

Screening for Distress, the 6th Vital Sign in oncology: from theory to practice

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In routine medical practice, health professionals take vital signs to assess basic bodily functions: they are an essential part of the patient's case presentation. In most medical settings the 4 standard vital signs are body temperature, pulse, blood pressure and respiratory rate. In 1999, the National Pharmaceutical Council and the Joint Commission for the Accreditation of Health Care Organizations in the United States acknowledged the impact of pain and the importance of pain management in effective patient care, and subsequently deemed pain the 5th Vital Sign.¹ In 2004, given multiple studies on the prevalence of distress (as defined by NCCN, 1999²), the Rebalance Focus Action Group (now the Cancer Journey Action Group [CJAG] of the Canadian Strategy for Cancer Control (now the Canadian Partnership Against Cancer [CPAC]) endorsed a proposal that distress be considered the 6th Vital Sign in Cancer Care.³ The Canadian Association of Provincial Cancer Agencies and the Canadian Coalition Advocacy Network also endorsed this proposal. An important milestone toward making distress screening and management the standard of practice in cancer care is that as of 2009, the standards for Cancer Care and Oncology Services of Accreditation Canada (formerly the Canadian Council of Health Care Accreditation) require processes to be in place to evaluate and monitor the client's emotional distress as "the sixth vital sign."⁴

In the November issue of *Oncology Exchange*, Vodermaier and Linden⁷ offered a snapshot of the status of distress screening programs in Canada. They reported that only 36.5% of cancer centres in Canada screen patients for distress at the time of admission, and they identified barriers to implementation such as time constraints, inconsistent usage, lack of resources and lack of buy-in. They also noted a need for education about the value of distress screening.

Several recent initiatives are helping Screening for Distress become standard practice. A March 2008 workshop held in Calgary brought together experts, decision makers and psychosocial practice leaders from all provinces.⁵ Points of consensus included that distress is highly prevalent among cancer patients; that it needs to be monitored and addressed; that distress is about more than anxiety and depression — it arises from difficulties such as pain, fatigue, common problems (e.g. finances, transportation, worry, etc.), nutritional concerns and other physical symptoms; that screening for distress should be considered when patients first begin cancer care, followed by appropriate responses and referral to services; and that national standards and Screening for Distress would be valuable.⁵ CPAC subsequently deemed Screening for Distress and recognition of the 6th Vital Sign as one of its priorities for the next 4 years.⁶

The Screening for Distress Toolkit Working Group, a CJAG subgroup, aims to develop guidelines for who, when, how, what to screen for, and what tools to use. Points of consensus

reached in an October 10th 2008 meeting in Calgary included that:

- all patients should be Screened for Distress
- screening should be routine and standardized, occurring at point of entry and at critical time points
- Screening for Distress should assess 3 domains: physical, practical and psychosocial

Further discussion will take place in upcoming months on how to conduct screening (e.g. computerized vs paper and pencil), screening tools (including recommended cut-offs), and referral algorithms.

Important expected benefits are that standardized, consistent Screening for Distress across Canada will allow for comparisons, and that sharing of strategies, methods and lessons learned will ease the challenges of implementing new Screening for Distress programs and help improve existing programs. The CJAG is currently facilitating Screening for Distress consultations and workshops in several sites across Canada. As we move forward, we continue to focus on the goal of improving the patient experience and shifting to a more patient-centred approach.

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