

Research Article

Development and Content Validation of a Brief French Tool for Self-Assessment of Supportive and Palliative Care Needs in Patients with Cancer: The ACCOmPAGNE Tool

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Objective. This study aimed to develop and perform a content validation of a brief French tool for self-assessment of supportive and palliative care needs in patients with cancer, using four different approaches: issue's importance, problem intensity, problem burden, and expressed need for help. **Methods.** Items, questions, and response scales were based on a literature review and discussions within a multidisciplinary scientific committee. A panel of experts evaluated the relevance, comprehensiveness, and comprehensibility of each item and question using the Delphi method. These properties were also assessed through cognitive debriefing interviews with cancer patients. **Results.** Eleven domains were selected from the literature review: physical, role, social, psychological, patient care and support, healthcare, information, financial, activities of daily living, spirituality, and sexuality. A scientific committee created 15 items and five questions. Two Delphi rounds were required to reach a consensus among the 29 experts on a pilot version. Twenty-three cancer patients were involved in the cognitive debriefing interviews. All items and questions were considered as relevant. Acceptability was good, and four items were reformulated based on patients' comments. **Conclusion.** This brief French tool has a very good content validity and can be used in clinical practice.

1. Introduction

The International Agency for Research on Cancer estimates that 13.6 million people were living with cancer in 2020 [1]. In France, 382,000 new cancer cases occurred in 2018, and 3.8 million people were living with cancer in 2020 [2]. In countries where health systems are strongly effective, survival rates of many types of cancers are increasing thanks to accessible early detection, improved treatment, and survivorship care [3, 4]. Cancer has turned from being a rapidly and inevitably fatal disease to one that can be managed over time so many authors consider it as a chronic disease or as a prolonged and uncertain disease trajectory [5, 6].

Maintaining and improving health-related quality of life (HRQOL) are critically important goals of integrated and patient-centered cancer care. HRQOL evaluations gauge the ramifications of the disease for different aspects of the patient's life experience [7, 8]. Patient satisfaction surveys more closely focus on perceived quality-of-care issues [9]. To ensure quality of care, it is recommended that the management of symptoms and side effects, as well as emotional, psychosocial, and spiritual domains, should be taken into account. All these aspects of support are generally classified as supportive and palliative care [10, 11]. Quality of care is defined as the adequacy of caregivers' responses in satisfying the care needs and care expectations of patients [12]. To date, there is no

consensus on how patients' care needs should be defined. Foot defined patients' care needs as "the requirement of some action or resource in care that is necessary, desirable, or useful to attain optimal well-being" (Foot, 1996, as cited in Sanson-Fisher, et al., 2000, p. 227) [13]. Cancer patients who experienced unmet care needs reported greater symptom distress and anxiety and reduced HRQOL [14]. Care needs assessments enable direct information of patients' perceived needs for help, care, or support. They allow a more direct indication of needed resources for better and personalized patient-centered care [15].

A variety of cancer-specific care needs assessment tools have been developed in recent years. Some questionnaires are generic, while others are specific to a type or stage of cancer. The number of dimensions and the psychometric properties differ between questionnaires [16, 17]. There is extensive heterogeneity in their development, content, and quality. There remains a lack of standardized and commonly accepted tools for a comprehensive evaluation of care needs among cancer patients in routine clinical practice. Johnsen et al. suggested four different approaches to needs assessment based on the literature: (a) an approach by problem intensity, that is the degree to which a specific problem is present, (b) another by problem burden, that is the degree to which this problem is distressing the patient, (c) another by felt need for help, which is what the patient demands and expects from the professional, (d) and a final one by issue's importance, that is the degree to which an issue is considered important by the patient [18]. To our knowledge, existing questionnaires mostly assess care needs by a quantitative "felt need" approach for each suggested issue or difficulty. The Three-Levels-of-Needs Questionnaire (3LNQ) is the one that comes closest to a combined approach. It presents problem intensity and problem burden and felt need items in 78 open, semiopen, and closed-ended questions. Furthermore, it requires using it with another questionnaire to measure problem intensity. This makes it difficult to use in routine clinical practice. The Problems and Needs in Palliative Care (PNPC) questionnaire combines only two approaches: it identifies whether a problem exists and whether the patient wants professional attention for this issue [19, 20]. The Cancer Rehabilitation Evaluation System (CARES) measures only problem intensity and the need for help by professionals [21]. This double approach seems to us insufficient for a comprehensive assessment of the patient care needs.

Since 2005 in France, care needs are often assessed during a dedicated consultation with a nurse. This takes place before the start of cancer treatments. Professionals can rely on tools such as the French 34-item Supportive Care Needs Survey questionnaire (SCNS-SF34-VF). It is the only existing French care needs assessment tool in cancer based on the original SCNS-SF34 [22, 23]. Its nonexhaustive items and length (34 items on four pages) can limit its use in daily clinical practice. It only addresses the question of care need for help from a quantitative approach. To date, to our knowledge, there is no French clinical tool that assesses the impact of cancer on the

patient's care needs and takes into account the importance of an issue, existing problem intensity, problem burden, and expressed care need for help. We hypothesize that this detailed approach would (a) provide a comprehensive assessment of the patient's care needs, (b) intend to help foster communication between patients and health caregivers, and (c) allow a more integrated and personalized care during the disease journey.

The objective of the current research was to develop a clinical and practical patient-reported outcome assessment tool that assesses care needs in cancer patients with a four-combined approach for use in real-world settings.

2. Methods

In this article, we present a questionnaire development study with the different phases of construction of the ACCOmPAGNE tool (a French acronym). The first phase focuses on its development and on items and questions generation. The second and third phases consisted of testing a draft version of the ACCOmPAGNE tool and then a pilot one with professionals and patients, respectively, until a final version was obtained. The study was approved by the local Ethics Committee in Human Research of Tours (No. 2021-064).

Based on these different stages of development, we were able to assess the content validity (including face validity) of the created new tool. According to COSMIN guidelines [24], content validity is based on a qualitative evaluation, which involves the analysis by experts and patients of (a) the relevance of all items for the study population and for the purpose of the tool and (b) the comprehensiveness of all items regarding the measuring construct. Face validity is based on interviews with patients about the comprehensibility and acceptability of the tool. It also includes the time to complete the questionnaire. We chose these quality judgment criteria because content and face validity are relevant for using tools in clinical settings.

We present the flowchart of the ACCOmPAGNE tool development in Figure 1.

2.1. Questionnaire Development and Item Generation.

Draft items, instructions, and response scales were based on a content review of existing instruments in the supportive and palliative care needs in adult cancer literature. The objective was to comprehensively identify all domains of patient HRQOL that can be impacted by cancer and that may cause difficulties and unmet needs. Searches were conducted in July 2019 in the electronic databases of PUBMED, EMBASE, and PsychINFO. The search strategy focused on three key concepts (i.e., cancer, needs, and instrument). A combination of Medical Subject Headings and keywords was formulated and informed by previously published search strategies [14, 16, 25]: (cancer* or neoplasm* or hematologic neoplasm*) AND (need* or health services needs and demand*) AND (needs assessment* or evaluation* or

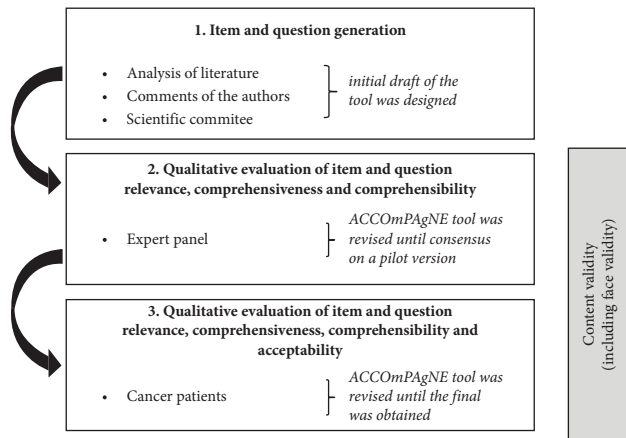


FIGURE 1: Flowchart of the ACCOmPAGNE tool development and its content validity assessment.

assessment* or tool* or instrument* or scale* or survey* or develop*).

A draft questionnaire was built by three researchers from various disciplines: a psychologist, a biostatistician, and a physician. Twelve multidisciplinary experts formed a scientific committee, involving hematology, oncology and palliative care nurses and physicians, psychologists, sociologists, linguists, methodologists, and biostatisticians. A physical meeting took place on January 23, 2020. Experts assessed the comprehensiveness of identified domains and needs, and the relevance and wording clarity of each item and question. The draft questionnaire was refined in line with experts' feedback.

2.2. Expert Panel: Assessment of Content Validity and Development of a Pilot Version. Therefore, we decided to use the Delphi technique to confirm items and questions for the tool [26]. For this Delphi study, we included a large panel of multidisciplinary experts. For each item, question and response scale, relevance, and wording clarity were assessed using a 10-point rating scale (from 1=very bad to 10=excellent). Experts had to specify a reason to justify any score less than 7. An item was considered as relevant or well-formulated if at least 80% of respondents had given a score higher or equal to 7. In this case, this item was kept in the next version of the questionnaire. Minor revisions could also be made if comments were relevant. In the situation where more than 20% of the scores were below 7, items were systematically discussed and/or reformulated based on participants' comments. They were then resubmitted in the next Delphi round. There was no a priori limit on the necessary number of Delphi rounds, until obtaining more than 80% of scores higher or equal to 7 [27]. This process resulted in a pilot version that was used in patient interviews.

2.3. Patient Interviews: Assessment of Content and Face Validity and Development of a Final Version

2.3.1. Patients. This pilot version was tested in a sample of representative patients using cognitive debriefing interviews.

Patient inclusion criteria were the same as those of the existing instruments: having confirmed diagnosis of any type of cancer (including solid and hematologic tumors and excluding nonmelanoma skin cancer); being 18 years or older; and being a native French speaker. Patients were not included if cancer was considered in remission if they presented cognitive disorders, or if they were under legal protection. Patient samples were diversified in terms of sex, age, family status, educational level, types of cancer, metastatic status, time from diagnosis, active cancer treatment, and level of functional impairments with the Eastern Cooperative Oncology Group Performance Status (ECOG-PS).

Patients were all recruited from the outpatient clinic, oncology day hospital, and conventional unit of a University Hospital. Informed consent was obtained individually from all participants included in the study.

According to standard recommendations about face validity, the number of patients to include was five to ten patients per tool version [28, 29].

2.3.2. Interviews. Patients were asked to complete the questionnaire without any help or distraction. Completion time was recorded. Cognitive debriefing interviews were conducted by a researcher with open-ended and prompted questions. Patients were asked (a) about the relevance of the covered domains, of the questions asked, and of the response scales proposed; (b) about the accessibility and comprehensibility of each; and (c) if any life domains were missing in relation to their own cancer experience (comprehensiveness).

Repeated descriptive analyses were performed after the inclusion of five to ten patients. Authors prospectively modified the questionnaire according to patients' comments and produced the final version of the ACCOmPAGNE tool. These repeated descriptive analyses focused on the comprehensible issues by the patients, ambiguities, and missing answers.

3. Results

3.1. Questionnaire Development and Item Generation. The article search was conducted in the electronic databases of PUBMED, EMBASE, and PsychINFO until 30th June 2019. It identified 28 assessment tools in quantitative studies. In studies that took a broad approach to the question of unmet needs (applying multidimensional measures or open interviewing procedures), eleven health-status-related and health-care-related domains were identified: physical related to a cancer symptom or a treatment's side effect; role related to patient's part played at home and in society; social related to relationships with friends, family, and partners; psychological related to feelings and emotions; patient care and support related to patient's access to support services and his relationship with health professionals, including communication; health-care-related to patient's access to medical services; information related to information, knowledge, or understanding about all aspects of the cancer journey; financial related to patient's finances, resources, and

administrative issues; activities of daily living related to essential activities necessary for everyday functioning and for taking care of yourself; spiritual related to finding meaning, purpose, and value in life, though not necessarily religious; and sexual related to intimate relationships and sexual function. Some studies grouped several domains in the same dimension, and others distinguished several dimensions for a single theme. For example, some studies included health system and information in the same dimension while others distinguished two different domains, empirically or based on confirmatory factor analysis.

Based on these results, authors drafted fourteen items, adapted to the French cultural context. Inspired by the work of Johnsen, et al. [18], a draft questionnaire was developed with five questions for each domain: “how important this topic is to you?,” “at this time, do you have a problem regarding this topic?,” “what is the intensity of this problem?,” “how painful is this problem for you?,” and “do you need help with this problem?.” Authors adopted a combination of formats to accommodate the different types of questions: a 3- or 4-point rating scale for quantifying topic importance and problem intensity, burden, and need for help (ranged from 0 “none” or 1 “weak or a little” to 3 “strong or a lot”) and a dichotomous “yes/no” format to identify the existence of an experienced problem.

This draft questionnaire was submitted to the multidisciplinary expert committee. All items were considered relevant, except the one concerning nutrition, which was then associated with the physical symptoms item. Some items were reformulated for better understanding (social role, cope with the disease, spirituality, and decision-making autonomy). Two items were split into two independent items because experts considered that two different topics were assessed in the same item (healthcare and communication, and body image, intimacy, and sexuality). The five questions related to each item (importance, existence of a difficulty, intensity, burden, and need for help) were considered relevant and well-formulated. Therefore, the expert meeting resulted in a 15-item version of the ACCOmPAGNE tool.

3.2. Expert Panel: Assessment of Content Validity and Development of a Pilot Version. Twenty-nine multidisciplinary respondents were involved in the first Delphi round: health psychologists, doctors, and nurses in oncology, hematology and palliative care, public health and health economics researchers, and biostatisticians. They considered all domains relevant with a score ≥ 7 in more than 80% of responses for each. For the entire questionnaire, writing in the first person was favored. Five items obtained a wording clarity score lower than 7 in more than 20% of responses (physical symptoms, social role, coping with the disease, healthcare system, and financial autonomy). We used suggestions and comments from participants to reformulate each item. Some items were also reworded based on helpful comments (family and friends, psychological, physical autonomy, and decision-making autonomy items). All questions were considered relevant and well-formulated.

The “need for help” question was reformulated to “wish for help” due to relevant suggestions from participants. Response scales were considered understandable except for the burden question which was reformulated. Moreover, we finally chose a dichotomous yes/no format for the need for help question because participants considered that the clinical issue was its identification and not its quantification. Twenty-two participants were involved in the second Delphi round. All items, questions, and response scales were considered relevant, well formulated, and clearly understandable in more than 80% of responses, except the healthcare support item which received only 79% of the scores ≥ 7 ; it was, therefore, slightly reformulated. This process resulted in a pilot version that was used in the face validity test.

3.3. Patient Interviews: Assessment of Content and Face Validity and Development of a Final Version. Twenty-three patients were included in the face validity test. Median age was 60 to 70 years. Twelve were men (52%), and 17 had a marital partner and/or one or more children (74%). The overall educational level was low (high school or lower). There were several types of cancer including solid and hematologic tumors, and most were metastatic (63%). The time since diagnosis was less than three years in 70% of cases. Most patients received cancer treatment and were recruited in the oncology day hospital (70%). The median ECOG-PS was 0 (Table 1).

All patients considered the completion time of the questionnaire acceptable with a mean time of seven minutes. We performed two repeated descriptive analyses after the inclusion of six and ten patients, respectively, and we made minimal changes to the questionnaire. Concerning the overall instructions for completing the questionnaire, they were initially considered complex and required a lot of “concentration” (reported by five of six patients; then four of ten patients). Therefore, we modified the layout twice to make the questionnaire easier to read and complete. After these changes, understanding of the instructions was very good (six of seven patients completed the questionnaire thoroughly and correctly). Eight patients (35%) considered that reading the questionnaire was not easy because of the double-entry table format, but they still answered the questions. Six respondents had a low level of education (French high school or less).

All patients considered the assessed domains, the 15 items contained within were relevant, and none made them feel uncomfortable. No patient identified a missing domain regarding their own cancer experience. After the first six cognitive debriefing interviews, two items were modified. “Physical impact” was changed to “physical symptoms and adverse effects,” and “emotions, feelings” was changed to “emotions, mood,” as suggested by participants. We also changed the order of items to group close domains. After the ten subsequent interviews, two additional items were reformulated. “The sense of my life, my spirituality” was inverted to “my spirituality, the sense of my life,” to limit the association with religion, and “my global medico-social

TABLE 1: Summary demographics of patients involved in cognitive debriefing interviews ($n = 23$).

Characteristics	n (%)
Age (years)	
18–39	1 (4)
40–49	4 (17)
50–59	4 (17)
60–69	7 (30)
70–79	6 (27)
≥ 80	1 (4)
Sex	
Male	12 (52)
Female	11 (48)
Familial status	
Married or similar	16 (70)
One or more children	13 (57)
Bachelor's degree or higher	11 (48)
Cancer site	
Hematologic	2 (9)
Lung	7 (30)
Breast or gynecologic organs	5 (22)
Genitourinary organs	1 (4)
Gastrointestinal organs	6 (27)
Head and neck	2 (9)
Metastatic status	14 (61)
Time since diagnosis (years)	
<1	7 (30)
1–3	9 (39)
4–5	4 (17)
>6	3 (13)
ECOG-PS ^a ≤ 1	21 (91)
Active cancer treatment	19 (83)
Recruitment place	
Outpatient clinic or day hospital	16 (70)
Conventional units	7 (30)

^aECOG-PS: Eastern Cooperative Oncology Group-Performance Status.

support” was changed to “my global support by the health system” to improve understanding of this item. After the final six interviews, this item was modified to “my medical and social support as a whole”; no other items required modification.

Regarding the five questions asked to patients in the questionnaire, only the first one about “importance” had to be modified. Two patients failed to respond because it required too much concentration. One patient responded only if he had a difficulty, and two others confused the domain importance with the intensity of a possible difficulty. We have, therefore, deleted “at this time” from the question to keep it general. The other questions did not pose any problem in their formulation or understanding.

Based on the changes made as a result of patient feedback, the authors produced the final version of the questionnaire (Appendix 1). Twenty patients (87%) expressed difficulty related to at least one item. The two most frequently found difficulties were related to the physical symptoms of the disease and adverse effects of treatment and to physical autonomy, in 13 and 10 patients, respectively (57% and 43%). Intensity score and burden score were similar in 79% of cases. Eleven out of twenty patients (55%)

expressed a need for help. The other nine did not want help from health professionals, most often because they felt it was outside their area of expertise (Table 2).

4. Discussion

Our work sought to develop a clinical and practical patient-reported outcome questionnaire that measures care needs in cancer patients with a combined approach. The findings support the content validity of the items and suggest that they can be used with confidence in all cancer patients from diagnosis to advanced stage. One strength of this new tool is the exhaustive character of the studied domains. These were identified from a rigorous literature review and from the recent work of Tian and Rimmer [16, 17]. Therefore, our questionnaire allows a global and complete approach to the impact of cancer on HRQOL and cancer-related needs. In the first part of our work, a multidisciplinary scientific committee including health professionals and health humanities professionals confirmed the list of selected domains. A second expert panel confirmed their relevance. In the second part of our study, a representative sample of cancer patients also considered all domains relevant. These patients did not identify any missing domains related to our topic. Compared to existing tools, item wording was kept very general, so as not to target any particular problem. Indeed, we wanted a practical tool, to allow patients to easily express his/her priorities and areas in which he/she would need help or support. We also wanted to build a tool that would allow professionals to easily identify patients' difficulties and need for help, in order to facilitate communication during a medical consultation.

Another asset of our work is the rigor with which the items and questions were written. A multidisciplinary expert group reviewed the wording of each item until a high level of consensus was reached using the Delphi method. Finally, the wording and understanding of each item were assessed by patients from a representative sample. Some domains and questions were reworded during the pretest, based on comments or difficulties in understanding expressed by the patients themselves. For example, the item regarding the sense of life and spirituality was modified to avoid reducing this question to religion. Indeed, “spirituality” placed last, induced a stronger link with religion. We limited this bias by reversing the order of wording between “sense of my life” and “spirituality.” This notion was important, especially in the French context with the secular nature of the health system.

The ACCoMPaGNE tool was considered acceptable by all patients. The average completion time was seven minutes, which confirms the feasibility of its use in clinical settings. However, one-third of the included patients considered that the questionnaire was difficult to complete because of the use of a double-entry table. These were patients with a low educational level in 75% of cases. In the literature, there are higher rates of missing responses in patients with a low educational level [23]. This suggests that attention should be paid to this population category. Despite this difficulty, these patients were able to complete the questionnaire. From our

TABLE 2: Importance, problem's intensity and burden, and need for help for each domain in cancer patients involved in the pretest survey ($n = 23$).

Domain	Importance score $\geq 2^a$ (n)	Problem (n)	Problem intensity $\geq 2^b$ (n)	Problem burden $\geq 2^c$ (n)	Need for help (n)
Physical symptoms and adverse effects	18 (78%)	13 (57%)	11 (48%)	12 (52%)	8 (35%)
Emotions, mood	13 (57%)	8 (35%)	6 (26%)	5 (22%)	1 (4%)
Social activities	14 (61%)	7 (30%)	7 (30%)	7 (30%)	2 (9%)
Social role	19 (83%)	4 (17%)	4 (17%)	5 (22%)	2 (9%)
Cope with the disease	13 (57%)	6 (26%)	4 (17%)	3 (13%)	3 (13%)
Social support	18 (78%)	3 (13%)	2 (9%)	3 (13%)	1 (4%)
Medical and social support as a whole	18 (78%)	2 (9%)	1 (4%)	0 (0%)	1 (4%)
Information	17 (74%)	4 (17%)	3 (13%)	2 (9%)	1 (4%)
Communication	19 (83%)	5 (22%)	3 (13%)	2 (9%)	1 (4%)
Financial autonomy	12 (52%)	3 (13%)	3 (13%)	3 (13%)	2 (9%)
Spirituality, sense of life	12 (52%)	4 (17%)	3 (13%)	1 (4%)	2 (9%)
Physical autonomy	11 (48%)	10 (43%)	9 (39%)	9 (39%)	5 (22%)
Decision-making autonomy	19 (83%)	5 (22%)	5 (22%)	3 (13%)	2 (9%)
Body image	12 (52%)	7 (30%)	6 (26%)	6 (26%)	3 (13%)
Intimacy, sexuality	6 (26%)	5 (22%)	4 (17%)	4 (17%)	3 (13%)

^aImportance score: 0 = none, 1 = low, 2 = moderate, and 3 = high; ^bintensity score: 1 = low, 2 = moderate, and 3 = high; ^cburden score: 1 = weak, 2 = moderate, and 3 = strong; ^dfor the need for help question, the percentage corresponds to the rate of patients involved in the study and who want help from health professionals.

point of view, this double-entry system limits the repetition of questions for each individual item and thus reduces the reading effort. However, it can lead to respondent fatigue or errors during completion, especially for items at the bottom of the page. However, the authors chose to keep this layout in order to produce a single-page questionnaire. This original layout seems to be an asset to the questionnaire because it is the most practical format for addressing five questions per domain with 75 total responses. We believe it also increases the likelihood that the tool will be used in current practice, that patients will agree to complete it, and that answers will be taken into account by professionals. In addition, our tool has fewer items than most existing unmet care needs questionnaires.

Five patients had problems with the importance question: two failed to answer, one answered only when a difficulty was present, and two confused importance with the intensity of a perceived difficulty. This may be explained by the way we presented the questionnaire to patients. The stated objective was potentially too focused on the need for help related to a perceived difficulty. It could, therefore, be difficult for the patient to “step back” and answer the important question in a general manner (independently of an existing difficulty). This could also be explained by the hospital's recruitment of patients. Hospitals are places of care where professionals respond to a given medical problem. However, this question seems relevant to us because it assesses the current state of the patient's priorities and concerns. These may evolve over the course of the disease and may detect a change or a possible difficulty in the patient's life [30]. The importance of a domain can also help prioritize the problems for which help is needed.

Compared with existing questionnaires, our tool is the only one to combine four different approaches to address the patient's needs (importance, intensity, distress of a problem, and perceived need for help). As was previously mentioned,

the 3LNQ questionnaire comes close to this objective, but it requires the combined use of the EORTC QLQ-C30 questionnaire. This makes it difficult to use in routine clinical practice, which was our priority. In addition, the 3LNQ questionnaire does not address the question of the importance of the proposed themes. However, it does allow the patient to identify his/her three most important issues [17, 18]. The ACCOmPAGNE tool is also the first original French questionnaire assessing the supportive and palliative care needs of cancer patients. The French version of the SCNS-SF34 obtained in 2012 was the only French questionnaire available until now, obtained from an English version. The proposed items are not exhaustive, and the length of the questionnaire may limit its use in daily clinical practice. It only addresses the question of the need for help and only by a quantitative approach. In addition, this is a retrospective questionnaire (i.e., over the past month) that does not ask the patient about their current care need for help. However, its psychometric properties are recognized as very good and make this tool very relevant in clinical research [16, 23].

We chose to construct a clinical questionnaire with the objective of facilitating communication between the patient and the health professionals and easily identifying the patient's needs. We believe that this can lead to more personalized patient care and to more satisfaction with care. We did not calculate a score from the patient's responses. The ACCOmPAGNE tool is, therefore, not a measurement tool but is closer than a clinimetric one [31]. Moreover, since the items deal with different domains, they form dimensions that do not necessarily have a propensity to be correlated. That is why we did not perform psychometric validation. A complementary study is required to evaluate its clinical validation: (a) on one hand, patients' care pathway and use of supportive and palliative care will be studied in two groups with and without the use of the ACCOmPAGNE tool,

respectively, and (b) on the other hand, patients and medical or nursing professionals will be questioned after a consultation on the interest of using the ACCOmPAgNE tool in order to facilitate communication between them. We hypothesize that its use could ultimately improve patient satisfaction, by personalizing the patient's supportive and palliative care.

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

All authors declare that they have no conflicts of interest.

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Supplementary Materials

The original French version of the ACCOmPAgNE tool is available in Appendix 1. (*Supplementary Materials*)

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