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On caring and sharing–Addressing psychological, biographical, and spiritual aspects in integrative cancer care: A qualitative interview study on physicians' perspectives

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ABSTRACT

Background: Patients confronted with a cancer diagnosis experience a variety of existential needs encompassing emotional, psychological, and spiritual areas of being. A patient-centered care approach addressing such existential issues is recognized as an essential aspect of health care. The aim of this study is to explore what role psychological, biographical, and spiritual factors play for experienced doctors working in integrative cancer care.
Method: The qualitative study was based on in-depth interviews with 35 purposively sampled doctors, all practicing integrative oncology in the field of anthroposophic medicine in hospitals and/or office-based practices in Germany and other countries. Data were analyzed using structured content analysis.
Results: Psychological, biographical, and spiritual factors are important issues in integrative cancer care. Prevailing themes identified in this study were enabling patients to participate in life, promoting autonomy and coping, stabilizing patients emotionally and cognitively, overcoming the disease, and–primarily if addressed by patients–integrating spiritual issues. Doctors offered conversation, counseling, and time, but also referred to art, music, literature, and nature, so that patients' ongoing emotional, psychological, and spiritual needs could be explored and addressed. Doctors' attitudes with regard to existential issues were seen as important, as was maintaining an attitude of openness towards existential issues.
Conclusion: Doctors in integrative cancer care utilize different methods to explore the needs of patients and employ a variety of treatment methods that address not just patients' medical issues but their existential concerns as well.

1. Introduction

Patients diagnosed with cancer are confronted with a life-threatening and often life-limiting disease. All areas of being are affected, and patients experience a variety of emotional, psychological, and spiritual existential needs. Understanding and addressing these needs has become a major goal in oncology and has increasingly become a focus of research.[1–6] Most patients want emotional and spiritual issues to be included in their care, particularly by their physicians.[4,7]. This may include being able to talk about fears; being given the chance to express thoughts on meaning-making, death, and dying; and transcendent beliefs as well as finding inner peace or feel spiritual connectedness.[4,5]. Particularly in end-of-life care, existential and spiritual issues for patients are ever-present and need to be addressed to maintain good quality of life, offer hope and positivity, facilitate sense-making and good relationships, and to support dying peacefully.[4,8,9] Despite this and the growing social and communication skills of doctors, the emotional and spiritual needs of severely ill patients often remain unmet and tend to be underestimated by doctors.[7,10–15]

About half of all cancer patients seek integrative medicine (IM).[16–20] IM integrates conventional and complementary methods, pursues a whole-person approach (addressing mental, emotional, spiritual, and social levels of care) and emphasizes the natural healing power of the organism, lifestyle, and the doctor-patient relationship as a partnership,[21,22] IM meets patients' spiritual needs without religious overtones or measures and facilitates finding inner peace.[23] A diverse range of IM

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models of care is established, such as Traditional Chinese Medicine, herbal medicine, mind-body medicine, Anthroposophic Medicine (AM) and others. IM is practiced in tandem with or within oncology centers, where it is regarded as “integrative oncology”.[21,24]

To better understand integrative cancer care and particularly the approach to psychological and spiritual needs of patients, a qualitative study was conducted[25] with IM doctors who practice AM. AM integrates conventional cancer treatments with complementary treatments (eg, counseling, psychotherapy, herbal remedies, art and music therapy, massage, poultices, nursing techniques); it offers a holistic understanding of the human being, including a strong emphasis on spiritual issues[26,27] and on biographical aspects that refer to the approach in which a disease is seen within the biographical context of the patient. The objectives of the analysis were to address the following questions:

(1) What roles do emotional, biographical, and spiritual issues play for physicians practicing integrative medicine and oncology?
(2) What do physicians observe and experience with regard to these issues in the treatment process?
(3) How do physicians support emotional and spiritual needs of patients?
(4) What are the underlying treatment goals, concepts and themes?

2. Methods

2.1. Design

We conducted a qualitative study based on in-depth, semi-structured interviews with highly experienced physicians in integrative cancer care and AM to assess their concepts, themes, procedures, experiences, and observations.[28,29] Data analysis was conducted using a deductive-inductive categorizing system based on structured qualitative content analysis.[30] The study was approved by the Ethics Committee of the University of Freiburg, Germany.

2.2. Recruitment and setting

Participants were purposively sampled[29,31] and were either recommended by other physicians or accessed through the literature: We derived a list of experts in the field and read publications by IM/AM doctors that were important references to certain topics in regard to cancer treatment. We then added to our list doctors who had published important articles or books and had individual treatments approaches. The list was then sent to a variety of experts in the field of AM/IM to review, and they were asked to recommend additional doctors or important publications. Criteria for selection included covering a broad spectrum of medical specialties, treatment contexts (eg, hospital- or office-based practices), ages, and countries. Physicians were contacted and offered information about the study and asked to prepare one or two case studies.

2.3. Interviews

Thirty-five physicians were interviewed by two different researchers (GK and MM) between 2009 and 2012. GK is a medical doctor and researcher who is well known in the field of integrative cancer care; MM is a psychologist and junior researcher. All interviews were conducted in person, and anonymity and confidentiality were ensured, enabling open communication. All but one of the physicians consented to digital audio recording; that physician’s interview consisted of field notes.

Interviews began with warm-up questions followed by one or two case examples in order to establish an unbiased account of doctors’ procedures, concepts, themes and observations. An interview guideline was used to follow up on topics and to give prompts[32] Interview topics included patient assessment, treatment decisions, monitoring therapy and making adjustments, treatment goals, psychological and spiritual issues, safety factors, and new insights. Doctors were often asked to concretize their answers and to illustrate them with case examples (350 altogether) throughout the interview. All interviews were transcribed according to the recommendations of Kuckartz et al.,[33,34] These include, for example, verbatim transcriptions, which additionally allows for writing in High German and grammatically correct dialect or everyday language. Emphasized expressions are underlined, and other verbal and non-verbal modulations and activities are noted with specific marks. To differentiate between speakers, everything said by interview participants is clearly coded and written in separate paragraphs. Any wording that could make it easy to identify a person is anonymized. Interview transcripts were finally sent to participants for validation.[29,32]

Data collection was terminated after 35 interviews because no new areas of information could be disclosed and no new categories were identified with respect to the research question.[29]

2.4. Analysis

For data analysis, a structured qualitative content analysis was used[28] in combination with techniques from the thematic framework approach[29] Data analysis was predominantly carried out by GK and MM using MAXQDA computer software (Kuckartz, 2010) to support for data management. Two more researchers took part in team meetings (HK, researcher and medical doctor; DF, psychologist and experienced qualitative researcher). Data analysis occurred in close exchange among researchers, and all steps were carefully documented.

First, the interviews were read and codes were applied using guideline categories, and new codes were also noted (open coding). Thematic domains were then defined and extracted for each doctor such as observations on psychological, biographical, and spiritual aspects (explication). The drafted charts then underwent a circular process of paraphrasing, shortening, and condensing the given information. They were continuously reviewed and discussed by at least two researchers. Apart from research triangulation, further triangulation measures were undertaken to increase validity and reliability and to integrate multidisciplinary perspectives.[25] In a final step, overarching concepts, themes and treatment goals, such as helping patients participate in life or supporting autonomy and coping (selective coding), were examined. Throughout this process, original quotations and words and phrases from the participants’ own language were used to summarize the core meanings and ground themes in data[29] Physicians received the interview transcripts and final results of analysis before publication in order to increase overall validity. Results contained anonymized codes rather than names so that doctors could revise them. Codes were removed before publication.

3. Results

3.1. Sample

Thirty-five doctors from the field of IM and AM were interviewed, and each interview lasted between 100 and 297 (mean 171) minutes. The doctors had different medical specialties and worked either in hospitals, cancer centers, or outpatient care (characteristics of the sample population is shown in Table 1). They combined conventional cancer treatments, provided either by themselves or by collaborating institutions, and holistic complementary treatment approaches[25] and cared for their patients over years or even decades.

3.2. Concepts, themes and treatment goals

The interviewed doctors perceived and treated cancer within two complementing concepts: the common medical concept in terms of modern tumor biology, and a holistic concept of the human organism

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