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Palliative Medicine Practitioners' Views on the Concept of Depression in the Palliative Care Setting

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Abstract

Background: Despite its clinical importance in palliative care, depression remains an ambiguous concept.

Objective: The purpose of this study was to explore how medical practitioners working in palliative care conceptualize depression in that setting.

Design: Medical practitioners who attended a palliative medicine conference ($N=185$) were invited to respond to a questionnaire, which explored their views on the concept of depression in the palliative care context. Descriptive statistics were used to summarize responses, and comparison between groups was conducted using nonparametric statistics. Themes in free-text comments were identified.

Results: Seventy-nine responses were obtained (response rate 43%). Depression was not a unified concept, but was generally considered to be an illness with psychological, spiritual, and existential causes. Respondents were more uncertain about depression being an illness in the palliative care setting compared with other settings, and were ambivalent about its causality. Treatment preferences leaned towards psychological interventions. Depression being different in the palliative care setting was a theme. It was considered to be more prevalent, different in quality, harder to define, and associated with greater barriers to diagnosis and treatment. Conceptual differences were associated with the respondents' area of work, work position, duration of practice, and previous mental health training.

Conclusions: Depression in the palliative care setting is a variable concept for palliative medicine practitioners. The conceptual diversity and complexities of depression in this setting must be acknowledged and further explored in order to develop nuanced approaches in clinical practice and in research.

Introduction

DEPRESSION IS WIDELY ACKNOWLEDGED to be an important clinical issue in palliative care, with an estimated prevalence of 5%–26%¹⁻⁴ and association with adverse outcomes such as high symptom burden,⁵ spiritual distress,⁶ poor performance status,⁷ shorter survival,⁸ longer length of hospice stay,⁹ and desire for hastened death.^{7,10} Nevertheless, depression remains an ambiguous concept. This situation is not unique to the palliative care setting, as multitudinous concepts of depression have beleaguered the field of psychiatry over the course of its history¹¹⁻¹³ and continue to be actively debated.^{13,14} The palliative care setting, however, arguably adds to the ambiguity because of the symptomatic similarities

between depression and conditions commonly occurring at the end of life (EOL), such as illness and the dying processes and the attendant emotions in this context.^{15,16}

Health professionals have reported difficulties with assessing and managing depression in the palliative care setting.¹⁷⁻²⁰ In particular, the distinction between depression and sadness or grief has been reported as challenging by family physicians,²⁰ palliative medicine physicians,¹⁷ nurses,¹⁸ and professional carers.¹⁹ In a U.K. survey, palliative medicine physicians reported using an assortment of screening methods to assess for depression and endorsed different symptoms as useful for this purpose,¹⁷ whereas general practitioners in the Netherlands emphasized clinical judgement of contextual factors in their assessment.²⁰ Discordant approaches to the

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detection and treatment of depression in the palliative care setting have similarly been reported among recognized experts in the area.²¹ Diversity in the definitions of depression and assessment approaches is reflected in the research literature,^{1,22} with one systematic review identifying 106 different assessment methods in 202 published studies and an assortment of criteria for defining caseness.²²

It is evident from the extant literature that EOL depression is a heterogeneous concept. Insofar as conceptualization fundamentally guides clinical and research efforts, it is crucial to understand how depression is conceptualized in the palliative care setting, in order to develop context-appropriate clinical and research approaches. How medical practitioners think about depression has been investigated to a far lesser extent than their clinical practice, and no study has primarily focussed on how they conceptualize depression in the palliative care setting. Therefore, this study was devised to explore how EOL depression is conceptualized by palliative medicine practitioners.

In view of the lack of terminological standardization in palliative care,^{23,24} it should be clarified that "palliative care" in this paper refers to an approach to care as defined by the World Health Organization,²⁵ and neither implies the involvement of specific health professionals nor the provision of care in particular settings such as hospitals, hospices, or the community. "End-of-life" is used as defined by Palliative Care Australia to mean "that part of life where a person is living with, and impaired by, an eventually fatal condition, even if the prognosis is ambiguous or unknown."²⁶ It thus captures the period of time during which patients receive palliative care.

Methods

The authors developed a questionnaire specifically for this study and conducted a small pilot ($n=7$) in order to test its comprehensibility and estimate completion time. The pilot participants had either research and/or clinical backgrounds in palliative care or psychiatry of old age, and were not in the study's target population. Minor formatting and wording modifications and the addition of a question about frequency of work in palliative medicine were made in response to the pilot. The final questionnaire comprised the following: (1) demographic information; (2) the respondent's level of clinical involvement with EOL depression; and (3) a series of 25 statements about EOL depression, relating to its distinction as a concept, prevalence, symptomatic consistency, causality, treatment, and outcome (see Table 1). These statements were informed by the literature and clinical anecdotal experience, and respondents were asked to indicate their level of endorsement of each statement on a five-point Likert scale that extends from "1=Strongly Disagree" through "3=Neutral" to "5=Strongly Agree." Respondents were also asked to provide free-text comments on their experiences with depression in patients receiving palliative care. The term "depression" was deliberately used without further qualification, because multiple constructs of depression were assumed and narrow definitions were avoided. Responses were anonymous.

The target population consisted of registrants of a palliative medicine conference held in Australia in 2010, who were primarily Australian and New Zealand medical practitioners involved in palliative medicine. The sample was one of

TABLE 1. STATEMENTS ABOUT DEPRESSION USED IN THE QUESTIONNAIRE

1. Depression is more common at the EOL.
2. Depression is normal at the EOL.
3. The quality of depression at the EOL is the same as depression in other settings.
4. Depression in general (not just at the EOL) is an illness.
5. Depression at the EOL is an illness.
6. Depression is a distinct concept.
7. Depression is distinct from grief.
8. Depression is part of the dying process.
9. All doctors understand depression as a concept in the same way.
10. Depression is understood by doctors and by patients in the same way.
11. Symptoms of depression are reasonably consistent from person to person.
12. There are core features of depression.
13. EOL depression has identifiable causes.
14. Biological factors are important in explaining depression at the EOL.
15. Psychological factors are important in explaining depression at the EOL.
16. Existential and spiritual factors are important in explaining depression at the EOL.
17. Socioeconomic status is important in explaining depression at the EOL.
18. Culture is important in explaining depression at the EOL.
19. Depression at the EOL should always be treated.
20. Depression at the EOL can be managed with medications.
21. Depression at the EOL can be managed with psychological support.
22. If untreated, depression at the EOL will worsen the person's quality of life.
23. If untreated, depression at the EOL will negatively affect the person's family.
24. Patients expect doctors to treat depression.
25. Depression at the EOL can abate without any active interventions.

EOL, end-of-life.

convenience. With permission from the organizing committee, a paper version of the questionnaire was distributed with the registration package at the conference site, and verbal and visual reminders (announcement, poster display, collection boxes) were used to encourage participation. A reminder e-mail that included a link to an electronic version of the questionnaire was sent to all registrants one week after the conference.

Descriptive statistics were used to summarize respondent characteristics and endorsement of statements about depression. Comparison of respondent views according to characteristics was performed using the Mann-Whitney U test and Kruskal-Wallis 1-way ANOVA, because of nonparametric data distribution. Significance was at $p < 0.05$ (2-tailed). Analyses were conducted using PASW version 18 (SPSS, Inc., Chicago, IL).²⁷ Free-text responses were examined for themes by the first author (FN) with the aid of NVivo9 software (QRS International Pty. Ltd., Doncaster).²⁸ A second author (ACH) undertook an independent analysis. The two analyses were compared and themes revised until consensus was reached.

This study received approval from the Human Research Ethics Committee at the University of Adelaide (H-086-2010).

TABLE 2. RESPONDENT CHARACTERISTICS SHOWN IN ABSOLUTE NUMBERS AND PERCENTAGES

Respondent characteristics	Number (percentage) n = 78 ^a
<i>Gender</i>	
Male	31 (39.7%)
Female	47 (60.3%)
<i>Main area of work</i>	
Palliative medicine	64 (82.1%)
General practice	7 (9.0%)
Other	7 (9.0%)
<i>Work position</i>	
Specialist	48 (61.5%)
Trainee	17 (21.8%)
Other (including GPs)	13 (16.7%)
<i>Training background for those who are palliative medicine specialists or trainees</i>	n = 64 ^b
General practice	32 (50%)
Physician	24 (37.5%)
Other	8 (12.5%)
<i>Work type^d</i>	
Clinical palliative medicine	78 (100%)
Academic palliative medicine	21 (26.9%)
Administrative palliative medicine	20 (25.6%)
<i>Work setting^d</i>	
Hospital	54 (69.2%)
Hospice	43 (55.1%)
Community	39 (49.4%)
Academic	15 (19.2%)
<i>Duration of practice (in years)</i>	
Years in medicine	
0–10 years	14 (17.9%)
11–20 years	18 (23.1%)
21–30 years	19 (24.4%)
>30 years	27 (34.6%)
Years in palliative medicine	
0–10 years	34 (43.6%)
11–20 years	26 (33.3%)
21–30 years	15 (19.2%)
>30 years	3 (3.8%)
<i>Mental Health Training</i>	
Received specific training ^c	20 (25.6%)
<i>Frequency of palliative care provision for patients</i>	
Most days	68 (87.2%)
At least once per week	8 (10.3%)
At least once per month	1 (1.3%)
Several times per year	1 (1.3%)
<i>Frequency of providing care for depression in the palliative care setting</i>	
Most days	26 (33.8%)
At least once per week	33 (42.9%)
At least once per month	12 (15.6%)
Several times per year	6 (7.8%)
<i>Usual personnel involved in the management of depression in the palliative care setting^d</i>	
None	4 (5.1%)
Social workers	57 (73.1%)
Nurses	55 (70.5%)

(continued)

TABLE 2. (CONTINUED)

Respondent characteristics	Number (percentage) n = 78 ^a
GPs	51 (65.4%)
Psychiatrists	51 (65.4%)
Chaplains/pastoral care workers	45 (57.7%)
Family	43 (55.1%)
Psychologists	37 (47.4%)
Others	14 (17.9%)

^an = 78 unless stated otherwise due to 1 missing response.^bn = 64 due to 1 missing response and 14 not applicable responses (i.e., not a palliative medicine specialist or trainee).^c12 respondents undertook psychiatric placements during pre-vocational or vocational medical training, 4 undertook accredited mental health training for general practice, 3 completed honors or masters degree in psychology or psychological medicine, 2 undertook psychotherapy training.^dThe total percentages for these characteristics are over 100 because multiple answers were possible.

GP, general practitioner.

Results

Respondent characteristics

Seventy-nine of 185 registrants (43%) responded to the questionnaire. All respondents practiced palliative medicine and 64 (82.1%) identified this as their main area of work. Respondent characteristics are detailed in Table 2.

Views on depression

Whilst respondents generally deemed depression to be an illness (92.3%), fewer considered it an illness at the EOL (80.5%), with 14.3% viewing depression as normal in this context and 11.5% viewing it as part of the dying process. A further 22.1% and 17.9% neither agreed nor disagreed with these latter statements, respectively. The vast majority (91.0%) saw depression and grief as distinct concepts. Most considered depression to be not only more common at the EOL (59.0%), but different in quality from depression occurring in other settings (59.7%). Although 89.7% believed core features of depression to exist, only 23.1% thought that depression symptoms were consistent between individuals. Understandings of depression were generally considered to differ among medical practitioners (93.6%) and between medical practitioners and patients (94.9%). Distributions are shown in Tables 3 and 4.

There was uncertainty about causality, with 47.4% of respondents indicating ambivalence about whether depression had identifiable causes. Of the proposed factors that could be considered to be causally important, psychological (88.5%) and existential/spiritual factors (84.4%) were most frequently endorsed, while biological factors (56.4%), culture (55.8%), and socioeconomic status (32.5%) were less often endorsed. Respondents showed a clear preference for psychological support as intervention compared with medications (87.0% versus 54.5%). Depression was considered by 93.5% to adversely impact on the patient's quality of life and by 87.0% to negatively affect the family. Over half of the respondents (54.7%) believed that depression should always be treated, while 51.9% believed that depression could abate without intervention. About half of the respondents (51.9%) agreed

TABLE 3. RESPONDENTS' ENDORSEMENT OF STATEMENTS RELATING TO DEPRESSION AS A CONCEPT, IN ABSOLUTE NUMBERS AND IN PERCENTAGES

Statement	Disagree in n (%)	Neutral in n (%)	Agree in n (%)
Depression (in general) is an illness (n=78)	2 (2.6)	4 (5.1)	72 (92.3)
Depression at the EOL is an illness (n=77)	4 (5.2)	11 (14.3)	62 (80.5)
Depression is normal at the EOL (n=77)	49 (63.6)	17 (22.1)	11 (14.3)
Depression is part of the dying process (n=78)	55 (70.5)	14 (17.9)	9 (11.5)
Depression is a distinct concept (n=78)	10 (12.8)	13 (16.7)	55 (70.5)
Depression is distinct from grief (n=78)	3 (3.8)	4 (5.1)	71 (91.0)
Doctors and patients understand depression in the same way (n=78)	74 (94.9)	4 (5.1)	0 (0)
All doctors understand depression in the same way (n=78)	73 (93.6)	4 (5.1)	1 (1.3)

Responses are collapsed into "agree," "neutral," and "disagree" categories. EOL, end-of-life.

that patients expected medical practitioners to treat their depression. Distributions are shown in Tables 5 and 6.

Comparison of views between groups

Views held by respondents differed according to their area of work, work position, duration of practice, and previous mental health training. The primary training background for those who were palliative medicine trainees or specialists did not significantly influence responses.

Compared with those mainly working in palliative medicine or other areas, respondents who primarily worked in general practice were more likely to consider depression as normal at the EOL (H(2)=13.472; p=0.001) and as part of the dying process (H(2)=12.672; p=0.002). They were also more likely than those mainly working in palliative medicine to agree that depression had identifiable causes (U=121.500; p=0.031) and that patients expected medical practitioners to treat depression (U=125.000; p=0.044). Those who worked in academic palliative medicine were more likely than nonacademics to view depression as a distinct concept (U=808.500; p=0.003) with core features (U=754.500; p=0.013) and consistent symptoms between individuals (U=818.000; p=0.002).

Trainees were more likely than specialists and those in other positions to consider depression an illness at the EOL (H(2)=9.195; p=0.010).

Respondents who had practiced in medicine for the shortest duration (≤10 years) more often agreed with depression in general being an illness than those with longer durations of practice (H(2)=6.071; p=0.048). Those who had practiced in palliative medicine the longest (>20 years) were most likely to regard the quality of depression at the EOL to be the same as in other settings (H(2)=6.431; p=0.040), and were

least likely to view socioeconomic status as important in the causality of depression (H(2)=8.493; p=0.014).

Those who had received specific mental health training were more likely to identify socioeconomic status as causally important (U=719.500; p=0.22), and to consider that EOL depression should always be treated (U=726.500; p=0.009).

Free-text themes

Thirty-nine respondents (49.4%) commented on their experience with depression in patients receiving palliative care. Comments are captured by the following seven themes.

Depression at the EOL is different from other times in life

Depression was seen to differ at the EOL in terms of its notion (e.g., "a totally different entity"); delineation (e.g., "harder to define," "bound up with spiritual distress"); and manifestation (e.g., "fewer vegetative features"). The idea of the intransferability of treatments from general to EOL settings also distinguished depression at the EOL and was expressed in reference to the limited timeframes for intervention, the complex physical and psychological milieu, and the illogicality of cognitive therapy where patients' concerns were considered to be realistic.

Depression at EOL is a difficult problem

The difficulty of depression at EOL was conveyed in terms of diagnostic and treatment difficulties and systemic barriers.

TABLE 4. RESPONDENTS' ENDORSEMENT OF STATEMENTS RELATING TO THE PREVALENCE AND SYMPTOMATIC CONSISTENCY OF DEPRESSION, IN ABSOLUTE NUMBERS AND IN PERCENTAGES

Statement	Disagree in n (%)	Neutral in n (%)	Agree in n (%)
Depression is more common at the EOL (n=78)	10 (12.8)	22 (28.2)	46 (59.0)
Quality of depression at the EOL is the same as in other settings (n=77)	46 (59.7)	12 (15.6)	19 (24.7)
There are core features of depression (n=78)	3 (3.8)	5 (6.4)	70 (89.7)
Symptoms of depression are consistent from person to person (n=78)	54 (69.2)	6 (7.7)	18 (23.1)

Responses are collapsed into "agree," "neutral," and "disagree" categories. EOL, end-of-life.

TABLE 5. RESPONDENTS' ENDORSEMENT OF STATEMENTS RELATING TO THE CAUSALITY OF DEPRESSION AT THE EOL, IN ABSOLUTE NUMBERS AND IN PERCENTAGES

Statement	Disagree in n (%)	Neutral in n (%)	Agree in n (%)
Depression has identifiable causes (<i>n</i> =78)	19 (24.4)	37 (47.4)	22 (28.2)
Biological factors are important (<i>n</i> =78)	11 (14.1)	23 (29.5)	44 (56.4)
Psychological factors are important (<i>n</i> =78)	2 (2.6)	7 (9.0)	69 (88.5)
Existential/spiritual factors are important (<i>n</i> =77)	4 (5.2)	8 (10.4)	65 (84.4)
Socioeconomic status is important (<i>n</i> =77)	18 (23.4)	34 (44.2)	25 (32.5)
Culture is important (<i>n</i> =77)	11 (14.3)	23 (29.9)	43 (55.8)

Responses are collapsed into "agree," "neutral," and "disagree" categories.
EOL, end-of-life.

Diagnostic difficulties were linked to the interchangeable use of terms such as "depressed," "sad," and "grieving;" the understandable context ("There is reason to be depressed"); and unclear delineation from natural emotions ("reactive sadness") and medical conditions. Respondents described depression as an affect (e.g., "Some people who are very sad or grief stricken...can be deemed as depressed"); a syndrome ("low mood, insomnia, loss of interest, agitation and anxiety, anorexia, constipation etc."); and an illness. Depression was also referred to as both "reasonable" and "never normal," and as both an "entity" and existing "in degrees." Difficulties of treating depression at the EOL included the short timeframes of expected survival and the physical weakness of patients, limiting both pharmacological and psychological treatment options. Systemic barriers, such as late referrals to palliative care, inadequate funding of professional time, and the inaccessibility of psychiatric services also challenged the assessment and management of depression at the EOL.

Depression is underrecognized

Depression was considered to be common and important but underreported by patients and underrecognized or dismissed as normal by clinicians. Several respondents commented on the need for screening and early recognition.

Causes of depression at the EOL

A variety of factors were linked to the occurrence of depression at the EOL, including premorbid cognitive style; stress of having a terminal illness; and symptoms such as pain, poor sleep, anxiety, and spiritual distress.

Depression has negative impact

Depression was seen to cause suffering, worsen prognosis, and negatively affect family. It was also seen to impede the assessment of patient progress and limit access to treatments.

Treatment of depression at EOL

Several respondents emphasized that treatment for EOL depression could not be generalized. Pharmacotherapy was seen to have a lesser role in treating EOL depression, with reasons including ineffectiveness, side effects, unacceptability to patients, inability of some patients to take oral medication, and the view that prescribing antidepressants is a "cop-out" for the clinician. Nonpharmacological interventions were considered to be key, and included good communication; counseling; support; acknowledgement of the patient's experiences; and making human connection (e.g., compassion, empathy, accompanying). Some commented on treatment choice as determined by severity (e.g., mild to moderate depression not needing medication). Several referred to a multidisciplinary approach.

Stigma

Stigma was perceived to underlie the unwillingness of some patients to accept a diagnosis of depression or its treatment, including referrals to psychologists or psychiatrists. "Psychiatric patients" were also considered to suffer discrimination in hospices.

Discussion

This study highlights the variability among palliative medicine practitioners in how they think about depression at

TABLE 6. RESPONDENTS' ENDORSEMENT OF STATEMENTS RELATING TO THE TREATMENT AND OUTCOME OF DEPRESSION AT THE EOL, IN ABSOLUTE NUMBERS AND IN PERCENTAGES

Statement	Disagree in n (%)	Neutral in n (%)	Agree in n (%)
Can be managed with medications (<i>n</i> =77)	12 (15.6)	23 (29.9)	42 (54.5)
Can be managed with psychological support (<i>n</i> =77)	2 (2.6)	8 (10.4)	67 (87.0)
Should always be treated (<i>n</i> =75)	20 (26.7)	14 (18.7)	41 (54.7)
Can abate without intervention (<i>n</i> =77)	23 (29.9)	14 (18.2)	40 (51.9)
Depression will worsen quality of life (<i>n</i> =77)	2 (2.6)	3 (3.9)	72 (93.5)
Depression will negatively affect family (<i>n</i> =77)	3 (3.9)	7 (9.1)	67 (87.0)
Patients expect doctors to treat depression (<i>n</i> =77)	12 (15.6)	25 (32.5)	40 (51.9)

Responses are collapsed into "agree," "neutral," and "disagree" categories.
EOL, end-of-life.

the EOL and the complexity of this clinical problem. On the whole, depression in this setting was considered to be an illness, with causes that were largely psychological and spiritual/existential in nature, in contrast with traditional biomedical frameworks of illness explanations. This may not be unique to the EOL, as there is evidence that primary care medical practitioners face dissonance from applying a biomedical framework of depression to various populations, where social contexts are recognized as etiologically important.^{29–31}

One of the main conceptual challenges identified in this study is the notion of whether depression at the EOL is an illness or is part of normative processes. This quandary was reflected in the finding that depression was less often considered to be an illness at the EOL than in general settings. The lack of specificity in the language used to convey depression, the emotionally evocative nature of the EOL, and the overt similarities between depression and sadness are relevant to this conceptual challenge. The difficulty of differentiating between depression and sadness is consistent with earlier studies in the palliative care setting^{17–20} and is salient, given that depression was almost unequivocally considered by participants in this study to be distinct from grief. This suggests a division between the intellectual clarity of concepts and clinical reality, which resonates with observations in the literature of the tension that arises from negotiating between categorical and dimensional concepts of illness.^{32–34} In this study, both of these concepts were applied to depression, which was variously described as an affect, a syndrome, and an illness. Such diversity in constructs is likely to fundamentally contribute to the ambiguity of depression when applied in the clinical setting.

Another conceptual issue apparent in this study is the uncertain causality of depression at EOL. Respondents were ambivalent as to whether identifiable causes existed. All proposed etiological factors for depression occurring at EOL were endorsed, but psychological, spiritual, or existential factors were more strongly endorsed than biological, cultural, or socioeconomic factors in terms of etiological importance. The clear preference for psychological intervention over pharmacotherapy suggests a relationship between attributed causality and treatment approach. Similar findings were reported by a study of family physicians active in palliative care, with management of depression mainly seen to be supportive and nonspecific in nature, while antidepressants were seldom prescribed.²⁰ In contrast, a qualitative study that explored the construction of depression among primary care physicians found a primarily biochemical etiological explanation,²⁹ which may suggest etiological conceptual differences in the EOL context. Indeed, depression being different at EOL was a theme in the respondents' comments, being seen to be more difficult to define, qualitatively different, and associated with unique diagnostic and treatment challenges.

Both area and duration of practice were associated with conceptual differences. Those mainly working in general practice were more likely to consider EOL depression to be a normative process and to have identifiable causes. A possible explanation is that general practitioners and palliative medicine specialists may hold different concepts of depression. Alternatively, the affective presentations of patients may differ between primary care and specialist palliative care settings. Trainees were more likely to view depression as an

illness at EOL, while those with the shortest medical careers were more likely to see depression as an illness in general. The reasons for these findings are unclear and warrant further investigation. Respondents involved in academic work had a qualitatively different view of EOL depression, being more likely to see it as a distinct concept with core features and as symptomatically consistent between individuals. This may signify a conceptual gap between academic and clinical practitioners, and by extension, between the published literature and clinical practice. Having had specific mental health training was associated with few differences in how respondents considered depression, except for a more proactive attitude towards treatment, which may reflect greater knowledge, skills, experience, and/or personal interest in mental health.

The results of this study need to be interpreted within the context of its limitations. The target population was restricted to Australasian medical practitioners who attended a palliative medicine conference, and is therefore not a representative sample of all palliative medicine practitioners. Nevertheless, the sample was highly relevant, being comprised entirely of practitioners who were active in clinical palliative medicine. The response rate was modest and the sample size was relatively small, which limited the comparative power among groups. Importantly, although this study demonstrates conceptual variability for depression at EOL, it does not characterize those concepts, their nuances, ambiguities, and overlaps. These concepts may be influenced by the medical practitioners' experience and training in both palliative medicine and mental health (which were varied in this sample), their areas of clinical interest and expertise, and their personal and cultural ideologies. Further understandings may be obtained through qualitative exploration of palliative medicine practitioners' constructs of depression.

The findings of this study have implications for clinical practice, education, and research. Palliative medicine practitioners have variable concepts of EOL depression and view depression to be different and complex in this setting. Yet clinical guidelines and research have not adequately acknowledged or addressed these conceptual challenges. This likely restricts the fruitfulness and clinical applicability of research that uses a unitary concept of depression. Medical education that implies depression is a well-defined concept with clear diagnostic boundaries and treatment pathways is similarly misleading, and may lead to over- or undertreatment of depression. For depression in the palliative care setting to be more meaningfully addressed, its conceptual ambiguities and diversity need to be acknowledged and further characterized through research. In particular, qualitative exploration of health professionals' and patients' concepts of EOL depression would be a useful focus for future research. This will complement knowledge regarding the diagnosis and treatment of EOL depression to inform the development of more sophisticated clinical guidelines for diagnosis and treatment decisions in this patient population.

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