

Journal Watch

Prepared by: Sharon Watanabe, MD

Presented at: Journal Club, Cross Cancer Institute

Title: Jackson VA, Mack J, Matsuyama R, Lakoma MD, Sullivan AM, Arnold RM, Weeks JC, Block SD. A qualitative study of oncologists' approaches to end-of-life care. *J Palliat Med* 2008; 11:893-906.

Abstract: Purpose: To understand how oncologists provide care at the end of life, the emotions they experience in the provision of this care, and how caring for dying patients may impact job satisfaction and burnout. Participants and methods: A face-to-face survey and in-depth semistructured interview of 18 academic oncologists who were asked to describe the most recent inpatient death on the medical oncology service. Physicians were asked to describe the details of the patient death, their involvement with the care of the patient, the types and sequence of their emotional reactions, and their methods of coping. Grounded theory qualitative methods were utilized in the analysis of the transcripts. Results: Physicians, who viewed their physician role as encompassing both biomedical and psychosocial aspects of care, reported a clear method of communication about end-of-life (EOL) care, and an ability to positively influence patient and family coping with and acceptance of the dying process. These physicians described communication as a process, made recommendations to the patient using an individualized approach, and viewed the provision of effective EOL care as very satisfying. In contrast, participants who described primarily a biomedical role reported a more distant relationship with the patient, a sense of failure at not being able to alter the course of the disease, and an absence of collegial support. In their descriptions of communication encounters with patients and families, these physicians did not seem to feel they could impact patients' coping with and acceptance of death and made few recommendations about EOL treatment options. Conclusion: Physicians' who viewed EOL care as an important role described communicating with dying patients as a process and reported increased job satisfaction. Further research is necessary to determine if educational interventions to improve physician EOL communication skills could improve physician job satisfaction and decrease burnout.

Strengths/uniqueness: This qualitative study provides insight into the perspectives of oncologists towards providing EOL care. The survey instrument was developed based on the literature and findings of a focus group of medical residents. The research group included representation from oncology, palliative care and psychology.

Weaknesses: The authors appropriately identified the limitations of their study. The participants were drawn from a highly specialized setting and the sample size was small, limiting generalizability of the findings. The analysis was based on physicians' recollections of the most recent death, which may not necessarily be representative of their actual practice or experiences of deaths generally. There is no information on patients' perceptions of the communication and care provided.

Implications for Palliative Care: The description of the two “types” of oncologist makes intuitive sense, and probably could be extrapolated to physicians practicing in other fields of medicine. It is unclear if success with communication experiences shapes physician attitudes towards EOL care, or vice versa. Nonetheless, educational efforts to increase physician comfort level with discussing EOL issues are worthy of consideration. Another issue is the relationship between the palliative care team and the referring physician. In an accompanying commentary, the editor suggests that it is important for the palliative care team to “diagnose” the “type” of oncologist with whom they are working. Oncologists who are comfortable with and derive satisfaction from EOL care should be allowed to assume a greater role in the care; for other oncologists, it may be appropriate for the palliative care team to take on more responsibility. Ultimately, physicians may not fit neatly into either “type”, highlighting the need for the palliative care team to individualize how it works with referring physicians.