

Decision making in the end-of-life care of patients who are terminally ill with cancer – a qualitative descriptive study with a phenomenological approach from the experience of healthcare workers.

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Abstract

Background: In Colombia, recent legislation regarding end-of-life decisions includes palliative sedation, advance directives and euthanasia. We analysed which aspects influence health professionals' decisions regarding end-of-life medical decisions and care for cancer patients.

Methods: Qualitative descriptive–exploratory study based on phenomenology using semi-structured interviews. We interviewed 28 oncologists, palliative care specialists, general practitioners and nurses from three major Colombian institutions, all involved in end-of-life care of cancer patients: Hospital Universitario San Ignacio and Instituto Nacional de Cancerología in Bogotá and Hospital Universitario San José in Popayan.

Results: When making decisions regarding end-of-life care, professionals consider: 1. Patient's clinical condition, cultural and social context, in particular treating indigenous patients requires special skills. 2. Professional conditions: training in palliative care and experience in discussing end-of-life options and fear of legal consequences. Physicians indicate that many patients deny their imminent death which hampers shared decision-making and conversations. They mention frequent unclarity regarding who initiates conversations regarding end-of-life decisions with patients and who finally takes decisions. Patients rarely initiate such conversations and the professionals normally do not patients directly for their preferences. Fear of confrontation with family members and lawsuits leads doctors to carrying out interventions such as initiating artificial feeding techniques and cardiopulmonary resuscitation, even in absence of expected benefits. The opinions regarding the acceptability of palliative sedation, euthanasia and use of medications to accelerate death without the patients' explicit request vary greatly. 3. Conditions of the insurance system: limitations exist in the offer of oncology and palliative care services for important proportions of the Colombian population. Colombians have access to opioid medications, barriers to their application are largely in delivery by the health system, the requirement of trained personnel for intravenous administration and ambulatory and home care plans which in Colombia are rare.

Conclusions: to improve end-of-life decision making, Colombian physicians and patients need to openly discuss wishes, needs and care options and prepare caregivers. Promotion of palliative care education and development of palliative care centres and home care plans is necessary to facilitate access to end-of-life care. Patients and caregivers' perspectives are needed to complement physicians' perceptions and practices.

Key Message: The results highlight the importance of improving access to end-of-life care in Colombia, and diminish the "denial of imminent death" among patients and caregivers to facilitate end-of-life discussions and shared decisions; interventions to prepare caregivers and promote home care.

Introduction

Despite advances in prevention, early diagnosis and new treatment options, many cancer patients eventually develop a terminal and advanced stage of disease, generating situations in which decision-making is difficult for patients, caregivers and doctors (1).

End-of-life (EoL) care, as part of palliative care, revolves around maintaining the quality of life of patients and their families, through comprehensive management of physical symptoms, psycho-social and spiritual difficulties. End-of-life care focuses on a short period of time before death (2) and includes discussion of medical practices (suspending or withholding specific cancer treatment and general care related to feeding, hydration, and resuscitation techniques; symptom management; euthanasia) and decision-making (3, 4). These decisions include *palliative sedation* (5) and euthanasia. Colombia is the only country in Latin America with a regulation to apply euthanasia. The process requires patients' request, multidisciplinary medical evaluation and verification by a special committee that all requirements are met (6).

Advance-care conversations and directives are increasingly used in high-income settings, seem to improve quality of life and quality of dying, and reduce unnecessary treatments (7-9)

There are some clinical and technical criteria to guide decisions at the EoL, but the patient's situation around the time of death is so particular to personal circumstances that decisions are mostly guided by clinical judgement and prior expertise (10).

Studies considering medical decision-making at the EoL have been mainly conducted in Europe the United States and Australia (10-13). No such studies have been conducted in Latin America. As cultural and social views on topics related to death vary greatly, and Colombia recently regulated euthanasia, it is important to explore what aspects determine decision-making at the EoL to identify difficulties and promote strategies to facilitate conversations, advance care planning and decision-making.

Methods

Design

We conducted a qualitative descriptive-exploratory study based on phenomenology (14) to explore the experiences of healthcare professionals in decision-making regarding EoL care of cancer patients through individual face-to-face semi-structured interviews. This approach recognizes that the experience of physicians making EoL decisions incorporates the interaction between professionals and their patient as well as their personal history and medical education and the influence of the health care system.

Ethics approval and consent

The study procedure was approved by the research ethics committees at Instituto Nacional de Cancerología (number INT-OFI-03581-2019) and Pontificia Universidad Javeriana (number FM-CIE-0086-17). The other institutions accepted the latter. All participants signed informed consent.

Participants and setting

This study was conducted in three Colombian institutions: Hospital Universitario San Ignacio (HUSI) and Instituto Nacional de Cancerología (INC), both in Bogota (capital city), and Hospital Universitario San Jose (HUSJ) in Popayan, located in the southwest of Colombia attending urban and rural populations. HUSI has a specialized centre for oncology and palliative care and attends mostly residents from Bogota (capital), most insured by a health insurance paid on the basis of a percentage of their income (contributive insurance), which implies they have income. The NCI attends around 10% of all Colombian cancer patients, from all types of socioeconomic background and health insurance, most patients are from the region close to Bogota, but an important proportion of patients come from remote areas. The population attended in HUSJ is largely of rural origin, living far away from big cities and clinics, many of them are from indigenous communities, most patients having a government subsidized health insurance type – implying low income.

Purposive sampling was employed to identify healthcare professionals who provide medical care for cancer patients at the EoL, including oncologists, pain and palliative care specialists, general practitioners and nurses that worked in these areas. Selection of participants was carried out seeking the greatest diversity of conditions including gender, time of experience with terminally ill patients, and socioeconomic conditions of patients attended. The research coordinator in each of the three participating hospitals provided names of the professionals matching the profiles.

Data collection

The interviewer (A.L., female general physician, masters in clinical epidemiology student and internal medicine resident, without formal relation with participants) collected informed consent and sociodemographic data of the participants after which she proceeded to the interview, based on an interview guide (supplementary table 1), previously pilot tested, including items about participants' perspectives on the influence of the clinical and socio-cultural condition of patients, the doctor-patient relationship, conditions of the health system, and ethical concerns in the decision-making process at the EoL.

Interviews were conducted between November 2018 and July 2019. One invited physician refused to participate due to lack of time. Interviews were done at the workplace, and audio recorded. Each interview lasted approximately 30-40 min. All personal information was anonymized for analysis and reporting.

Data analysis

A qualitative analysis of semi-structured interviews was conducted, coding was performed by two researchers (A.L. and N.G.), using a phenomenological approach and discourse analysis. Interviews were transcribed verbatim and coded using Nvivo 12 software. Segments of transcripts were assigned codes based on their significance. Emergent codes were revised through discussions within the research team. Through an inductive process, examining significance, finding similarities and relationships, codes were

organized into categories and later into themes. Initially, a total of 20 interviews were planned. Though there is not a definitive test for data saturation, according to the methods proposed by Francis et al, we defined that each time researchers think saturation has been reached an additional three interviews were carried out to make sure no new themes arise (15). Following this method more interviews were performed until three consecutive interviews with data saturation were obtained, resulting in a total of 28 interviews.

Results

Twenty-eight semi-structured interviews were conducted. Demographic characteristics of participants are shown in Table 1. The mean age of participants was 37.4 years (ranging from 23 to 59), 82% were physicians ($n = 23$) and 75% ($n = 21$) worked in palliative care settings.

Table 1: Demographic characteristics of participating healthcare professionals ($n = 28$)

Variables	n (%) or mean (SD)
Sex	
Female	10 (36%)
Male	18 (64%)
Age in years (mean, SD)	37.4 (9.6)
Race/Ethnicity	
White	6 (21%)
Mestizo ^a	20 (71%)
Black	0 (0%)
Indigenous	1 (3%)
Other	1(3%)
Education	
Medical oncologist	6 (21%)
Palliative care physician	9 (32%)
Anaesthesiologist	1 (4%)
Internal medicine physician	1 (4%)
General practitioner	6 (21%)
Nurse	2 (7%)
Nurse assistant	3 (11%)
Discipline:	
Oncology	7 (25%)
Palliative care	21 (75%)
Years of practice with cancer patients at the end of life	
Less than 6 months	0 (0%)
6 to 12 months	1 (3%)
1 to 4 years	12 (43%)
More than 4 years	15 (53%)
SD: standard deviation	

Through the interviews three main themes emerged around decision-making and medical practices in the EoL care of patients who are terminally ill with cancer:

1. The cancer patient from the health professionals' point of view
2. Physicians' conditions
3. Medical practices at the EoL and their application in the health system

The cancer patient from the health professionals' point of view (Box 1)

Physical needs. Most participants describe patients predominantly from the perspective of the disease: the symptoms and functional impairment due to the illness. The main source of concern identified for patients, families, and participants themselves is symptom-related suffering, most importantly pain.

Non-organic needs. Some health-professionals described patients' feelings and other sources of concern such as spiritual aspects, family, and financial matters. Also, physicians consider patients may be afraid of being "abandoned" at the EoL, especially when disease-modifying therapy such as chemotherapy is no longer an option.

Interviewees describe how for patients living in rural areas, the progression of the disease to the end of life, is not only determined by the course of the illness but also by limitations to receive appropriate treatment due to distances and economic implications of displacement to the city.

In Popayan, patients' culture takes on greater relevance, especially for patients belonging to indigenous populations; they have a different, more peaceful vision of death and their beliefs and traditions expand management options to include traditional medicine.

Caregivers concerns. Participants identify patients as autonomous individuals with the right to be informed and make decisions regarding their health. Later in the course of the disease, when perhaps the level of conscience of the patient is affected, the family usually act as the patient's representative.

Families residing in rural areas are identified as generally more willing to take care of the patients at home, considering pain, suffering and death as processes that are a part of life, and being used to an active role of families and communities in caring for people. Economic limitations to bring the corpse back to the community for the funeral, should the patient die in a different city, may also influence this willingness. Participants indicate that family members who are reluctant to take care of patients at home seem to be feeling unprepared and have less time and economic resources available to be able to provide the needed care to their relative.

Physicians' conditions (Box 2)

The doctor-patient relationship. For the health-professionals, the oncologist is the main responsible for cancer patients: providing cancer treatment, giving information regarding disease progression and prognosis, and making initial EoL decisions. Patients often don't have access to palliative care from an early stage in the disease as a consequence of the way the Colombian healthcare system works and because of shortage of palliative care services. Where oncology services are not available, palliative care, internal medicine specialist and surgeons are identified as those in charge of EoL decisions.

Oncologists report that they inform patients and caretakers progressively from diagnosis, explaining the prognosis and treatment intention in each visit. The majority of healthcare-professionals consider that patients frequently mention not to have been informed regarding their disease status because they are in a denial stage within the mourning process of having a terminal disease.

Empathy (ability to recognize and understand patients' emotions) and trust are the two main attributes identified by the participants in the doctor-patient relationship, both developed through communication. Participants mention that special skills are required to give bad news and make EoL decisions, to provide clear information without eliminating hope in the patient and conveying confidence from the physicians' point of view. They mention that this skill is acquired through experience.

Some physicians are identified by colleagues as people with greater empathic ability to communicate with patients at the EoL. Upon interviewing these physicians, we found they had more experience working with patients at the EoL and all talked with their patients about non-organic needs and worries. They express that time invested in these conversations leads to greater knowledge of the patient's life, builds trust, opens a comfortable space for patients to express their own ideas regarding management options and initiate EoL discussions.

The Colombian healthcare system is another barrier to a trusting patient-doctor relationship; cancer patients are frequently forced to change healthcare provider because of changing contracts between their health insurance and providers. This move from one physician to the next may result in the patient and his family perceiving the treating physician at the EoL as a stranger who has come to bring down hopes and expectations.

Medical practices at the EoL and their application in the health system (Box 3)

Decisions made about EoL care involve changes in the treatment and practices related to dying:

Not initiating or suspending specific cancer treatment (mostly chemotherapy) is a decision made by the oncologist who considers patient's clinical condition, functional and nutritional status as the basis to contemplate treatment options. Participants explain that it is always more difficult to suspend treatments than to not initiate them, and although there are some clinical criteria to guide these decisions, clinical judgement remains key.

Earlier referral to availability of palliative care services would diminish patients' fear of abandonment and facilitate decision-making. In Popayan, very limited access to oncology services sometimes imply that

palliative care is the main attention received by cancer patients from diagnosis, representing frustration for all involved.

Suspending general care measures. This practice most frequently present ethical dilemmas to the participants: who should make these decisions and who should start EoL conversations with the patients? There is no clarity among professionals how these roles are and should be distributed.

Health-professionals identify nutrition as the main source of anxiety at the EoL among patients and caretakers. As long as the patient can eat, intake is guided by patient's wishes. Oncologists are generally against artificial feeding techniques (enteral and parenteral feeding), other physicians argue these may present possible benefits in terms of quality of life. All participants agreed that once artificial feeding techniques have been established, withdrawing these is almost impossible: this causes ethical dilemmas and confrontation with patients and caregivers.

They also agreed that artificial hydration, when provided in a home-care setting, requires training, delivery of resources and availability of programs to avoid and manage complications. Oxygen is considered a basic measure and hardly ever withdrawn as this generates feelings of abandonment.

Regarding advanced procedures such cardiopulmonary resuscitation procedures, participants state that patient wishes should guide decisions, but that patients hardly ever have advance directives. Some physicians think patients do not initiate EoL conversations because they do not want to talk about death. Despite this, few health-professionals ask patients directly for their preferences and state that most patients do not express clear wishes.

Some physicians consider "do not resuscitate" agreements are valid medical options in this scenario. Others mention that fear of confrontation with family members and lawsuits can lead doctors to carrying out interventions ranging from initiating artificial feeding techniques to initiating cardiopulmonary resuscitation, even in absence of expected benefits.

Intensified symptom management. All participants considered this practice the basis of EoL care. The existence of opioid medications with different relative potency and routes of administration available in Colombia is one of the strengths mentioned. Barriers to their application are largely because of difficulties in delivery by the health system, the requirement of trained personnel for intravenous administration and ambulatory and home care plans which in Colombia are rare.

Palliative sedation. Oncologists have a clear definition of palliative sedation but consider this beyond their area of expertise. Most physicians working in palliative care have a clear concept of this practice, they commonly consider in-hospital settings and require in most situations a written consent of the patient or caregiver. Some health-professionals consider this practice can accelerate the arrival of death and therefore have ethical objections.

Euthanasia: participants mention to hardly ever receive euthanasia requests, some think euthanasia is not yet culturally accepted and therefore their patients do not request information, others state that they

do not feel prepared to discuss euthanasia as they lack clarity regarding the procedures.

Participants think euthanasia should not be mentioned as an option before a patient mentions it himself; this would be considered to go against the principles of professional practice.

One physician believed that some of his patients may have committed suicide and thinks these patients may have considered but never formally requested euthanasia or had difficulties in obtaining approval. Another participant considered that using medications to accelerate the moment of death of patients in the final stages of life can be a valid medical decision to “facilitate a dignified death”, even without the request or consent of patients or relatives.

All participating palliative care physicians were against euthanasia arguing that optimal palliative care is still not accessible to all patients in Colombia and therefore euthanasia should not “replace” optimal care. They also relate euthanasia with a feeling of failure and frustration for not being capable to control patients’ symptoms. Some consider the approved protocol for euthanasia in Colombia technically inadequate, for others euthanasia goes against their personal religious beliefs.

Discussion

Main findings

This study explored perspectives of health-professionals on the decision-making process in the EoL care of terminally ill cancer patients in different settings in Colombia. Three main conditions influence the way this process flows: patients clinical and socio-cultural conditions, physicians’ relationship with patients and caregivers and palliative care education, and health system possibilities and limitations.

In line with literature, the expected benefit of each intervention alleviating suffering and improving quality of life are the first factors to influence decisions (16).

The plurality of cultures within the Colombian population causes frequent differences in physicians own’s culture versus their patients’, requiring special skills in the management. Physicians attending patients from rural areas must consider distance from treatment centres, economic limitations for traveling and limited access to home-care services in the decision-making process, as has been reported elsewhere (17, 18).

However, a recent systematic review regarding rural EoL care from the experiences and perspectives of patients and family caregivers did not include any study from Latin America (19). In the experience of our participants, many patients coming from rural areas are part of indigenous populations. They indicate that when patients belong to indigenous groups, physicians are required to understand patients’ beliefs, the structure and functioning of families and communities as a social organization, be open to some alternative management options from traditional medicine and have enough time to discuss each of these topics.

Previous investigations from patients' perspective have shown the main problems at the end-of-life care to be communication, difficulties in accessibility and responding quickly to acute problems (20). In the main cultural groups in Colombia, the taboo on talking about death and dying, physicians' perception of patients not willing to talk about these topics impedes optimal decision-making processes, causing suboptimal communication and probably suboptimal care and symptom management (21, 22). Unfortunately, there are no studies from the patients' perspective from similar populations to contrast these findings. It seems that in Latin America many physicians may feel their task is to cure patients, and that accompanying them to a "good death" is not their responsibility. Nevertheless, these findings are in agreement with studies in other worldwide populations where talking openly about death and dying is not acceptable because it is considered disrespectful, bad luck, or causes loss of hope (23-25).

Important barriers to proposing home-care for patients in the EoL, besides fear of abandonment by the healthcare system among patients and caregivers (26), are the very limited offer of home-based palliative care and perceived feelings of unpreparedness from caregivers. Prior research has shown caregivers' preferences changed in demand of the situation and the level of uncertainty (27, 28). Unfortunately, there are no studies from the caregivers' perspective in our population to contrast physicians' impressions.

In addition, regulation regarding prescription, delivery and application of opioids hamper home-care of patients; professionals are required to formulate most drugs and delayed delivery causes a barrier which is not always necessary (22, 29). In other LMIC home-care including effective opioid administration, from prescription to administration, has been made possible (30, 31).

During the decision-making process other significant barriers for doctors are lack of clarity regarding the intention of each practice and their application processes which can relate to ethical dilemmas (32) and for our interviewees also feelings of frustration, confrontation with caregivers and fear of lawsuits. For palliative sedation and euthanasia to be accepted, having regulation is not enough. It is also necessary to socialize the requirements, processes, and protocols with patients and physicians, since confusion regarding these topics cause ethical dilemmas and limit discussions and, in some particular scenarios, might generate situations where drugs are applied to terminate the lives of patients even without their request or consent. On the other hand, our data show that perception of lack of openness to discuss euthanasia may lead to patients committing suicide without physicians accompanying the patients nor their families.

Some of these findings, such as the importance of the expected benefit of each intervention alleviating suffering and improving quality of life and difficulties in communication between physicians and patients, are in line with findings from other countries (16-18, 24-26), others, like limitations to access early palliative care and fragmentation of care in different institutions and cities, have not been reported from other countries and have to do with the socio-cultural circumstances in Colombia combined with limited healthcare system capabilities (33).

Strengths and limitations of the study

The strengths of this first study to report on the situation in Latin America include the large and diverse group of participants from different areas and fields, receiving a variety of responses on the most controversial topics and having achieved saturation of the data. The participating institutions represent different social and cultural contexts, although the selection of participants mainly from major hospitals may not represent the reality of several more rural areas of the country where patients are mainly attended by general practitioners. It would be interesting to include more testimonies from other health-professionals. Another limitation was the difficulty in examining more closely ethical dilemmas related to EoL care identified by doctors and their ability to analyse and resolve them. Some problems of the health system that lead to difficulties described in the decision-making process deserve more in-depth research.

Implications for practice and research

Further research on patients' thoughts about the decision-making process at the EoL in Colombia is necessary to contrast our physician's perceptions and to develop strategies that facilitate starting EoL conversations. It is necessary to promote further education of health-professionals in the practical and ethical issues and application of end-of-life care and in other social and cultural aspects of the populations that have direct implications on the final stage of life. Also, there is a need to inquire about caregivers' concerns and design programs to train and support them.

It is essential to promote continued care by a fixed, stable team of health-professionals as this facilitates a trusting doctor-patient relationship and allows more time to discuss topics different to clinical needs.

More home-based care services and palliative care centres and effective communication between them and oncology services are required to facilitate access to specialized care and transition to EoL care.

Declarations

Availability of data and materials

All data sets on which the conclusions of the paper are based are available upon request to the corresponding author.

Declaration of conflicting interests

The authors have no potential conflicts of interest, no relationships with any company that might have an interest in the submitted work in the previous 3 years, and no other relationships or activities that could appear to have influenced the submitted work.

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Ethics approval and consent to participate

The study procedure was approved by the research ethics committees at Instituto Nacional de Cancerología (number INT-OFI-03581-2019) and Pontificia Universidad Javeriana (number FM-CIE-0086-17). The other institutions accepted the latter. All participants signed informed consent. All methods were performed in accordance with the relevant local and international guidelines and regulations.

Consent for publication:

not applicable

Authors' contributions:

EdV, ALM, NGC, CGR, FG conceptualised the study, EdV, ALM, CGR developed the methodology and analytical plan. ALM, NGC undertook data collection and preliminary analysis assisted by JAC, OM FL. JAC, ED, FG, OM, FL, CGR and EdV contributed to final analysis and interpretation of the data. All authors read and approved the final manuscript.

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Abbreviations

EoL End of Life

QoL Quality of Life

HUSI Hospital Universitario San Ignacio, Bogotá, Colombia

INC Instituto Nacional de Cancerología, Bogotá, Colombia

HUSJ Hospital Universitario San Jose, Popayan, Colombia

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Boxes

Box 1. Patient conditions	
Subthemes	Quotations
Physical needs:	
Patients' clinical condition and symptoms are the basis of medical decisions	<ul style="list-style-type: none"> · <i>"I think the most frequent concerns are the physical symptoms: pain, thirst, respiratory distress"</i> · <i>"The difficult part of oncology is not deciding when to start a treatment but to know when to stop it, so many times the decision to stop is related to the functional status of the patient and his/her prognosis and treatment goals"</i>
Non-organic needs:	
Serving patients with different cultural contexts require special skills	<ul style="list-style-type: none"> · <i>"When discussing the end-of-life with indigenous people the situation changes dramatically. Both the cultural and religious perception of death is completely different. People who have ancestral beliefs live the process of death and dying in a more peaceful way, in their culture it's a normal event"</i> · <i>"I do not debate his (the patients') beliefs or his attitude towards end-of-life. I try to adapt and for that I have tried to educate myself regarding their cultural and historical aspects, about the way they think and feel, and what might be important to them"</i>
Patients coming from rural areas or different cities face different problems related to distance and cost of traveling	<ul style="list-style-type: none"> · <i>"(...) In Popayan and probably in Colombia in general, one of the main barriers is the need to go to different cities for treatment, some patients travel 2 or 3 hours on horseback (...) they miss appointments because they don't have money (...) "</i> · <i>"Some (patients) say: - I don't live here. If I die here, taking my body home will be expensive-. They live very far and are poor"</i>
Caregivers concerns:	
Caregivers' feelings of unpreparedness and fear of abandonment can hinder the transition to exclusive end-of-life care and diminish their willingness to take care of patients at home at this stage of the disease.	<ul style="list-style-type: none"> · <i>"when the family does not have the means to provide the necessary comforts at home to take care of the patient, they prefer he'd stay at the hospital"</i> · <i>"country people have greater support of the family to take care of them at home"</i> · <i>"Many times, patients keep going to the oncologist until death because they are afraid no one will take care of them anymore. If they know that we'll be the ones (palliative care team) who take care of them until death and even after that - care for the family is part of our grief protocol - it is easier to stop specific cancer treatment and other interventions"</i>

Box 2. Physician's conditions	
Subthemes	Quotations
<i>The relationship between physician, patient and caregivers:</i>	
Physician's perceptions of patients being in denial or being already informed and prefer to avoid these topics is the one of the main barriers to initiate and discuss end-of-life care options and make decisions earlier in the course of the disease	<ul style="list-style-type: none"> · <i>"... many patients say: -nobody told me anything-, but this is part of the process of denial, it's completely normal (...), that is why we reinforce our concepts in the medical records"</i> · <i>"It's not common for us to talk about death. We talk about symptom control, patients know that their disease has progressed, and that death is near, but they almost never ask questions about it and for me to bring it up, it feels like putting my finger deeply into this wound. So, I ask indirect questions like: -where do you want to be now that you are not going to have treatment anymore? "</i>
Empathy and trust build with time shared and facilitate end-of-life care discussions and decision making	<ul style="list-style-type: none"> · <i>"Over time, I inadvertently learn some things about his (the patient) life: e.g. what his children do, and that makes him feel important, he trusts me."</i>
Confrontations with caregivers and fear of lawsuits can impulse physicians to perform some interventions even when they know these will not represent any benefit to the patient	<ul style="list-style-type: none"> · <i>"When patients are taken to the emergency department because of dyspnoea some family members say: -I want him to be resuscitated, to be intubated, to do everything possible - and it is difficult for the doctor to go against that wish, especially from a legal point of view, the doctor usually end up performing these manoeuvres, even when, in his opinion, it is useless."</i>
<i>Medical practice</i>	
Training in end-of-life care is considered insufficient and theoretical. Physicians consider communications skills to inform and discuss end-of-life management options are skills acquired through practice and experience.	<ul style="list-style-type: none"> · <i>"I am convinced that communicating appropriately requires sensitivity. One can train that and become proficient in the ability to inform in a smooth but realistic way the patient's situation and the possible outcomes"</i> · <i>"I think the problem resides in undergraduate medical school. There is no theoretical training in these topics and even less a practical one. We do offer a palliative care seminar for a week but it is very theoretical and unfortunately not all med students rotate with us, those that do are here five days - practice time also falls short"</i>
For palliative sedation and euthanasia: lack of knowledge of definitions and application process as well as feelings of frustration and ethical dilemmas	<ul style="list-style-type: none"> · <i>"(Euthanasia) is not common here, it seems to not be culturally accepted, occasionally a patient has asked about it but not with the legal formality needed... It seems to me that patients don't know much about this practice"</i> · <i>"We don't really have a protocol to handle a request for euthanasia in our institution, there are a couple of initiatives to hold a meeting regarding the issue, but there is not a real plan on how we should act as professionals if a patient comes to this hospital and requests euthanasia "</i>

Box 3. Conditions related to the health system	
Subtheme	Quotations
Fragmentation in care decreases trust, hinders doctor-patient relationship and therefore end-of-life discussions	<i>"When I see the patient for the first time and he is already at the end-of-life, it's more complicated. If I'm presenting palliative sedation as an option or talking about home-care options, for example, there will be mistrust of the patient and the family. Many times, there are confrontations. They don't want the participation of an unknown person who is also cutting their hopes and expectations"</i>
Lack of home-care services limit at options of care at the end-of-life	<i>"Let's say a patient requires a subcutaneous morphine infusion. That is relatively simple. But for us there is no way to do it at home. So, it would be a waste of time to inform the patient about this option of home-care, since at the end it won't be possible. I do believe that we are still lacking home-care services throughout the country and particularly in Popayan"</i>
Time limits during physicians' consultations or visits prioritizes clinical aspects of care, causing neglect of other patient needs	<i>"Because of time restrictions we have to prioritize medical management of the patient. We don't have time to discuss other topics like grief "</i>

Supplementary Files

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