How General Practitioners in Bulgaria Tackle Palliative Care?: A Cross-Sectional Study

Bulgaristan'da Pratisyen Hekimler Palyatif Bakımı Nasıl Uygulamaktadırlar?: Kesitsel Bir Çalışma

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Geliş Tarihi/*Received:* 06.11.2015
Kabul Tarihi/*Accepted:* 03.12.2015

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ABSTRACT Objective: One of the substantial reforms of the health care system in Bulgaria was the establishment of primary medical care provided by the general practitioners (GPs). This type of care is particularly important for the provision of palliative care in the community. To present GPs' opinion on palliative care related to current situation in the health care system. **Material and Methods:** Questionnaire-based study among 337 GPs. **Results:** The demographic indices showed prevalence of the age groups over 40, almost 2/3 were women. The group included GPs working in different types of inhabited places. The responders pointed out organization and financing as the main difficulties in providing palliative care. A half of the physicians stated that they provided care for more than ten patients per year, who were in a severe condition. These patients in the greater part of the cases (81.00%) remained in their homes. There was an adjustment in the most of GPs to coordinate palliative care in home setting, if it can be organized appropriately. The GPs shared the opinion that palliative care should be provided in cases of life expectancy amounting to one year. Almost 2/3 of the respondents evaluated quality of life/care subjectively and not systemically. Need of training was pointed out by 2/3 of the GPs. **Conclusion:** GPs accept and realize their role in palliative care providing, but they face the lack of organizational and financial security.

Key Words: General practice; palliative care; health care quality;
access, and evaluation

ÖZET Amaç: Bulgaristan'da sağlık hizmetleri sisteminde yapılan reformlardan biri, primer tıbbi bakımın pratisyen hekimler (PH) tarafından gerçekleştirilmesi konusudur. Bu hizmet özellikle, toplumda palyatif bakımın pilot çalışması olarak önemlidir. Amacımız, sağlık sisteminde mevcut durumda palyatif tedavi hizmeti veren PH'lerin düşüncelerini araştırmaktır. **Gereç ve Yöntemler:** Ankete dayalı bu çalışma 337 PH üzerinde yapılmıştır. **Bulgular:** Demografik veriler yaş ortalamasının 40 üzerinde ve katılımcıların 2/3'ünün kadın olduğunu göstermiştir. Katılımcı PH'ler farklı yerleşim birimlerinde yaşıyorlardı. Ankete cevap veren katılımcılar palyatif bakım hizmeti sağlamada ana sorunlar olarak organizasyon güçlükleri ile finans yetersizliklerini bildirmişlerdi. Hekimlerin yarısı yılda, kötü durumdaki 10'dan fazla hastaya tedavi/bakım hizmeti verdiklerini beyan ettiler. Bu hastaların çoğu (%81) evlerinde yaşıyorlardı. Hekimlerin çoğu, yeterli organizasyon yapılabilirse bu hastalara evlerinde sağlık hizmeti verilebileceğini tespit etmişlerdi. PH'ler palyatif tedavi/bakımın birçok olguda yaşam beklentisini 1 yıl kadar uzatabileceğini açıklamışlardır. Katılımcıların 2/3'ü, verilen bu hizmetin kalitesini değerlendirdiklerinde subjektif bulduklarını, sistematik olmadığını bildirmişlerdir. Bu konuda 2/3'ü eğitim gerektiğini saptamışlardır. **Sonuç:** Pratisyen hekimler palyatif tedavide yer almak istediklerini, ancak organizasyon ve finans eksiklikleri ile karşılaştıklarını beyan etmişlerdir.

Anahtar Kelimeler: Genel uygulama; palyatif bakım; sağlık hizmeti kalitesi;
erişim ve değerlendirme

doi: 10.5336/intermed.2015-48459

Turkiye Klinikleri J Intern Med 2016;1(1):6-12

Palliative care is an approach that improves the quality of life of patients with advanced illness. The ever increasing need of palliative care is a challenge for the health care systems.[1] Although this need is found worldwide, considerable differences are observed in the different countries, with respect to disease incidence and mortality, as well as the provided medical care.[2]

One of the substantial reforms of the health care system in Bulgaria was the establishment of individual primary medical care provided by the general practitioners (GPs). This type of care is particularly important for the provision of palliative care in the community by forming functional or formal multidisciplinary teams in a number of European countries, Canada, Australia and the United States. The GP is expected to provide information for the patient and his/her relatives concerning the nature and progression of the disease, as well as play the role of a palliative care coordinator.[3-8]

Palliative care is provided by GPs in Bulgaria pursuant to the obligations they have regarding each one of the patients who have chosen them, but there is no legislative framework for palliative care. The aim of the study has been to present GPs' opinion on palliative care related to current situation in the health care system.

MATERIAL AND METHODS

The cross sectional study has been carried. Two-step method of Stein was used; first on the base of study among 30 GPs we calculated SD according ages and then we applied the formula (where $P(u)=0.95$; $SD=4.38$ and $r=0.5$) to find the needed units for observation. The individual questionnaire was distributed among 400 randomly selected GPs; 337 were returned it, in fully completed. By the statistic analysis of data are used percentage distribution and non-parametric analysis χ^2 (Pearson chi-square test). Level of significance was accepted at $P<0.05$. The SPSS statistical software (version 17) was used for all analyses.

The analysis of the views of GPs took place as part of wider research on palliative care in primary health care setting, and it has been approved by Ethics Committee of Medical University Plovdiv.

RESULTS

CHARACTERISTICS OF THE GROUP OF GPs STUDIED

The demographic indices showed prevalence of the age groups over 40 years (160/47.47%), almost 2/3 (211/62.62%) were women. In accordance with the age structure, almost a half of the physicians (140/41.54%), had a professional experience of over 20 years.

The group included GPs working in different types of inhabited places: in a town with a population of over twenty thousand people (206/61.12% of the GPs) and 48/14.24% were practicing in villages. A patient's list of less than 1500 people had 182/54.00% of the GPs studied.

Almost a half of the GPs (159/47.18%) had no specialty. Thirteen GPs had another medical specialty-internal medicine or pediatrics, before obtaining the specialty of general practice.

ORGANIZATION OF PALLIATIVE CARE

The group of GPs studied pointed out different difficulties in providing palliative care (Table 1). The physicians working in large towns found it easier to organize their patients' palliative care, $P<0.05$.

TABLE 1: Difficulties in providing palliative care.

Difficulty	N	%
Organization of palliative care	220	62.28
Financing	189	56.08
Providing with trained carers	171	50.74
Providing with medical supplies	141	41.83
Providing with medications	134	39.76
Relationships with relatives	108	32.04
Discussion on the prognosis	90	26.70
Physicians' palliative medicine training	88	26.11
Relationships with patients	75	22.25
Relationships with colleagues	57	16.91
Diagnostic process	38	11.27

GPs pointed out a number of sources of palliative care financing. Highest was the percentage of those stating health care insurance as the source of financing (282/83.67%). The prevalent opinion (245/72.70%) was that the most appropriate type of palliative care organization was the specialized units of palliative care.

The GPs were definitely of the opinion that the patients preferred their homes as the main place to provide palliative care; 49/14.54% of the GPs pointed institutions (nursing homes and hospitals) combined with palliative care in home setting. No dependence was found between the GPs' gender, professional experience, and place of work on the one hand, and the places they pointed as preferred by their patients for provision of palliative care, P>0.05.

PLACE AND ROLE OF THE GP IN PROVIDING PALLIATIVE CARE

A half of the physicians (171/50.74%) involved in the questionnaire study stated that they provided care for more than ten patients per year, who were in a severe condition. These patients in the greater part of the cases (273/81.00%) remained in their homes, cared for mainly by the GPs.

On the background of the existing lack of interaction between physicians and health care organizations, half of the GPs (166/49.25%) considered that they performed the role of palliative care coordinators. As far as the cooperation with other medical specialists is concerned, the GPs pointed in the first place their cooperation with the out-of-hospital specialists in the patient's disease profile (272/80.71%), followed by nursing home medical specialists (57/16.91%).

Theoretically, the participants in the questionnaire study arranged the GP's activities in palliative care by giving priority to the provision of support for the relatives (263/78.04%), followed by their role as coordinators and the control of symptoms (225/66.76%).

The "ideal" team formed by the respondents was consistent with the bio-psycho-social approach, characteristic of both general medical practice and palliative care. Side by side with the different medical specialists, the team included psychologists, social workers and carers. Although less frequently, the team included volunteers and clergymen (Table 2).

TABLE 2: The "ideal" palliative care team.

Type of members	N	%
Nurse	256	76
Physician - Specialist	244	72
General practitioner	236	70
Psychologist	228	68
Carer	215	64
Social worker	185	55
Volunteer	94	28
Clergymen	88	26
Anesthesiologist	57	17
Dietitian	41	12
Clinical pharmacologist	12	4

The guided question of "who should inform the patient of his unfavourable prognosis" was answered by 190/56.37% of the physicians studied that this person was the patient's GP; 166/49.25% of them thought that it was the obligation of the physician who diagnosed the disease.

IDENTIFICATION OF PATIENTS AS "APPROPRIATE FOR PALLIATIVE CARE"

Identifying patients as appropriate for palliative care is a difficult process. Since no rules have been established in Bulgaria with respect to the determination of the need of palliative care, a theoretical model was used based on three criteria – diagnosis, prognosis and symptoms with their respective indicators.

In the GPs' opinion, diagnosis came in the first place, followed by symptoms as indicators in determining the need of palliative care.

The greatest part of the physicians, who chose the diagnostic criterion (316/93.76%), pointed multiple organ failure in the first place (210/62.34%). This diagnostic entity is in fact a complex syndrome resulting from a considerable number of individual disease entities. Oncological diseases with presence of metastases were pointed out by 193/5.27% of the physicians. Oncological diseases without development of metastases were pointed out in the fourth place (118/35.12%), preceded by chronic heart failure (157/46.51%), whereas 70/20.88% chose chronic obstructive pulmonary diseases as a diagnosis-indicator. Diagnoses-indicators were added - cerebrovascular disease manifested by stroke; other causes of immobilization were also included, such as fractures, as well as mental disorders.

The symptoms-indicators, chosen by the GPs as criteria, were arranged in the following way: pain, cachexia and shortness of breath. There were some individual answers including other symptoms, such as intoxication syndrome, decubital ulcers, cognitive impairment and gastrointestinal tract symptoms.

The prognostic criterion, measured by time indicators, occupied the last place. Most of the GPs who had chosen this criterion pointed out the one-year period as the longest period as indicator, followed by the six month period, and then the three-month one. Significantly more rarely, GPs with professional experience of up to 15 years chose the three-months indicator $P<0.05$.

DETERMINING THE QUALITY OF PALLIATIVE CARE

The conception of quality of life in palliative care presupposes a parallel study of factors on the part of the patients, as well as on the part of medical care. In our questionnaire study, 228/67.65% of the GPs stated that they evaluated their patients' quality of life mostly in non-formal conversation.

The following aspects of the conception of quality of life were pointed out by the physicians and arranged according to their importance: the first place was occupied by organizational problems (community support) (290/80.05%), as well as psychological ones, followed by physical symptoms (267/79.22%), support from relatives (241/71.51%), social problems and spiritual aspects (219/64.98%).

If we accept to discuss the assessment of the quality of life based on a non-formal conversation, no dependence was found with respect to gender, professional experience, number of patients on the patients' list, and size of the inhabited place, in which the GP's practice was seated; the same applied to the assessment of satisfaction, $P>0.05$.

NEED OF TRAINING IN PALLIATIVE CARE/MEDICINE

Need of training was pointed out by 2/3 of the GPs. This need did not depend on gender, age, professional experience, inhabited place, in which the GP's practice was seated, or number of patients on the patients' list, $P>0.05$; 137/40.46% of the GPs were of the opinion that palliative medicine should be differentiated as an individual specialty.

DISCUSSION

The GPs constitute a heterogeneous group with respect to specialization, as a result of objective and subjective causes accompanying the health care reform in Bulgaria. The specialization in family medicine is directly related to the competences of physicians in the general practice, and more specifically to the application of the patient-centered approach and the inclusion of relatives in the decision making process regarding health problems - an aspect directly connected with the palliative care philosophy.

Two of the tendencies assessed as difficulties in the provision of palliative care were observed in the group studied, namely increased mean age and feminization.[9] These difficulties are not topical for Bulgaria on the background of the lack of organizational and financial security in palliative care, stated by more than half of the respondents.

Almost 2/3 of the GPs considered it a necessity to organize specialized units for palliative care, which should have resources to carry the latter out in both home and hospital setting. The observed result was influenced not only by the physicians' views, but to a considerable extent by reality itself. In the present situation of scarcity of this type of care, most of the patients remained in their homes to be cared for by their GPs. Much like the situation in other countries, due to the fact that towns are satiated by various medical specialists, GPs in towns found it easier to care for their patients, to a degree of even giving over all medical activities to other services.[10]

There was an adjustment in the most of GPs to coordinate palliative care in home setting, if it can be organized appropriately, which shows that the physicians look upon palliative care as their duty. With the passage of years, the GPs accumulate knowledge about the patient and his/her family, which helps to provide them with optimum care.[11] Coordination is a basic need of the patients and their relatives. The main barrier for quality palliative care is the disrupted communication between the GP and the other medical specialists taking part in the patient's care.[12]

In the present study, GPs cooperated mainly with the specialists in the disease profile. Family doctors are isolated from the institutional palliative care. In the study of S. Borgsteede et al., 98% of the GPs cooperated directly with at least one specialist when providing palliative care, the mean number of these cooperation being four.[13] The data obtained from the general practices studied concerning the patients in need of palliative care are comparable to those found in the literature - an average of 5.5 palliative patients/year in one general practice for Great Britain, 4-5 patients/year for Australia, with the GPs caring for a minimum of two of these patients independently in their homes.[11,14]

A substantial shortcoming that makes difficult the application of the palliative care approach is the lack of established criteria and indicators for initiation of this type of care.[15] According to the respondents, a given diagnosis can be accepted as an indicator for palliative care, as well as the presence of certain symptoms, characterizing the severity of the condition. The practice, especially in relation to the health insurance financing and the requirements of encoding every condition of the patient according to International classification of diseases, make the diagnosis a principal criterion in the whole health care system. This approach facilitates administration but in some cases it hinders clinical activities. In certain cases, and very frequently in multiple pathology, the symptoms are the most important criteria in determining the need of care, including the choice of an appropriate place for the treatment – the patient's home or an institution.

The GPs shared the opinion that palliative care should be provided in cases of life expectancy amounting to one year. The long-term period stated is in agreement with the modern tendency of parallel provision of both palliative care and treatment approach. On the other hand, this choice on the part of the GPs is closely related to their experience in direct prolonged provision of care for chronic, severely ill patients. Instead of giving a fixed prognosis for a specific period of time, Brumley et al. proposed to formulate the criterion by making the statement "It won't be surprising, if the patient dies next year".[16] There is no consensus as to the ways, in which to determine a patient as appropriate for palliative care. This group of patients is heterogeneous in gender, diagnosis, stage of disease. Different instruments have been developed with a different number of indicators.[17,18] The Golden Standards that were developed in Great Britain contain criteria/indicators for identification of patients as "appropriate for palliative care". 1300 practices use this standard in their work, providing care for 15% of the population, which improves palliative care quality.[19]

In the opinion of the respondents, the conception of quality of palliative care had a leading aspect-community support, followed by the psychological and physical aspects. This result reveals how close the GPs are to their patients' problems in a clinical, as well as social plan. The spiritual aspects of quality of life occupy the last place. These aspects of care may cause the physician a subjective discomfort. Other causes, because of which physicians do not comment on their patients' spiritual needs, include lack of an established conception, competence and time.[20] The arguments reported in the literature are valid for our country as well. But the most important cause is probably the lack of tradition in Bulgaria. The spiritual aspects of quality of life are considered to be too personal, and it is unacceptable for medical specialists to discuss them. Besides, it is not considered regularly for clergymen to participate side by side with medical specialists in the care of patients in need of palliative care.

Almost 2/3 of the respondents evaluated the patient's condition subjectively and not systemically. The natural course of the disease leads to worsening of the symptoms, and due to this, the assessment of the effectiveness in this type of care is specific.

The integration of palliative care into the health care systems means development of a variety of models, provision of access to palliative care for every one in need, as well as training of the medical specialists.[15] Caring for patients in need of palliative care is a challenge, because it requires maintenance of topical knowledge and skills in this dynamically developing field of medical science. In a number of studies family doctors have reported the need of training; the specific areas of training most frequently pointed out being clinical symptom management and communicative skills.[14,21-24]

CONCLUSION

GPs accept and realize their role in palliative care providing, but they face the lack of organizational and financial security. GPs mark the third place for themselves in the "ideal" palliative care team, after the nurses and the specialists in the patient's disease profile. Such an arrangement is most likely associated with the adjustment, already established in our health care system, to prioritize the role of the specialist, leaving the role of the general practitioner not yet well specified.

STRENGTHS AND LIMITATIONS

This is the first systematic description of the GPs opinion on palliative care after the health care reform. On the other side, the survey was limited to Bulgaria, thus the finding may differ across other countries.

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