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Bereavement Practices Among Head and Neck Cancer Surgeons

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Abstract

Objectives: Head and neck cancer surgeons frequently interact with dying patients with advanced disease and their families, but little is known about their bereavement practices after a patient's death. The aim of this study is to elucidate the frequency of common bereavement practices, cited barriers to bereavement, and predictive physician factors that lead to an increase in bereavement practices among head and neck cancer surgeons.

Methods: A 20-item survey was sent to 827 active surgeons of the American Head and Neck Society. Approval was obtained and the survey was distributed through the American Head and Neck Society. Demographics, frequency of common bereavement practices, empathy, and barriers were assessed. Multiple linear regression was performed to determine physician factors associated with more frequent bereavement follow-up.

Results: There were 156 respondents (18.9% response rate). Overall, surgeons were more likely to usually/always call (48.5%) or send a letter (42.4%) compared with other practices such as attending funerals (0%), offering family meetings (18.6%), or referring family members to counseling (7.7%). Many barriers were cited as being at least somewhat important: being unaware about a patient's death (67.3%) was the most cited, whereas 51.3% cited a lack of mentorship/

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Additional supporting information may be found in the online version of this article.

This study was presented as a poster presentation at the Virtual AHNS 10th International Conference on Head and Neck Cancer "Survivorship through Quality" and at the end of Innovation on July 22–25, 2021, virtually. (Abstract submission P084)

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training in this area. Scoring higher on empathy questions ($P = .001$) was associated with more frequent surgeon bereavement follow-up with the family of deceased patients.

Conclusion: There is substantial practice variation among surgeons suggesting a lack of consensus on their roles in bereavement follow-up. Having higher empathy was predictive of higher engagement.

Keywords

Bereavement; cancer; death; head and neck; survey

INTRODUCTION

Despite substantially improved treatment options for patients with head and neck cancer, the 5-year overall survival is about 66%.¹ In 2021, it is estimated that 14,620 deaths will occur due to head and neck cancer in the United States.² Consequently, head and neck cancer surgeons will frequently interact with dying patients and their loved ones.

Bereavement follow-up after losing a patient is considered important for oncologic physicians, as families will experience various degrees of grief and therefore need help to cope with a loss.³ It has been reported that 46%–70% of caregivers of patients with advanced cancer desire bereavement follow-up.^{4,5} Recently, the American Heart Association/American Stroke Association provided policy statements urging its members to provide support to the family members of deceased patients, recognizing the importance of bereavement support in patients with advanced disease.⁶ Bereavement practices such as writing condolence letters, calling family members, and attending funerals after the death of a patient have been studied in multiple specialties including palliative care, medical oncology, radiation oncology, and surgical oncology,⁷ but have not been studied within otolaryngology.

Head and neck surgeons develop long-term relationships with their patients and are uniquely positioned to provide support for the caregivers of their deceased patients. Despite this important component of a head and neck cancer surgeon's practice, little is known about their bereavement practices and therefore a greater insight and understanding is warranted, especially in the setting of increased awareness of burnout within the field.^{8,9}

The aim of this study is to elucidate the frequency of common bereavement practices, cited barriers to bereavement, and predictive physician factors that lead to an increase in bereavement practices among head and neck cancer surgeons.

MATERIALS AND METHODS

Survey Design

A 20-item anonymous survey was formulated by the head and neck oncology team in conjunction with a palliative care physician at UC Davis. A final version was approved by our institution's Institutional Review Board and the American Head and Neck Society (AHNS) review committee. The survey was disseminated online through REDCap to all

active AHNS members between June 22, 2020, and July 6, 2020 in three separate emails per AHNS protocol. AHNS cancer surgeons were included in the study, whereas non-surgical respondents and incomplete surveys were excluded.

The survey aimed to explore demographics, frequency of common bereavement practices, physician opinions, and perceived barriers of bereavement practices. We asked bereavement practices and physician opinion questions commonly assessed in the literature for other specialties that also evaluated bereavement.^{7,10–13} We asked questions related to empathy that were scored from 0 to 4 corresponding from “strongly disagree” to “strongly agree,” and averaged these scores to correlate with bereavement activity for multiple linear regression analysis.

Statistical Analysis

Categorical variables were summarized as counts and percentages and quantitative variables as means and standard deviations (SD). Multiple linear regression analysis was performed to examine the relationship between bereavement activity and physician factors of gender, years in practice (0–5, 6–10, 11–20, >20 years), work setting (academic, non-academic), percentage of patients with head and neck cancer (0%–25%, 26%–50%, 51%–75%, and 76%–100%) and their average empathy score. All statistical tests were two-sided and evaluated at a significance level of .05. Statistical analyses were conducted with R version 4.0 (R Project for Statistical Computing).

RESULTS

Demographics

Of the 827 active AHNS surgeons, there were 156 respondents meeting inclusion criteria (18.9% response rate), in line with other recently published surveys distributed through AHNS.^{14,15} The majority of respondents were male (75.0%), >20 years in practice (37.2%), working in academic centers (72.4%), and having a practice of mostly head and neck cancer patients (71.2%). These findings are summarized in Table I.

Bereavement Practices and Physician Opinions

Frequencies of different bereavement practices and physician opinions are summarized in Table II. The two most common bereavement follow-up practices were calling or sending a condolence letter to a caregiver; respondents indicated usually or always 46.8% and 42.9%, respectively. Funerals or memorial services were rarely or never attended by 87.2% of respondents. With respect to referral practices, 39.8% of respondents at least sometimes referred caregivers to counselors or support groups, whereas 37.8% of respondents offered family meetings. Most respondents (81.4%) reported they tend to get attached to their patients and practice bereavement care (74.3%) to show respect to families. A quarter of respondents practice bereavement care as part of self-care. Two-thirds of respondents do not question whether they should continue caring for head and neck cancer patients, whereas 17.3% sometimes question this.

Perceived Barriers to Bereavement Care

Respondents' opinions regarding barriers to practicing bereavement care are summarized in Table III. Of the barriers asked, 46.1%–67.3% of respondents indicated these to be at least somewhat important to practicing bereavement. Being unaware about the death of a patient was the most endorsed barrier, whereas being uncomfortable with what to say was the least cited. A lack of training or mentorship in bereavement was cited as being at least somewhat important by 51.3% of respondents.

Factors Associated with Bereavement Care

The results of the multiple linear regression analysis examining factors associated with the bereavement activity are summarized in Table IV. Respondents' demographics were not statistically significant predictors, whereas a higher empathy level was associated with a higher bereavement activity ($P < .001$). The empathy level was the average score the following questions in Table III: "I tend to get attached to my patients," "I feel guilty after a patient's death," "I do bereavement practices as part of self-care," and "I do bereavement practices to show respect to families."

DISCUSSION

This is the first study to explore bereavement follow-up practices among head and neck cancer surgeons, which is an important first step to understand the roles surgeons have in bereavement care. Our results demonstrate there is substantial variation among head and neck cancer surgeons, with an overall low average of bereavement follow-up being practiced. However, nearly half of respondents indicated that they usually or always call or write a letter to the caregivers of their deceased patients, whereas funeral attendances are rare. Being unaware about a patient's death was the most common cited barrier. The only factor associated with increased bereavement engagement was having a higher level of agreement to questions related to empathy.

Interestingly, the rates in our study of making phone calls, writing condolence letters, and initiating family meetings were higher among head and neck surgeons compared with palliative care specialists, medical oncologists, surgical oncologists, and radiation oncologists in two large studies.^{10,12} The differences may be explained by our study results demonstrating that 81.4% of surgeons felt attached to their patients, whereas only 49.7%–58.0% of respondents felt attached in Chau et al. study.¹⁰ No respondents in our study regularly attended funerals, whereas 0.5% to 4.0% of respondents from various specialties that manage cancer patients indicated that they regularly attended funerals.^{10,12,13} Being female, working in an academic setting, having a higher number of patient deaths per month, and having access to bereavement programs are factors identified by Chau et al. that may influence bereavement practices.¹⁰ Our results did not demonstrate any physician demographic to be predictive of increased bereavement practice. Interestingly, Kusano et al. who assessed 123 physicians who were mostly specialized in palliative care (41%) and radiation oncology (23%) more frequently referred family members to bereavement counselors (46%) compared with our respondents (8.6%).¹³ This represents an opportunity

for head and neck surgeons to consider for patients who are often in need of bereavement support.

There are only three studies to our knowledge that explore bereavement practices among surgeons.^{12–14} Two of the studies do not analyze the responses from the surgical oncologists due to low numbers.^{12,13} One study from Australia of 78 surgical oncologists who evaluated funeral attendance showed that 52% of respondents have attended at least one funeral in their career but was not a common practice.¹⁴ This result is comparable to our study in that 44.9% of respondents have attended a funeral but it is something that is mostly rarely or never done. Although bereavement patterns have been well studied in palliative care and medical specialties, there is a need to further study difference among surgeons.

A lack of time, need to maintain boundaries, lack of training, and being unaware about a patient's death were all barriers cited by at least half of respondents as being somewhat important to very important to practicing bereavement. Physicians have many constraints with busy practices, which could limit the frequency of bereavement care offered. Interestingly, most of our respondents practiced bereavement to show respect to their patients' families compared with only a quarter doing this as part of self-care. Self-care is an important aspect of being a physician, especially in a field that is burdened by high rates of burnout.^{8,16} The death of a patient can also allow cancer clinicians opportunity for self-reflection to ameliorate the stress that caring for dying patients can bring to personal and professional lives. Some oncologists have encouraged reading, reflecting, and sharing stories as way for professional and personal growth as well as strengthening therapeutic skills for patient care.¹⁷

Bereavement care is a poorly understood topic that is not widely discussed among physicians, especially trainees. It is important to highlight that 51.3% of respondents cited a lack of training or mentorship in bereavement care as being at least somewhat important to very important as a barrier of practicing it. This result indicates there is a need to incorporate such discussions with medical students, residents, and fellows to train physicians who are adept at providing bereavement care for the caregivers and family members who tend to desire such actions from their physicians.^{4,5} Medical societies are recognizing that bereavement care is an essential part of the patient–physician relationship and have started to urge their members to offer such care to families after patients die.⁶ Historically, surgeons have been viewed as being callused, but there is growing awareness that patients desire empathy and bereavement especially at the end of life for which surgeons are uniquely positioned to deliver.

Our study has several limitations including selection and nonresponse bias, which are inherent in survey studies. This was a non-validated survey instrument that was curated with the assistance of four head and neck cancer surgeons and one palliative care physician from a single institution by selecting pertinent questions from previously published studies on this topic.^{7,10–13} There were other bereavement practices, opinions, potential barriers that we did not assess, which could have been important for some respondents; however, this could have potentially limited our response rate if the survey was too lengthy. The respondents of this study may not represent the entire population of head and neck surgeons; although

most respondents cited having practices composed of mostly head and neck cancer patients, 28.8% of respondents have practices caring for <50% of patients with cancer. Our study's response rate was low but acceptable at 18.9%, which is comparable to other AHNS studies recently published.^{15,18}

CONCLUSION

There is substantial variation regarding bereavement follow-up being practiced by head and neck cancer surgeons after a patient's death. However, nearly half will call or write a letter to the family most of the time, which is a higher communication rate than other cancer specialties. A lack of time, need to maintain boundaries, lack of training, and being unaware about a patient's death were all barriers cited by at least half of respondents as being somewhat important to very important to practicing bereavement. Further research is required to define the role of head and neck cancer surgeons in bereavement care and the preferences of caregivers after a loss.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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TABLE I.

Respondents' Demographics.

	Respondents (%), n = 156
Gender	
Male	117 (75.0)
Female	39 (25.0)
Years in practice	
0–5	46 (29.5)
6–10	30 (19.2)
11–20	22 (14.1)
>20	58 (37.2)
Practice environment	
Academic	113 (72.4)
Non-Academic	43 (27.6)
% of patients with HN cancer	
0–25	15 (9.6)
26–50	30 (19.2)
51–75	39 (25.0)
>75	72 (46.2)

TABLE II.

Frequency of Bereavement Practices and Physician Opinions.

	Respondents %
Phone call to family	
Never	11 (7.3)
Rarely	27 (17.6)
Sometimes	42 (26.7)
Usually	49 (31.5)
Always	27 (17.0)
Send a letter	
Never	32 (20.6)
Rarely	28 (18.2)
Sometimes	30 (18.8)
Usually	38 (24.2)
Always	28 (18.2)
Attend a funeral/memorial	
Never	84 (53.9)
Rarely	49 (31.5)
Sometimes	21 (13.3)
Usually	2 (1.2)
Always	0.0
Offer a meeting with family	
Never	49 (31.5)
Rarely	45 (29.1)
Sometimes	30 (19.4)
Usually	22 (13.9)
Always	10 (6.1)
Refer family to counselor/support group	
Never	54 (34.4)
Rarely	38 (24.5)
Sometimes	50 (32.5)
Usually	10 (6.1)
Always	4 (2.5)
I tend to get attached to my patients	
Disagree or strongly disagree	8 (5.4)
Neutral	22 (13.9)
Agree or strongly agree	126 (80.6)
I feel guilty after a patient's death	
Disagree or strongly disagree	56 (36.4)
Neutral	44 (27.9)
Agree or strongly agree	56 (35.8)
I do bereavement practices as part of self-care	

	Respondents %
Disagree or strongly disagree	78 (49.7)
Neutral	37 (23.9)
Agree or strongly agree	41 (26.4)
I do bereavement practices to show respect to families	
Disagree or strongly disagree	21 (13.5)
Neutral	18 (11.7)
Agree or strongly agree	117 (74.8)
I sometimes question whether I should continue treating cancer patients	
Disagree or strongly disagree	105 (67.5)
Neutral	25 (16.0)
Agree or strongly agree	26 (16.5)

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TABLE III.

Barriers to Bereavement.

	Respondents (%)
Lack of time	
Not important at all	32 (20.5)
Not important	39 (25.0)
Somewhat important	49 (31.4)
Important	34 (21.8)
Very important	2 (1.3)
Need to maintain barriers	
Not important at all	24 (15.4)
Not important	36 (23.1)
Somewhat important	50 (32.1)
Important	39 (25.0)
Very important	7 (4.5)
Unaware about the death of a patient	
Not important at all	20 (12.8)
Not important	31 (19.9)
Somewhat important	59 (37.8)
Important	34 (21.8)
Very important	12 (7.7)
Discomfort with what to say	
Not important at all	32 (20.5)
Not important	52 (33.3)
Somewhat important	40 (25.6)
Important	23 (14.7)
Very important	9 (5.8)
Lack of training/mentorship in this area	
Not important at all	37 (23.7)
Not important	39 (25.0)
Somewhat important	41 (26.3)
Important	29 (18.6)
Very important	10 (6.4)

TABLE IV.

Results of Multiple Linear Regression Relating Physician Characteristics to Bereavement Activity Score.

Physician Characteristics	P-Value*
Gender	.17
Years in practice	.31
Practice environment	.45
% of patients with HN cancer	.5
Empathy level	<.001

* P-values are Type III sum of squares F-tests.

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