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Psycho-oncology care in breast cancer centres: a nationwide survey

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ABSTRACT

Objective To describe psycho-oncological care structures and processes in German breast cancer centres from the perspective of the centre administration.

Methods The findings are based on a postal survey of a representative random sample of surgical sites of certified breast cancer centres in Germany. Data were collected in 2013 and 2014. The questionnaire included questions about infrastructure, patient information standards, psycho-oncological services and aspects of organisational culture. Data analyses included frequencies, means and bivariate relationships.

Results The return rate was 88.3% (53 hospital sites). Psycho-oncological care is provided by permanent employees in 87%. The average number of full-time-equivalent employees (FTE) is 1.23. Most breast cancer centres engage the occupational group of psycho-oncologists for psycho-oncological care (90%), followed by the medical service (80%) and breast care nurses (78%) (multiple answers were possible). The correlation coefficient between FTEs and surgical treatments per year is not significant ($r=0.292$, $p=0.051$). Hospitals are screening every inpatient for the need of psycho-oncological support in 76% of all sites. Frequently used screening instruments are distress thermometer (19%), clinical interview (13%) and basic psycho-oncological documentation (11%).

Conclusion Our data provide insights into the self-reported structural and procedural quality of psycho-oncological care in German breast cancer centres. Further research should examine patient and caregiver perspective on the psycho-oncological services provided by breast cancer centres.

BACKGROUND

Psycho-oncological care is recognised as an important part of cancer treatment. Representative differentiated data are still missing on the need for psycho-oncological treatment. Needs assessment shows heterogeneous results depending

on the diagnosis and course of the disease. A review shows that 20%–70% of patients with breast cancer surveyed need psychosocial support.¹ In contrast, the prevalence of psychological distress has been well described; about one-third of patients with breast cancer suffer from anxiety or depression.² However, this is a fact which might give hints to estimate the proportion of patients being in need for psychosocial support only at first sight. There is some evidence that anxiety and depression do not explain much of the variance of subjective psychosocial support needs.³

Psycho-oncological care for patients with breast cancer might be provided by clinics or departments such as psychosomatic medicine, psychiatry or medical psychology, by independent departments in cancer centres, or by cooperating psychotherapists established in practice. In the German National Cancer Plan, psycho-oncological care has been defined as ‘graduated psychosocial and psychotherapeutic interventions for cancer patients and their relatives’.⁴ Psychosocial care includes ‘information, counseling, psychoeducation, crisis intervention and support. Psychotherapy includes diagnostics, crisis intervention and psychotherapeutic treatment of patients with continuing or severe disorders [...]’.⁴ Standards of psycho-oncological care are described in oncological guidelines and disease management programmes, and they are certification criteria for breast cancer centres in Germany. Initial data show that between 33%⁵ and 67%⁶ of inpatients with breast cancer receive psycho-oncological care. Occupational groups involved are medical service, psychological service, social service, nursing and spiritual care. The larger the institution, the more psychologists are involved.⁵

Objective

The aim of the present work is to describe psycho-oncological care structures and processes in German breast cancer centres⁷ from the perspective of the centre administration.

METHODS

This study is part of a project funded by the German Federal Ministry of Health as part of the national cancer plan (PIAT study: strengthening patient competence - breast cancer patients' information and training needs). As part of the study, a postal survey with breast cancer centre key informants (heads or managers) was conducted. The instruments were pretested in two interviews and a focus group with professionals working in breast cancer centres (physicians, breast care nurses and breast cancer centre managers) using cognitive probing and think-cloud techniques. Validated scales and indices as well as newly developed items were used. The instruments were pretested using cognitive think-cloud techniques. A random sample of 60 surgical sites from 46 breast centres were drawn from all certified German breast cancer centres. The survey was carried out by mail with three reminders. The questionnaire included factual items about structural aspects of the site, working hours, psycho-oncological care, psycho-oncological screening routines and organisational culture. Items were answered on dichotomous, multiple-answer scales or open-ended. Data were recorded electronically using the software TeleForm and checked for possible errors and plausibility. Data were analysed using the IBM SPSS Statistics V.24 software. Absolute or relative frequencies, mean values and correlation measures were calculated.

RESULTS

In total, 53 of 60 sites participated in the survey (return rate 88.3%). The structural characteristics of the sample are described in [table 1](#). Breast cancer centres claim to screen all patients for psycho-oncological support needs in 76% of the cases, whereas 19% do not screen all patients. The most frequently used screening tools are distress thermometer (19%), clinical interview (13%) and basic psycho-oncological documentation (11%). For all other instruments the usage is less than 10%. Descriptive results on psycho-oncological care are presented in [table 2](#).

DISCUSSION

Psycho-oncological care is provided by the permanent staff in most of the breast cancer centres, and most of the employees have a psychological or medical background. However, psycho-oncological care is commonly provided by (breast care) nurses or spiritual and social service workers as well. These data are in line with the results of Bergelt *et al.*⁵ It cannot

Table 1 Structural characteristics of the participating breast cancer centres

Ownership	Frequency %			
Public ownership	28	52.8		
Independent non-profit ownership	17	32.1		
Private ownership	7	13.2		
Missing	1	1.9		
Total	53	100		
Status of a teaching hospital	Frequency %			
Yes	45	84.9		
No	7	13.2		
Missing	1	1.9		
Total	53	100		
Hospital size	Mean	SD	Minimum	Maximum
Number of surgeries, 2012	187.4	97.2	55	445
Number of surgeons, 2012	3.3	1.7	1	10

be clarified to what extent social service, nursing or spiritual occupational groups supplement or possibly replace the psycho-oncological care provided by medical or psychological staff. Presumably several occupational groups are involved in the psycho-oncological care in most sites.⁵ However, it remains unclear whether this is the case in the supportive care of individual patients or whether the occupational groups are involved in screening procedures or in the provision of psycho-oncological care. Conversations with social workers or nurses trained in empathic conversation can reduce feelings of inadequacy and increase self-esteem by validation and normalisation; therefore, they fall under the realm of psychosocial care of patients with cancer, but cannot be considered as psychotherapeutic treatment of patients with cancer. Whether this terminology is consistent with the perception of the respondents cannot be assessed.

The number of full-time-equivalent employees for psycho-oncological care is not significantly related to the number of breast cancer surgeries at the sites. Those breast cancer centres that are part of a comprehensive cancer centre may have higher level and centralised psycho-oncological structures at their disposal. It remains unclear to what extent the surveyed centres have taken these resources into account. Psycho-oncological employees do not solely care for inpatients during their acute primary surgical treatment, but especially care for patients in advanced stages of the disease or in palliative situations.^{8,9} In addition, the psycho-oncological staff are engaged in activities with direct patient contact and involved in administrative or coordinative tasks.

The majority of centres report to be screening all patients comprehensively for psycho-oncological support needs. The implementation of the recommendations of the guideline 'Psycho-oncological diagnostics, counseling and treatment of adult cancer patients' has made considerable progress.¹⁰ At the time

Table 2 Structures of psycho-oncological care in the participating breast cancer centres

Provision of psycho-oncological care by permanent employees	Frequency	%
Yes	46	86.8
No	5	9.4
Missing	2	3.8
Total	53	100
Full-time-equivalent employees	Frequency	%
0.1	1	1.9
0.5	11	20.8
0.65	1	1.9
0.75	1	1.9
1.0	13	24.5
1.3	1	1.9
1.5	4	7.5
2.0	11	20.8
3.0	2	3.8
Missing	8	15.1
Total	53	100
	Mean	SD
Full-time-equivalent employees	1.23	0.70
Professions involved in the psycho-oncological care	Frequency	%
Psychological service	45	90.0
Social service	31	63.3
Medical service	41	80.4
Nursing staff	20	41.7
Breast care nurses	39	78.0
Spiritual service	31	66.0
Is the staffing level sufficient to meet the psycho-oncological care needs of patients with breast cancer?	Frequency	%
Yes	33	62.3
No	12	22.6
Missing	8	15.1
Total	53	100
Correlation analysis	r	P value
FTE × number of surgeries (proxy for hospital size/number of patients)	0.292	0.051

FTE, full-time-equivalent employees; r, Pearson correlation coefficient.

of the survey, comprehensive screening has not been implemented in about one-fifth of the centres. This proportion may have further reduced at the time of publication. The instruments listed are psychometrically tested and validated questionnaires recommended in the guideline 'Psycho-oncological diagnostics, counseling and treatment of adult cancer patients'.¹⁰ It cannot be assessed to what extent the conversation with the psycho-oncologist is used in addition to a standardised instrument. The guidelines recommend a clinical interview following a positive screening result or as needed or requested by the patient.¹⁰

The available data are valuable as they describe structural and process characteristics of the psycho-oncological quality of care as perceived by the

heads or managers of German breast cancer centres. The strength of this survey can be seen in the high return rate and the nationwide sample of centres, although there are limitations to be considered. The information is based on self-reports by the heads or managers of breast cancer centres and might therefore be biased. However, key informant interviews are a recommended method in organisational health services research.¹¹ The key informants interviewed here are not routinely involved in the psycho-oncological care of the breast cancer centres. Moreover, the definition of psycho-oncological care as graduated psychosocial and psychotherapeutic interventions⁴ makes it difficult for both experts as well as other health professionals to capture the concept. Thus, different concepts of psycho-oncological care may impede the interpretation of the results. The fact that the results on the involvement of individual occupational groups confirm the results of Bergelt *et al*⁵ supports the validity of the information, since Bergelt *et al* interviewed the psycho-oncological professionals themselves. The subjective needs assessment provides only initial evidence out of one single perspective that some centres could not meet the needs of the patients at the time of the survey coverage and might be biased by political considerations. To what extent these structures are adequate from the patients' perspective has to be subject to further research. There are indications that the support needs of specific groups of patients with breast cancer, for example, patients with an immigration background,¹² patients with comorbidities,¹³ patients receiving neoadjuvant chemotherapy or showing passive-resigning coping skills,¹⁴ patients who are offered individualised treatment approaches based on molecular genetic methods,¹⁵ male patients with breast cancer, or patients' partners or caregivers,^{16 17} have not yet been addressed adequately. Should subsequent studies reveal that disease-specific, treatment-related or target group-specific needs are not fully met, it will be necessary to examine the institutional determinants in order to derive specific measures for the underserved patient groups.

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Competing interests None declared.

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