Study of collaboration methods between nurses and medical social workers during facility transfer of end-of-life cancer patients

Miyuki Hoshina
College of Nursing, Kanto Gakuin University, Yokohama, Kanagawa, Japan

Corresponding author: Miyuki Hoshina
E-mail: mhoshina@kanto-gakuin.ac.jp
Received: February 27, 2015, Accepted: June 12, 2015

Abstract

Objective: The purpose of this study is to clarify how nurses and medical social workers (hereafter, MSW) collaborate in providing nursing and support to cancer patients who will transition to end-of-life care. Methods: Informants were comprised of 18 nurses and 8 MSW working at a large hospital practicing state-of-the-art cancer treatment. Interviews were conducted by forming focus groups comprised of a mix of nurses and social workers. The focus group interview survey involved the author transcribing audio recordings of these interview sessions, extracting sections relevant to the study purpose, and performing qualitative analysis. Codes relevant to the study purpose were extracted and compiled into cards. These cards were then grouped according to similarity of contents. Sentences expressing the contents of each group were composed, and small tags were appended to meaningful codes. These groups were further grouped together if similar groups were found. Large tags were appended to meaningful codes. Results: Seventeen small tags and six large tags were appended. Based on the remarks of informants in the focus group interview facilitated by the author, storylines were drawn up by arranging the small tags and large tags. The storylines were then compiled into a results diagram. Even if the patient and the family were in agreement as to his care after hospital discharge, the patient himself agreed to the transfer, and good relations had been established between the nurse and patient and the MSW and patient, as collaboration between the nurses and MSW had been insufficient, there were cases in which the hospital transfer did not proceed smoothly. Conclusions: This study reflects how a transfer will not proceed smoothly simply by establishing trusting relations between the patient and nurses, and this study demonstrated that the collaboration between nurses and MSW is indispensable when it concerns transferring the patient to end-of-life care at another facility.

Key words: Cancer patients, collaboration, end-of-life care, facility transfer, medical social worker

Introduction

All Japanese citizens are enrolled in some form of public health insurance. A patient treated for an illness or accident at a medical institution pays 30% of the whole medical cost (children under elementary school age pay 20%, and seniors 70 years or older pay 10% or 30% depending on their income). The remaining medical costs are covered by public medical insurance. Japan’s healthcare costs are increasing at a pace exceeding the gross domestic product and national income. National healthcare costs grew by 24.1% in a 10-year period from FY 2000 to FY 2010.[1] And total healthcare costs in FY 2013 amounted to 39.3 trillion yen.[2] (On the other hand, curbing healthcare costs through functional differentiation of medical institutions has become an important healthcare policy in Japan).[3]
One aspect of the functional differentiation of medical institutions is that public healthcare insurance payments for long-term hospitalization are being kept down. Therefore, large hospitals such as those that offer state-of-the-art cancer treatment cannot provide long-term hospitalization for terminal patients. For these reasons, patients, who do not improve after advanced medical treatment and are judged to be past recovery, are advised to transfer to a hospital with a palliative care unit or to a hospice soon after admittance. Because of this, there are many patients who feel they have been abandoned by the hospital. Moreover, patients who cannot make up their mind to leave the hospital within a certain period may miss the opportunity to transfer as their symptoms have progressed. This has resulted in an increase in patients called “cancer refugees” and has become a social issue. From the viewpoint of management at large hospitals, an increase in long-term patients will decrease revenue. However, from the viewpoint of the public healthcare insurance system, the medical costs borne by the patient before and after transferring hospitals will hardly change at all. Rather, the medical costs borne by the patient will lessen after transferring to another facility or a hospice, as advanced treatment will not be provided to the patient.

Of studies thus far into care setting chosen by patients, Umada suggests that cancer patients need support in choosing and coordinating their care setting at an early stage. None of these studies, however, have clarified the structural interplay between nurses and cancer patients during the period of transition to end-of-life care. Meanwhile, of studies relating to support in hospital discharge, while there are studies that focus on modeling the hospital discharge support process from the perspective of medical social worker (MSW), there are almost no studies which describe the hospital discharge support process from the perspective of nurses.

The purpose of this study is to clarify how nurses and MSWs collaborate in providing nursing and support to cancer patients who will transition to end-of-life care. It is surmised that clarifying how nurses and MSW collaborate will help us understand how cancer patients can transition smoothly to the end-of-life care stage.

**Methods**

**Analysis method**

In this study, qualitative analysis was performed on data obtained through the focus group interview method. By employing the focus group interview method, it was surmised that information could be gathered on the dynamic interplay among plural nurses and MSW, and that new theories could be established by systematically organizing what nurses and MSW really think.

The focus group interview survey involved the author transcribing audio recordings of these interview sessions, extracting sections relevant to the study purpose, and performing qualitative analysis. Codes relevant to the study purpose were extracted and compiled into cards. These cards were then grouped according to similarity of contents.

Sentences expressing the contents of each group were composed, and small tags were appended to meaningful codes.

These groups were further grouped together if similar groups were found. Large tags were appended to core meaningful codes. As a result, 17 small tags and 6 large tags were appended. Based on the remarks of informants in the focus group interview facilitated by the author, storylines were drawn up by arranging the small tags and large tags. The storylines were then compiled into a results diagram.

**Research facilities and informants**

The author made research survey requests to large hospitals possessing over 400 beds and that practice state-of-the-art cancer treatment in Japan. The reason why hospital G was ultimately chosen was because of the hospital’s location at the center of Japan in the Tokyo Metropolitan area, and the hospital being very cooperative toward our study in terms of providing a conference room and selecting informants.

There were a total of 26 informants. The author conducted interview surveys toward nurses and MSW possessing 3 years or more experience working at hospital G. Informants included 18 nationally-certified nurses with 8.1 average number of years of work experience, and 8 nationally-certified social workers with 6.3 average number of years of work experience. Informants were divided into 6 focus groups comprised of a mix of nurses and MSW. Interview schedules were organized giving top priority to the working hours of informants. One interview was 52-110 min long, at an average of 63 min.

**Overview of the interview survey**

In this survey, case studies were created with a focus on disease name, patient condition, gender, age, family makeup, and hospital transfer destination, among other factors. Hypotheses and additional questions were prepared to promote the lively development of the focus group interview. The author had completed training as a focus group interview facilitator and possessed ample experience.
The author facilitated the focus group interviews while paying particular attention to do the following:1,1[1]
1. Maintain a neutral stance with respect to the contents.
2. Listen proactively to what others have to say, and ask the informants do the same.
3. Draw out their eagerness to participate.
4. Encourage informants to talk to each other.
5. Welcome differences of opinion.
6. Record, organize, and summarize the remarks of informants.
7. Grasp the direction of the conversation and show it in diagram form.
8. Have an overall grasp of the discussion [Table 1].

**Ethical considerations**

The study objectives were explained to informants and the hospital supervisor. The author later received approval to conduct the interview survey from hospital G’s ethics committee. Specifically, ethical considerations included the following:
1. Subjects are participating in the study freely and have the right to withdraw from the survey mid-way through.
2. Individuals participate in the study of their own will and will not be disadvantaged because of their participation.
3. Confidentiality of personal information will be maintained.
4. Data obtained will not be used for purposes other than research.

The study objectives, study method, and ethical considerations were explained to the informants verbally and in writing, and their consent was obtained before starting the interviews.

**Results**

Large tags denoting core codes have been indicated in << >>, small tags denoting meaningful codes have been indicated in [ ], and codes that have been grouped and summarized have been underlined. Six large tags and 17 small tags were generated by the analysis [Table 2]. These tags were then grouped into the following 3 large storylines. These storylines started from (1) <<The patient decides to stop proactive treatment and takes the first step toward getting a hospital transfer>>, (2) <<MSW and nurses determine what the patient “can” and “can’t” do in living his life. There are cases where a patient thinks he can do something, but actually cannot.>>, (3) <<The patient cannot accept the lifestyle changes in line with the treatment plan, and does not wish to proceed to the next step toward transferring hospitals.>> And followed a course shown in Figure 1. All 3 storylines eventually reached <<difficult hospital transfer>>. Patients then progressed to a case of either <<MSW and nurses support the patient solve each of his problems to break his dependency from the current hospital and agree to transfer.>> where the patient accepts end-of-life care at another facility, or to a case of [While keeping a wait-and-see attitude, nurses and MSW appreciate that the patient feels uncertain and cannot commit to the hospital transfer.] where he does not accept end-of-life care at another facility.

The category <<difficult hospital transfer>> that all 3 storylines passed through include the two concepts [The patient cannot accept leaving his current hospital and refuses to transfer.] and [MSW encounter difficulties in coordinating the destination hospital’s admittance capabilities with the patient’s wishes when they do not.].

[The patient cannot accept leaving his current hospital and refuses to transfer.] is defined as: The cancer patient denies transfer from a large prestigious hospital that has the established reputation and provides advanced medical treatment, to a hospice or to the palliative care unit of a hospital that is not as prestigious because it does not possess high-level medical facilities and technology.

[MSW encounter difficulties in coordinating the destination hospital’s admittance capabilities with the patient’s wishes when they do not coincide.] is defined as: The MSW feels that adjusting the patient’s transfer to another medical institution that meets the patient’s wishes is difficult due to the progression of the patient’s cancer.

| Table 1: Overview of case studies |
|----------------------------------|
| **Case** | **Gender** | **Age** | **Disease name** | **Main symptoms** | **Family makeup** | **Residence after discharge** |
| A | Female | 70's | Brain tumor | Paralysis on right side of body (using wheelchair) | Living with husband | Hospice |
| B | Male | 60's | Esophageal cancer | Tracheotomy, esophageal stenosis | Living with wife | Hospice |
| C | Female | 70's | Stomach cancer | Vomiting, depression | Husband deceased, living with family of the eldest son (his wife and 2 children) | At-home |
| D | Male | 70's | Colon cancer | Ileus, colostomy | Living with wife | Hospice |
| | | | | | Two sons (living separately) | |
In the "MSW and nurses support the patient solve each of his problems to break his dependency from the current hospital and agree to transfer." The category where patients accepted the hospital transfer, the misgivings of patients who were difficult to transfer were resolved by the careful explanations of nurses, MSW, and doctors.

This category includes the 2 concepts of [Nurses and MSW resolve the patient's misunderstandings that stand in the way of the hospital transfer.] and [MSW determine and coordinate the timing at which the destination hospital can admit the patient, with the timing at which the patient accepts the transfer.].

[Nurses and MSW resolve the patient’s misunderstandings which stand in the way of the hospital transfer.] is defined as: Nurses and MSW confirm how the patient feels about the period to switch to an end-of-life care facility. Then, they resolved the negative impressions associated with a hospital transfer.

[MSW determine and coordinate the timing at which the destination hospital can admit the patient, with the timing at which the patient accepts the transfer.] is defined as: MSW coordinate the timing at which the cancer patient resolves to transfer, with admittance by the destination facility.

On the other hand, patients who could not agree to a transfer had [While keeping a wait-and-see attitude, nurses and MSW appreciate that the patient feels uncertain and cannot commit to the hospital transfer.] which is defined as: The cancer patient is unable to make up his mind to switch to an end-of-life care facility until the very end, and misses the transfer timing as cancer has progressed.

Ultimately, all 3 storylines progressed to "MSW and nurses support the patient solve each of his problems to break his dependency from the current hospital and agree to transfer." or [While keeping a wait-and-see attitude, nurses and MSW appreciate that the patient feels uncertain and cannot commit to the hospital transfer.] The following details how the 3 storylines start from their respective categories and reach "difficult hospital transfer."

In the "The patient decides to stop proactive treatment and takes the first step toward getting a hospital transfer." category of storyline (1), the cancer patient and the patient’s...
family accepted the limitations of cancer treatment when the doctor talked to them about switching to a terminal care facility. The nurses and MSW began providing nursing and support toward the patient’s transfer to a terminal care facility. This category contains the 2 concepts [MSW listen deeply to the patient, following his lead.] and [The nurse draws out the patient’s honest feelings about how he would like to live out the remainder of his life.].

[MSW listens deeply to the patient, following his lead.] is defined as: MSW provides support at the cancer patient’s pace, listening to his hopes and wishes without rushing him.

[The nurse draws out the patient’s honest feelings about how he would like to live out the remainder of his life.] is defined as: Nurses ask in a frank manner how the patient would like to live out the remainder of his life.

Within this <<support cycle>> category, the 3 concepts did not proceed in the same direction, but rather went back...
and forth between concepts depending on the progression of the patient’s cancer. The storyline then proceeded to the "difficult hospital transfer" category as shown in Figure 1.

In the "MSW and nurse determine what the patient “can” and “can’t” do in living his life. There are cases where a patient thinks he can do something, but actually cannot." category of storyline (2), although the cancer patient wishes to return home to live out the remainder of his life, his family feels greatly burdened about supporting the patient at home on a daily basis, and the opinions of the patient and the family conflict.

This category includes the 2 concepts [Understand how the patient’s hospital transfer wishes differ from the family’s hospital transfer wishes.] and [filling the gap between the patient’s notions and the reality.]

[Understand how the patient’s hospital transfer wishes differ from the family’s hospital transfer wishes.] is defined as follows: Although the cancer patient wishes to receive at-home care, the patient’s family is not confident about providing at-home care. MSW and nurses coordinate the transfer to another facility while listening to both parties.

[Filling the gap between the patient’s notions and the reality] is defined as: If a cancer patient’s disease state has worsened, nurses judge how much of his everyday life a cancer patient can manage. While being receptive to the patient’s wish to return home, if this seems impossible, nurses propose realistic options such as transfer to a hospice. Nurses aspire to the kind of nursing that enables cancer patients to imagine their life after transferring to another facility.

Next, the storyline proceeded to the [Nurses and MSW determine a realistic posthospital discharge living environment for the patient in line with his wishes.] concept as shown in Figure 1.

[Nurses and MSW determine a realistic post hospital discharge living environment for the patient in line with his wishes.] is defined as: After a patient resolves to transfer, nurses and MSW assess a realistic transfer scenario in line with the patient’s wishes, such as undergoing medical exams at a hospice if the patient receives at-home care, or acquiring permission to stay overnight at the patient’s home if the patient is admitted to a hospice. The storyline then proceeded to the "difficult hospital transfer" category as with storyline (1).

In the "The patient cannot accept the lifestyle changes in line with the treatment plan, and does not wish to proceed to the next step toward transferring hospitals." Category in storyline (3), while the hospital tries to make preparations toward the patient’s transfer, the patient avoids discussing the issue of the transfer. Days go by in which the doctor, nurses, MSW are unable to form good relations with the cancer patient. For this reason, the nurses and MSW are unable to get very close to the patient.

This category contains the 3 concepts of [The patient exudes an aura of not wanting to talk about it.], [Nurses are subjected to the repulsive and evasive behavior of a patient who does not want to transfer.], and [Nurses remain unaware that the patient has stopped proactive treatment and is taking steps toward shifting to palliative care.].

[The patient exudes an aura of not wanting to talk about it.] is defined as: As the patient exudes a vibe of not wanting to talk about the hospital transfer, nurses are unable to broach the subject.

[Nurses are subjected to the repulsive and evasive behavior of a patient who does not want to transfer.] is defined as: A cancer patient, sensing that the nurse or MSW, who visits his bedside wants to talk about a hospital transfer, avoids contact with them. The patient ignores the nurse or MSW, suddenly gets angry or becomes cynical.

[Nurses remain unaware that the patient has stopped proactive treatment and is taking steps toward shifting to palliative care.] is defined as: As nurses did not sufficiently share information with MSW, they were unable to provide requisite care in preparing to transfer a patient to a terminal care facility.

The storyline then proceeded to the [As the patient does not wish to transfer, he intentionally tries to stop the hospital transfer process.] concept as shown in Figure 1.

[As the patient does not wish to transfer, he intentionally tries to stop the hospital transfer process.] is defined as: The cancer patient and his family deliberately impede the hospital transfer and frustrate the nurses and MSW. The storyline then proceeded to the "difficult hospital transfer" category as with storyline (1) and storyline (2).

Discussion

Although it can be said that there is uncertainty in the standards for measuring trust in human relations in qualitative research, this study derived the following results and discussions.
Throughout the entire process, if either the nurse or MSW had established trusting relations with the patient, in most cases, they were able to transfer the patient to end-of-life care at a hospice or at home. On the other hand, even if the patient and the family were in agreement as to his care after hospital discharge, the patient himself agreed to the transfer, and good relations had been established between the nurse and patient and the MSW and patient, as collaboration between the nurses and MSW had been insufficient, there were cases in which the hospital transfer did not proceed smoothly. This reflects how a transfer will not proceed smoothly simply by establishing trusting relations between the patient and nurses, and this study demonstrated that the collaboration between nurses and MSW is indispensable when it concerns transferring the patient to end-of-life care at another facility.

Furthermore, this study makes clear how, in making a smooth transition to end-of-life care at another facility, it is essential that nurses and MSW build trusting relations with the patient, as well as that they collaborate to mutually complement their respective duties.

How swiftly and accurately nurses and MSW can share patient information will be key to providing smooth discharge support toward transferring a patient to a terminal care facility.

**Limitations**

As the time to collect data was limited due to the circumstances of the hospital where the study was conducted, strict theoretical sampling could not be conducted for this study. As analysis was conducted on a limited amount of data, there were limitations in standardizing the precision of analysis for the entire process. Hereafter, the author will continue conducting interview surveys to increase the amount of data, with a goal to generalize theories. This will also be backed up by quantitative research to generate theories with a higher degree of precision.

**References**

1. Japan Ministry of Health, Labour and Welfare Japan Annual Report on Health Labour and Welfare. Tokyo: Gyouseit; 2014. p. 27-34.
2. Japan Ministry of Health Labour and Welfare. The general condition of national medical expenses. Tokyo: Gyousei; 2014. p. 3-4.
3. Japan Ministry of Health, Labour and Welfare Japan Annual Report on Health Labour and Welfare. Tokyo: Gyousei; 2012. p. 362-78.
4. Aoki A. Public medical insurance system makes cancer refugees. Tokyo: Gentosha; 2012. p. 11-21.
5. Umada M. Support for choice and arrangement of treatment environments for patients with cancer hospitalized in a university hospital. Sasakawa Medical Research Foundation research report 1999;1:29-31.
6. Suzuki Y, Ikenaga M, Tamura K, Hirai K, Kashiwagi T. Psychological process of patients with cancer and hope for medical service-in the process until receiving hospice care. Cancer Nurs 2001;6:255-60.
7. Oku S, Sasaki H, Tsukamoto Y, Ushio R, Nakamata N. A study of changing gear from general hospital to the palliative care ward. J Japan Soc: Nurs Res 2006;39:215-22.
8. Mike M. Assistance and Assistance Infrastructure Development for Life Revitalization Tokyo: Aikawa Book Inc.; 2003. p. 21-48.
9. Kinoshita Y. Practice of the grounded theory approach. Tokyo: Koubundo; 2003. p. 23-56.
10. Flick U. Translated by Oda H, Yamamoto N, Kasuga J, Miyaji N. Qualitative Forschung. Tokyo: Shunjusha; 2006. p. 310-79.
11. Anme T. Group Interview Method. Tokyo: Ishiyaku Pub, Inc.; 2004. p. 13-64.
12. Vaughn S, Schumm J, Sinagub J (Supervisor). Translated by Inoue O. Focus Group Interviews in Education and Psychology. Tokyo: Keio Univerisity Press; 1999. p. 112-98.

**How to cite this article:** Hoshina M. Study of collaboration methods between nurses and medical social workers during facility transfer of end-of-life cancer patients. Asia Pac J Oncol Nurs 2015;2:264-70.

**Source of Support:** Nil. **Conflicts of Interest:** None declared.