

Knowledge and Awareness on the Role of Occupational Therapist in Oncology Care: A Cross-Sectional Study among Saudi Arabian Students and Healthcare Providers

Senthil Vadivel^{1, 2*}, Munirah Alsubaie^{1, 2}, Nawaf al Anazi^{3, 4}, Christopher Amalraj V⁶, Paramasivan Mani^{1, 2}, Suresh Melamal^{1, 2}, Abdulmaniem albader^{1, 2}, Abdullah alessa^{1, 2}, Rakan alheliby^{1, 2}, Abdullah almodairas^{1, 2}, Raju Suresh Kumar⁵

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Department of Occupational Therapy, College of Applied Medical Sciences, King Saud bin Abdulaziz University for Health Sciences, Al Ahsa, Kingdom of Saudi Arabia,

²King Abdullah International Medical Research Center, Alahsa, Saudi Arabia

³Department of Pediatrics, King Abdulaziz Hospital, National Guard Health Affairs, Alahsa, Saudi Arabia

⁴College of Applied Medical Sciences, King Saud bin Abdulaziz University for Health Sciences, Al ahsa, Kingdom of Saudi Arabia,

⁵Department of Basic Sciences, College of Science and Health Professions, King Saud bin Abdulaziz University for Health Sciences, Jeddah, Kingdom of Saudi Arabia.

⁶Vice Deanship for Development and Community Partnership, College of Medicine, Imam Abdulrahman Bin Faisal University, Dammam, Saudi Arabia

*Corresponding Author: senthilvadivelpalanichamy@yahoo.co.in

ABSTRACT:

Aims: - To investigate the level of awareness and to improve healthcare professionals' and students' knowledge of the role of occupational therapists in Saudi Arabian cancer patients.

Method: A descriptive, cross-sectional survey was conducted via an online questionnaire among healthcare providers and health care students (male/female) in Saudi Arabia. The study's estimated sample size was 382, based on the estimated population.

Results: The study's findings revealed that a sizable majority of the participants had experience working with cancer patients, either in the past or currently. However, the study also highlighted some gender differences (Out of the participants, 77(67.5%) subjects were females, and the other 37(32.5%) subjects were males) in the types of health professionals involved in assisting cancer patients. The study also found that there were no significant differences between male and female participants in their knowledge about barriers to providing occupational therapy and who should be referred to such therapy.

Conclusion: The study suggests that occupational therapy has an important role to play in cancer care in Saudi Arabia. However, to further enhance Occupational therapy's significance in cancer treatment and the need to remove obstacles that may prevent health care professionals from referring patients to occupational therapy services and to tailor educational programs to the unique needs and perspectives of male and female occupational therapists.

Keywords: occupational therapy, oncology patients, health care providers, health care students, Saudi Arabia.

INTRODUCTION:

Globally, cancer is a leading cause of illness and death (1). Cancer had a significant impact on health with 15,807 instances in Saudi Arabia in 2014. However, because to improvements in medicine and early diagnosis, the number of cancer survivors is rising (2), and the anticipated new cases in 2020, all cancers, both sexes and

all ages as per WHO reports is 27,885. Cancer and it's the quality of life (QoL) can be significantly impacted by treatment. of mature cancer survivors, leading to limitations in completing fundamental daily activities (ADLs) and/or practical daily activities (PDAs). These limitations can be a direct result of cancer or caused by its treatment. (3).

Additionally, cancer patients usually struggle with executing ADLs, essential for leading a self-sufficient existence in society. Even though several research studies have evaluated ADL-related disability, the heterogeneity in evaluation, context, and population makes it challenging to interpret the results. We sought to identify the most common types of ADL-related disabilities, globally and by setting (4). Due to advancements in diagnosis and therapy, more patients are surviving cancer or coping with it. However, cancer survivors may develop functional limitations that influence their health. Life quality and work potential. For instance, physical symptoms of illnesses could be weariness, decreased muscle strength, cognitive impairment, paresthesia, or issues with eating, whereas mental symptoms could be anxiety, depression, relapse fear, or sleeplessness (5).

Cancer survivors often experience long-lasting symptoms such as reduced range of motion, stamina and cognitive differences, making survivorship a chronic illness (6). Cancer patients have diverse medical and socio-demographic backgrounds, resulting in varying rehabilitation requirements. Depending on the circumstance and care of cancer, patients may experience chronic issues like lymphedema, urinary and fecal incontinence, and sexual dysfunction. Apart from these physiological concerns, cancer patients are projected to suffer from emotional distress during and after treatment (7). The most frequently occurring symptom of cancer is fatigue, which can greatly impair a patient's ability to function.

As per the World Health Organization (WHO), the process of rehabilitation aims to minimize the effects of disabling and handicapping conditions and support the complete social inclusion of individuals with disabilities (7). Occupational therapy (OT) was pressured by the medical profession to become more scientific in its early days. As a result, it shifted its focus from occupations to the biomedical aspects of impairment of body structures and functions (8).

Occupational Therapy (OT) is a type of rehabilitation that utilizes specific techniques and tools to enhance functional capabilities. The therapy plans are customized according to the goals and requirements of each patient, with a focus on optimizing the activities that are vital for their quality of life and overall well-being (3). Also, occupational therapy examination and intervention will be necessary for many cancer patients throughout their lifespan and the course of the disease. The key to facilitating occupational participation via negotiating is occupational therapy. Patient and family-center care with a focus on goals. Therefore, occupational therapy is a crucial component of the multidisciplinary treatment provided to cancer patients, and workforce planning, as well as pertinent policy and service delivery frameworks, should acknowledge this (9). The core aim of Occupational Therapy (OT) is to foster the health and functional outcomes of patients by utilizing everyday activities like self-care, leisure, and productivity. Although medical disorders can be addressed through surgery and medication, rehabilitation is the most successful treatment for managing several conditions.

OT is vital in the treatment of debilitating disorders such as neurological, orthopedic, and autism spectrum disorders, and educational disabilities. (10). Managing disease and the shorter life expectancy that results can often be a difficult challenge for both patients and their families. It can seem like there is no chance for a positive future, and patients may struggle to perform daily tasks. Some people may adopt a negative mindset and become inactive and reliant on others, while others may focus on their abilities and take action. Therefore, it's crucial to take the patient's needs into account while creating a treatment program. level of understanding and acceptance, and to help them identify achievable goals (11).

An occupational therapist (OT) can be extremely helpful in improving one's ability to perform daily activities. They can provide guidance and demonstrate innovative methods to maintain or improve independence. This includes prescribing adaptive equipment, such as specific equipment for clothing or self-feeding, and using custom-made splints and orthoses to reduce dysfunctions, maintain reducing discomfort or using accessible positions. Some examples of these methods include foot drop splints for radial nerve palsy and wrist splints., either stiff or flexible collars are used to treat cervical bone metastases. By working with an OT, individuals can gain new skills and improve their ability to perform important tasks in their daily lives (11).

Moreover, the prevalence of adult brain tumor diagnoses and the survival rates are rising. Brain tumor-related neurological deficits can affect participation and activities. Post-acute rehabilitation is advantageous for adults with brain tumors (12). A recent study found that cancer can result in muscle weakness. However, physical training can help increase strength and activity levels (13). Insufficient attention has been given to the increased

risk of falls and fractures among cancer survivors, despite their higher risk of functional decline (14). Chemotherapy-induced peripheral neuropathy can cause reduced sensation and reflexes leading to an increased risk of falls in cancer survivors (15).

Interventions in rehabilitation and exercise lessen the negative effects of treatment-related symptoms and enhance function in people with cancer and those who have recovered from it (16). Although occupational therapy (OT) plays a significant role in multidisciplinary care for chronic illnesses, there is a lack of evidence regarding its effectiveness for individuals suffering from chronic cancer-related illnesses (15). Therapy, care, rehabilitation, and occupational therapy (OT) are all available in various settings including hospice care, community-based general practitioners, cancer hospitals, and outpatient divisions.

These services can be provided in parallel to assist cancer patients in controlling their symptoms and enhancing their quality of life. OT can be particularly helpful in this context, as it can assist individuals in maintaining their independence and improving their ability to perform daily activities. By working with a team of healthcare professionals across different settings, individuals with cancer can receive comprehensive care that addresses their physical and emotional needs (17).

A study was conducted in Australia to analyze the involvement of different healthcare professionals in cancer care. The study revealed that general practitioners were recognized by oncologists, nurses, and other members of the medical team as actively participating in cancer care. On the other hand, social workers, pharmacists, and surgeons were observed to be less involved. The study showed that three-quarters of the participants believed that occupational therapy was commonly used in cancer survivorship care, more so than psychology, physiotherapy, and speech pathology. Additionally, the participants identified 20 other professions and services involved in cancer survivorship care, including dietitians, music therapists, alternative health practitioners, and exercise physiologists (15).

METHODOLOGY:

Materials and Methods:

The study's population was health care professionals (Male/Female) in Saudi Arabia.

Inclusion criteria: healthcare providers and healthcare students (male/female) from different parts of Saudi Arabia.

The research was a cross-sectional, descriptive survey. N=382 healthcare professionals and students from various regions of Saudi Arabia made up the study's sample. The sampling technique was convenient sampling. The process of data collection by sending Online surveys to health care providers and health students. It was followed by data analysis.

Study area/Setting:

This study was conducted via an online survey of healthcare providers and healthcare students, both male and female, in Saudi Arabia.

This research was conducted in the Occupational therapy department of the College of Applied Medical Sciences (COAMS) at King Saud bin Abdulaziz University for Health Sciences (KSAU-HS) in Al-Hasa Saudi Arabia.

Study Subjects:

The study's population consisted of healthcare providers and healthcare students (male/female) from all regions of Saudi Arabia. The inclusion criteria were health care providers and health care students (male/female). The exclusion criteria were staff managers and retired health care providers.

Study Design:

The research was a cross-sectional, descriptive study with a closed-ended questionnaire to acquire quantitative data. The information was gathered from healthcare providers and healthcare students in Saudi Arabia.

Sample Size:

The sample size was estimated by using the Raosoft® software from the website www.raosoft.com/sample_size.html. The margin of error is equal to 5%, and the confidence level is equal to 95%. After we have done the calculation, the estimated sample size based on our study population was 382(1).

Sampling Technique:

Convenience random sampling technique (non-probability sampling method) was used because it was simple and quick to collect while still being affordable. Furthermore, convenience sampling had fewer standards to follow, reducing the likelihood of making mistakes.

Ethical Clearance: The research committees of the Both the Institutional Review Board (IRB) and the King Abdullah International Medical Research Center (KAIMRC) have authorized this investigation (study number NRA22A/032/09). research protocol, questionnaire survey, and consent forms. Everyone who took part in this questionnaire survey gave their informed consent.

Data Collection Methods, Instrument Used, Measurements:

The questionnaire was shared with occupational therapists and healthcare professionals in Saudi Arabia via social media for awareness about the role of OT in oncological cases, and we took the response rate by mail and social media (WhatsApp app, Email messages, Twitter). The medical specialty of oncology focuses on the prevention, detection, and treatment of cancer. An oncologist is a medical doctor who is an expert in cancer detection and treatment, providing medical care and support to cancer patients.

Variables were considered for the questionnaire, including demographic variables such as age, gender, experience, professional category, and the region of the workplace. Questions were included to assess healthcare providers' and students' awareness and attitude towards occupational therapy's role in treating oncology patients in Saudi Arabia.

Validity was done with a group of independent subject experts did the content validity and a set of medical educationists performed the face validity of the questionnaire. Reliability: A pilot survey was distributed to 30 participants who were outside the study population. reliability coefficient Cronbach's alpha was found to be ($\alpha = 0.73$) (15).

Data Management and Analysis Plan:

Statistical analysis

IBM Corp.'s Statistical Package for Social Sciences (SPSS. Version 20.0) was used to analyze the study's data. Frequencies and percentages were used to present the results. To compare nominal data, the Chi-square test was utilized. A p-value of less than 0.05 was regarded as significant because the degree of confidence was set at 95%.

RESULTS:

Baseline characteristics of enrolled participants (n= 114):

The majority (67.5%) of participants were 18-24 years old while only three participants exceeded 50 years old. Twenty-two (19.3%) and 11 (9.6%) participants were 25-29 and 30-49 years old, respectively. Out of the participants, 77 (67.5%) subjects were females, and the other 37 (32.5%) subjects were males. Thirty-nine (34.2%) participants worked in contract positions and 46 (40.4%) participants had post-qualification education.

Among the participants, thirty-nine (34.2%) were employees, and seventy-five (65.8%) were students. In terms of the participants' present employment status, 52 (45.6%) were unemployed, 50 (43.9%) worked as full-time staff, and 12 (10.5%) worked part-time. 46 individuals (37.7%) had post-qualification education.

There were 51 (44.7%) participants who were previously working with cancer patients. Only five participants were currently working with cancer patients. Additionally, only three participants had cancer, while 44 (38.5%) participants had a cancer-stricken relative.

Table 1: Characteristics of the participants' demographics

N= 114			
Age group		Post-qualification education	
18-24 years	78 (68.5%)	Yes	43 (37.7%)
25-29 years	22 (19.3%)	No	71 (62.3%)
30-49 years	11 (9.6%)	Previously working with cancer patients	
≥ 50 years	3 (2.6%)	Yes	51 (44.7%)
Sex		No	63 (55.3%)
Male	37 (32.5%)	Currently working with cancer patients	
Female	77 (67.5%)	Frequently	11(9.6%)
Occupation		Sometimes	14 (12.3%)
Employee	39 (34.2%)	Rarely	15 (13.2%)
Student	75 (65.8%)	Never	74 (64.9%)
Primary work		Setting of working	
Private	10 (8.8%)	Not working	71 (62.3%)
Public	104 (91.2%)	Oncology ward	17 (14.9%)
Current work arrangement		Post-surgical ward	2 (1.8%)
Full time	50 (43.9%)	In the community	4 (3.5%)
Part time	12 (10.5%)	Rehabilitation	16 (14%)
Unemployed	52 (45.6%)	Others	4 (3.5%)
Contract position		Previously had a cancer	
Yes	39 (34.2%)	Yes	3 (2.6%)
No	75 (65.8%)	No	111 (97.4)
Region of work place		family member had a cancer	
Middle region	49 (43%)	Yes	44 (38.6%)
Eastern region	44 (38.6%)	No	70 (61.4%)
Western region	14 (12.3%)		
Northern region	1 (0.90%)		
South region	6 (5.2%)		

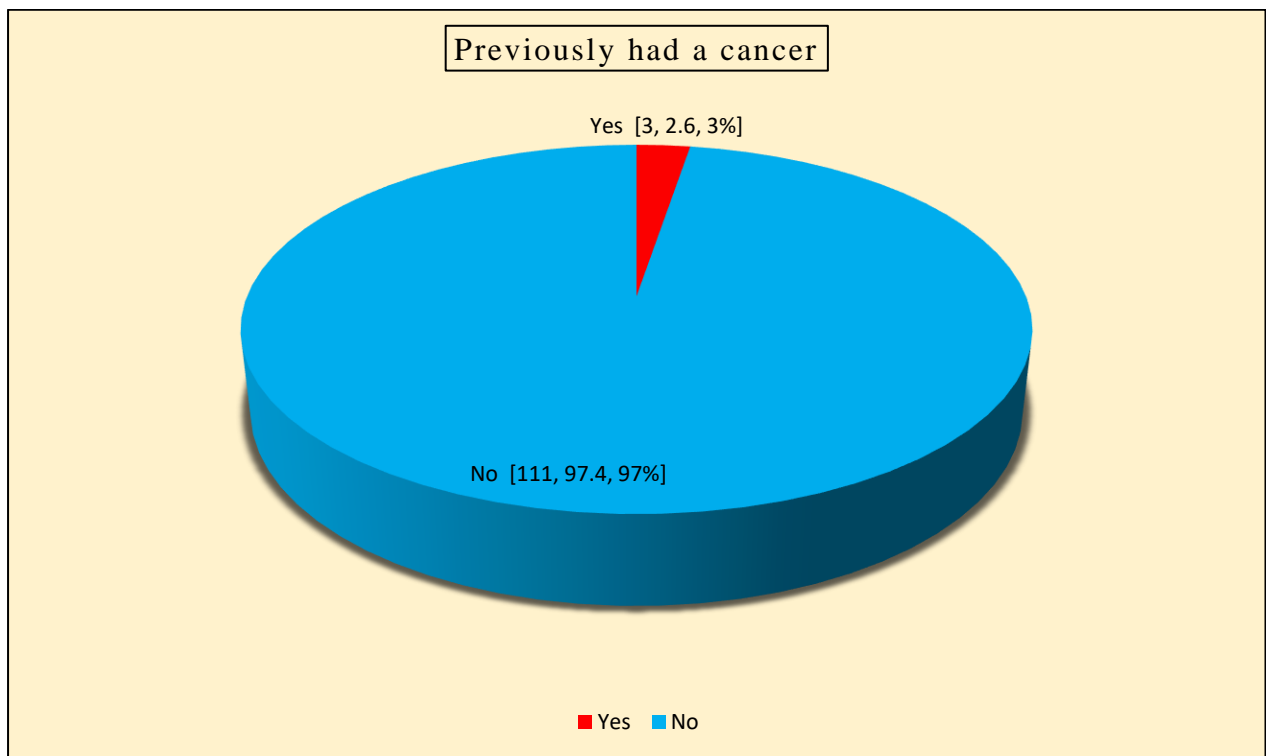


Figure 1: Percentage of having cancer among the study population

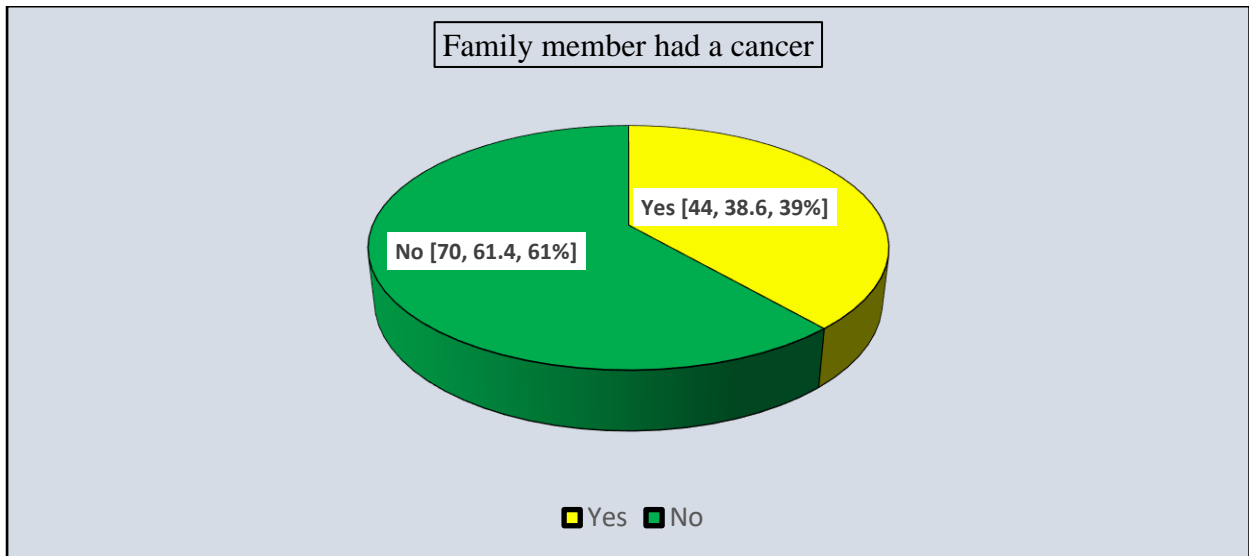


Figure 2: Percentage of family member with cancer among the study Population

There is a statistically significant difference between the demographic groups, as seen in Figure 1, previously had cancer (2.6%) or not (97.4%), nearly 97% of the participant do not have cancer disease in this study.

Figure 2 demonstrates unequivocally that there is a statistically significant difference between the family members who have cancer (38.6%) or not (61.4%), nearly 40% of the participant family members have cancer in this study.

Health professionals routinely help people with cancer, regardless of gender-related occupational performance issues.

With a very high proportion of female participants who believed physiotherapists were regularly involved (35.1% vs. 16.2%; $P = 0.02$), When it comes to how frequently health professionals assisted cancer patients, there were statistically significant disparities between the genders. With an exception of a high percentage of male participants who thought anxiety and depression were major concerns commonly addressed by OTs (62.2% vs. 41.6%; $p=0.03$), the frequency of occupation performance concerns frequently addressed by the OTs varied significantly between the genders.

Table 2: Health professionals routinely help people with cancer, regardless of gender-related occupational performance issues.

Health professionals currently are involved routinely in assisting people with cancer-based on gender			
	Male (n = 37)	Female (n = 77)	P value
Nurses			
Yes	26 (29.7%)	65 (84.4%)	0.06 ^{ns}
No	11 (29.7%)	12 (15.6%)	
OT			
Yes	17 (45.9%)	33 (42.9%)	0.45 ^{ns}
No	20 (54.1%)	44 (57.1%)	
Oncologist			
Yes	25 (67.6%)	55 (71.4%)	0.41 ^{ns}
No	12 (32.4%)	22 (28.6%)	
Pharmacist			
Yes	12 (32.4%)	25 (32.5%)	0.58 ^{ns}
No	25 (67.6%)	52 (67.5%)	
Physiotherapist			
Yes	6 (16.2%)	27 (35.1%)	0.02*
No	31 (83.8%)	50 (64.9%)	

Surgeons			
Yes	13 (35.1%)	23 (29.9%)	0.36 ^{ns}
No	24 (64.9%)	54 (70.1%)	
What are most common occupational performance issues related to cancer or its treatment that OTs address			
Anxiety & depression			
Yes	23 (62.2%)	32 (41.6%)	0.03*
No	14 (37.8%)	45 (58.4%)	
Decreased range of motion			
Yes	22 (59.5%)	49 (63.6%)	0.40 ^{ns}
No	15 (40.5%)	28 (36.4%)	
Joint bone protection			
Yes	19 (51.4%)	48 (63.2%)	0.16 ^{ns}
No	18 (48.6%)	29 (36.8%)	
Lifestyle adjustment			
Yes	27 (73%)	55 (71.4%)	0.52 ^{ns}
No	10 (27%)	22 (28.6%)	
Side effect			
Yes	21 (56.8%)	49 (63.6%)	0.30 ^{ns}
No	16 (43.2%)	28 (36.4%)	

*- Among the study participants, there is a statistically significant difference between the categories ($p < 0.05$).

^{ns}- There was no statistically significant difference between the groups of research subjects ($p > 0.05$).

Knowledge and role of Oncological occupational therapy based on Gender:

It was found that neither gender has considerable knowledge of the challenges associated with providing occupational therapy ($p=0.45$) or the people who require such therapy ($p=0.84$).

Additionally, most participants of both genders agreed that it is important to enforce the requirement that occupational therapists complete additional training to deal with cancer patients.

There was a significant difference between both genders as regard different extra training and education priorities that would be beneficial to enable occupational therapy to undertake a greater role in cancer treatment ($p= 0.04$). It was found that the most frequent educational priorities that were considered by female participants were medical management of cancer (39%) and communications with care and family (23.4%). Meanwhile, the most frequent educational priorities that were considered by male participants were communication with care and family (29.8%) and medical management of cancer (24.3%).

Table 3: Knowledge and Role of Oncological occupational therapy based on gender

What are the most common cancer or treatment-related occupational performance issues addressed by OTs			
	(M = 37)	(F = 77)	P value
Lack of interdisciplinary communication	9 (24.3%)	15 (19.5%)	0.45 ^{ns}
Limited referral	4 (10.8%)	3 (3.9%)	
Lack of recognition of the OTs role	19 (51.4%)	50 (64.9%)	
Inadequate education in OT preparation programs	5 (13.5%)	8 (10.4%)	
Others	0(0)	1 (1.3%)	
When is it appropriate to refer individuals with cancer to occupational therapy?			
Immediately following diagnosis	7 (18.9%)	13 (16.9%)	0.84 ^{ns}
Upon commencement of treatment	5 (13.5%)	12 (15.6%)	
During treatment	6 (16.2%)	9 (11.7%)	
Upon discharge from treatment	4 (10.8%)	4 (5.2%)	
Following surgical discharge	1 (2.7%)	4 (5.2%)	
When functional issues identified by the person with cancer arise	12 (32.5%)	32 (41.5%)	
In particularly complex cases	2 (5.4%)	3 (3.9%)	
Is extra training necessary for occupational therapists to work with cancer patients			
Yes	21 (56.8%)	54 (70.1%)	0.11 ^{ns}

No	16 (43.2%)	23 (29.9%)	
To enhance the role of occupational therapy in cancer treatment, what additional training and education would be most beneficial			
Medical management of cancer	8 (21.6%)	30 (39%)	0.04*
Physical treatment	5 (13.5%)	16 (20.8%)	
Cancer pathology	9 (24.3%)	5 (6.5%)	
Communication with care and family	11 (29.8%)	18 (23.4%)	
Support needs of carers and family	4 (10.8%)	8 (10.3%)	

*-Among the study participants, there is a statistically significant difference between the categories ($p < 0.05$). ns stands for a difference between the categories among study participants that is not statistically significant ($p > 0.05$).

Health professionals routinely assist cancer patients with treatment-related occupational performance issues based on post-qualification education.

Participants with post-qualification education believe health professionals routinely assist cancer patients and occupational therapists best address performance issues ($p > 0.05$).

Table 4: Health professionals and treatment-related occupational performance issues are involved routinely in assisting people with cancer-based on post-qualification education

Health professionals currently are involved routinely in assisting people with cancer-based on post-qualification education			
Post-qualification education	No (n= 71)	Yes (n= 43)	P value
Nurse			
Yes	55 (77.5%)	36 (83.7%)	0.28 ^{ns}
No	16 (22.5%)	7 (16.3%)	
OT			
Yes	27 (38%)	23 (53.5%)	0.07 ^{ns}
No	44 (62%)	20 (46.5%)	
Oncologist			
Yes	49 (69%)	31 (72.1%)	0.44 ^{ns}
No	22 (31%)	12 (27.9%)	
Pharmacist			
Yes	20 (28.2%)	17 (39.5%)	0.14 ^{ns}
No	51 (71.8%)	26 (60.5%)	
Physiotherapist			
Yes	18 (25.4%)	15 (34.9%)	0.19 ^{ns}
No	53 (74.6%)	28 (65.1%)	
Surgeons			
Yes	19 (26.8%)	17 (39.5%)	0.11 ^{ns}
No	52 (73.2%)	26 (60.5%)	
Which cancer or treatment related occupational performance issues do you think are most addressed by OTs based on post-qualification education			
Anxiety& depression			
Yes	35 (49.3%)	20 (46.5%)	0.46 ^{ns}
No	36 (50.7%)	23 (53.5%)	
Decreased range of motion			
Yes	43 (60.6%)	28 (65.1%)	0.38 ^{ns}
No	28 (39.4%)	15 (34.9%)	
Joint bone protection			
Yes	46 (65.7%)	21 (48.8%)	0.06 ^{ns}
No	24 (34.3%)	22 (51.2%)	
Lifestyle adjustment			
Yes	48 (67.6%)	34 (79.1%)	0.13 ^{ns}
No	23 (32.4%)	9 (20.9%)	

Side effect			
Yes	43 (60.6%)	27 (62.8%)	0.48 ^{ns}
No	28 (39.4%)	16 (37.2%)	

*-There is a statistically significant difference between the categories among the study participants ($p < 0.05$).

^{ns}-not statistically significant difference between the categories among the study participants ($p > 0.05$).

Knowledge and role of Oncological occupational therapy based on gender:

Based on post-qualification education, it was discovered that neither set of participants knew anything noteworthy about the individuals who should be referred for occupational therapy ($p = 0.26$) or the barriers to providing such therapy ($p = 0.60$).

Additionally, most of the participants from both groups agreed that it is important to implement a requirement for occupational therapists to complete additional training to deal with cancer patients. In terms of priorities for more training and education, there was no statistically significant difference between the two groups that would help occupational therapy play a major role in cancer treatment ($p = 0.15$).

Table 5: Knowledge and role of Oncological occupational therapy based on post-qualification education

Post-occupational education	No (n= 71)	Yes (n= 43)	P value
While all these barriers are recognized what do you think is the current most important barrier in providing occupational therapy to people with cancer			
Lack of interdisciplinary communication	12 (16.9%)	12 (27.9%)	0.26 ^{ns}
Limited referral	3 (4.2%)	4 (9.3%)	
Lack of recognition of the OTs role	48 (67.6%)	21 (48.8%)	
Inadequate education in OT preparation programs	7 (9.9%)	6 (14%)	
Others	1 (1.4%)	0(0)	
When should people with cancer be referred to occupational therapy			
Immediately following diagnosis	11 (15.5%)	9 (20.9%)	0.60 ^{ns}
Upon commencement of treatment	10 (14.1%)	7 (16.3%)	
During treatment	10 (14.1%)	5 (11.6%)	
Upon discharge from treatment	3 (4.2%)	5 (11.6%)	
Following surgical discharge	3 (4.2%)	2 (4.7%)	
When functional issues identified by the person with cancer arise	30 (42.3%)	14 (32.6%)	
In particularly complex cases			
	4 (5.6%)	1 (2.3%)	
Should there be a requirement for occupational therapist to undertake extra training to work with people with cancer			
Yes	49 (69%)	26 (60.5%)	0.32 ^{ns}
No	22 (31%)	17 (39.5%)	
To enable occupational therapy to undertake a greater role in cancer treatment what extra training and education would you prioritize as being the most beneficial			
Medical management of cancer	26 (36.6%)	12 (27.9%)	0.15 ^{ns}
Physical treatment	10 (14.1%)	11 (25.5%)	
Cancer pathology	10 (14.1%)	4 (9.3%)	
Communications with cares and family	15 (21.1%)	14 (32.6%)	
Support needs of carers and family	10 (14.1%)	2 (4.7%)	

^{ns}-not statistically significant difference between the categories among the study participants ($p > 0.05$).

DISCUSSION:

The study's findings show that a sizable majority of participants had prior experience working with cancer patients, either in the past or currently. This is consistent with the growing recognition of the importance of OT in cancer care, as studies have shown that occupational therapy interventions can improve the QOL and functional outcomes for cancer patients (18, 19).

However, the study also highlights some gender differences in the types of health professionals involved in assisting cancer patients, with As per the results it is With a very high proportion of female participants who believed physiotherapists were regularly involved (35.1% vs. 16.2%; $P = 0.02$). This may reflect differences in the roles and responsibilities of male and female health professionals in Saudi Arabia.

Interestingly, the study found that anxiety and depression were more commonly addressed by female occupational therapists, compared to male occupational therapists. This is in line with other study that shown female occupational therapists have a propensity to give mental health issues a higher priority in their practice (20). However, noting that taking care of mental health concerns is a crucial part of cancer care, as cancer patients often experience psychological distress because of their diagnosis and treatment. According to a recent study, a significant number of cancer patients do experience anxiety and depression (21). Hospital admissions can be reduced and the quality of life for older people with lung cancer can be enhanced. can be avoided or reduced with the support of an outpatient OT intervention. It is advisable to recognize the role of OT interventions for the benefit of cancer patients (22).

Our study also found that Participants' knowledge did not significantly differ between men and women. Regarding barriers to providing occupational therapy to cancer patients and who should be referred to such therapy. This could be taken as a reflection that both male and female health professionals in Saudi Arabia have a similar level of comprehension of occupational therapy's function in cancer treatment. However, Male, and female participants differed significantly in their perspectives on the additional instruction. and education priorities that would be beneficial for OT to undertake a greater role in cancer treatment. This research emphasizes the significance of taking gender variations into account when creating and putting into practice occupational therapy training programs for cancer patients.

To strengthen occupational therapy's role in the treatment of cancer, it is important to address the barriers that may prevent health professionals from referring patients to occupational therapy services. Some of the common barriers reported in the literature include a lack of knowledge about the scope of occupational therapy, a lack of time and resources, and referral pathways that are not well-defined (23). By removing these obstacles, occupational therapy services may be used more frequently in the treatment of cancer and patient outcomes may be improved.

The results of this study indicate that male and female health professionals have different educational priorities when it comes to occupational therapy in cancer care. The most frequent educational priority for males was medical management of cancer, while for females it was communication with patients and their families. This may reflect differences in the perceived roles and responsibilities of male and female health professionals in Saudi Arabia. However, it is important to note that both medical management and communication skills are important aspects of cancer care, and both should be included in the education and training of occupational therapists.

The study found no significant variations in participants' knowledge and comprehension of the function of oncological occupational therapy in cancer care between participants with and without post-qualification education. This implies that post-qualification education may not have a significant impact on the understanding of occupational therapy in cancer care. However, participants without post-qualification education were more likely to consider the lack of recognition of occupational therapists' role as a barrier to providing occupational therapy in cancer care.

This research emphasizes the need to raise awareness and acknowledge the function of occupational therapists in the treatment of cancer among medical professionals and the general public. To strengthen occupational therapy's role in the treatment of cancer, it is important to address the barriers that may prevent healthcare professionals from referring patients to occupational therapy services. Lack of recognition and awareness of the role of occupational therapy is a common barrier reported in the literature (23).

By increasing awareness and education about the role of occupational therapy in cancer care, it may be possible to address this barrier and increase the uptake of occupational therapy services. In addition, the research

emphasizes the importance of tailoring educational programs to the unique needs and perspectives of male and female occupational therapists. This includes considering the different educational priorities and perceived roles and responsibilities of male and female health professionals in cancer care. By tailoring educational programs to meet the specific needs of different groups of occupational therapists, it might be possible to raise the standard of cancer patients' care and expand the role of occupational therapy in cancer treatment.

CONCLUSION:

In conclusion, this study provides valuable insight into healthcare professionals' and students' knowledge, attitudes, and educational priorities regarding occupational therapy's role in cancer care in Saudi Arabia. The study suggests occupational therapy has a crucial role in cancer care. It's important to enhance awareness among healthcare professionals and the community. The study emphasizes the significance of designing educational programs that cater to the distinctive requirements and viewpoints of male and female occupational therapists.

It is also important to address the obstacles that might hinder healthcare professionals from recommending occupational therapy services to their patients. The study's conclusions have a big impact on how occupational therapy is developed and used in cancer treatment in Saudi Arabia. Raising awareness and acknowledging the crucial role of occupational therapy, customizing educational programs to cater to the unique needs of different groups of occupational therapists, and addressing the obstacles to providing occupational therapy services might improve the role of occupational therapy in cancer care. This, in turn, could enhance the quality of life and functional results of cancer patients. More extensive research is needed to look deeper into these challenges and to provide practical solutions for enhancing the contribution of occupational therapy to cancer care.

LIMITATIONS:

The limitations of this study should be considered when evaluating the results. Because of the study's tiny sample size, it's probable that it doesn't accurately represent all Saudi Arabian students and medical personnel.

The study has some limitations that should be considered. Firstly, the data collected was self-reported, which means that it might not accurately reflect the participants' actual knowledge, attitudes, and practices due to social desirability bias. Secondly, the study did not delve deeply into the reasons behind the differences in educational priorities and perceived barriers to providing occupational therapy in cancer care.

RECOMMENDATIONS:

Although this study has its limitations, it offers valuable insights into the knowledge, attitudes, and educational priorities of healthcare professionals and students in Saudi Arabia about the role of occupational therapy in cancer care. To build on these findings and further improve the role of occupational therapy in cancer care, the following recommendations are proposed:

1. Conduct further research with larger and more diverse samples to confirm and extend the findings of this study.
2. Develop and implement educational programs that are tailored to the unique needs and perspectives of male and female occupational therapists, as well as other healthcare professionals involved in cancer care.
3. Address barriers to occupational therapy in cancer by increasing awareness, improving referral pathways, and providing support.
4. Explore in-depth the reasons behind the reported differences in educational priorities and perceived barriers to providing occupational therapy in cancer care and develop strategies to address these differences.
5. Evaluate the effectiveness of educational programs and interventions aimed at enhancing the role of OT in cancer care, using rigorous research designs and outcome measures that capture both patient-center and healthcare professional-center outcomes.

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