The role of the occupational therapist in oncology

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Introduction

In recent years, occupational therapists have increasingly been found working in a variety of clinical settings including acute wards, specialist units, within hospices or the patient's home environment (1). The role and contribution of the occupational therapist in the care of the patient with malignancy is both diverse and challenging, and requires a mix of both new and traditional skills. The primary drive and focus of the occupational therapist is to facilitate and enable an individual patient to achieve maximum functional performance, both physically and psychologically, in everyday living skills regardless of his or her life expectancy. An individual can benefit from occupational therapy intervention at any stage of an illness from primary diagnosis, through attempts at curative treatment, to palliation and finally terminal illness (2). Intervention may be directed towards practical assistance and advice in relation to life skills, such as personal care, or to supporting the individual in adjusting emotionally to the effects and implications of the disease, or to assisting the individual to maintain social and leisure activities as far as possible.

Occupational therapists have a dual training in both physical and mental health fields, and consequently have developed a high level of specialization within each field. Cooper suggests that 'the unique feature which separates the occupational therapy knowledge base from all other professionals is the study and management of purposeful occupations (activities)' (3). In 1994, the College of Occupational Therapists in the U.K. defined occupational therapy as 'The treatment of people with physical and psychiatric illness or disability through specific selected occupation for the purpose of enabling individuals to reach their maximum level of function and independence in all aspects of life. The Occupational Therapist assesses the physical, psychological and social functions of the individual, identifies areas of dysfunction and involves the individual in a structured programme of activity to overcome disability' (4).

It is the belief and view of the occupational therapist that activities and occupations are fundamental to an individual's physical and psychological well-being; and that through occupation, an individual can influence their state of
health (5). In 1994, Stewart suggested that 'occupational therapy is very much about enablement'. She states that 'enablement is about helping the individual to achieve what is important to that person and not necessarily about seeking normality or conformity. It is about helping individuals to respond to their circumstances, to assert their individuality and establish their goals' (5).

Scope of occupational therapy in oncology

The main objective of occupational therapists’ interventions in patients with cancer is to consider the unique needs and desires of each individual at the centre of treatment. It is paramount that as much control as possible is given back to the individual as long as he or she wishes and is able to take control. Any intervention offered should be centred around the person and not implemented without collaborative discussion with the patient. The occupational therapist will work with an individual in assisting the person to re-establish his/her sense of control and to focus on what is important to him/her through flexibility of assessment and treatment packages. When identifying individual needs, the therapist will also include those of the patient’s family and carers offering support and advice, as well as the patient.

In 1981, Dietz stated that the overall aim of cancer rehabilitation is ‘to improve the quality of survival of cancer patients so that during the period of survival they will be able to lead as independent and productive a life as possible at the minimum level of dependency, regardless of life expectancy’ (6). In many ways, this statement reflects the whole ethos of occupational therapy and its belief that, through occupation, an individual may influence his/her state of health.

The occupational therapist is committed to helping an individual live realistically with cancer. Individuals are encouraged to live within their limitations and to maximize the potential of each day. Since each individual will present with their own unique set of problems and fluctuations in disease status, the therapist must acknowledge and accept that the patient’s condition may change rapidly and, in some instances, may result in constant need for re-evaluation and modification of the treatment programme (2).

It has been suggested that the types of problems that may require occupational therapy can be viewed broadly as fitting into two categories, namely cancer-related and treatment-related (2). The individual’s functional ability and status will (or may) not only be affected by the effects of the primary tumour, but also by the presence of metastases or by the treatment they are undergoing (2). This last group have additional problems related to the use of cytotoxic agents or to sites being treated with radiotherapy.

The most common cancer-related problems that are presented to an occupational therapist are:

1. Neurological deficits, including hemiplegia, loss of co-ordination, loss of power resulting from primary brain tumour or cerebral metastases.
2. Paraplegia/quadraplegia from either a primary spinal malignancy, or more often as a result of metastatic growth involving the spinal cord.
3. Loss of a limb or part from amputation for soft tissue or bone tumour, usually sarcoma.
(4) Pathological fractures due to either primary bone tumour or secondaries, for example fractured neck/shaft of femur needing surgical intervention and/or radiotherapy.

(5) Shortness of breath resulting from primary or secondary lung or pleural disease, or, occasionally, superior vena caval obstruction.

(6) General weakness/fatigue and lethargy.

(7) Lymphoedema affecting either upper or lower limbs.

(8) Disturbances and impairment of auditory or visual function.

(9) Pain.

(10) Cognitive and perceptual deficits caused by primary brain tumour or cerebral metastases (2).

Many of the treatment-related problems do not necessarily fall within the scope of occupational therapy, but the therapist should be aware and consider these; for example, cerebral oedema associated with radiotherapy, or peripheral neuropathies caused by some cytotoxic agents (2).

Assessment for occupational therapy

As a result of the above problems, a patient may present with complex functional deficits requiring intervention from occupational therapy. Many patients, their families and/or carers experience a degree of difficulty in accepting the diagnosis and their shortened life-expectancy, which may result in an individual expressing unrealistic expectations about the future and, more importantly, their functional ability. An individual may in turn adopt a helpless or hopeless approach becoming passive and dependent on others rather than taking an active role in their own care, while others may strive for functional activities of which they are no longer capable. Acknowledgement of the patient's level of insight and acceptance should always be considered when developing a programme of intervention with an individual.

The most common areas of function affected are:

(1) Personal care and domestic tasks.
(2) Work tasks.
(3) Role-related tasks.
(4) Recreational, leisure and play activities.

It is essential that a thorough initial assessment is completed and that further assessments are carried out to include: components of usual lifestyle, effects of illness on functional tasks and the individual's priorities in their rehabilitation (3). The occupational therapist will discuss and address with the individual how they usually spend the day, how the illness has affected the ability to carry out these activities and roles, and their concerns about not being able to manage and cope with former levels of activity. Standardized assessments may be used, but a problem-solving approach is often adopted (3). A treatment outline will begin to formulate, but will depend on the stage that an individual is referred to occupational therapy for assessment. Intervention will be quite different for
someone taking successful medical treatment to that for an individual whose illness can only be controlled or palliated, but no longer cured.

Occupational therapy interventions

Activities of daily living

Occupational therapy has much to offer patients who want to remain at home or work in order to remain as independent as possible. Kielhofner suggests that the disruption or loss of skills associated with cancer may include permanent functional loss, an intermittent loss of skills or a steady decline in skills (7). For individuals with advancing cancer and for those entering the terminal stage of the disease, this steady deterioration in skills can be very distressing and anxiety provoking, especially when an individual's functional status from day to day is unpredictable. The occupational therapist can provide advice and teach new methods and strategies to increase, or maintain, skills of independence through assessment for, and provision of, adaptive equipment and adaptations, such as special equipment for enabling self-feeding or dressing. Consideration should be given to daily living skills that are important for the patient to maintain his/her self-respect and dignity. Assessments should include identifying an individual's priorities where fatigue and tiredness prevent independence throughout the whole day. Patients who spend long periods of time hospitalized receiving treatment, invariably experience disruption to their normal daily routines and habits. The structure and routine of the hospital ward may not enable the individual to pursue a normal habit pattern, and may be necessary to facilitate the re-establishment of such a pattern before returning home (7).

Wheelchair assessment and prescription

For most patients, loss of mobility is devastating and they are often reluctant to accept the use of a wheelchair. Discussion preceding this requires much sensitivity and empathy. Where stamina and energy levels are low, the use of a wheelchair may enable the individual to participate in a greater sphere of activity and reduce their exclusion from the mainstream of everyday activity (8). However, the decision to use a wheelchair must ultimately lie with the individual and carer. In some circumstances, for example when extensive bone metastases result in pathological fractures or spinal cord compression, it may be necessary to consider prescribing a wheelchair for permanent use. Whenever assessment for a suitable chair is being carried out, consideration must be given not only to the individual's level of function, but also to the environment in which the chair is to be used. It will also be necessary to consider appropriate accessories and pressure-relieving cushions. Initially, the patient may be assessed with a variety of different cushions in order to ascertain which type will provide optimum relief and meet the needs of the individual. Types of cushions may include foam, air or gel, or a combination. Following supply of a chair, the individual and their family/carer will require instruction in the use of the chair and appropriate transfer techniques.
Orthotics

Occupational therapists may employ the use of custom-made orthoses/splints and collars as a way of minimizing particular dysfunction, maintaining functional positions or reducing pain. These methods include the use of foot drop splints, wrist splints for radial nerve palsy, and soft or hard collars in the management of cervical bone metastases.

Energy conservation

Some patients may benefit from advice on the importance of pacing themselves according to their energy levels, and to include rest periods and less strenuous activities as strength and stamina deteriorate, especially where the condition is well advanced. Through occupational therapy intervention, the patient may also be assisted with labour-saving devices and techniques in order to maximize functional performance.

Relaxation/anxiety management

Many patients with advanced disease may experience periods of stress (9). Tension can increase an individual's pain, but this may be eased through the use of relaxation techniques (8). The occupational therapist may carry out specific assessments of anxiety-based problems in order to identify the triggers that may precede anxiety and stress, the situations in which it is likely to occur and, most importantly, the resulting consequences on the patient's ability to carry out functional activities.

The occupational therapist can work with patients to help them recognize the onset of physiological symptoms, and can subsequently assist them to acquire and develop positive attitudes and coping strategies. An individual can be taught and encouraged to practice the application of relaxation as an approach to everyday life. These techniques can be employed by a patient undergoing chemotherapy as part of a coping strategy. Patients are also encouraged to explore and use their own routes to relaxation, and are encouraged to acknowledge the importance of social and leisure activities during their day.

Pain/symptom control

Occupational therapy can complement the usual medical approaches to pain and symptom control by utilizing energy conservation techniques, considering postural re-education, and seating and environmental changes, for example, use of equipment during transfers. Occupational therapy aims to restore a patient's confidence and self-esteem, and to help the patient to continue with purposeful roles in life with a sense of value to their families and to the community. Families are encouraged to have a positive regard for, and an acceptance of, patients as they are. Possibly recreating a sense of worth may ease the pain threshold. A person's lack of ability to cope with functional tasks may exacerbate anxiety and depression which an occupational therapist may
help to ease through maximizing purposeful functional activity. For patients
with localized pain, for example in rectal and vaginal cancers, relief can be
provided through pressure care management, optimizing relief through the use
of appropriate cushions (1).

Lymphoedema management

As a consequence of treatment or as part of the progression of disease, patients
may present restricted independence due to gross swelling of a limb. The
occupational therapist can assist and advise the individual in how to gain
maximum functional use of the affected limb, and how to compensate for
independent living skills impeded by the lack of function, especially where the
dominant limb is affected, such as the use of one-handed kitchen devices,
writing devices and dressing equipment.

Home assessments

As well as visiting patients living at home, occupational therapists may facilitate
a patient’s discharge home through carrying out a home assessment with the
patient, the family and appropriate community services. Home assessments
are usually carried out when the possibility of discharge is imminent or under
consideration. The decision to carry out this assessment is made through the
professional judgement of the occupational therapist treating that patient,
following collaborative discussions with the multidisciplinary team, the patient,
family and carers. The home assessment is a component of the patient’s overall
treatment programme and should be considered as an opportunity for the
therapist to identify and observe the interaction of the individual within their
home environment or familiar surroundings, including his or her family unit.
Through assessing the patient’s home before discharge from hospital, the
occupational therapist is able to establish a clear picture of their circumstances
and the support network in which they will have to cope. Therefore, this enables
the occupational therapist to make realistic recommendations to the patient,
carer and medical staff. Following the assessment, it may be necessary to
reconsider further treatment goals and to arrange necessary adaptive equipment
to maximize safety and independence or assisted function at home. The
occupational therapist may also undertake an assessment visit when there is
some doubt as to whether the patient can function safely at home even with
full community support. From assessing that the patient will be safe and able
to cope at home, even for a short period of time, the occupational therapist
will work with the patient to facilitate transfer from hospital/hospice to home.

Support

Families, as well as patients, require continual support and should be given
time to express their fears and anxieties, as well as both practical and emotional
support to help enable them to care for the patient and cope with stressful
situations. Boore suggests ‘A rehabilitative approach can offer patients a
positive focus to their condition and this should continue until the last stages
of illness’ (1). Families may need advice and encouragement on enabling a patient to remain as independent as possible and to have some control of their management and future. If the individual's disease has reached the terminal stage, many families and carers wish to care for their loved ones at home so that they may live within their own familiar environment. In these circumstances, the occupational therapist can provide practical assistance with adaptive equipment to facilitate care at home.

Liaison with other agencies

Occupational therapists working in oncology will need to liaise closely with other agencies and professionals recognizing and acknowledging the expertise and skills of other disciplines. The need for collaborative care should be emphasized to ensure that both patients and family have all the support necessary to cope as effectively and successfully as possible at home. Occupational therapists based in acute healthcare units may carry out a joint home assessment with their community colleagues based in social services to ensure continuity of care and effective channels of communication.

Conclusion

Occupational therapists are important members of the multidisciplinary teams caring for patients with cancer; they are particularly highly valued by patients and their families. Their role is to assess and alleviate disability consequent upon the physical, psychological and social effects of cancer in both the hospital environment and patients’ homes. With the increasing prevalence of cancer and lengthening of patients’ life-expectancy, the demand for occupational therapy in oncology is expected to grow.

References