ABSTRACT

Impediments and Solutions to Improving the Management of Cancer-Related Fatigue

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Fatigue is a highly prevalent and distressing symptom of cancer and its treatment. However, fatigue is often underdiagnosed and undertreated because of a multitude of barriers. These barriers fall into three broad categories: patient-related, health care provider-related, and system-related.

With regard to patient-related barriers, it is clear that cancer patients often fail to communicate with their oncologists about fatigue. We conducted a study (1) to help identify the patient-related barriers to communication about fatigue as cited by patients. Two hundred patients were sampled across the Community Cancer Care, Inc., network of Indiana using assessment instruments, a new measure meant to understand these barriers. Scores on the instruments did not differ significantly based on whether the patient was from a rural or urban site. One hundred thirty-two patients (66%) reported that they had never spoken to their doctor about fatigue. The most frequently reported reasons for this lack of patient communication about fatigue included the doctor’s failure to offer interventions (47%), patient’s lack of awareness of effective treatments for fatigue (43%), a desire on the patient’s part to treat fatigue without medications (40%), and not wanting to complain to the doctor (28%). This study suggested that there are multiple barriers contributing to why cancer patients do not comment about fatigue and that these are not nearly as universal as those that interfere with pain communication and management. Potential solutions to patient-related barriers include screening for fatigue to initiate dialogue, increasing patients’ knowledge of fatigue treatments, and assisting patients in locating efficacious nonmedical interventions. An assessment of the particular barriers that are germane to a given patient may be helpful in tailoring an educational approach to overcoming that patient’s particular impediments.

Additionally, there are health care provider-related barriers to improving fatigue assessment and management. Time pressures, reimbursement difficulties, lack of clarity with regard to fatigue assessment, and a primary focus on cancer treatments can combine to lead to marked inactivity where fatigue is concerned. Screening for fatigue can be helpful and can be as brief as a single-item screening (2), but screening must trigger a more detailed assessment, which is often beyond the expertise of clinic staff. New diagnostic criteria (ICD-10) have been developed and field testing is ongoing (3). These criteria for an official diagnosis may help not only in standardizing fatigue assessment but also in providing oncology staff with a code for which they can “officially” intervene (and receive reimbursement). An additional problem is the lack of empirically derived evidence to support a range of fatigue interventions. Epoetin alpha and exercise have empirical support (4 – 8), but the widely varying interventions targeting other causes are largely based on anecdotal evidence. Thus, staff members can face a daunting differential diagnosis with unclearly supported interventions in many instances.

Finally, system-related barriers can be major impediments to fatigue assessment and management. These barriers include reimbursement systems that disenfranchise oncology providers from palliative care involvement of all kinds. Payment structures that limit reimbursement on a per diagnosis basis can limit the use of costlier palliative care interventions for fatigue and other symptoms. Inflexible and packed clinic schedules and other time pressures can limit attention to patients’ quality of life. Solutions to such impediments include working with the logistics of a particular clinic routine to incorporate some level of assessment and intervention for fatigue (for example, standing orders for nurses to enact based on laboratory values) and working to clarify reimbursement issues for fatigue interventions.

REFERENCES


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