED (Cancer Patient with Severe Mental Disorders).

Setting

Danish healthcare is tax-financed and provides free universal healthcare services for Danish citizens [9]. The prevalence of schizophrenia in Denmark is 0.65%, while that of bipolar disorder is 0.5% and depression 10.0% [10]. The study was conducted at a Danish university hospital.

Participants

Medical specialists, nurses and radiation therapists at an oncology department and two psychiatric departments (specialised in psychotic and affective disorders, respectively) were invited by group emails and each participant self-selected to participate. Experience with the patient group was required to participate.

Interviews

The participants took part in a tape-recorded, semi-structured interview [11].

An interview guide was developed from existing literature [1, 6-8, 12]. The open-ended questions included: challenges experienced, thoughts about the patient group, cooperation and communication with colleagues and improvement of care.

Participants were encouraged to elaborate on their views and experiences, allowing the interviews open to explore unforeseen topics.

The interviews lasted between 22 and 53 minutes (median: 37 minutes) and were conducted individually with each participant except for two radiation therapists who were interviewed together.

Data analysis

All interviews were transcribed verbatim and coded using Nvivo 12 software. The analysis involved qualitative content analysis comprising:

1) Line-by-line open coding of the full data set, identifying all seemingly interesting passages and remaining open to any categories that might occur

2) Arranging recurring codes into themes

3) After deciding on themes, a focused coding was conducted, searching for themes developed in the coding

process [13].

Analysis moved back and forth between open and focused coding, allowing new themes to emerge and ensuring an explorative approach to the coding and analysis process. The coding and primary analysis were conducted by the first author and discussed with co-authors before choosing the final themes.

Ethical considerations

Participants were informed orally and in writing before interviews. All participants provided written informed consent, and participant anonymity was ensured.

Trial registration: This study is registered in the internal register of research projects of the Central Denmark Region (R. no 1-16-02-227-21).

Results

Participant demographics are presented in **Table 1**. The following seven themes emerged from the analysis:

Patient characteristics according to participants

TABLE 1 Characteristics of healthcare professionals participating in semi-structured interviews.

	Study participants (N = 20)
Sex, n (%)	
Female	18 (90)
Age, mean (range), yrs	49 (25-67)
Profession, n (%)	
Oncologists	7 (35)
Oncology nurses	6 (30)
Radiation therapists	4 (20)
Psychiatrists and psychiatric nurses	3 (15)

All participants defined patients with cancer and pre-existing SMD as a vulnerable patient population that has difficulties adhering to cancer treatment. The most frequently reported characteristic of the patient population was a lack of social support and network. Several participants reported taking a special interest in caring for this patient group and acknowledged that these patients had 'a strong presence' in the Oncology Department (Quote 1, **Table 2**).

TABLE 2 Quotes from semi-structured interviews.

Theme	Quote no.	Quote	Healthcare professional
Patient characteristics according to healthcare professionals	1	Quote "I would say that they have a stronger presence because they are different from the average patient. So, in a regular treatment pathway there isn't much to talk about. But when the psychiatric patients come in, then it's a little different. Then there's something to talk about"	Radiation therapist
	2	"I mean, there are often more patients [with SMD] than we think because we are not very good at noticing [them]. Unless it's very obvious ... But it's not the depressed patients we notice, because they don't say much. Usually, it's more those who get manic or anxious ... I think there are many of the others [the depressed patients], but we notice the others. They have a strong presence, I think. The schizophrenic patients"	Oncologist
Lack of knowledge	3	"The municipal system is very big and difficult to navigate ... Earlier, patients had a social worker and then you could ask her, and then she could find out what kind of help was available in the municipality ... Now, ... you have to contact many different [people]"	Outpatient oncology nurse
	4	"I think, we do what we can but ... we don't have a specific way, you know. It's kind of a home-made way every time"	Oncologist
	5	"Well, if we had more knowledge about it, I think we would be better at handling it ... It's just easier to read about a lung disease than how to handle a patient with schizophrenia ... It's more factual, you might say ... So, more experience and knowledge. I think that would help us ... The more we know about psychiatric disorders, the more – the calmer we would be, I think. I mean, feel more comfortable dealing with this patient group"	Oncology ward nurse
	6	"Yes, my feeling is ... that people get scared. I think that's what I feel. And resignation ... because of the ignorance. And things we don't know about, we get scared of. And then it's easier to just not deal with it. That's what I experience ... I've experienced colleagues who couldn't manage talking to him [a patient with SMD]"	Oncologist
Reluctance to deal with SMD	7	"It's kind of like feeling a little bit lonely as a physician with these patients because there is some reluctance to deal with them. So, you are a little alone with these patients... I just experience that reluctance to deal with them, like: 'You'll just take [this patient] yourself, right?' ... I get it. I would feel the same way. But now that I know him [a patient], I'm not afraid of him"	Oncologist
	8	"I think it [the patients' appointment in the department] takes up much energy before they arrive ... You read some things about the patient and think: Oh no, we cannot handle him at all ... As a nurse, I feel among my colleagues that it causes a stir ... But often it turns out that we worry more than necessary ... I think it's a clear picture that we're not good enough at handling psychiatric patients"	Oncology ward nurse
Limited professional discussions	9	"Sometimes we don't know what's going on. We can see what's written in the medical record, so we can keep up a little... I think, I've never tried to be contacted by a somatic department. Actually, never"	Psychiatric nurse
	10	"I think, what I want to stress the most is this: Try to make use of us ... Sometimes, we have a colleague who has known the patient for 15 years. They have a different type of contact. And we really want to be contacted because we are also interested in doing something about the excess mortality in these patients"	Psychiatrist
	11	"We don't have [contact with the psychiatric department], and we could be a lot better at that ... But it's not really something we're conscious about"	Outpatient oncology nurse
Treatment dilemmas	12	"If you are already manic and you get corticoids, then you can become really manic ... [A patient] received immune therapy and got... so severe side effects; in fact, you could die from these side effects. Then we had to give corticoids. But he got really manic ... then we just made him mentally ill instead. ... And that was also an ethical consideration: What's the right thing to do?"	Oncologist
Challenges in transitions	13	"When I can see that he [a patient] is getting into a manic phase again, then I often ask if his partner can come, or if he wants his mother to join him. And sometimes I think this is difficult; he doesn't want that. ... I don't like that. I send him out of the door thinking: I wonder where he's going now? ... Are there someone out there to help him? That's unpleasant. I don't like that"	Oncologist
	14	"I think that's my biggest worry. The transitions. The transition to the home, the transition from having been in a... safe environment here, where there's always someone around you, to coming home and then having someone come occasionally... Also, is the patient able to react if it doesn't work out for them to be at home?"	Oncology ward nurse
Lack of time and continuity	15	"When you are a hospital physician, ... you don't see the patients that often ... Even though you wish to see your patients, then others will decide it for you. I can choose to say, 'can I see that patient?' and then they will reply, well, your schedule is full so you cannot see that patient that day'"	Oncologist
	16	"It would definitely make it easier if they [the patients] didn't have to start with their story from the beginning ... Both for the physician and the patient. Then they're comfortable with; 'alright, she [the physician] already knows that I'm mentally ill'"	Oncologist
	17	"You are allowed to say; 'now it's simply too much. Now I can't handle this patient one more time' right? 'Now I need a break'"	Outpatient oncology nurse
	18	"What I lack the most, I think, is time. That our entire damn system is tied up on some appointments where you only have ½ an hour or so... You have to examine the patient, communicate, you need to establish a relation, you need to explain what our plan could be, explain that they have the right to go home and think about it , and what their wishes are as well ... And is our treatment even compatible with the treatment they receive for their psychiatric disorder? ... The time factor is increasingly stressful"	Oncologist
	19	"I think the challenge is that you will spend more time to get to know the patient and figure out which resources the patient has. And figure out, well, did the patient understand the information you just gave? ... That's more demanding"	Oncology ward nurse
	20	"If we don't create the relation, if [patients] can feel that we are on our way out of the door before we came in ... I can say it like this; 'if I was in their situation, I wouldn't talk about the difficult things'"	Oncology ward nurse

SMD = severe mental disorder.

However, it was also mentioned that not all patients with pre-existing SMD would necessarily be recognised in clinical settings, indicating that only patients with active SMD symptoms would be noticed (Quote 2, Table 2).

Lack of knowledge

Participants from both the oncology and the psychiatric departments reported a lack of knowledge about possibilities in the social system in place to help vulnerable patients (Quote 3, Table 2).

All participants from the Oncology Department reported that no guidelines existed on managing patients with SMD symptoms. Consequently, they often relied on ad hoc solutions (Quote 4, Table 2).

Challenging situations with patients often relied on oncology healthcare professionals' personal experiences

(e.g., family members with SMD) or former work experience from psychiatric departments and thus not on knowledge obtained through formal training (Quote 5, Table 2). Some participants even explained that a lack of knowledge of patients with SMD made them and their colleagues feel insecure (Quote 6, Table 2).

Reluctance to deal with severe mental disorders

Participants were asked about general sentiments among colleagues dealing with this patient group. All agreed that patients should be treated equally. However, some participants from the oncology department experienced a reluctance within themselves and among their colleagues to deal with patients with SMD (Quote 7, Table 2). Several participants reported that lacking knowledge often led to insecurities *before* the patient even showed up in the department if the staff was aware that the patient had SMD (Quote 8, Table 2).

Limited professional discussions

Most participants experienced that workplace relationships were well functioning and felt comfortable sharing their insecurities. However, they found it challenging to find time to discuss difficult situations with colleagues.

Participants from the Psychiatric Department expressed concerns regarding lack of contact between psychiatric and somatic departments in general. They considered that contact between departments is important and considered that they were good patient-advocates, especially if they knew the patient (Quote 9 and 10, Table 2).

Participants from the Oncology Department had various experiences concerning contact with the Psychiatric Department. Some did not recall having had any contact, whereas others remembered having contacted psychiatric departments for psychiatric assessments of hospitalised patients (Quote 11, Table 2).

Treatment dilemmas

In general, participants reported making a special effort to treat the patients' cancer disease if they assessed that their mental condition was stable. However, participants feared sending patients home with side-effects to which they might not be able to respond. Dilemmas arose, e.g., when assessing if patients would be able to receive corticoids, which increase the risk of escalating psychosis (Quote 12, Table 2).

Furthermore, participants reported that they found it challenging to assess whether patients refused treatment due to SMD symptoms or because of a genuine wish not to receive the recommended treatment.

Challenges in transitions

Multiple participants described discharging patients to their homes as worrying, especially when dealing with patients with a limited social network (Quote 13, Table 2).

Transitions between the hospital and the patients' homes were considered a major barrier to an ideal cancer trajectory for patients with pre-existing SMD because no part of the hospital system was able to support the patients, thus increasing the risk of disrupted treatment (Quote 14, Table 2).

Lack of time and continuity

Participants were encouraged to describe factors that would make caring for their patients less challenging. A general, recurring answer identified the need for continuity. Oncology nurses and radiation therapists reported that it was generally possible to maintain some measure of continuity, whereas physicians reported that continuity was challenging due to staff shortage (Quote 15, Table 2).

Lack of continuity was described to affect patient-provider relationships, thus decreasing trust (Quote 16, Table 2).

Participants reported that continuity was essential. However, they also attributed importance to having the

possibility to withdraw from a patient trajectory if it was experienced as too demanding (Quote 17, Table 2).

Additionally, lack of time was reported as a general barrier to optimal cancer care. Especially critical when dealing with patients with pre-existing SMD (Quote 18 and 19, Table 2).

Creating trustful relationships with patients was further impeded by lack of time (Quote 20, Table 2).

Discussion

Multiple worries and uncertainties among the participants were reflected in the interviews. Participants from the Oncology Department were aware that only patients with obvious symptoms of SMD were recognised in clinical settings. They experienced a reluctance to deal with the patient group among some colleagues and therefore felt alone when dealing with difficult situations. Insecurities in assessing patients' psychiatric conditions and absence of formalised guidelines gave rise to several dilemmas regarding treatment decisions. A lack of social network to ensure patient support was considered a considerable barrier as was lack of time and continuity.

Comparison with previous findings

Several studies have emphasised mental disorder-related stigma among healthcare professionals as a barrier in cancer trajectories [1, 6-8, 14]. Stigmatising attitudes in healthcare settings may be a result of misinformation and are known to potentially cause suboptimal healthcare and diagnostic overshadowing [7, 8, 15]. Avoiding to handle patients with SMD and the feelings of anxiety among colleagues reported in our study indicate a level of stigma among healthcare professionals, potentially leading to a poorer treatment outcome [15]. A new finding in our study was that these factors left some healthcare professionals at the Oncology Department feeling alone and without collegial back-up.

Previous studies have considered compartmentalisation of somatic and psychiatric departments a barrier to cancer care for people with SMD [6-8, 16]. Our study supported this finding as limited experiences of contact between oncology and psychiatric departments were reported along with a lack of regular multidisciplinary meetings.

Assessment of patients' psychiatric conditions and decision-making capacity has previously been reported as a barrier in cancer care [6, 8]. Our findings revealed that difficulties in assessing patients' conditions would occasionally lead to ethical dilemmas if patients refused recommended treatment [17]. Decisions on recommendation of cancer treatment was furthermore considered challenging due to pharmacodynamic interactions between cancer and psychiatric treatment [18].

While lack of time has been recognised in previous studies, both lack of time and continuity were experienced as challenging among participants in the present study [6, 8]. The limited timeframe in which the professionals had to familiarise themselves with each patient was considered especially challenging in patients with SMD. Lack of continuity and time was experienced to compromise the patient-provider relationship and may also lead to burn out among employees [19, 20].

Study strengths and limitations

A strength of this study is that several types of professionals and both oncology and psychiatry departments are represented. However, the study also carries several limitations. A very limited number of healthcare professionals from the psychiatric departments chose to participate. Still, the main focus of the study was cancer trajectories that are mainly located to the oncology department. Therefore, we included their perspectives on contact between the departments only.

Furthermore, the response rate to the email invitations was low. This might, in part, be because the recruitment period coincided with the Covid-19 pandemic, which caused understaffing at the departments. Due to the low number of participants and the sampling strategy (self-selection), the results may potentially only represent perspectives of employees with a specific interest in the topic.

Perspectives

Guidelines are needed on the possibilities for support within the healthcare and social systems to increase professional confidence and boost awareness of SMD and unconscious biases through formal training, thereby reducing stigmatisation. A systematic approach to focussing on patients with pre-existing SMD and to assessing mental conditions is important to provide the needed patient-centred cancer treatment. Furthermore, increasing available time and continuity would improve care. Further research into the perspectives of employees in psychiatric departments would be beneficial.

Conclusions

Several inter-related barriers to optimal cancer care were reported among healthcare professionals caring for patients with pre-existing SMD. Most notable was the self-reported lack of knowledge about SMD among healthcare professionals at the Oncology Department. Stigmatisation and reluctance to deal with the patient population among some staff members produced a feeling of loneliness among the healthcare professionals who took on the task. Furthermore, a lack of formalised guidelines on how to handle care for patients with SMD led to treatment dilemmas. To provide optimal patient-centred care for patients with pre-existing SMD, the participants requested more time and a higher level of continuity to increase patient-clinician trust.

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