Confronting Oncologists’ Emotions

I was exceptionally pleased to read Morgans and Schapira’s [1] paper, “Confronting Therapeutic Failure: A Conversation Guide,” in The Oncologist.

As the authors document, the oncologist’s awareness of patient affect has been associated with increased patient satisfaction and better care. This point has been well-documented in the medical literature, but what made Morgans and Schapira’s [1] paper innovative is the recognition that oncologists’ awareness of their own emotional responses to patients is crucially important in ensuring good quality patient care, particularly around end-of-life communication. This is a conversation that oncologists urgently need to be having. A recent study found, for example, that many patients do not receive the care they want at end of life due to lack of communication with the physician about their preferences [2]. The study found that patients who relied on designated health care proxies (compared with those who had end-of-life conversations with the physician) were frequently treated with aggressive interventions at end of life [2].

In addition, my own research corroborates the authors’ views about the importance of acknowledging oncologists’ emotional reactions in clinical practice in the context of patient care. My work looked at oncologists’ responses to patient death in Canadian and Israeli adult and pediatric oncologists using mixed methods [3–12]. What was common across the patient populations and cultures was that the grief that resulted when patients died included emotional, physical, and cognitive symptoms. This grief had an impact on oncologists’ personal and professional lives, including affecting decisions about patient care and withdrawing emotionally and sometimes physically from patients at end of life. In essence, although this research examined grief in response to patient loss, the subtext of these studies is looking at relationships and attachments to patients. To my knowledge, Morgans and Schapira [1] are some of the few clinicians to openly acknowledge the issue of attachment in the context of patient communication. Their paper magnifies what all oncologists know and what my participants consistently tell me: the best and worst part of practicing oncology is the attachment to patients. Without this attachment, the work would be unbearable and unsatisfying. With this attachment, however, comes the pain of loss when patients die, suffer from a disabling loss of function, experience a “bad death,” or run into therapeutic failure.

Morgans and Schapira’s [1] paper can serve as a catalyst for all oncologists and health care professionals to begin addressing this tension between attachment to patients and the pain that comes when they die or suffer. As the authors suggest, the SPIKES (setting, perception, invitation for information, knowledge, empathy, summarize and strategize) model, a patient-centered communication protocol for delivering bad news, can be an effective strategy for oncologists to use when facing this emotional labor in their work. In addition, given the significant challenges of dealing with physician emotion in the oncology context, oncologists need education and training about how to manage emotional responses throughout their careers. Such education would provide oncologists with both the necessary skills to deal with patient death and validation that these feelings are normal, expected, and part of the work involved with caring for oncology patients.

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REFERENCES

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