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Prospective Pilot Survey of Bereavement Practices of Cancer Care and Palliative Care Physicians in the Northwest United States

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Introduction

Physicians caring for patient's with cancer will frequently encounter individuals who die from their disease. The primary objective of this study is to examine the frequency and nature of bereavement practices among cancer care and palliative care physicians in the Pacific Northwest United States. Secondary objectives include identification of factors and barriers associated with bereavement follow up.

Methods

Eligible subjects included attending radiation oncologists, medical oncologists (including pediatric oncologists), surgical oncologists (including surgical subspecialties) and palliative care or hospice physicians directly involved in patient care in Alaska, Idaho, Montana, Oregon, Washington and Wyoming. Subjects were identified through 2010 membership directory listings of the American Society of Clinical Oncology (ASCO), American Society for Therapeutic Radiology and Oncology (ASTRO) and the American Academy of Hospice and Palliative Medicine (AAHPM). Potential participants were contacted via email and post card in October of 2010 and invited to complete an anonymous online survey.

Comparison of bereavement practices between palliative care physicians, medical oncologists and radiation oncologists was performed using Fisher's exact test with a predefined level of significance of $p \leq 0.05$. We considered physician initiated telephone calls, sending of condolence letter/card and attending funerals as active forms of bereavement follow up. A binary measure summarizing participation in active bereavement practices was derived for each physician by assigning a score of 1 to 5 to the Likert scale responses of "never" to "always", respectively. Each physician's responses to the three active practices items were summed and then divided by 3 to obtain a mean active bereavement score. This mean score was then dichotomized into ≥3 (sometimes, usually, or always) and <3 (rarely or never).

Univariate and multivariate logistic regression was used to explore possible predictors of active bereavement practices (mean active bereavement score ≥ 3). Multivariate analysis was conducted using stepwise selection method with cutoffs of $p \leq 0.25$ for entry into the model and $p \leq 0.05$ to remain in the model.

Results

Characteristics

A total 194 out of 856 contacted potential subjects accessed the online survey tool for an overall response rate of 22.7%. Four respondents declined further participation at the electronic consent statement. Excluded subjects included 23 respondents who were not attending physicians and three respondents who were not currently involved in direct patient care. Following these exclusions, a total of 164 subjects (19.1%) met inclusion criteria. Basic demographics are presented in Table 1.

Table 1: Characteristics of Respondents (N=164)

Demographic	n (%)
Sex	
Female	56 (34%)
Male	107 (66%)
Median age (range), years	52 (32-73)
Ethnicity	
Asian	13 (8%)
Hispanic/Latino	4 (2%)
White/Caucasian	142 (88%)
Other	3 (2%)
Religion	
Christian	68 (42%)
Jewish	14 (9%)
Hindu	1 (1%)
Other	12 (7%)
Unaffiliated (atheist, agnostic, etc)	57 (35%)
Prefer not to answer	10 (6%)
Specialty	
Medical Oncology	67 (41%)
Palliative Care	40 (24%)
Radiation Oncology	36 (23%)
Surgical Oncology	8 (5%)
Pediatric Oncology	5 (3%)
Other	7 (4%)
Tenure as Staff Physician, y	
≤5	29 (18%)
5-10	29 (18%)
11-15	21 (13%)
>15	85 (51%)
Practice Location	
Community Hospital	64 (39%)
Academic Hospital	39 (24%)
Cancer Center	40 (25%)
Other	20 (12%)
Palliative Care Program	
Yes	131 (80%)
No	31 (19%)
Unsure	2 (1%)
Bereavement Program	
Yes	74 (45%)
No	66 (40%)
Unsure	24 (15%)

Table 1: Characteristics of Respondents (N=164); continued

Demographic	n (%)
Average Work Hours per week	
≤40	28 (17%)
41-50	43 (26%)
51-60	51 (31%)
61-70	26 (16%)
>70	16 (10%)
New Patients per week	
≤5	39 (24%)
6-10	86 (53%)
11-15	17 (10%)
16-20	6 (4%)
>20	14 (9%)
Percentage of patients with advanced illness	
≤25	78 (48%)
26-50	48 (30%)
51-75	9 (5%)
>75%	27 (17%)
Average deaths per month, Median (range)	4 (0-60)
Percentage of time spent on patient care	
≤25	18 (11%)
26-50	20 (12%)
51-75	26 (16%)
>75%	99 (61%)
Percentage of time spent on research	
≤25	133 (83%)
26-50	16 (10%)
51-75	6 (4%)
>75%	4 (3%)

Bereavement Practices

Overall, 89.4% of respondents reported that they would always or usually be available to answer phone calls from a patient's family or caregiver (Figure 1). When focusing on active bereavement practices, 69.8% of respondents reported always or usually performing at least one of the activities of making a telephone call to families, sending a condolence letter or attending a funeral service. Between specialties, medical oncologists were more likely to report always or usually placing a telephone call to family and sending a condolence letter. Referral to bereavement support groups was most frequently reported by palliative care physicians (Table 2).

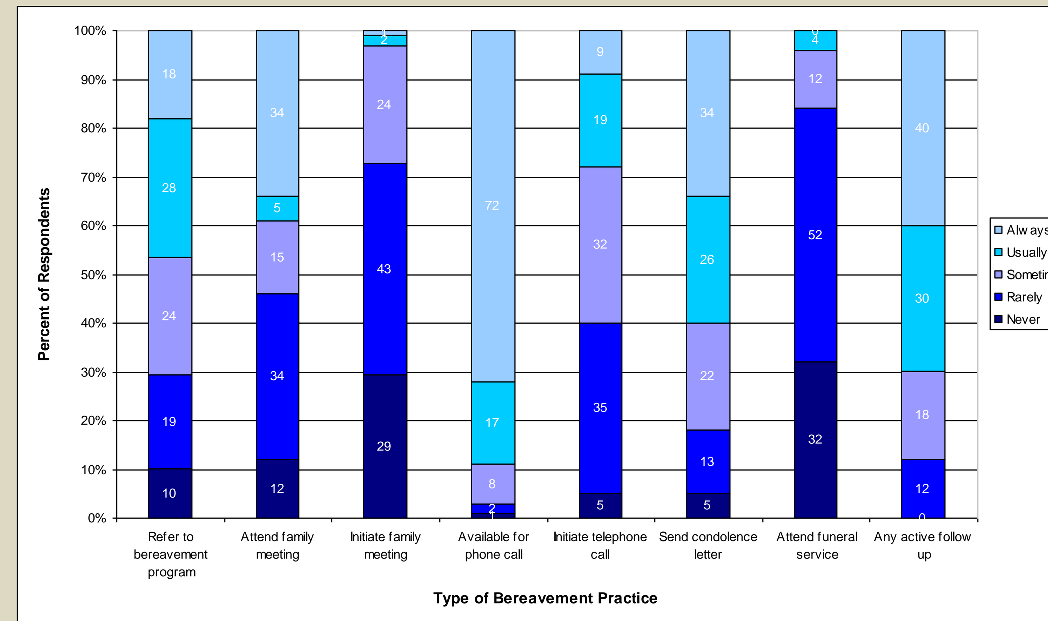

Figure 1: Frequency of Surveyed Bereavement Practices

Table 2: Frequency of Bereavement Practices According to Specialty, n (%)

Bereavement Practice	Radiation Oncologists (N=37)	Medical Oncologists (N=72)	Palliative Care Physicians (N=40)	p-value
Telephone call to family				
Always/Usually	4 (11.1)	30 (42.3)	6 (15.0)	0.002
Sometimes	15 (41.7)	21 (29.6)	13 (32.5)	
Rarely	13 (36.1)	17 (23.9)	20 (50.0)	
Never	4 (11.1)	3 (4.2)	1 (2.5)	
Send condolence letter				
Always/Usually	12 (33.3)	51 (71.8)	22 (55.0)	0.004
Sometimes	13 (36.1)	13 (18.3)	7 (17.5)	
Rarely	9 (25.0)	5 (7.0)	8 (20.0)	
Never	2 (5.6)	2 (2.8)	3 (7.5)	
Attend funeral/memorial				
Always/Usually	0 (0.0)	3 (4.2)	2 (5.0)	0.002
Sometimes	3 (8.3)	7 (9.9)	6 (15.0)	
Rarely	12 (33.3)	39 (54.9)	27 (67.5)	
Never	21 (58.3)	22 (31)	5 (12.5)	
Initiate family meeting				
Always/Usually	2 (5.6)	2 (2.8)	1 (2.6)	0.90
Sometimes	8 (22.2)	16 (22.5)	9 (23.1)	
Rarely	13 (36.1)	33 (46.5)	19 (48.7)	
Never	13 (36.1)	20 (28.2)	10 (25.6)	
Attend requested meeting				
Always/Usually	10 (28.6)	29 (41.4)	16 (40.0)	0.73
Sometimes	8 (22.9)	11 (15.7)	5 (12.5)	
Rarely	12 (34.3)	24 (34.3)	13 (32.5)	
Never	5 (14.3)	6 (8.6)	6 (15.0)	
Available to answer phone calls				
Always/Usually	32 (91.4)	64 (91.4)	32 (80.0)	0.40
Sometimes	3 (8.6)	5 (7.1)	5 (12.5)	
Rarely	0 (0.0)	1 (1.4)	2 (5.0)	
Never	0 (0.0)	0(0)	1 (2.5)	
Refer to support program/group				
Always/Usually	12 (33.3)	27 (38.0)	30 (75.0)	0.002
Sometimes	8 (22.2)	22 (31.0)	4 (10.0)	
Rarely	11 (30.6)	13 (18.3)	5 (12.5)	
Never	5 (13.9)	9 (12.7)	1 (2.5)	

Table 3: Opinions Regarding Patients and Bereavement Follow Up According to Specialty, n (%)

Opinion	Radiation Oncologists (N=37)	Medical Oncologists (N=72)	Palliative Care Physicians (N=40)	p-value
Tend to get attached to patients				
Strongly Disagree or Disagree	7 (19.4)	4 (5.6)	1 (2.5)	0.003
Neutral	7 (22.2)	12 (16.9)	17 (42.5)	
Agree or Strongly Agree	21 (58.3)	55 (77.5)	22 (55.0)	
Prefer not to show true feeling				
Strongly Disagree or Disagree	28 (77.8)	60 (84.5)	38 (95.0)	0.23
Neutral	5 (13.9)	7 (9.9)	2 (5.0)	
Agree or Strongly Agree	3 (8.3)	4 (5.6)	0 (0.0)	
Like to meet family members				
Strongly Disagree or Disagree	0 (0.0)	1 (1.4)	0 (0.0)	0.50
Neutral	4 (11.1)	4 (5.6)	1 (2.5)	
Agree or Strongly Agree	32 (88.9)	66 (93.0)	35 (97.5)	
Like to treat family unit				
Strongly Disagree or Disagree	3 (8.3)	2 (2.8)	0 (0.0)	0.003
Neutral	7 (19.4)	5 (7.0)	0 (0.0)	
Agree or Strongly Agree	26 (72.2)	64 (90.1)	40 (100.0)	
Physicians have responsibility to write condolence letter				
Strongly Disagree or Disagree	15 (41.7)	20 (28.2)	10 (25.0)	0.001
Neutral	17 (47.2)	17 (23.9)	18 (45.0)	
Agree or Strongly Agree	4 (11.1)	34 (47.9)	12 (30.0)	
Feel anxious speaking to family after patient death				
Strongly Disagree or Disagree	20 (55.6)	46 (64.8)	35 (87.5)	0.02
Neutral	9 (25.0)	11 (15.5)	2 (5.0)	
Agree or Strongly Agree	7 (19.4)	14 (19.7)	3 (7.5)	
Feel sense of failure				
Strongly Disagree or Disagree	25 (69.4)	53 (74.7)	39 (97.5)	0.001
Neutral	7 (19.4)	5 (7.0)	1 (2.5)	
Agree or Strongly Agree	4 (11.1)	13 (18.3)	0 (0.0)	
Received adequate bereavement training in residency/fellowship				
Strongly Disagree or Disagree	25 (69.4)	47 (66.2)	28 (71.8)	0.14
Neutral	8 (22.2)	12 (16.9)	2 (5.1)	
Agree or Strongly Agree	3 (8.3)	12 (16.9)	9 (23.1)	

Physician Opinions

The majority of physicians in each specialty agreed that they like to meet a patient's family and treat patients as part of a family unit. Palliative care physicians reported the lowest frequency of feeling anxious speaking to families following a death (Table 3). The majority of respondents in each specialty (68.3% overall) did not feel that they had received adequate training on bereavement follow up during their residency or fellowship training.

Table 4: Frequency of Perceived Barriers to Bereavement Follow Up Reported as "Important", "Very Important" or "Somewhat Important", n (%)

Perceived Barrier	Radiation Oncologists (N=37)	Medical Oncologists (N=72)	Palliative Care Physicians (N=40)
Lack of time	25 (69.4)	45 (65.2)	23 (57.5)
Lack of bereavement support services	18 (50.0)	31 (44.9)	8 (20.0)
Uncertain which family member to contact	20 (54.3)	20 (28.2)	11 (27.5)
Uncomfortable about what to say	18 (50.0)	22 (31.0)	4 (10.0)
Fear of burnout	11 (30.6)	18 (25.4)	6 (15.0)
Guilt about the patient's death	6 (16.7)	8 (11.3)	0 (0.0)
Have no legal responsibility to do so	4 (11.1)	1 (1.4)	1 (2.5)

Perceived Barriers and Needs from Bereavement Programs

The most commonly perceived barrier of bereavement follow up among all specialties was lack of time (Table 4). Of those services surveyed, respondents believed that providing a list of bereavement support services available in the community and identifying the appropriate family member to contact were the most important services that a bereavement program might offer.

Table 5: Logistic Regression of Predictors of Frequency Active Bereavement Activities

Characteristic	Univariate Analysis: Odds Ratio	Univariate Analysis: p-value	Multivariate Analysis: Odds ratio	Multivariate Analysis: p-value
Age (each additional year)	1.03	0.09	NR	NS
Sex				
Male	1 [ref]		NR	
Female	1.44	0.29	NR	NS
Specialty				
Palliative Care	1 [ref]		1 [ref]	
Medical Oncology	2.54	0.02	4.68	0.005
Radiation Oncology	0.37	0.05	0.79	0.69
Practice duration				
<=15 yrs	1 [ref]		NR	
>15yrs	1.88	0.06	NR	NS
Academic status				
Nonacademic	1 [ref]		NR	
Academic	1.38	0.42	NR	NS
Palliative care program				
No/Don't know	1 [ref]		1 [ref]	
Yes	3.00	0.02	3.24	0.03
Bereavement care program				
No/Don't know	1 [ref]		NR	
Yes	1.57	0.17	NR	NS
Hours worked per week				
<40 hours	1 [ref]		NR	
40-60 hours	1.35	0.52	NR	NS
>60 hours	4.04	0.01	NR	NS
New Patient's per week				
≥ 6	1 [ref]		NR	
< 5	1.18	0.67	NR	NS
Percent of patient's with poor prognosis				
≤ 25	1 [ref]		NR	
26-75	0.64	0.23	NR	NS
>75	0.74	0.52	NR	NS
Percent of time spent on patient care				
≤ 25	1 [ref]		NR	
26-75	0.50	0.23	NR	NS
>75	0.69	0.48	NR	NS
Each additional patient death	0.99	0.56	NR	NS
Opinion Predictors				
Tend to get attached to patients				
≤ Disagree	1 [ref]		NR	
≥ Agree	5.89	0.03	NR	NS
Prefer not to show patients true feelings				
≤ Disagree	1 [ref]		NR	
≥ Agree	1.42	0.69	NR	NS
Like to meet my patient's family members				
≤ Disagree	1 [ref]		NR	
≥ Agree	<0.001	0.98	NR	NS
Tend to treat patients as part of a family unit				
≤ Disagree	1 [ref]		NR	
≥ Agree	1.55	0.31	NR	NS
Have responsibility to write condolence letter				
≤ Disagree	1 [ref]		1 [ref]	
≥ Agree	6.33	<0.001	6.62	0.001
Feel anxious speaking to family members				
≤ Disagree	1 [ref]		NR	
≥ Agree	0.67	0.56	NR	NS
Feel a sense of failure after a patient's death				
≤ Disagree	1 [ref]		NR	
≥ Agree	2.8	0.09	NR	NS
Received adequate training on bereavement follow-up during residency/fellowship				
≤ Disagree	1 [ref]		NR	
≥ Agree	1.58	0.41	NR	NS
Perceived Barriers				
Lack of time				
Not Important	1 [ref]		NR	
Important	0.87	0.68	NR	NS
Lack of bereavement support resources				
Not Important	1 [ref]		1 [ref]	
Important	0.63	0.18	0.38	0.04
No legal responsibility to contact family				
Not Important	1 [ref]		NR	
Important	0.20	0.14	NR	NS
Feel uncomfortable about what to say				
Not Important	1 [ref]		1 [ref]	
Important	0.42	0.02	0.31	0.03
Fell guilty about patient's death				
Not Important	1 [ref]		NR	
Important	1.42	0.54	NR	NS
Unsure who to contact				
Not Important	1 [ref]		NR	
Important	0.62	0.17	NR	NS
Fear of burnout				
Not Important	1 [ref]		NR	
Important	0.84	0.66	NR	NS

Logistic Regression Analysis

Multivariate analysis demonstrated the specialty of medical oncology, presence of a palliative care program and belief that physicians have a responsibility to write a condolence letter were positive predictors of active bereavement follow up. Feeling uncomfortable about what to say in addition to lack of bereavement support services were significant negative predictors of active bereavement follow up

Conclusions

Greater than two-thirds of respondents in our regional domestic survey reported regularly participating in some form of active bereavement follow up. Multivariate analysis demonstrated that relative to palliative care physicians, medical oncologists were more likely to engage in some form of active bereavement follow up. The majority of those surveyed reported that they lacked adequate training regarding bereavement activities during residency or fellowship.

While the role of the physician in bereavement follow up is not clearly defined, efforts to improve communication, identify available resources and address bereavement activities in postgraduate training and maintenance of certification may, in part, lead to improved multidisciplinary treatment of cancer patients, their families and caregivers.