

Assessment Of The Knowledge Of Palliative Medicine Among General Practitioners

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Abstract

Background: Palliative patients who stay at home require exceptional medical care provided by General Practitioners (GPs) in conjunction with specialists in palliative medicine. To ensure effective treatment, proper cooperation between them is essential.

Aim: An assessment of the knowledge and attitudes of GPs towards palliative medicine

Design: The research was based on a survey questionnaire, consisting of 8 multiple choice questions. A total of participated anonymously in the survey. The data analysis included descriptive statistics and logistic regression. Participants: 83 GPs from the Pomeranian Region, 58 female and 25 male practitioners.

Results: 59% of respondents defined palliative care as an activity that improves the quality of life of patients and their families facing problems related to a life-threatening illness. The coordination of the work of the palliative team was the most important task for the specialist in palliative medicine (58% of respondents). The majority stated that the most important activity was the prescription of painkillers (86%) and 84% found that being available during business hours was the most important. The next most important activity was delivering bad news (42% of respondents).

Conclusions: Most of the GPs knew the correct definition of palliative care and the basics of pain management. Experienced physicians declared a lower willingness to be available during working hours and less often delivered bad news to terminal patients, compared to their younger colleagues. Individual treatment planning (98% of respondents) and reducing antibiotic therapy seem to be the most important aspects in pharmacotherapy.

Introduction

Patients with advanced cancer may receive palliative care in inpatient or home hospices. Those individuals that remain at home may receive the care of a general practitioner as well as the home hospice team. Effective cooperation between them has been found to be necessary for proper holistic care and due to the time devoted to and required for a particular patient. Home hospices are available for any patient in the advanced stages of cancer, although other indications that significantly affect quality of life are also included. Nevertheless, general practitioners are the ones who can provide end-of-life care due to their close relationship with their patients. This care includes, for instance, the recognition and recommendation of appropriate hospice care when it is required¹. General practitioners coordinate the work of all parties involved in dealing with cancer patients staying at home. This cooperation also includes the involvement of other institutions, not only medical but also social welfare ones. The palliative care specialists and general practitioners also take care of the families of palliative care patients, especially at the time of death and during the mourning period. Once the decision to refer a patient to a hospice has been made, the general practitioner usually continues attending to them. Individuals that are affected with advanced cancer require not only medical assistance but also nonmedical support both in the field of rehabilitation and psychological functioning. In the advanced stages of cancer, however, palliative medicine specialists with sufficient experience in that area take on a key role in patient care. Their knowledge and practice in the therapy of pain as well as the treatment of common symptoms such as nausea, vomiting, constipation, pruritus, and bedsores are particularly important. Finally, in the terminal stages of cancer, the dominant care is provided by the home hospice team. Firstly, they may be able to devote more time to the patient and his family and provide psychological support as well. Furthermore, the time of death is extremely difficult for the patient and their family, which may lead to many conflicts and problems. To achieve the proper and holistic care of palliative care patients, effective and conflict-free cooperation between GPs and the home hospice team is essential.

AIM

The aim of the study was to assess the knowledge and attitudes of general practitioners towards palliative medicine and their personal approach to cancer patients in home care.

Methods

Design

The questionnaire survey created by the researchers consisted of eight questions and was carried out anonymously among general practitioners working in the Pomeranian Region.

Data analysis

A total of 83 completed questionnaires were received back and then the data analysis, including descriptive statistics, was carried out with a comparison of the groups in terms of age and years of practice. Furthermore, logistic regression was used to assess the influence of certain factors on individual opinions.

Data collection/processing

Respondents were surveyed from December 2017 to December 2019.

The data from the study were stored at the Department of Palliative Medicine of the MUG in Gdansk.

Key statements

What is already known about the topic?

Home is the best place for terminally ill patients. Home hospice patients get the care of the home hospice team and general practitioners.

Proper cooperation between general practitioners and the home hospice team guarantees good quality of care.

What this paper adds?

General practitioners define palliative care as an activity that improves the quality of life of patients and their families facing problems related to a life-threatening illness.

General practitioners, although those are available during business hours from Monday to Friday, is the most important activity in taking care of palliative patients. Next is prescribing painkillers and breaking bad news.

The coordination of the work of the palliative team is the most important task for the palliative medicine specialists in GP's opinion.

Implications for practice, theory or policy

A holistic approach to palliative care is required to ensure proper quality of care

General practitioners with longer work experience declared a lower willingness to be available during working hours and to break bad news to patients who are terminally ill. There is a high need to prevent the syndrome to burn out and find a relevant way to do it.

Results

A total of 83 GPs filled in the questionnaire, comprised of 58 women and 25 men. The characteristics of the surveyed group are presented in **Table 1**.

The respondents were asked to choose the most appropriate definition of palliative care (out of 5 definitions), 59% of respondents were convinced that palliative care is an activity that improves the quality of life of patients and their families facing problems related to a life-threatening illness, 33% that palliative care is an activity that improves the quality of life of non-curable patients.

2% - palliative care is an activity aimed at eliminating or reducing all adverse somatic symptoms in terminally ill patients, 1% palliative care is an activity aimed at alleviating or reducing pain in terminally ill patients.

The most chosen definition of palliative care did not depend on the age or work experience of the respondents (checked with the chi-square test).

Moreover, the GPs also expressed their opinion on activities that could be considered as being part of the responsibilities of the primary care physician while caring for a cancer patient (five multiple choice answers connected to the given activities were presented).

The results of the assessment of the importance of certain activities in the primary care of patients suffering from cancer are presented in **Table 2**.

The results of the survey indicate the importance of being available during working hours from Monday to Friday.

Moreover, the prescription of non-opioid pain medications turned out to be significantly associated with the length of practice of the physicians (checked with the Fisher test). In the assessment of the importance of the activities performed by the palliative medicine specialists (question 3), **the coordination of the work of the palliative team was found to be the most important role of the palliative specialist** (score in question 3b: 1.75, sd:1). **This was followed by specialised counselling for a GP's needs** (answer to question 3a, score: 2.48, sd:1) **and the sharing of clinical responsibility for the patient's wellbeing** (3d score: 2.61, sd:1,12). The least important of the responsibilities was providing training for GPs (score 3.24, sd:0.85 in question 3c).

Interestingly, no differences were found when comparing groups by gender. The further results highlighted the opinions of the GPs on the importance of activities (such as the responsibilities of the primary carer) in the treatment of cancer patients.

The respondents were asked to give a rating from 1 to 4 for each mentioned activity, with 1 being the most important activity, in their opinion, and 4 being the least important. The obtained results are presented in **Table 3**. The analysis showed no differences between women and men.

The next question concerned the opinions of the participants on the importance of the listed activities towards patients in the terminal phase of their illness. They were asked to rank the listed activities from 1 (most important) to 6 (least important). The results are presented in **Figure 1**.

According to the results of the survey, the most important activity in the terminal phase of life is the inclusion of palliative sedation if the patient is suffering and analgesia is ineffective (mean: 1.83, sd: 1.17). This was followed by the withdrawal of medicines that are not beneficial for symptomatic treatment (mean 2.57, sd: 1.05), the continuation of analgesic therapy even if the patient is unconscious (mean: 2.75, sd: 1.43), the reduction of antibiotic therapy (mean: 4.17, mean: 1.01) and visiting the patient daily or several times a week (mean 4.39, sd: 1.33). The least important activity for the respondents was admission of the patient to the hospital (mean: 5.49, sd: 1.14).

The next question assessed in the study concerned the requirements of palliative care according to the experience of the participants. As part of this inquiry, respondents were asked to choose three statements from the presented list. The overall results are presented with a special focus on the gender and work experience of the participants (**Table 4**).

The analysis showed no difference between the years of practice and age (only at the point of – standard therapy in accordance with international guidelines – was there a statistically significant difference, which was checked with the Kruskal-Wallis test). The final questions concerned knowledge about palliative

care and the management of symptoms. The majority of respondents correctly pointed out that the analgesic ladder has three steps (78%). However, there were also some who stated that the analgesic ladder has 4 steps (16%), and other respondents who even indicated it had 5 steps (6%). Finally, the descriptive statistics were completed by an analysis of logistic regression to assess the influence of certain factors on the individual opinions of the respondents (by choosing certain answers). In the survey's second question, the choice of activities such as prescribing opioid pain medications was not fully explained by any researched factors (e.g., age, gender, years of practice). Interestingly, the analysis showed some tendency ($p=0.076$) in being available for palliative patients within working hours from Monday to Friday (with the longest working experience being associated negatively with this conviction). This model was explained by 20% variance. Willingness to deliver bad news was also explained by length of practice, with longer experience being associated with a lower willingness to deliver bad news. Moreover, the logistic regression model highlighted this as statistically significant ($p=0.03$), explained by a 9% variance.

Discussion

Main findings

In this study, the majority of respondents (59%) defined palliative care as an activity that improves the quality of life of patients and their families facing problems related to a life-threatening illness. They also considered that the availability of medical care from Monday to Friday is the most important criterion that should be met by a GP dealing with a patient with a terminal illness who is staying at home. Similar results have also been obtained by Italian research. In that study, GPs pointed out that within their daily practice, in regard to caring for patients in the terminal stage of illness, "constant availability on weekdays" was the most frequently indicated activity (93.7%), although conversely the least important was "availability during the night" (16.7%)¹⁰. We can assume that giving a patient emotional comfort and a sense of security is the most essential thing for a caring doctor. However, our respondents with the longest work experience (over 20 years) less often chose the answer that it was their duty to be available during regular business hours.

Furthermore, the respondents considered that prescribing painkillers (including opioid drugs) is the second most important task in their daily care for cancer patients, followed by breaking bad news in the third place. Practitioners with longer experience (over 20 years) were more likely to assess their duty as being to prescribe painkillers and less likely to claim that breaking bad news is part of their vocational responsibilities. The question arises about the possible reasons for such results. What makes senior physicians less willing to deliver bad news and to be available for patients in advanced stages of cancer who are staying at home (when the GPs surveyed were still responsible for the medical care of this group of patients)? This may be a result of training in palliative care and delivering bad news (in Poland a five-day palliative medicine course has only been included in the curriculum of the final year of medical studies since 1991)¹². Another reason may also be the degree of burnout which the surveyed individuals could be experiencing¹³. Several studies have suggested that physicians engaged in end-of-life care are more susceptible to burnout because they may experience multiple stressors, including a sense of failure or frustration when a patient's illness progresses¹⁴. Breaking bad news is also a stressful situation for physicians, which they sometimes avoid during a consultation. Some data in the literature reveal that many GPs have received no formal training in breaking bad news and half of them felt that they were inadequately prepared for task^{15,16}.

Strength/weakness

In the face of a cancer epidemic, it should be assumed that the number of patients suffering from cancer who will die at home in the advanced stage of the disease will increase. A number of studies have indicated that GPs are aware of this fact and have a great need for cooperation and integration with a professional home hospice team¹. It should be noted that in recent years a number of studies regarding the knowledge, attitudes, opinions, and duties of GPs during palliative care have been carried out in the US, Australia, the Netherlands, the UK, Denmark, Romania and Hungary^{2,3,4-8}. It is indisputable that the cooperation between palliative medicine specialists and GPs is necessary to ensure the proper holistic care of patients in the terminal stage of cancer^{9,10}.

What this study adds

This study is one of the only a few carried out in European conditions to assess opinions about cooperation between palliative medicine specialists and GPs. The implementation of specialised palliative care at the earliest stage of care is beneficial and valuable for a patient with advanced cancer. When introduced at the time of diagnosis, palliative care leads to a decreased number of events of hospitalisation¹¹. Our study showed that GPs have a good theoretical knowledge about pain treatment (daily doses of morphine) and these results are comparable with the aforementioned Italian study¹³. Additionally, the majority of respondents (98%) agreed that palliative care requires an individual treatment plan, with 42% considering that it requires a diagnosis and therapy based on previous experience. When considering pharmacotherapy, the GPs concluded that reducing unnecessary antibiotic therapy and carrying out effective analgesic therapy, even if the patient is unconscious, is most important. What is more, in the case of ineffective analgesic therapy (in spite of intensification), they highlighted palliative sedation as a leading option (in the face of patient suffering).

Implications for practice

Home hospices can also offer more support and improved care for patients during their terminal phase of illness, and patient care is enhanced when the primary care physician maintains control over the patient's care until his or her death. In this group of GPs, participation rates were high for most of the therapeutic and communication tasks suggested in the questionnaire. GP participation is feasible not only in palliative care, but also in some aspects of oncological treatment and clinical follow-up. Communication with both patients and hospital seems good in this local setting, and GPs are important helpers for some cancer patients.

The dynamic development of palliative care and the aging of many societies make palliative care increasingly important. In the case of integrated care of home hospice and general practitioners, defining the problems occurring in this care will allow to improve. One of the main goals of our research was to assess the

attitudes of GPs towards specialists in palliative medicine. In this study, GPs pointed out that the coordination of the palliative care team and conducting specialised counselling for the needs of the primary care physician were the most important tasks of the palliative medicine specialists. Among the surveyed respondents, the need for cooperation with palliative medicine specialists in the area of pain treatment and breaking bad news was highlighted. The review of the literature also showed similar trends among GPs in other countries. For instance, additional training in palliative medicine and better collaboration with palliative medicine specialists is highly demanded¹.

Conclusions

1. GPs define palliative care as an activity that improves the quality of life of patients and their families facing problems related to a life-threatening illness.
2. The majority of GPs regard being available during business hours from Monday to Friday as the most important activity. Prescribing painkillers and breaking bad news are the next most important activities, although respondents with longer work experience declared a lower willingness to be available during working hours and to deliver bad news to patients who are terminally ill.
3. In the opinion of the GPs, the coordination of the work of the palliative team is the most important task for the palliative medicine specialists.
4. An individual treatment plan and reducing antibiotics are the most important aspects of pharmacotherapy for palliative care patients.

Declarations

Ethics approval and consent to participate

Full ethical approval was obtained from the Ethical Committee of the MUG (Medical University of Gdansk), resolution number NKBBN/361/2020.

Informed consent was obtained from all participants of the study.

I confirm that all methods were performed in accordance with the relevant guidelines and regulations.

Consent for publication

All authors of the manuscript have read and agreed to its content and are accountable for all aspects of the accuracy and integrity of the manuscript in accordance with ICMJE criteria

That the article is original, has not already been published in a journal, and is not currently under consideration by another journal. All authors agree to the terms of the BioMed Central Copyright and License Agreement and Open Data policy.

Availability of data and materials

Data and materials are depositing in a public repository of Medical University of Gdansk

<https://ppm.gumed.edu.pl/info/researchdata/GUMaefbd15928e84bc19fd7012e445a5498/Szczeg%25C3%25B3%25C5%2582y%2Brekordu%2B%25E2%2580f%2582r=researchdata&ps=20&tab=&lang=pl&pn=1&cid=7996>

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Authors' contributions

MO, AW and AG wrote the main manuscript text. AW is responsible for statistics.

PM prepared figure and tables. All authors reviewed the manuscript.

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Tables

Table 1: The characteristics of the surveyed group

Age	Number of GPs	Female	Male
25-30	21	15	6
31-45	29	19	10
46-60	25	18	7
Over 60	8	6	2
Total	83	58	25

Table 2 : Which actions do you consider to be part of the responsibilities of a primary care physician while caring for a cancer patient?

Question 2: Which actions do you consider to be part of the responsibilities of a primary care physician while caring for a cancer patient (multiple answers possible) * = dependence on seniority (Fisher test)							
Chosen answer	% of choices (n=83)	Gender % of choices		Seniority % of choices			
		W% (n=58)	M % (n=25)	0-5 (n=26)	6-10 years (n=7)	11-20 years (n=23)	over 20 years (n=27)
2a. Being available during business hours from Monday to Friday* (p=0.008)	84.00%	83	88	88	86	100	67
2b. Being available "on the phone" throughout the week	10	12	4	12	14	0	15
2c. Breaking bad news	42	40	48	58	71	39	22
2d. Prescribing painkillers (except opioid drugs)* (p=0.022)	5	7	0	0	0	4	11
2e. Prescribing painkillers (including opioid drugs)	86	81	96	88	86	9	81

Table 3: Which of the given activities of a palliative care specialist do you consider to be important?

Question 3: Which of the given activities of a palliative care specialist do you consider to be important? (Give a rating to the answers in a range from 1 to 4, with 1 being the most important activity and 4 the least important).				
Activity	1 the most important	2	3	4 the least important
3a. Conducting specialised counselling for a GP's needs	20%	30%	33%	17%
3b. Coordinating the work of the palliative team	58%	19%	13%	10%
3c. Providing training for family doctors	5%	12%	37%	46%
3d. Sharing clinical responsibility for the patient's wellbeing	18%	35%	14%	33%

Table 4 : What does palliative care require ?

Question 5: What does palliative care require, from your experience? (Please tick up to three answers)							
Chosen answer:	% of choices (n=83)	Gender % of choices		Seniority % of choices			
		W% (n=58)	M %	W% (n=58)	M %	W% (n=58)	Above 20 (n=27)
5a. Individual treatment plan	98	100	92	96	100	100	96
5b. Treatment according to hospital recommendations	2	3	0	0	14	0	4
5c. Diagnosis and therapy based on previous experience	42	43	40	42	43	43	41
5d. Diagnosis and therapy based on scientific evidence	37	34	44	38	43	30	41
5e. High-performance technology	18	22	8	12	29	26	15

Figures

Question 4: Which of following actions do you consider to be important for patients in their terminal phase of life? (Number the answers from 1 to 6, where 1 is for the most important activity and 6 for the least important)

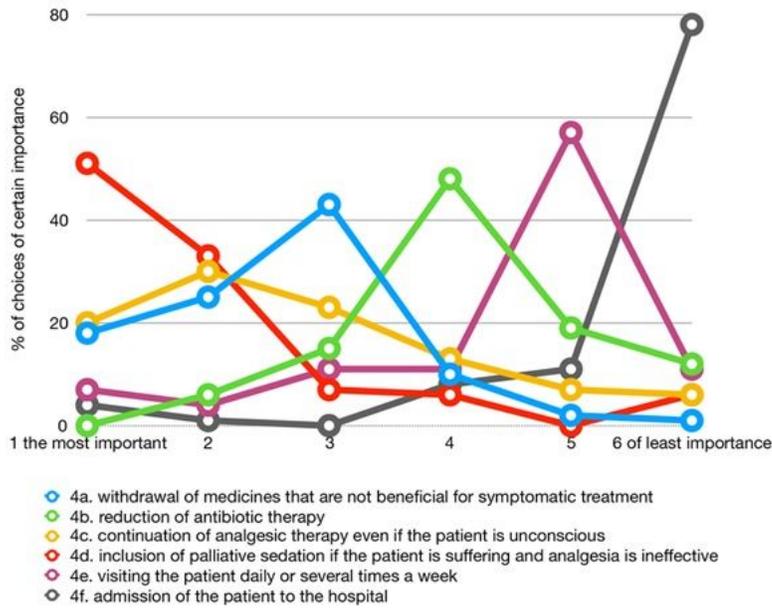


Figure 1

Which of following actions do you consider to be important for patients in their terminal phase of life?

Supplementary Files

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- [Answersforquestionesfrom1to8rawdata.ods](#)