

Analysis of physician views towards end-of- life care



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Introduction:

It has been estimated that more than 15 million people will suffer cancer worldwide by 2020(1). According to the report by Ministry of Health, over 30000 people die because of cancer annually and about 70000 new cases occur every year(2). Therefore cancer is the third most common cause of death in Iran following coronary heart disease and accidents (3, 4). There are considerable evidences that most of patients who encounter a life-threatening condition such as cancer are growing rapidly in Iran in the last few decades (1, 5, 6).

Unfortunately, most of these patients are diagnosed in the late stages of disease, therefore they reach a stage that surgery, chemotherapy and other curative interventions are unable to improve their quality of life. They often suffer severe distress, in physical, psychological, spiritual, social and financial dimensions (7)Hence, the relief from such a suffering is considered as a basic and universal human right (8) and a basic action in achieving Universal Health Coverage(UHC) which has been introduced by World Health Organization in recent years (9). Universal health coverage is defined as access to key promotive, preventive, curative , rehabilitative, and palliative care for all at an affordable cost(8).

Palliative or hospice care is an interdisciplinary, comprehensive, patient-centered approach in response to these needs. In other word hospice is a model for end-of-life care based on a team approach to control symptoms, manage pain, and provide emotional and spiritual support for terminally ill patients and their families (10). According to the World Health Organization

(WHO), palliative care is ' an approach to improve the quality of life of for threatening illness situations (11). The hospice care is not to cure disease but alleviate symptoms and improve quality of life at the end of life are the main objectives. Furthermore the mission of hospice care is to enable the end of life patients to die at home, with their beloved people around them (12).

Despite the fact that cancer is a leading cause of mortality with rapidly growing rate and late stage diagnoses in Iran, very little is known about the physicians' beliefs, attitudes and experiences about of end-of-life care. This study surveyed Iranian physicians' attitudes and practices on end-of-life care for the first time.

Materials & Methods:

A cross-sectional study was conducted among all doctors who participated in the biggest regional annually conducted educational seminar in the Tabriz city and end of year medical students in September 2012. This Physicians came from East-Azerbaijan and some provinces in north-east of Iran.

Generally seminar is conducted annually and consists of clinician-specialists in different specialty groups. The seminar presented the opportunity to obtain current information on End of life care training, knowledge and attitudes, demographic and organizational characteristics, and personal experience with end of life patients.

The population consisted of 560 medical students, general physicians, specialist and sub-specialists. The sample size was determined based on the

WHO recommendation on 400 sample and results of a pilot study consisting <https://assignbuster.com/analysis-of-physician-views-towards-end-of-life-care/>

of 30 physicians which resulted in an Odds Ratio of 1.8. Considering 95% confidence and 95% power, two tailed test, and utilizing G-Power software, 161 cases were computed and regarding a dropout rate of 45% the total sample size increased to at least 234 cases.

Data were collected using a voluntary self-administered, anonymous questionnaire that originally developed by John Mastrojohn and Agnes Csikos in 2010 (13) and we confirmed and retained its validity and reliability after translation to Farsi in this survey. A translation – back translation process was used to translate the measure; two English language specialists and two native English speaking persons respectively involved in the translation and back translation processes. In addition to apply the translated questionnaire in the study population on 15 persons, a linguistic edit of the measure was done. The content validity of the questionnaire was evaluated based on opinions of an expert panel consisted of eight specialists in the fields of Health service research. After conducting some modifications and corrections the content validity was approved. In addition, we assessed the reliability of questionnaire totally using Cronbach's Alpha coefficient. The Cronbach's Alpha values were calculated for all 22 items (0.92.) and showed reasonable reliability (internal consistency).

Questionnaires were distributed prior to the sessions and internship workshops. A total of 38.3% (215 of 560) of participants completed the survey. Participation was voluntary and no incentives were offered.

Completion of the anonymous questionnaire was taken as consent to participate in the study. Questionnaire includes a letter explaining its general purpose and providing assurances of the confidentiality of individual

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answers. Questionnaire contains 22 questions about care of terminally ill patients, 2 questions about personal (age and sex) and 5 questions in relation to organizational characteristics’.

All returned questionnaires were checked manually for completeness before they were forwarded to electronic data computer. Frequencies and percentages were calculated to compare results and Cross-tabulations using Kendall’s tau-b to test for significance were conducted to compare within-sample bivariate associations between demographic and practice variables with belief and attitudinal variables. Most of these tests were not statistically significant, with the exception of those reported here. All study data were analyzed using SPSS version 16. 0. Only quantitative results are discussed in this article.

Ethical consideration for this study and the study protocol were approved by the Ethics Committee of Tabriz University of Medical Sciences (TUMS), which was in compliance with Helsinki Declaration.

Results:

In this study, 215 questionnaires were completed from 560 (overall response rate of 38. 3%). Of all participants, 60% were males. In terms of their graduated universities, (76. 2%) of the respondents were graduated students of Tabriz medical university. Every physician had visited 24. 63 (16. 57) patients every day and the average length of service was 5. 23 (4. 53) years. The physicians identified their degrees as 60. 7% generalist and 39. 3% specialist.

Socio-demographic and organizational characteristics of participations are shown in table 1.

Table 1 Socio-demographic and organizational characteristic

Characteristic	N (%)	Characteristic	N (%)
<i>Age</i>	25-34	<i>Gender</i>	12
	35-44		9
	45-54		60
	55-64		86
	> 65		40
<i>Graduating university</i>	Tabriz	156 (73.2)	
	medical university	23 (10.8)	
	university	34 (16)	
	Tehran medical university		

	ty			
	Other			Faculty
				membe
				r-
				Teachin 22
	Non			g (10
		46 (21. 5)		Hospital . 3)
<i>The number of terminal illness in the past 12 month</i>	1-3	83 (38. 8)	Place of employment	Residen 39
	4-7	33 (15. 4)		t - (18
	8-11	14 (6. 5)		ent Teachin . 2)
	12 or more	38 (17. 8)		g 67
				Hospital (31
				Intern- . 3)
				Teachin
				g
				Hospital
	General			
Last degree in medicine	ist MD	130 (60. 7)		
	speciali	84 (39. 3)		
	st			
Total		214		

According to the table 1 more than eighty percent of physicians have had at last 1-3 EOL patients. It is considerable that 72% of mentioned patients received medical care in the hospital, 23% at home and 4. 7% in other settings.

Further investigation did not show any statically significant differences between gender groups, specialty or generalists in the number of their daily visiting patients, however differences about their terminal illness patients were statically meaningful ($p < 0.0001$).

Physicians' believes about the most appropriate type of care for end of life patients illustrated in Table2

Table 2- Physician opinion regarding most appropriate type of care for end of life patients

Most Appropriate care for Terminal Patients	N (%)
Continuous curative care until death	42(19.6)
Palliative care only	38(17.8)
Combination of curative and palliative care	132(61.7)
Other	2(0.9)

Total	214(100)
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The responses of physicians about opinion on current cares for end of life patients in our country were as following: 1. 9 percent indicated the best, 15. 8 percent sufficient with deficiencies, 59. 5 percent insufficient, and finally 22. 8 percent there is not any care. In other words nearly all of the physicians evaluated these services as insufficient. Furthermore their response to :” In your opinion, the best setting for care of terminally ill patients is usually” approximately were: 20 percent hospital, 62 percent the patients home, 18 percent a nursing home, that obviously is in contrast with their practices that indicate more than 72. 4 percent of end of life patients were cared in hospital. Furthermore the differences among two groups of physicians about Best Setting for care of terminally ill patients were statically significant ($p < 0.0001$). On the other hand differences of age, gender, working place, and graduating groups of physicians were not statically significant.

Physicians’ beliefs about the ability of end of life patients to maintain dignity until death showed in the Table 3:

Table 3. Physicians’ beliefs about the ability of end of life patients to maintain dignity

Maintain dignity	N(%)
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)	
Most or all end of life patients are able to maintain personal dignity	69	(32.6)
Sometimes end of life patients are able to maintain personal dignity	104	(49.1)
Most or all end of life patients are not able to maintain personal dignity	39	(18.4)
Total	212	(100)

Further investigation about mentioned differences in last table didn't show any significant relationship among specialty, age, gender, work place and graduating groups of physicians.

Nearly one percent of physicians stated that they were quite knowledgeable about hospice care and 57.1 percent did not possess any familiarity with this type of care. In other way, 97.2 percent of physicians indicated that they would not participate in educational course about hospice care. Hence 82.2 percent of them were interested in participating in educational course on hospice care. Table 4 shows familiarity of physicians with hospice care and their interest in participating in educational course.

Table 4: physicians' familiarity, behavioral with hospice care and educational course

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	N(%)
Familiarity with hospice as a type of care)
Quite knowledgeable	2 . 9)
More than a basic knowledge	15 7. 1)
Only a basic knowledge	42 19. 8)
Only heard about it	32 15. 1)
Never heard about it	121 57. 1)
Attention CME workshops to increase your knowledge about hospice	
Definitely	10 4. 7)
probably	22 10. 3)

Did not think so 181 (85)

Participating in workshops or course about hospice

Yes 6 (2.8)

No 209 (97.2)

Interest to Participating in workshops or course about hospice

Yes 175 (82.2)

No 38 (17.8)

Investigation on significant relationship between physicians' knowledge about hospice and demographic characteristics were meaningful only in Age groups, where differences in physicians on searching workshop in different groups were significant only in work place ($p= 0.025$).

DISCUSSION:

There are numbers of important implications of this study. First, the study demonstrates that familiarity of Iranian physicians with end of life cares was <https://assignbuster.com/analysis-of-physician-views-towards-end-of-life-care/>

low in spite of frequent contact with those patients. Second, there isn't any kind of structured or organized system to deliver services for end of life patients. Third, there isn't any developed educational plan neither in medical school curriculums nor continuity medical education programs.

In this study the participation rate was 38.3% which was lower than that of similar studies in Hungary (54%), United States (48%) and Pakistan (63.6%) (13, 14). This differences could be attributed to methods of sampling and low level of Iranian physicians' knowledge about end of life cares .

Most of the Iranian physicians (72%) in the current study claim that they didn't have any knowledge about hospice care, which is similar to Pakistani doctors (57.1%) who stated that they had heard about a hospice (14). In contrast to the most of U. S. physicians who were quite knowledgeable most of the Hungarian physicians had only a basic knowledge (13). However there is a high level of interest in the physicians of U. S., Hungary, Iran (82%), and Pakistan to participate in continuing medical education to learn more about hospice care. These findings are consistent with previous studies that indicate physicians' common interest in continuing medical education for end-of-life care(7, 13-17).

In this study 72% of EOL patients received medical care in the hospital and 23% at home, whereas other studies are focusing to physicians' awareness of patients' preferred place for dying(18, 19).

However 27% of Iranian physicians mentioned that the preferred place of providing terminal care is hospital, the reasons for this obvious conflict are related to lack of delivering any end of life care in health system in hospital
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or home. Furthermore 82% of physicians demonstrated that level of present end of life care in Iran is insufficient and 22% believed that there is not any structured service for end of life patients. This finding is in accordance with other study results and reports, therefore Iran was categorized in second group on Palliative Care Development in the world (20). Iranian physicians believed that combination of curative and palliative care is most appropriate approach for terminally ill patients (61. 7%) which matches with U. S. physicians and contrasts with most of Hungarian physicians that supported a palliative care only approach for terminally ill patients (13). This may be attributed to the current practice of aggressive curative treatment until the last days of life in Iran and Hungary.

Iranian Physicians' beliefs about the ability of End of life patient to maintain personal dignity were differed from those of other countries(13, 19) especially for this opinion " Most or all end of life patients are not able to maintain personal dignity" it was 18% in our study but in the mentioned countries it was 9% and 5 %. These differences could be attributed to difference of social contexts and family structures in these three countries.

Most of the Iranian physicians in the current study claim that they would not participate in educational course about hospice care neither would they do in collage curriculums nor in continuity medical education programs. These results are in contrast to most of the U. S. and Hungarian physicians (13) but are in accordance with previous studies on Iranian nurses (8). Intense interest of Iranian physicians to participate in continuing medical education for end-of-life care is clear evidence for this finding.

Conclusions:

A growing trend of chronic, non-communicable diseases especially cancers in Iran, has led to new condition of needs for providing care to EOL patients. Furthermore our findings clearly indicate unacceptable level of knowledge and attitudes of physicians about delivering services for EOL patients. Physicians of our study were interested in participating in continuing education programs about EOL patient. In response to these realities, designing the specific care for EOL patients, is inevitable and should be starting as soon as possible.

Furthermore the education of physicians about EOL care should be included in the formal curriculums of medical schools and continuous medical education programs.