
LETTER TO EDITOR**Use of coping strategies of pediatric oncologists for patient death***Hüseyin Çaksen^{1*}**¹Divisions of Pediatric Neurology and Genetics and Behavioral-Developmental Pediatrics,
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Dear Editor,

Cancer remains one of the most serious public health problems in many parts of the world today [1,2]. Grief and bereavement are often present among both child and adult patients and their families during courses of cancer. Cancer patients and their parents/caregivers use a variety of strategies such as problem-focused (task-oriented), emotion-focused (emotion-oriented), social (support-seeking), maladaptive (dysfunctional or negative), meaning-focused (meaning-making), or religious (turning to religion) coping during grief and bereavement [3]. Although overlooked by many healthcare professionals, pediatric oncologists are also affected by the death of children with cancer and use a variety of coping strategies. Herein, we discuss use of coping strategies of pediatric oncologists for patient death to draw attention that aside from parents, pediatric oncologists also use various coping strategies during bereavement.

There are very few studies on pediatric oncologists' strategies for coping with patient death in the literature. Granek *et al.* (2015) [4] classified challenging factors pertaining to patient death in pediatric oncologists' grief reactions into three categories as follows: (a) Relational factors encompassed dealing with families perceived as challenging; (b) Domain captured the process of death and dying; (c) Domain included patient factors that included suffering of the child, and the sense that no child should die [4]. Most pediatric oncologists (82%) recognized that they were grieving over the death of children [5]. Their

grief responses featured crying, sadness, withdrawal, and recurring thoughts of the dying conditions and the death of the child. They also often noted guilt feelings and an active search for philosophic explanations that would make their distress more tolerable [5]. Pediatric oncologists used engagement coping strategies with primary and secondary responses including emotional regulation (social support and religion), problem solving (supporting families at end of life), cognitive restructuring (making a difference and research), and distraction (breaks, physical activity, hobbies and entertainment, spending time with own children). They also used disengagement coping strategies that included voluntary avoidance (compartmentalization and withdrawing from families at end of life) [6].

In conclusion, limited studies showed that majority of pediatric oncologists bereaved for patient death and used various coping strategies. We think that similar to cancer patients and their parents/ caregivers, some pediatric oncologists also use religious coping for patient death because a large proportion of pediatric oncology healthcare professionals identify themselves as spiritual [7,8]. We recommend that comprehensive studies should be performed about coping strategies of pediatric oncologists for patient death in societies with different sociocultural and religious backgrounds. These studies may guide healthcare professionals who train pediatric oncologists and will fill the gap in the literature.

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