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Original Article

The role of occupational therapists in palliative care teams: differences of rehabilitation occupations expected by other occupations

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ABSTRACT

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Objective: This study aimed to compare the role of occupational therapy (OT) with that of rehabilitation occupations in palliative care teams (PCT).

Methods: A questionnaire survey was conducted on PCT representatives and OT department managers at cancer hospitals.

Results: Approximately 40% of facilities had an occupational therapist registered (OTR) in the PCT. Differences among the roles of each rehabilitation occupation were not found. Regarding the role of the OTR in the PCT, items that had significantly higher scores in the responses of PCT representatives were "support for transition and selection of treatment places" and "care for outpatient/home care patients." Items that had significantly higher scores in the responses of OT department managers were assessment approaches for mental distress, patient decision support, and family care.

Conclusions: It is necessary to clarify the role of not only OT but also all rehabilitation occupations in the PCT. It is also important for OTRs to take advantage of their own strengths and focus on the roles required by other occupations.

Key words: palliative care team, rehabilitation, occupational therapy, role

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Introduction

In 2002, the World Health Organization (WHO) defined palliative care as "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" [1]. Since this definition was made, palliative care teams (PCT) have been established at cancer hospitals in Japan. The establishment of a PCT is one of the requirements of a cancer hospital, and the team consists of the physician in charge of physical symptoms, physician in charge of psychiatric symptoms, full-time nurse, pharmacist, and psychologist [2]. Individuals with rehabilitation occupations were excluded. However, the Japanese Society for Palliative Medicine considered individuals with rehabilitation occupations as part of the team members in the PCT [3]. Individuals with rehabilitation occupations are Registered Physical Therapist (RPT), Occupational Therapist Registered (OTR), and Registered Speech-Language-Hearing Therapist (RST). No previous studies have systematically investigated the differences in the roles of the RPT, OTR, and RST. Therefore, this study aimed to clarify the role of the OTR in comparison with individuals with other rehabilitation occupations. We determined the role of the OTR in the PCT in this study, to provide action guidelines for the OTR in the PCT and to lead to smooth cooperation with other occupations.

Methods

1. Subjects

We targeted cancer hospitals in Japan, and conducted a self-administered questionnaire survey by mail. We

extracted 335 hospitals of 400 cancer hospitals that were listed in the 2015 Japan Association of Occupational Therapists Members (April 1, 2017). The subjects were the PCT representatives and occupational therapy (OT) department managers of the target facilities.

2. Questionnaire

The questionnaire asked about the attributes of the subjects, basic information about PCT (participating occupations, etc.), and roles in the PCT. Regarding the roles in the PCT, Morita et al. had investigated the purpose of clarifying the activities of the PCT in many cancer hospitals [4], and so we used the results of that study. The 12 items listed in Tables 1 and 2 were rated using a 5-point scale (1: not applicable to 5: very applicable). We asked the PCT representatives regarding the roles of the RPT, OTR, and RST, and the OT department managers regarding the role of the OTR.

3. Implementation period

The questionnaire was mailed to the subjects on November 1, 2017. The deadline for responding was November 20, and a reminder postcard was posted on November 16. The forms that were collected from November 7 to December 22, 2017 were analyzed.

4. Statistical analysis

The Mann-Whitney *U* test was used to compare the two groups, and the Kruskal-Wallis test (Scheffe's method for multiple comparisons) was used to compare the three groups. The significance level was set at 5%.

5. Ethical considerations

The study was approved by the Research Ethics Committee of The Open University of Japan (Notification No. 32).

Results

The recovery rate was 53.4% for PCT representatives and 52.5% for OT department managers.

1. Basic information

The breakdown of PCT representatives (*n*=179) was as follows: 80 physicians (44.7%), 89 nurses (49.7%), 9 RPTs (5.0%), and 1 blank (0.6%). Of the occupations (*n*=179) belonging to the PCT, there were 175 physicians (97.8%), 178 nurses (99.4%), and 175 pharmacists (97.8%). There were a total of 135 social workers (75.4%), 119 psychologists (66.5%), 114 registered dietitians (63.7%), 102 RPTs (57.0%), and 71 OTRs (39.7%). Moreover, 30% of the target facilities did not have rehabilitation occupations in the PCT. The following distribution was found: RPT + OTR 25%, RPT 21%, and OTR 16%.

Table 1. Roles of individuals with rehabilitation occupations in the PCT considered by the PCT representatives.

	RPT (*n*=178)	OTR (*n*=174)	RST (*n*=164)	*p*-Value
1. Identification of patient problems, worries, and needs	4.22±0.70	4.22±0.71	4.07±0.75	0.07
2. Identification of family problems, worries, and needs	3.93±0.80	3.94±0.81	3.84±0.82	0.42
3. Assessment approach for physical distress	4.25±0.64	4.16±0.69	3.97±0.73	<0.01** RPT-RST : <0.01** OTR-RST : <0.05*
4. Assessment approach for mental distress	3.80±0.89	3.90±0.85	3.80±0.79	0.37
5. Assessment approach for social distress	3.60±0.92	3.75±0.87	3.63±0.84	0.26
6. Assessment approach for spiritual distress	3.66±0.90	3.76±0.88	3.65±0.85	0.35
7. Patient decision support	3.47±0.89	3.50±0.93	3.45±0.92	0.92
8. Support for transition and selection of treatment places	3.97±0.82	3.89±0.84	3.51±0.93	<0.01** RPT-RST : <0.01** OTR-RST : <0.01**
9. Care for outpatient/home care patient	3.72±0.99	3.71±0.98	3.58±0.98	0.26
10. Family care	3.48±0.87	3.55±0.88	3.54±0.89	0.70
11. Support of other staff	3.72±0.89	3.63±0.93	3.53±0.96	0.18
12. Making adjustments within the palliative care team	2.75±1.01	2.80±1.02	2.76±1.01	0.80

5-point scale (1: Not applicable at all to 5: Very applicable).
Kruskal-Wallis Test (Scheffe's method for multiple comparisons), significance level is 5%. *p<0.05, **p<0.01.

2. Role of individuals with rehabilitation occupations in PCT considered by the PCT representatives (Table 1)

The score of the RPT was significantly higher than that of the RST in the two items of "assessment approach for physical distress" and "support for transition and selection of treatment places" (both $p < 0.01$). The score of the OTR was significantly higher than that of the RST in the "assessment approach for physical distress" ($p < 0.05$) and "supporting the transition of treatment site selection" ($p < 0.01$). However, in other items, no significant difference was observed among RPT, OTR, and RST. Particularly, no significant difference was observed between RPT and OTR. The average scores for most items were in the latter half of the third to the first half of the fourth.

3. Comparison of the role of the OTR in PCT between PCT representatives and OT representatives (Table 2)

Items that had significantly higher scores in the responses of PCT representatives were "support for transition and selection of treatment places" ($p < 0.01$) and "care for outpatient/home care patients" ($p < 0.05$). Items that had significantly higher scores in the responses of OT department managers were "assessment approach for mental distress" ($p < 0.01$), "patient decision support" ($p < 0.01$), and "family care" ($p < 0.01$). The average scores of most items were in the latter half of the third to the first half of the fourth.

Discussion

1. Basic information

Generally, 30% of the facilities had no rehabilitation occupations in the PCT. As one of the factors, the participation of individuals with rehabilitation occupations in the PCT seems to be unnecessary in the system, and there is no preferential treatment in terms of health care fees even if individuals with rehabilitation occupations participate in the PCT. However, we believe that individuals with rehabilitation occupations should also participate in the PCT to provide high-quality palliative care to meet the diverse wishes of patients and their families. In the future, it will be necessary to clarify the role and effectiveness of each rehabilitation occupation in the PCT. Approximately 40% of the facilities had an OTR in the PCT. Nishikori et al [5]. reported that a shortage of OTRs was the reason why OT was not performed for patients with cancer. They also revealed that it is necessary for other occupations to understand the role of the OTR. In this study, the causes of the small number of OTRs in the PCT may be the shortage of OTRs and a lack of understanding of OT specialty.

2. Role of each rehabilitation occupation in PCT considered by the PCT representatives

Focusing on the role of the OTR, the scores for "assessment approach for physical distress" and "support for selection and transition of medical treatment place" were higher than those of the RST, but no other significant difference was observed. This suggests that PCT representatives may not be aware of the differences in the role of each rehabilitation occupation. However, the average score for each item

Table 2. Comparison of the roles of the OTR in the PCT between PCT representatives and OT department managers.

	PCT representatives (n=174)	OT department managers (n=166)	p-Value
1. Patient problems, worries, need identification	4.22±0.71	4.25±0.68	0.81
2. Family problems, worries, need identification	3.94±0.81	4.11±0.69	0.06
3. Assessment approach of physical distress	4.16±0.69	4.24±0.63	0.27
4. Assessment approach of mental distress	3.90±0.85	4.29±0.59	<0.01**
5. Assessment approach of social distress	3.75±0.87	3.87±0.79	0.22
6. Assessment approach of spiritual distress	3.76±0.88	3.73±0.79	0.45
7. Patient decision support	3.50±0.93	3.86±0.86	<0.01**
8. Support for transition and selection of treatment places	3.89±0.84	3.53±0.84	<0.01**
9. Care for outpatient/home care patient	3.71±0.98	3.48±0.93	0.01*
10. Family care	3.55±0.88	3.80±0.71	<0.01**
11. Support of other staff	3.63±0.93	3.69±0.72	0.68
12. Make adjustments within the palliative care team	2.80±1.02	2.86±0.88	0.53

5-point scale (1: Not applicable at all to 5: Very applicable).
Mann-Whitney U test, significance level is 5%. *p<0.05, **p<0.01.

was in the latter half of the third to the first half of the fourth, and many subjects answered 3 or 4. Each item was expressed abstractly. The items used in this study were the job contents of the PCT, so it could be considered that any PCT staff would be more or less involved in any job category, which may also have influenced the results of this study.

3. Role of the OTR in PCT considered by PCT representatives and OT department managers

Items that had significantly higher scores in the responses of the OT department managers were "assessment approach for mental distress," "patient decision support," and "family care." This indicates that OTRs were more aware of their role, and could be the strength of the OTR. In addition, items that had significantly higher scores in the responses of the PCT representatives were "support for transition and selection of treatment places" and "care for outpatient/home care patients." This indicates that these items were the roles required from other occupations. We believe that these points should be considered when an OTR is involved in patients receiving PCT intervention. In the future, when an OTR is involved in patients with cancer in the palliative period, it will be necessary to take advantage of the OTR's own strengths and provide interventions focusing on the points required by other occupations.

Conclusion

This study aimed to clarify the role of OT from that of each rehabilitation occupation in the PCT. A questionnaire survey was conducted on the PCT representatives and OT department managers of cancer hospitals. As a result, 30% of the facilities had no rehabilitation occupation in the PCT. Approximately 40% of the facilities had an OTR in the PCT. Differences in the roles of each rehabilitation occupation were not found. The OT department managers believed that the roles of the OTR in the PCT were support for mental distress, patient decision support, and family care. These could be considered the strengths of the OTR. PCT representatives believed that the roles of the OTR in the PCT were support for selecting and shifting treatment sites and care for home care patients. These could be considered as the roles required from other occupations. In the future, it will be necessary to clarify the role of each rehabilitation occupation in not only OT but also PCT. It is necessary for OTRs to take advantage of their own strengths and to focus on the roles expected from other occupations. This study provides basic information for establishing the roles of rehabilitation occupations in PCT. However, we believe it will be necessary to formulate more specific roles for the OTR and to prepare a questionnaire.

Limitations of this study

Since the questionnaire survey was conducted by mail, it was not possible to confirm whether the subjects fully understood and answered the questions. Some items were omitted. Therefore, it cannot be confirmed that the results of this study reflect the actual conditions of PCTs in Japan.

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