RESEARCH ARTICLE

Palliative Care Education in Gynecologic Oncology: a Survey of Gynecologic Oncologists and Gynecologic Oncology Fellows in Thailand

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Abstract

Background: The main purpose of this study was to survey the education and training of certified gynecologic oncologists and fellows in Thailand. A secondary objective was to study the problems in fellowship training regarding palliative care for gynecologic cancer patients. Materials and Methods: A descriptive study was conducted by sending a questionnaire regarding palliative care education to all certified gynecologic oncologists and gynecologic oncology fellows in Thailand. The contents of the survey included fellowship training experience, caring for the dying, patient preparation, attitudes and respondent characteristics. Statistics were analyzed by percentage, mean and standard deviation and chi-square. Results: One hundred seventy completed questionnaires were returned; the response rate was 66%. Most certified gynecologic oncologists and fellows in gynecologic oncology have a positive attitude towards palliative care education, and agree that "psychological distress can result in severe physical suffering". It was found that the curriculum of gynecologic oncology fellowship training equally emphasizes three aspects, namely managing post-operative complications, managing a patient at the end of life and managing a patient with gynecologic oncology. As for experiential training during the fellowship of gynecologic oncology, education regarding breaking bad news, discussion about goals of care and procedures for symptoms control were mostly on-the-job training without explicit teaching. In addition, only 42.9 % of respondents were explicitly taught the coping skill for managing their own stress when caring for palliative patients during fellowship training. Most of respondents rated their clinical competency for palliative care in the "moderately well prepared" level, and the lowest score of the competency was the issue of spiritual care. Conclusions: Almost all certified gynecologic oncologists and fellows in gynecologic oncology have a positive attitude towards learning and teaching in palliative care. In this study, some issues were identified for improving palliative care education such as proper training under the supervision of a mentor, teaching how to deal with work stress, competency in spiritual care and attitudes on responsibility for bereavement care.

Keywords: Palliative care education - gynecologic oncology - Thailand

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Introduction

From hospital based cancer registries and WHO cause of death, the current incidence of gynecologic malignancy is rising (Attaasara et al, 2011; Attaasara et al, 2012; WHO, 2012; Office of the Permanent Secretary for Public Health, 2013). Novel advances in technology in cancer care are able to prolong life; nevertheless human beings cannot avoid death. At the end of life, many cancer patients are frequently faced with suffering from pain and other symptoms, which are treatable. Therefore, palliative and symptomatic control treatments play the most important role in end of life of patients.

Nevertheless, some clinicians may neglect or pay less attention to palliative care services. A literature review found that the quantity and quality of training in palliative care was low compared to other common procedural and oncological issues. Fellows may benefit from more teaching on pain management, psychosocial care, and communication skills, and training may improve care to patients at the end of life (Weissman and Block, 2002; Farber et al, 2004; Buss et al, 2011; Lesnock et al, 2013). However, there have not been any studies of this kind in gynecologic oncologists in Thailand. The aim of this research, a survey of attitudes towards palliative care, is to study the problems faced by fellows and gynecologic oncologists regarding the education of palliative care for gynecologic cancer patients.

Materials and Methods

This research is a descriptive study. Of a total

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population of 255 surveyed, 218 are certified gynecologic oncologists and 37 are gynecologic oncology fellows who received training in palliative care at university hospitals, hospitals administration by the Bangkok Metropolitan Authority, the Ministry of Public Health and Ministry of Defense, Thailand. Sampling was done by purposive sampling with a sample size of 170 subjects. The instrument was a questionnaire that consisted of 77 items in seven categories. The categories of attitudes surveyed include fellowship training, fellowship experience, caring for the dying, education, preparation, attitudes and respondent characteristics.

The survey was tested for content validity by three experts in palliative care, and reliability was tested by 10 obstetrics and gynecology residents at the Faculty of Medicine, Chulalongkorn University. This study was reviewed and approved as exempt by the Chulalongkorn Medical Institutional Review Board.

A survey package, including a cover letter describing the study, informed consent, the survey instrument and a stamped return envelope was sent to the head of hospital where potential respondents worked, asking for cooperation. Approximately three months following the distribution of surveys, a reminder email was sent. The close of the return of surveys was the end of the February 2015. A total of 170 questionnaires were received for a response rate of 66%.

Data were analyzed by software package used for statistical analysis (SPSS) version 22 and used descriptive statistics, percentage, mean and standard deviation and chi-square.

Results

Demographic data of the 170 respondents are shown in Table 1. The majority of the study population was 40-49 years old, female, Buddhist, practice in university hospital and current working as gynecologic oncologist.

Palliative care-focused teaching was similar to fellows' training in procedural or other patient care activities. On a scale of 1–10, respondents rated the amount of teaching in managing post-operative complications and endometrial cancer patients as 9.5 and 9.5, respectively. They rated teaching for managing a patient at the end-of-life as 7.5 (Figure 1).

In recalling their experience during their gynecologic oncology fellowship training, 90% recall having to discuss the diagnosis by themselves without coaching, while, 62.5% were observed by their attending mentors during telling of the truth and 42.5% were given feedback by their mentors after telling the truth. Discussion regarding changing the goals of care from curative to palliative with a patient and/or their family in 80% was done by the respondent themselves, 72.5% were observed by their mentor during the discussion and 40% were given feedback by their mentors after discussion. Performing procedures on an end-stage patient was 70% by themselves, 65% were observed by their mentors during the performance and 42.5% were given feedback by their mentors after performing.

Figure 2 shows the perceived percentage of patients who received the kind of care that the respondents would want their own loved ones to receive at the end of life, grouped as follows: (i) 10-20%, (ii) 21-40%, (iii) 41-30%, (iv) 61-80% and (v) 80-100% as 20.0 , 25.0 , 10.0 , 32.5 and 12.5, respectively.

Fellows were asked what palliative care skills they were explicitly taught during fellowship. All skills were explicitly taught to more than 40% of respondents (Figure 3). More than 80% of respondents were specifically taught how to assess neuropathic pain or how to rotate opioids.

From this study, the majority of respondents agreed that it is gynecology oncologists' responsibility to provide bereavement care to the family after death (86.9%) and to help patients prepare for death (95%). Additionally,

Table 1. Demographic Characteristics

Demographic Characteristics (n=170)	Value (%)
Age	
29 - 39	94 (55)
40 - 49	62 (36.88)
50 - 60	14 (8.12)
Sex	
Male	72 (42.5)
Female	98 (57.5)
Religion	
Buddhist	168 (98.8)
Setting of practice / training	
University hospital	136 (80)
Hospital administration by Bangkok metropolitan	17 (10)
Hospital administration by ministry of public health	9 (5.56)
Hospital administration by ministry of defense	8 (4.44)
Current working	
First year of fellowship	26 (15)
Second year of fellowship	14 (8.12)
Gynecologic oncologist	130 (76.88)

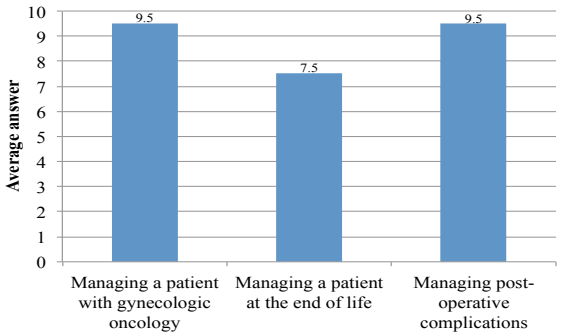

Figure 1. Amount of Teaching During your Fellowship

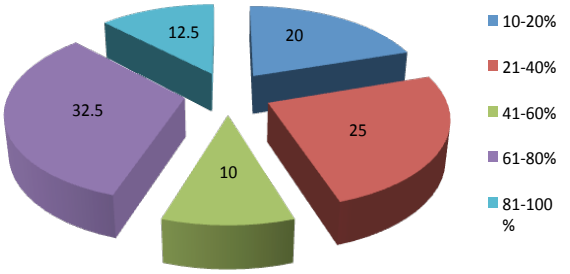

Figure 2. Percent of Patients who Received the kind of Care as the Respondent's Loved ones to Receive at the end of Life

Table 2. Attitudes about end of Life Care

Attitudes about end-of-life care	Completely disagree (%)	Generally disagree (%)	Generally agree (%)	Completely agree (%)	Mean	Standard Deviation
1. Responsibility to provide bereavement care to the patient's family after death	0	13.1	81.3	5.6	2.92	0.41
2. Psychological suffering can be as severe as physical suffering	0	15.6	36.9	47.5	3.32	0.72
3. Depression is treatable among patients with terminal illnesses	0	14.4	63.1	22.5	3.06	0.6
4. Possibility to tell patients the truth about a terminal prognosis	0	24	36	40	3.09	0.63
5. Family members tend to interfere in the care of patients with terminal illnesses	0	19.4	58.1	22.5	3.02	0.66
6. Responsibility to help patients at the end of life to prepare for death	0	5	64.4	30.6	3.24	0.54
7. Dread to deal with the emotional distress of family members	0	41.9	47.5	10.6	2.67	0.66
8. Caring for dying patients is depressing	9.4	40.6	48.1	1.9	2.41	0.7
9. Feeling guilty after a death	26.9	59.4	13.8	0	1.84	0.61

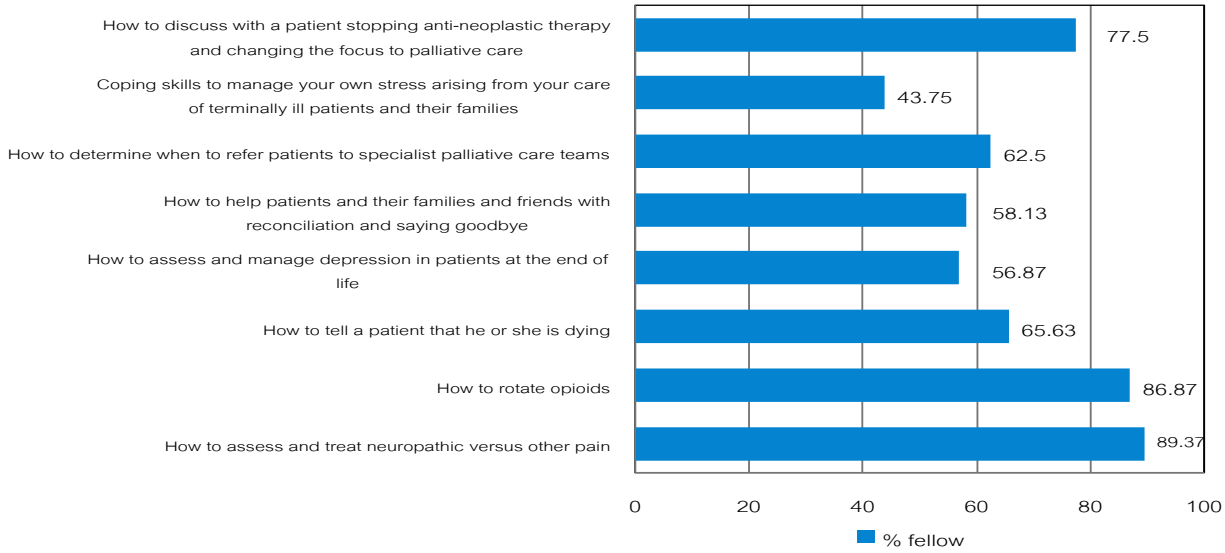

Figure 3. The Percentage of Fellows who have been Explicitly Taught Various Skills During their Fellowship

greater than 50% of respondents disagreed that they feel guilty after a death or that caring for such patients is depressing (Table 2).

When asked about experience with clinical preparation for palliative care, the respondents agreed that it includes managing the pain of a dying patient (100%) and discussion of end-of-life care decisions with a patient (97.5%).

Discussion

Although advanced technology has been developed, end-stage cancer cannot be cured and palliative care is one treatment that focuses on improving quality of life for both the patient and the family; however some clinicians may neglect or pay less attention to providing palliative care. Increasing the quantity and quality of teaching of palliative care during fellowship training may improve care to patients at the end of life (Weissman and Block, 2002; Farber et al, 2004; Buss et al, 2011; Lesnock et al, 2013). The American Society for Gynecologic Oncologists also recognized the importance of palliative training for physicians (The Society for Gynecologic Oncologists, 2013). The American Society of Clinical Oncology states that palliative care is an integral part of medical oncology and is committed to improving oncologists' education in this domain (Hansen et al, 2004). In Thailand, palliative care specialists have tried to set palliative programs for medical students within the organizational structure of the medical hospital, but not it is not clearly included in the curriculum in fellowship training in gynecologic oncology.

This study was the first survey of palliative care education in certified gynecologic oncologists and fellows in gynecologic oncology in Thailand. The response rate was high, at 66% , or 170 questionnaires returned from a total 255 sent.

This study found a lack of teaching under supervision by a mentor during training, particularly feedback from mentors on topics of communication with patients and families and procedures in end-stage patients. Average scores of experience of teaching during gynecologic oncology fellowship training were similar in three aspects: managing post-operative complications, managing a patient at the end of life and managing a patient with gynecologic oncology.

One third of the respondents thought that as many as 60-80% of patients received the kind of care they would want the respondent's own loved ones to receive at the end of life, but the most concerning issue was only one half could done less than 60% of patients received the kind of care they would want their own loved ones to receive.

While in their fellowship training in gynecologic

oncology, as many as 87.6 % of the respondents were taught the assessment and treatment of neuropathic versus other (somatic or visceral) pain. In contrast, only 42.9 %. of the respondents had been taught coping skills to manage their own stress arising from the care of terminally ill patients and their families.

Attitudes about care of terminally ill patients were determined on a Likert scale describing the level of satisfaction on four levels as, completely agree, generally agree, generally disagree and completely disagree, scoring from 1 to 4. After calculating class interval (0.38), the setting of the mean intervals was 3.32-2.94 as "completely agree", 2.93-2.55 as "generally agree", 2.54-2.16 as "generally disagree" and 2.15-1.87 as "completely disagree". As shown in Table 2, attitudes about end-of-life care fell into "completely agree" for most topics. Attitudes that psychological suffering can be as severe as physical suffering was the highest where 81.3% fell into "generally agree", and that the doctor was responsible for dealing with the emotional distress of family members of a patient at the end of life was at the minimum level. This finding disagreed with previous studies that found the attitude that a physician had a responsibility to help patients at the end of life to prepare for death at a maximum level (Lesnock et al, 2013).

One striking finding in this survey is all of respondents agreed that it is managing the pain of a dying patient (100%). This may be due to the emphasizing of teaching on pain control and systemic consultation of anesthesiologist. Clinical preparation for palliative care is mostly in the "moderately well" category, the highest being for managing patients' pain at the end-of-life care as 85.3 % ($p < 0.01$), the lowest level in addressing spiritual issues related to a patient's end-of-life care , as 47.5% ($p < 0.01$).

The results from this study should have implications in the development of training in the topics of supervision by a mentor, managing stress arising from care of terminally ill patients, sharing about using kindliness and spiritual issues for palliative care related to a patient's end-of-life and emphasis on attitudes towards responsibility with family bereavement after patient death.

From comments, most certified gynecologic oncologists and fellows agreed that palliative care should be a clearly stated part of the curriculum, as a required subject in gynecologic oncology, with this content completely separate in the curriculum, especially regarding discuss the diagnosis and psychosocial support techniques. One 33 year old certified gynecologic oncologist in a medical hospital wrote, "Palliative care is a long term study ongoing throughout medical training, so good basics should begin at the level of medical student. Good moral traits and empathy should be cultivated at this level, along with academic topics. There should be emphasis on frequently used techniques, such as pain control, living wills etc., at the level of fellowship training, as these are useful techniques". Some certified gynecologic oncologists and fellows in gynecologic oncology think that "doctors should have principles of dharma, such as meditation on death for passing to patients".

In conclusion, certified gynecologic oncologists and fellows in gynecologic oncology have a positive attitude towards learning and teaching palliative treatment, especially attitudes that agree that psychological distress can result in severe physical suffering.

This study found that the teaching in palliative care during fellowship training should be supervised under mentors. Teaching should focus on how to deal with the stress caused by caring for the patients and their families, preparation for talking about spiritual issues and the attitudes about physician's responsibility for the bereavement care of the family after the patient has died.

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