Physician caring for patients 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 subspecialists) and palliative care or oncology 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 (AAPHM). Potential participants were contacted via email and post card in October 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 the Likert scale responses of “never” to “always”, respectively. Each physician’s responses in 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 $\leq 3$ (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 $\geq 3$). 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

A total 194 out of 856 contacted potential subjects accessed the online survey tool for an overall response rate of 22%. 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.

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).

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% overall) did not feel that they had received adequate training on bereavement follow up during their residency or fellowship training.

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.

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.