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Is shared decision making an aspect of palliative care integration? An observation of collaboration between oncologists and palliative care professionals

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Abstract

Background Early palliative care interventions in oncology, as recommended by international oncology societies, promote patient understanding and support decision-making. At the same time, shared decision-making models are being developed to enhance patient participation as part of a new model of patient-physician relationship. For patients with palliative needs, this participation is essential and helps to avoid futile and aggressive treatments at the end of life. The aim of this study is to observe decision making during meetings between oncology and palliative care professionals, focusing particularly on the components of shared decision-making models, but also on the role played by palliative care professionals.

Methods We conducted a non-participant observation of multidisciplinary meetings and outpatient clinic activities in two Comprehensive Cancer Centres in France. Field notes were then coded using thematic content analysis. Deductive analysis was conducted using the observation grid developed from Elwyn's three-talk model.

Results Only a few elements of the different models of shared decision-making are apparent in the multidisciplinary meetings. Palliative care professionals emphasise the importance of involving patients and providing them with information about the advantages and disadvantages of different treatment options.

However, patient involvement in decision-making remains difficult in daily practice. Decisions to discontinue oncological treatment are often driven by clinical and biological signs of terminal evolution rather than shared decision-making.

Conclusions There are still cultural and organisational barriers to actual implementation of early integrated onco-palliative care. Promotion of shared decision making can be a strong lever of change which is frequently mobilised by palliative care teams.

Keywords Cancer, Advance care planning, Shared making decision, Ethics, Palliative care

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Background

Based on a growing body of literature, both the American Society of Clinical Oncology and the European Society of Medical Oncology have recommended early palliative care interventions alongside treatment for all patients with advanced cancer [1, 2]. Early palliative care has been shown to improve quality of life and reduce intensive care in the last months of life, without shortening duration of survival [3–6]. The aim is not only to enable better assessment and management of physical and psychological symptoms, but also to provide regular information, with particular emphasis on the patient's understanding of their prognosis. This component of early palliative care have been described as "illness understanding/education, decision making, and coping with life-threatening illness" [7]. In addition, early palliative care can help to address the social impact and spiritual suffering related to life-limiting diseases [8]. This will support decision-making at the end of life, in accordance with the patient's wishes.

Shared decision making (SDM) can be seen as a key element of early palliative care to support end-of-life decision making [9]. This concept has been growing in North America since the 1980s and in Europe since the early 2000s, reflecting a shift towards a more patient-centred approach. The paternalistic model evolved into one of informed and then SDM [10]. In 2013, the French National Authority for Health (*Haute Autorité de Santé* (HAS)) conducted a review of SDM [11], using the most common definition at the time: SDM involves a patient and a physician, whose exchange allows information sharing between the two parties and the expression of treatment preferences on both sides. Ultimately, a consensus on a treatment plan is reached through this discussion. However, there are many practical variations of this model [12, 13], depending on the setting or health-care professional. SDM is mainly used in oncology when several treatment options are available and nearly equivalent in terms of benefits and risks. Examples include prostate cancer screening and surgical reconstruction after breast cancer [14].

At the same time, the integration of early palliative care in oncology is taking shape around two models: multidisciplinary meetings [15–19] and palliative care outpatient clinics [20]. The multidisciplinary meeting model promotes communication between the referring oncologist and other professionals involved with the patient. It also encourages consideration of patient preferences. As for palliative care outpatient clinics, they allow the patient to meet with different professionals at the same time, promoting the bond of trust between the patient, the oncologist, and the palliative care team. In this organisational model, some oncologists fear losing control over the therapeutic project in favour of palliative physicians

[21]. The practical implementation of this integration still raises questions, both in France [22, 23] and internationally [24]. There are still many questions about the ideal time to introduce it, the type of care to be provided and the professionals that should be involved [25].

Regarding decision support, no study in France has focused on the SDM model implemented in early palliative care. However, the terms "care planning" or "advance discussions" are sometimes mentioned, which may reflect the implementation of SDM [26]. The aim of this study is therefore to observe decision making during meetings between oncology and palliative care professionals, focusing particularly on the component of SDM models, but also on the role played by palliative care professionals.

Methods

Method and findings are reported as per the Consolidated Criteria for Reporting Qualitative Research (COREQ) [27].

Design and setting

This study uses a descriptive approach [28] to the decision-making process, in the form of non-participant observation of collaboration between oncologists and palliative care professionals who have published data on their organisation of integrated palliative care and who indirectly claim to be working on the implementation of SDM process.

Participants

The research was carried out in two Comprehensive Cancer Centres in Paris, France (Curie Institute and Gustave Roussy Institute) from March to June 2022. Gustave Roussy developed the *Reunions Collégiales d'Appui* (Collegial Support Meetings—CSM), which are described in detail in 2023 [29]. Meetings are held weekly in four of the hospital's oncology departments. They bring together all the professionals in the unit (physicians, residents, nurses and care assistants) as well as members of the palliative care teams (physician, residents, nurses, psychologist) and a member of the ethics committee (an intensive care unit physician).

At the Curie Institute, palliative care professionals (physician and nurses) participate in multidisciplinary onco-palliative meetings (OPM) held in the oncology department [16]. In addition, an outpatient clinic run by the palliative care team will also be set up. Patients are mainly referred to this outpatient clinic when entering the final stages of their disease, regardless of whether oncological treatment has been discontinued. The aim of this approach is threefold: to relieve symptoms, to support the patient's frequent wish to stay at home as long as possible and to help the patient come to terms with

their incurable illness [30]. While the palliative care team may not always play a direct role in these actions, it does contribute to them, working alongside the referring oncologist.

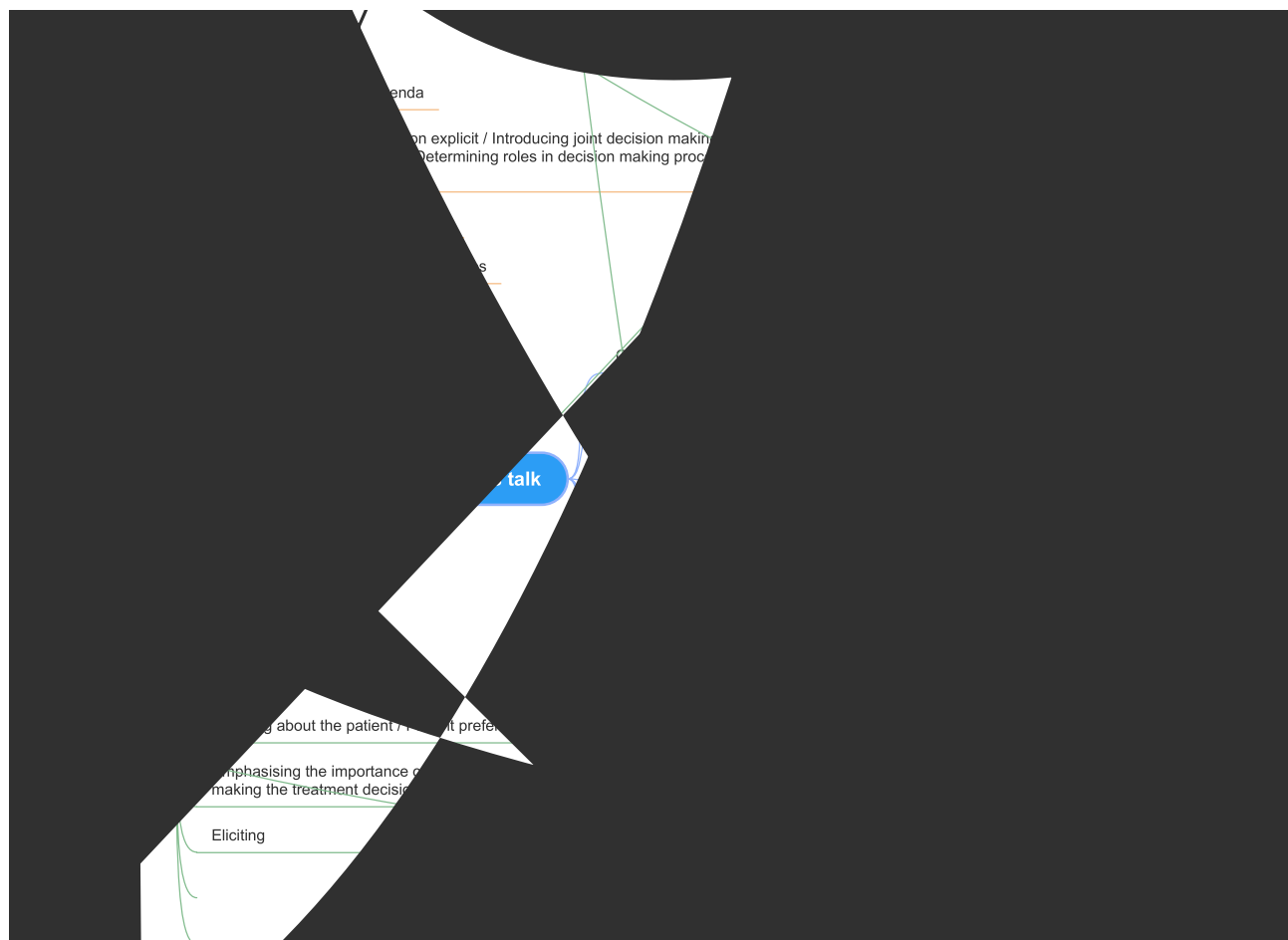
In both types of meeting (CSM and OPM), the case will be discussed at the initiative of the oncology team, either physicians and/or nurses, when the case is particularly clinically, psychologically or socially complex or presents complications during hospitalisation. Physicians including oncologists, surgeons, and intensive care physicians, as well as residents, nurses, psychologists, social workers, and care assistants involved in patient care, along with palliative care professionals, are invited to attend the meeting. It is acknowledged that not all individuals may be present at each meeting. The discussion goes on to address the goal of treatment, the intensity of care, ethical and psychosocial issues, and the patient's life plan. The case is typically presented by the patient's nurse, with physicians providing necessary details for

comprehension. Patients and their families do not attend these meetings.

Observations were made within the CSM, the OPM and the outpatient clinic activity, making it possible to observe SDM. From the beginning, it was decided not to observe exchanges between professionals and patients. This made it possible to focus on the research question, which was to describe the process of decision making between the oncologists and the palliative care team.

Data collection

Prior to the observations, the researcher (MP) developed an observation grid (Fig. 1). This grid was based on the three-talk model developed by Elwyn (choice talk, options talk and decision talk) [31–33] and on characteristics found in literature reviews of other theoretical models of SDM [12, 13, 34]. Justifying the need to make a choice (choice talk) is followed by deliberation where the work of becoming informed about possible alternatives



(option talk) and developing informed preferences is supported (decision talk).

Before each non-participant observation, the physicians in charge of the CSM at Gustave Roussy and of the outpatient clinic at the Curie Institute were contacted and informed of the study. Due to the sensitivity of the meetings, audio-recordings were not allowed. Hence, data collection took the form of non-participant observation, i.e. field notes and the use of an observation grid. A field diary was kept throughout the fieldwork to facilitate reflection during both data collection and data analysis.

Enrolment stopped when data saturation was reached (i.e., no new information emerged during the non-participation observation meetings).

The non-participant observation was conducted by MP, a female palliative care physician (MD) who did not work in the facilities observed and did not know the participants. This research was conducted as part of her research internship in the field of palliative and end-of-life medicine. MP informed participants of the study's rationale and objectives before starting the observation. To conduct the study and the analyses, MP was supervised by IC (PhD in public health) and KL (PhD in psychology), two researchers trained in qualitative research, with expertise in the field of palliative care and oncology.

Data analysis

The handwritten field notes were digitised and imported into Nvivo 12 software [35]. They were then transcribed into descriptive sentences to ensure homogeneity between narratives. They were then coded using thematic analysis [36–38]. A deductive analysis [39] was then carried out based on the observation grid. For the secondary objectives, an inductive analysis [38] was carried out. The narratives were read and then analysed line by line to familiarise oneself with the data and to gain a general understanding of the observations. Initial codes were then generated and grouped into recurring themes that illustrated the roles of palliative care professionals. The analysis was carried out by MD and the first two narratives were reviewed by two other researchers (AT and AR) to ensure that the codes were consistent. Disagreements were discussed. Following the analysis of the first two narratives, a code book was created, which was to be supplemented as necessary in the subsequent analyses. Qualitative research team meetings were used to discuss the development of the coding framework and data analysis. In addition to the qualitative analysis, descriptive statistics were calculated to determine the mean duration of multidisciplinary meetings and the mean number of people present during them. Data collection, processing and analysis were carried out simultaneously throughout the observation period.

Results

Descriptions of the observation locations (Table 1)

The palliative care outpatient clinic welcomed three to four patients per day. Each day began with a morning report between the physicians and nurses to discuss patient care, then each patient was seen by the team. When necessary, the referring oncologist would come see their patient or be reached by telephone. On each non-participant observation day, the researcher was present in the meeting room listening to the morning report, discussions between palliative care professionals and the referring oncologist when they occurred, and liaison correspondence with other professionals.

Four days, from 9am to 5pm, of non-participant observation were conducted at the Curie Institute's outpatient clinic, during which 13 patients' files were discussed. Additionally, five discussions were observed between palliative care physicians and oncologists concerning the patient's oncological treatments.

In the afternoon, two or three other members of the palliative care teams (a doctor, a nurse, and a psychiatrist) participated in the OPM. Four OPM were observed in two different oncology departments during which 9 cases were presented. The referring oncologist was present at two of the meetings.

At Gustave Roussy, four CSM were observed in the same oncology department, where 4 cases were discussed. The referring oncologist attended only once. Hence, the nurse or physician in charge of the hospital department presented the patient's file.

The four CSMs observed lasted about 30–40 min each, in which only one case was discussed per meeting. They took place in the nurses' office and gathered many professionals simultaneously. The researcher remained in an observational role, taking note of the interactions between the various professionals involved. Exchanges were mainly between the department physicians, the physicians of the palliative care team and the ethics committee.

At the Curie Institute, each OPM lasted about 30 min per case, and sometimes two or three cases were discussed. Depending on the department, the meeting was held either in the nurses' room or in the family room so as not to be disturbed. These meetings involved fewer professionals. At the end of the meeting, a report was written by the palliative care physician in the patient's medical notes.

During these meetings all the professionals agreed to the non-participant observation study. Furthermore, all the cases discussed during the outpatient clinic, OPM and CSM were presented only once (i.e., one case was not discussed at the first meeting and then at the second or other meeting).

Table 1 Description of the observation locations

Locations	Curie										Gustave Roussy						Total
	Outpatient Clinic					OPM					CSM						
	Subtotal					Subtotal					Subtotal						
Days / Sessions	1	2	3	4	4	1	2	3	4	4	1	2	3	4	4	12	
Number of cases discussed	4	3	3	3	13	2	2	3	2	9	1	1	1	1	4	26	
Member attending the meeting (number)																	
Oncology team																	
Referring	3		1	1	-	1	1			-	1				-	-	
Physician ward						2	1	2	2	-	2	2	2	2	-	-	
Resident / student						1				-	1	2	2	1	-	-	
Nurses						5	2	3	1	-	3	4	4	6	-	-	
Other ^a						3				-	2	2	2	4	-	-	
Palliative Care Team																	
Physician	1	1	2	1	-	1	1	1	1	-	1	1	2	2	-	-	
Resident	1	1	1	1	-								1	1	-	-	
Nurses	2	2	3	2	-		1		1	-	1		1	1	-	-	
Psychologist											1	1	2	1	-	-	
Psychiatrist							1	1	1	-						-	
Ethics committee																	
Physician											1		1		-	-	
Total number of professionals attending	7	4	7	5	-	13	7	7	6	-	13	12	17	18	-	-	

CSM Collegial Support Meetings, OPM onco-palliative meetings; - = no subtotal / total calculated due to repeated participation of the same healthcare professionals to several days/sessions

^a Dietician, care assistant

Characteristics of the observed SDM process

The characteristics of the observed SDM process are described within the framework of the three-talk model. Examples of field notes are presented in Table 2.

Choice talk

In the outpatient clinic, the objective of the consultation was determined before meeting the patient. In most cases, it was a clinical symptom reassessment. For two patients, however, the aim was to make a decision on the treatment plan.

The palliative care team informed the patient that a decision needed to be made and verified their understanding of the information. When required, the psychologist evaluated the patient's psychological condition and decision-making ability by meeting with the patient and/or their family.

Because OPM and CSM are scheduled systematically every week, the palliative care team did not always know which patient's files would be discussed. At the beginning of these meetings, the objective was not always pre-defined. Typically, the case to be discussed was chosen for its complexity and the decisions to be made emerged during the discussion. The choice

between continuing or stopping the oncological treatment was justified by the presence of a clinical or biological contraindication or the ineffectiveness of the current treatment. These elements also emerged during the discussion of the benefits and risks of treatments between the oncology and palliative care teams.

The possibility of the patient's participation in the decision-making process was not discussed when the need for a decision arose. It only appeared in the discourse of palliative care professionals. The patient's decision-making preferences were not assessed beforehand and were only brought up if the subject was raised during the discussion. In these cases, the patient was described as saying little, not asking questions, sometimes even being passive. The department physicians or oncologists often felt that the patient was not ready to hear about the severity of the disease or the possibility of withdrawing oncological treatment. Communication between physicians and patients was sometimes perceived as difficult, limiting the information given to the patient.

Physicians expressed the principle of medical responsibility in decision making. Final decision on the continuation of oncological treatment was made by the referring oncologist.

Table 2 Observed material (extract)

Themes	Subthemes	Selected example
Choice Talk ^a	Making need for decision explicit	The member of ethics committee asks what decisions need to be made that day
	Introducing joint decision-making	The palliative care physician mentions the possibility of asking the patient to make a choice about chemotherapy
	Checking preferred decision-making style	Oncologist quotes patient as saying: "I have no choice"
	Discussing decision-making abilities	The department physician provides input on the interaction with the patient, who is very passive
Options Talk ^a	Benefits and risks	The oncologist says that the patient still has a chance to get better if he has the chemotherapy
	Checking understanding	The oncologist thinks the patient realises what is happening
	Checking knowledge	Verify in the patient's record that they understand the prognosis and current treatment plan
Decision Talk ^a	Making the decision	The referring oncologist makes the decision not to do chemotherapy (Clinical contraindication)
	Patient preference	The referring oncologist reports that the patient's comments lead her to think that he agrees with the continuation of chemotherapy
	Reviewing the decision	The referring oncologist will confirm continuation of chemotherapy in consultation
Role of palliative care professionals ^b	Moderating role	The palliative care physician summarises the discussion The member of ethics committee asks the team for their opinion. The member of ethics committee asks what decisions need to be made today
	Acculturation—team support	The palliative care physician provides tools to help the oncologist to speak with the patient The palliative care physician provides support to the team
	Patient advocate	The member of ethics committee emphasises the importance of informing the patient about the possibility of whether or not to carry out a chemotherapy treatment The palliative care physician emphasises the importance of sharing decision-making with the patient and family

^a Inductive analysis^b Deductive analysis

Options talk

In the outpatient clinic, the palliative care team systematically reads the patient's file before meeting with him/her. This made it possible to identify the elements the patient needed to know and understand. At the end of the day, these elements were included in the liaison letter.

The physician from the palliative care team discussed oncological treatment options with the referring oncologist. During the discussion, the palliative care physician provided information about the patient's understanding and preferences. If there was an alternative oncological treatment option available, the referring oncologist would present them to the patient. The palliative care physician would make recommendations to the patient if treatment choices were not based on cancer treatments, such as pain medication.

Most often, the palliative care team had not yet met the patients who were presented during OPM and SCM. The oncology team, usually after a question from a palliative care professional, then provides the elements of patient's knowledge of the disease and prognosis. There was no enumeration of options during the meetings. When discussing treatment options, the oncology team discussed the current or planned oncological treatment.

Other possible treatments are mentioned without further detail. Withdrawal of disease-specific treatments and prioritization of quality end-of-life through exclusive palliative care are not made explicitly put forth as options. The discussion therefore focused on the benefits and risks of oncological treatment, not on those of exclusive palliative care. Oncologists sometimes pursue oncological treatment for effective symptom management which reflects a more palliative intention to alleviate. Risks are rarely mentioned. The most frequently discussed element justifying the decision was the clinical-biological feasibility of the treatment.

The discussions highlighted these different considerations, and it is not mentioned whether that the patient had received this information before the meeting. It was therefore not possible to verify the patient's understanding of the options. The oncology team reported that the patient had integrated information on the disease, prognosis, and feasibility of treatment.

Decision talk

In the outpatient clinic. If a decision about oncological treatment was made during the patient's outpatient assessment, the referring oncologist would discuss it with

the patient. The patient would be seen in consultation a few days later if the referring oncologist was not present. The palliative care team assessed the patient's preferences and worked with them to determine the optimal course of action if the decision concerned treatment other than specific cancer treatment. The palliative care physician arranged for the treatment to be followed up, either during a new consultation in the clinic or by telephone reassessment by one of the palliative care nurses.

During the meetings, the patient's knowledge, preferences, or opinions were questioned by the palliative care team. Often it seemed that the patient was closed off. Communication is difficult and therefore this element was not explored. Sometimes the patient expressed a lack of choice or did not tell them that he or she did not want to receive treatment. There is also an element of caregivers interpreting the patient's behaviour as an acceptance of treatment. The importance of respecting the patient's preferences is emphasised time and again by the palliative care team and was welcomed by the nurses on the oncology team. Everyone's opinion can be expressed during the meetings. However, the opinion of the referring oncologist prevails. The physician's treatment recommendations were not always well based on scientific evidence. Phrases such as "we want to follow the treatment" or "we have to do it or we'll miss it" were used.

When it came to deciding, either it was a simple matter and the decision was made at the end of the team discussion, or it was a more complex decision and the referring oncologist needed to be involved. The decision was made immediately if there was a clear contraindication to restarting chemotherapy. The decision would be delayed if it is less clear, especially if there was a chance of improvement in the next few days or if tests were still needed.

The role of palliative care professionals

Palliative care professionals, regardless of their grade, encouraged the team to involve the patient more. During discussions, they often suggested the possibility of the patient's participation, of their opinion being considered in the decision, thus recognising the patient's right to refuse treatment.

If they knew the patient, they would provide the team with information such as the patient's knowledge or understanding of the current situation, and sometimes his or her preference to be informed or involved in the decision-making. Whenever possible, they elicited the patient's understanding, preferences, and opinions. These elements are recorded in the patient's file and transmitted, orally and in writing, to the referring oncologist and the rest of the team.

During the meetings, they participated in the discussion of treatment options by questioning the expected goals of the treatments, as well as the tolerance and risks.

They do not express their own opinion at the beginning of the meeting but encourage everyone to do so. When the outcome of the discussions led to a consensus that they were comfortable with, they stated their agreement with the therapeutic project. If the decision was more complex or if there seems to be resistance, they suggested that the case be discussed again in the next few days. There was often a request for a meeting with the patient or the patient's family if the situation was complex, particularly in terms of communication or relationships between the patient and the team. Even when not requested, they did not hesitate to offer their intervention.

The palliative care team acted as a third party to lead and facilitate meetings. It is common for palliative care physicians to interject when the meeting falls silent. They encouraged nursing staff to speak up, express their differences, and voice the patient's opinion. Questions from the palliative care team punctuated the meeting. If necessary, they reiterated elements of legislation or symptom management.

Discussion

We found little evidence of implementation of SDM, despite best intentions and the participation of palliative care professionals in meetings and outpatient clinics. Palliative care professionals focus their interactions with other professionals on two objectives: providing the patient with information about their illness and treatments to increase understanding and gathering information about the patient's wishes. Thus, SDM appeared to be a strong potential lever to progress towards an effective early integration of palliative care in oncology, and to improve quality of end-of-life care.

Barriers to the implementation of SDM

One element that may explain the low representation of the concept of SDM is the lack of preparation and framework for meetings. Indeed, there do not seem to be any objective criteria justifying the presentation of one case more than another in a meeting. The notion of complexity is an element that often comes up without being elaborated on. The objective of the meeting and the nature of the decisions to be taken are not explicit at the beginning of the meeting.

The case file, especially the biomedical elements, is largely detailed, but the patient's voice is often absent. What is more often evoked is physician's and caregiver's interpretations of the patient's opinion. The patient seems to consent a priori to the therapeutic project [40,

41]. This lack of attention to the patient's preferences and wishes favours a decision-making process that focuses on the technical feasibility of the treatment [42–45].

Another important element is the distribution of roles in SDM. Here, the decision-maker remains the referring oncologist, as far as specific oncological treatment is concerned. In their absence, their opinion is systematically sought and mentioned. The difficulty of considering a shared decision, even if only between physicians [21, 46, 47], leaves the referring oncologist in a lonely position when deciding to withdraw treatment [47].

Finally, the idea of withdrawing cancer treatment is still difficult, especially for oncologists. This is what philosopher Jean Christophe Mino describes when he speaks of "the therapeutic ideology of cancer treatment" [47]. The essence of the oncologist's role is to treat the cancer, thus rejecting the idea of the end of life and of death and perceiving the withdrawal of treatment as a failure. To confront this feeling of failure, oncologists need training to be able to perceive alternative palliative treatment options. Giving patients several options and allowing them to participate in the decision-making helps them to find meaning in their end-of-life care.

Indeed, it is often difficult to discuss withholding oncological treatment [48–50]. The patient is sometimes seen as incapable of having this conversation, with the caregivers anticipating the difficulties. There is also clear evasiveness when the patient does not ask a question. There may be other behaviours that limit the patient's ability to participate in decision-making, such as focusing the discussion on physical symptoms [49], on oncological treatment only, or using evasive [51] or optimistic language [52].

The inability to have these discussions limits the physician–patient relationship and prevents further questioning of the patient's desire for information and involvement in decision making. It also prevents the search for the patient's preferences and goals [53–57]. It encourages patients to accept treatment as the only possible option [50]. This is even more detrimental as patients are looking for more time and sometimes more detailed information [58–61], and they need to be given the opportunity to imagine a situation in which they will have the option of stopping oncological treatment [52].

Strengths and limitations of palliative care integration in oncology

For oncology team caregivers, multiprofessional meetings are a place where the goal of care can be questioned. This makes it possible to question the purpose of current care, but also the burden of care in terms of treatment goals [47]. This allows the departmental physicians, who are not the referring oncologists, to openly

discuss the treatment plan together and affirm their therapeutic orientation. Data from those same cancer centers in 2010 were analysed to describe the intensity of care in the last month of life. The study showed that respectively 16% and 26% of patients received chemotherapy in the last 14 days of their lives [23]. These indicators reflect the general difficulty that medical teams and patients face when deciding to withdraw from or give up specific cancer treatments as the disease progresses. A study conducted between January 2020 and February 2021 has shown that patients receiving palliative care are frequently discussed at a late stage of their hospitalisation, with only seven days elapsing between CMS and the patient's death [29]. Despite these meetings, the orientation towards palliative care remains too late.

Whether the patient is known to the palliative care team or not, palliative care professionals ensure that the patient's thoughts, knowledge, understanding and wishes are taken into account [62–64]. The palliative care team's intervention with the patient is often seen as a relationship aid, a way of re-establishing dialogue with the patient [65, 66]. As "outsiders" supporting the decisions of the department physicians, they can help resolve conflicts with families. The palliative care team are often well versed in communication skills. It is often at these meetings that introducing palliative care is suggested. Although professionals are satisfied with the approach, palliative care professionals regret the lack of involvement of the referring oncologist who is usually the physician who has a long-standing relationship with the patient and is responsible for making decisions regarding cancer-related treatment. However, the analysis of the CSMs revealed that the participation rate of the referring oncologist was only 25% [29]. An onco-palliative care meeting cannot really contribute to true SDM if the organisation is not designed in such a way that the participation of the referring oncologist is a requirement.

In the outpatient clinic, the organisation is more flexible and allows palliative care professionals to be reflective and inventive. The team focuses on the patient. His or her words are recorded and passed on in the patient report.

Here again, the division of roles is quite clear. While some palliative care physicians felt that it was their responsibility to manage symptoms and treatment-related complications, the oncologist remained the decision-maker about oncological treatment. Despite discussions in which the palliative care physicians contributed their opinions and the patients' wishes, the referring oncologist remained reluctant to decide to stop cancer-related treatment [67]. They insist on regaining control over specific treatments, by being able to see the patient again in consultation, alone.

Study limitations

Firstly, these two Comprehensive Cancer Centers in Paris are reference centers for rare cancers and often a place for second opinions. The palliative care physicians are almost all trained in oncology. These two centers are by no means representative of all the collaborations between oncology and palliative care teams, or even of the structures that palliative care teams have set up throughout France to manage their patients. The findings could be enriched by additional research into the decision-making process in other institutions that have developed early integration of palliative care, in oncology [15] or hematology [68].

Secondly, few interactions between the palliative care team and the referring oncologist were observed. OPM and CSM differed from the mandatory multidisciplinary consultation meetings used to determine the therapeutic oncology strategy. There was no systematic presentation of cases in the meetings observed. The concept of complexity was not elaborated upon. There was no opportunity to further explore this concept with oncology department professionals, nor verify whether palliative care professionals concurred on its complexity. It is plausible that decision-making in situations of uncertainty (such as prognosis and benefit-risk balance) is sufficient to justify the notion of complexity [69, 70]. However, on the assumption that all professionals are capable of providing basic palliative care, the intervention of palliative care professionals is regularly motivated by this notion of complexity [25, 63, 71].

Thirdly, transcripts were not returned to the participants nor were the results discussed directly with them. It would have been interesting to include a second step in the study to discuss the results with the participants and to obtain their feedback.

Finally, verbatims are lacking as there was no audio recording. The decision not to record was made after an initial test observation, which confirmed that notetaking was feasible and provided an understandable account of the exchanges. The aim was to identify the elements that constitute an SDM process, rather than to evaluate the nature of the decision and the reasons for it.

Clinical applications

Although few elements of the different models of SDM are observed, it is possible to see these interventions as part of a decision-making process that extends over a longer period. Decision-making does not take place in a single meeting, but is a continuous process, unpredictable because of the evolution of the disease and the effectiveness of treatments [72, 73]. Informed decision making by patients and their families can be supported

by close triangular collaboration between cancer specialists, primary care and palliative care teams. To achieve this, however, it is essential to clarify roles, to circulate information between the different actors and to identify the moments of decision-making in the patient's trajectory. Then, to improve the decision-making process during meetings, it seems necessary to prepare them by setting a goal and ensuring the presence of the referring oncologist.

The concept of SDM, in which patients' preferences are elicited and their wishes respected, is an integral part of palliative care. Supporting its development in advanced cancer patients will enhance the effective implementation of palliative care [74–76]. This will be promoted through training in SDM and communication, and the development of tools to support patients in the expression of their preferences.

Finally, if SDM itself is popular, it would also be appropriate to explore the impact of its implementation on the patient's care pathway and whether it brings satisfaction to both the patient and the caregivers.

Conclusion

This qualitative study of collaboration between oncology and palliative care teams aimed to describe the decision-making process by comparing it with the elements of SDM models found in the literature. The results show that few elements of the theoretical model are observed in current practice, despite the commitment of palliative care teams to this shared medical decision-making process. Indeed, they continue to promote elements like patients' wishes and preferences and their involvement in the decision-making process.

Where SDM exists in oncology, it seems limited to situations where therapeutic options are curative. Thinking about withdrawing disease-specific treatments remains difficult. To continue the ongoing change in the approach to the therapeutic management of patients with advanced cancer, communication training of oncologists and close collaboration with palliative care professionals are essential.

There are still cultural and organizational barriers to actual implementation of early integrated onco-palliative care. Promotion of SDM can be a strong lever of change which is frequently mobilised by palliative care teams.

Abbreviations

SDM	Share Decision Making
HAS	Haute Autorité de Santé
CSM	Collegial Support Meetings
OPM	Onco-Palliative Meetings

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Not applicable.

Authors' contributions

MP designed the data collection tool, collected and analysed the data, drafted and revised the paper. AR analysed the data, drafted and revised the paper. KL revised the data collection tool, discussed and validated the data analysis data and revised the paper. AT analysed the data and revised the paper. AB, FB revised the paper. IC discussed and validated the data analysis and revised the paper.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The study protocol was validated by the Clinical Research Ethics Committee of the Valenciennes Hospital Centre on 24 March 2022 under the reference Ref-CHV-2022-004.

All methods were carried out in accordance with relevant guidelines and regulations. The medical and nursing teams at the observation sites were informed about the study and gave their informed consent to participate.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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