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Problems Experienced by Physicians Treating Elderly Patients in the Palliative Care Process and Solution Proposals

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Abstract

Objective: This study aimed to determine the opinions of physicians treating elderly patients in palliative care units in government and private health institutions about the problems experienced and the solution proposals for these problems.

Materials and Methods: From qualitative research designs, a single case design was adopted. The study group consisted of 16 physicians determined using the maximum variation, convenience, and criterion sampling methods from purposive sampling methods. The dataobtained using the "Personal Information Form" and the "Interview Form", were analyzed using descriptive and content analysis methods.

Results: In the palliative care process, problems related to chronic diseases were most common in elderly patients, followed by problems related to neuropsychiatry and pai. While routine treatment proposals came to the fore in solving problems arising from chronic diseases, medication and related specialist support were emphasized to solve problems caused by pain, oncology, and the gastrointestinal system.

Conclusion: Because elderly patients in the palliative care process experience multiple problems, it is recommended that physicians adopt an individualized approach, including a comprehensive evaluation with an interdisciplinary team, to solve these problems.

Keywords: Palliative care, problems in palliative care, solutions in palliative care, physician, elderly patient.

Introduction

Today, with the increase in the average age worldwide, the care of the elderly has become more important. Because individuals have the right to spend their last days in quality and peace, palliative care is considered among the most important human rights today (1).

The Latin word "Palliate (Palliare)" means protective or inclusive. "Palliative" means "mitigating, soothing, or temporary remedy" in English (2). Palliative care is a medical concept that does not have a single generally accepted definition (3). It has been defined differently in different sources and its definition has changed over time (4). According to the widely accepted definition, palliative care is an approach in which appropriate medical treatment methods are offered simultaneously to meet the physical, psychosocial, and spiritual needs of patients and their family (caregiver) in the terminal period of any life-threatening illness, focusing on reducing the problems and increasing the quality of life (5).

Consistent with the criteria determined by the World Health Organization, each country has created a plan and strategy regarding the palliative care process according to the country's health system, culture, beliefs, and needs. In Turkey, the first palliative care practices began in the 1990s (6). In 2010, the Ministry of Health developed a palliative care organization model, and as of the beginning of 2010, 10 palliative care centers, most of which are located within university hospitals, have been established. According to the latest data, palliative care services are provided with 5,302 beds in 396 health institutions under the Ministry of Health in Turkey (7). In addition, this service is provided in care centers affiliated with the Ministry of Family and Social Services.

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At the institutional level, the palliative care process begins with diagnosis and covers holistic and humanistic care, and functional and emotional care and support. Palliative care, a multidisciplinary healthcare service, requires team effort. The palliative care team, whose aim is to increase the quality of life rather than life expectancy (8), includes physicians (family physicians, anesthesiologists, algologists, oncologists, surgeons), nurses, pharmacologists, dietitians, psychologists, social service specialists, and grief counselors (9). The most important group in the team-providing palliative care services are physicians with the responsibility for diagnosis, treatment, and organization (6).

This study aimed to determine the opinions of physicians treating elderly patients in palliative care units in government and private health institutions regarding the problems experienced in the palliative care process and the solution proposals for these problems, and whether there are differences and similarities between the opinions of physicians in the two groups.

Materials and Methods

This study has a qualitative approach in which a single case study design from qualitative research designs was adopted. The study was conducted between January 2023 and March 2023.

Participants

One government institution and two private institutions with palliative care centers were included in the study. The study group consisted of 16 physicians who were determined using maximum diversity, easy accessibility, and criterion sampling methods from purposive sampling methods. Eight physicians were working in government institutions and eight were in private institutions. The number of beds in the palliative care service in the government institution was 18, whereas the total number of beds in the two private palliative care centers was 74. The number of patients hospitalized in palliative care services per month is 30 in government institutions and 10 in private institutions. The inclusion criteria were working in palliative care centers/services of government and private health institutions in the city where the study was conducted and volunteering to participate in the study. The exclusion criteria were being employed in the relevant centers but not volunteering to participate in the study.

Data collection and analysis

The data were obtained using the "Personal Information Form" and "Interview Form" developed by the researchers. Personal information forms were used to determine the characteristics of the participants, whereas the interview form was used to investigate the opinions of the participants about the problems experienced in the palliative care process and the solution proposals for these problems. The preparation of data collection tools followed the stages of preparing possible questions according to the conceptual framework, presenting the forms to expert opinions, making the necessary corrections according to expert opinions, conducting the pilot testing, and giving the final shape to the forms.

The study was approved by the Medical Research Ethics Committee of a university (date: 28/11/2022; no: 22-11.1T/37) and was conducted in accordance with the principles of the Declaration of Helsinki. Necessary permissions were obtained from the Health Directorate and private care centers of the city where the research was conducted. Before the interview, the interviewee was informed about the purpose of the study, the informed consent form was read, and written consent was obtained. In addition, the interviews were tape-recorded by taking verbal consent.

Statistics

Descriptive analysis and content analysis methods were used. Analysis of data included coding the data into the conceptual framework, presenting the data, and interpreting the data. The findings were grouped under six themes: pain, gastrointestinal system, nutrition, oncological diseases, chronic diseases, and neuropsychiatry. Tables with codes and frequency (frequency of physicians' opinions in government institutions/frequency of physicians' opinions in private institutions) values for the problems and solutions within the scope of each theme were created. For example, the value (4/5) in the table indicates that 4 of the relevant theme or code reflects the opinion of physicians working in government institutions, whereas 5 reflects the opinion of physicians working in private institutions. To support the findings with direct quotations, participant statements were included. During the analysis process, direct quotations were numbered to represent the institutions and rankings of the physicians [GP1,..., GP8 for physicians working in government institutions (G: government institutions, P: physician) and PP1,..., PP8 for physicians working in private institutions (P: private institutions, P: physician)].

Validity and reliability

To ensure validity, personal information and interview questions were prepared in accordance with the main and subcategories of palliative care. To ensure reliability, the consistency obtained from analyzing the data at two different times was calculated as. Eighty nine using the percentage of agreement formulas. A value of 70% and above indicates the reliability of a study (10,11).

Results

Eight physicians were working in government institutions, 8 were in private institutions, 7 were female, 9 were male, and 12 were married. Five participants aged between 24 and 58 years were specialist physicians and 11 were general practitioners.

The seniority of the participants varied between 6 months and 36 years, and the working period in the palliative care service ranged from 2 months to 14 years. Only one participant was permanently working in the palliative care service and only one stated that he/she had received palliative care training.

Our study findings are tabulated and interpreted below within the framework of the sub-problems of the research (Table 1-6).

When the problems related to pain and suggestion proposals were examined, they mostly concentrated on general pain, joint pain, and bone pain. General pain-related problems were experienced more in government institutions, and narcotic analgesics were suggested as a solution. Joint pain problems were mostly experienced in private institutions, and painkillers were proposed as a solution (Table 1). Sample expressions are given below:

"Our patients mostly express general pain. Bone and joint pain are also common conditions. In this case, we preferred painkillers and narcotic agents. Sometimes we can provide physical therapy, anthropology, or psychologist support" (GP3).

"We encounter complaints in different parts of the body and joint and bone pains, which are quite intense. In addition to painkillers, physical therapy, and hot-cold applications, we perform alternative medicine applications such as myotherapy and ozone" (PP2).

The problems related to the gastrointestinal system were constipation, diarrhea, gas, and bloating. Additionally, the problems and solutions in government and private health institutions were similar in terms of constipation, bloating, and gas, whereas they differed in terms of diarrhea and oral/dental problems (Table 2). Sample expressions are listed below:

"The most common gastrointestinal problem in bedridden elderly patients is constipation. Additionally, we encountered diarrhea, gas, and bloating complaints. In this case, we applied treatments such as medication, dietitian support, laxative agents, and increasing oral fluid intake" (GP4).

"The most common condition we encounter is constipation. Therefore, we recommend dietitian support, drug combinations, laxative agents, increasing oral fluid intake, and in-bed exercises (PP4) .

The problems related to nutrition and solutions were concentrated on swallowing difficulties, loss of appetite, chewing problems, nutritional disorders, and weight loss. Within the context of nutrition, the problems and intensities experienced in government and private health institutions were similar, but the solution proposals differed (Table 3). Sample expressions are presented below:

"With regard to nutrition, we usually observe difficulty in swallowing, loss of appetite, nutritional disorder, and weight loss. As a solution, we recommend percutaneous endoscopic gastrostomy (PEG) or enteral nutrition. We receive dietitian support or recommend nutritional support products" (GP3).

"The nutritional problems we experience in elderly patients include loss of appetite, difficulty in swallowing, chewing problems, and weight loss. When necessary, we can recommend nutritional support products, nasogastric nutrition, and nutrition with PEG. We can obtain relevant specialist and dietitian support" (PP6).

Table 1. Problems related to pain in the palliative care process in government and private health institutions and solution proposals

Theme		Code
	Problem (*f*)	**Proposal (*f*)**
Pain	General pain (7/5)	Narcotic analgesics (7/1), painkillers (6/2), physiotherapy (1/5), algologist support (4/1), alternative medicine (3/2), algorithm based treatment (3/1), exercise (-/2), psychologist support (1/-), neurologist support (1/-), related expert support (-/1)
	Joint pain (6/6)	Painkillers (6/3), physiotherapy (1/5), algologist support (4/-), narcotic analgesic (3/-), exercise (-/3), massage (-/2), neurologist support (1 /-), related expert support (-/1), alternative medicine (-/1), algorithm based treatment (-/1), hot/cold application (-/1)
	Bone pain (6/3)	Painkillers (6/-), physiotherapy (1/3), algologist support (3/-), narcotic analgesic (3/-), hot/cold application (-/2), massage (-/2), exercise (-/2) neurologist support (1/-), alternative medicine (-/1), positioning (-/1), algorithm based treatment (-/1)
	Wound pain (2/4)	Painkillers (2/3), narcotic analgesic (-/2), algorithm based treatment (-/1)
	Post-surgical pain (-/4)	Algorithm based treatment (-/2), painkillers (-/1), narcotic analgesic (-/1), physical therapy (-/1)
	Neuropathic pain (-/2)	Physical therapy (-/2), painkillers (-/1), related expert support (-/1), algorithm based treatment (-/1)
	Gastrointestinal pains (-/2)	Painkillers (-/1), narcotic analgesic (-/1), massage (-/1), exercise (-/1)
	Vascular pain (-/2)	Painkillers (-/1), narcotic analgesics (-/1)
	Positional pain (-/1)	Painkillers (-/1), positioning (-/1), hot/cold application (-/1), massage (-/1)
	Regional pain (-/1)	Painkillers (-/1), narcotic analgesics (-/1)

f, frekans; (..../....), (number of physicians working in government institutions supporting the relevant theme or code/number of physicians working in private institutions supporting the relevant theme or code)

Table 2. Problems related to the gastrointestinal system in the palliative care process in overnment and private health institutions and solution proposals

Theme		Code
Gastrointestinal system	**Problem (*f*)**	**Solution (*f*)**
	Constipation (8/7)	Medication (5/4), exercise (2/6), surgical ıntervention (2/2), laxative agents (2/2), dietitian support (4/-), massage (1/-), nutritional support product (2/-), follow-up fluid balance (-/1), ıncreasing oral fluid ıntake (1/2), consultation (-/1)
	Diarrhea (2/6)	Dietitian support (1/4), medication (1/3), follow-up fluid balance (-/2), ıncreasing oral fluid ıntake (-/2), consultation (-/1), hygiene (-/1)
	Gas and bloating (3/4)	Medication (2/3), dietitian support (1/3), exercise (-/1), consultation (-/1)
	Indigestion (4/-)	Dietitian support (3/-), exercise (1/-)
	Oral / dental problems (-/3)	Daily oral care (-/3), dentist support (-/2)
	Dyspepsia (2/-)	Medication (2/-)
	Low oral intake (1/-)	Dietitian support (1/-)
	Acid reflux (1/-)	Medication (1/-)

f, frekans; (..../....), (number of physicians working in government institutions supporting the relevant theme or code/number of physicians working in private institutions supporting the relevant theme or code)

Table 3. Nutritional problems in the palliative care process in government and private health institutions and solution proposals.

Theme		Code
Nutrition	**Problem (*f*)**	**Solution (*f*)**
	Swallowing difficulty (6/5)	PEG* (5/3), dietitian support (4/3), nutritional support product (4/1), nasogastric nutrition (1/3), enteral nutrition (3/-) oral aqueous food (1/1), parenteral nutrition (1/1), nutrition monitoring (1/-), specialist nurse support (-/1)
	Loss of appetite (5/4)	Dietitian support (1/3), nutritional support product (1/2), vitamin-mineral supplement (1/-), weight monitoring (-/1), specialist nurse support (-/1), psychologist support (-/1))
	Chewing difficulty (4/5)	PEG (1/2) nutritional support product (1/2), enteral nutrition (1/-), weight monitoring (-/1), specialist nurse support (-/1)
	Nutritional disorder (4/4)	Dietitian support (2/2), nutritional support product (1/2), peg (1/1), specialist nurse support (-/1), snack (-/1), nutrition follow-up (-/1)
	Weight loss (3/4)	Nutritional support product (2/1), dietitian support (1/2), vitamin-mineral supplement (1/-), psychologist support (-/1), snack (-/1), weight monitoring (-/1) , specialist nurse support (-/1)
	Temporary swallowing function (-/2)	Dietitian support (-/2) nutritional support product (-/1), ınternal medicine specialist support (-/1)
	Food refusal (-/1)	Psychologist support (-/1), snack (-/1)

*PEG: Percutaneous endoscopic gastrostomy; *f*, frekans; (..../....), (number of physicians working in government institutions supporting the relevant theme or code/number of physicians working in private institutions supporting the relevant theme or code)

The problems experienced in the palliative care process of oncology patients and solution proposals were concentrated on general pain, side effects due to chemotherapy, nausea, nutritional disorder, and loss of appetite. There was a difference between government and private health institutions in terms of the intensity of the general pain problem, whereas there were similarities in terms of the intensity of other problems (Table 4). Sample expressions are listed below:

"General pain and chemotherapy-related side effects are common problems in oncology patients. Nausea, vomiting, and loss of appetite are common complaints. As in pain treatment, we use painkillers and receive support from algologists and neurologists" (GP1).

"The pain management of such patients is essential. These patients may also have social and psychological needs during treatment. In addition to drug treatment, socialization and psychologist support may be required" (PP7).

When the findings related to the theme of chronic diseases were examined, the problems and solution suggestions in the palliative care process focused on diabetes, hypertension, and cardiovascular diseases. The problems experienced within the scope of this theme are more common in private health institutions in general (Table 5). Sample expressions are given below:

"Chronic diseases such as heart failure, hypertension, and diabetes are generally in all our patients. We apply routine treatments, follow-up, and consultation when necessary" (GP3).

Table 4. Problems related to oncology patients in the palliative care process in government and private health institutions and solution proposals

Theme		Code
Oncology patients	**Problem (*f*)**	**Solution (*f*)**
	General pain (4/9)	Algorithmic pain treatment (1/3), medication (1/1), narcotic analgesic (1/1), consultation (1/-), psychologist support (-/1), psychiatrist support (-/1), neurologist support (-/1), physiotherapy (-/1)
	Chemotherapy-related side effects (4/3)	Medication (1/2), consultation (1/-), specific treatment (1/-), dietitian support (1/-), psychologist support (-/1), psychiatrist support (-/1)
	Nausea (3/3)	Medication (1/2), specific treatment (1/-), dietitian support (1/1), consultation (1/-)
	Nutritional disorder (2/2)	Parenteral nutrition (1/1), peg (1/-), ng probe (1/-), nutrition monitoring (-/1)
	Loss of appetite (1/3)	Consultation (1/-), medication (-/1), nutrition monitoring (-/1)
	Vomiting (2/1)	Specific treatment (1/-), dietitian support (1/1), consultation (1/-), medication (-/1)
	Psychiatric disorders (1/2)	Socialization support (-/2), referral to a specialist (1/-)
	Movement restriction (1/2)	Physical therapy support (1/1), psychologist support (-/1)
	Radiotherapy-induced pain (1/1)	Painkillers (1/1), narcotic analgesic (1/-)
	Decubitus ulcers (-/1)	Wound care (-/1), oncologist support (-/1), psychiatrist support (-/1), psychologist support (-/1)
	Neuropathy (1/-)	Neurologist support (1/-), algologist support (1/-)

f, frekans; (..../....), (number of physicians working in government institutions supporting the relevant theme or code/number of physicians working in private institutions supporting the relevant theme or code)

Table 5. Problems related to chronic diseases in the palliative care process in government and private health institutions and solution proposals

Theme		Code
Chronic diseases	**Problem (*f*)**	**Solution (*f*)**
	Diabetes (7/8)	Routine treatment (3/5), laboratory (5/1), dietitian support (2/3), consultation (3/-), endocrine support (-/2), neurologist support (-/2), psychologist support (- /2), positioning (1/-)
	Hypertension (5/7)	Routine treatment (4/4), blood pressure monitoring (4/2), dietitian support (2/2), consultation (3/-), endocrine support (-/3), neurologist support (-/3), psychologist support (-/2) positioning (1/-), vitamin d support (-/1)
	Cardiovascular diseases (5/6)	Routine treatment (3/3), cardiologist support (-/4) laboratory (3/-), dietitian support (2/1), endocrine support (-/3), neurologist support (-/3), psychologist support (- /3), consultation (2/-), radiology (1/-), positioning (1/-), ambulance support (-/1)
	Osteoporosis (2/5)	Routine treatment (-/4), gynecologist support (-/2), consultation (1/-), dietitian support (1/1), vitamin d support (-/1),
	Osteoarthritis (2/5)	Routine treatment (-/3), dietitian support (1/1), consultation (1/-), vitamin d support (-/1)
	Movement restriction (1/-)	Consultation (1/-), dietitian support (1/-)
	Multiple drug use (1/-)	Consultation (1/-)

f, frekans; (..../....), (number of physicians working in government institutions supporting the relevant theme or code/number of physicians working in private institutions supporting the relevant theme or code)

"Chronic diseases are the underlying diseases of our palliative care patients. These include hypertension, diabetes, and heart disease. For the solution, we plan treatment in line with the recommendations of our endocrine, neurology, gynecology, and cardiology specialists" (PP4).

Within the scope of the neuropsychiatry theme, the problems experienced in the palliative care process and solutions were concentrated on depression, fear of death, intense anxiety, and loneliness, which were more common in private health institutions (Table 6). Sample expressions are presented below:

"Neuropsychiatric complaints are quite common. Depression, fear of death, sleep disorders, and delirium are the most common complaints. We often administer medication, and when necessary, we receive support from a psychologist or psychiatrist for the patient and his family." (GP8)

"I have observed sleep disorders, depression, anxiety, delirium attacks, and fear of death. In this case, in addition to drug treatment, we provide both psychologist and psychiatrist support to the patient and his family" (PP7).

Table 6. Problems related to neuropsychiatry in the palliative care process in government and private health institutions and solution proposals

Theme		Code
Neuropsychiatry	**Problem (*f*)**	**Solution (*f*)**
	Depression (5/8)	Psychologist support (4/6), psychiatrist support (1/6), medication (1/4), family education (1/-), medication use ınformation (1/-), social activity (-/1), family psychologist support (-/1)
	Fear of death (5/8)	Psychologist support (4/6), family psychologist support (2/3), medication (1/4), psychiatrist support (1/4), consultation (1/-), medication use ınformation (1/-)
	Intense anxiety (4/6)	Psychologist support (4/4), medication (2/3), psychiatrist support (-/4), family psychologist support (1/2), family psychiatrist support (-/2), consultation (1/-)
	Loneliness (2/4)	Psychologist support (3/3), psychiatrist support (1/2), medication use ınformation (1/-), medication (-/1), social activity (-/1)
	Delirium (2/2)	Medication (2/2), psychologist support (1/1), family psychologist support (1/1), consultation (1/-), family education (1/-), social activity (-/1)
	Sleeping disorder (1/3)	Medication (1/1), psychiatrist support (-/2), family education (1/-), psychologist support (-/1)
	Intense hallucination (1/-)	Neurologist support (1/-), psychologist support (1/-)
	Memory problems (1/-)	Medication (1/-), family education (1/-)

f, frekans; (..../....), (Number of physicians working in government institutions supporting the relevant theme or code / Number of physicians working in private institutions supporting the relevant theme or code)

Discussion

When the results were evaluated in general, the most common problems were seen to be due to chronic diseases in the palliative care process, followed by neuropsychiatric and pain-related problems.

In a study conducted by Göksel et al. (12), the most common diagnosis of hospitalization in palliative care centers was oncological diseases (35%), neurological diseases (22%), and chronic diseases (11%), while pain was the most common symptom (25%). Although these results are similar to our results, they differ in terms of the frequency of the problems, which can be explained by the difference in the study groups of the two studies.

The results of our study are consistent with the conclusion that neuropsychiatric disorders such as depression and anxiety are important problems encountered in the palliative care process in a study conducted by Jacobsen et al. (13). These results suggest that patients treated with palliative care need psychiatric support throughout the process.

Similar to our study, in the studies conducted by Gültekin et al. and Henson et al., one of the reasons why patients needed palliative care was pain (14,15). These results indicate that pain is one of the most important problems in the palliative care process.

In our study, in addition to the problems experienced intensively in the palliative care process, nutrition, oncology, and gastrointestinal system-related problems were also experienced. Similarly, in a study conducted by Güler Baynd r et al. (16) one of the reasons for the hospitalization of palliative care patients was found to be nutritional problems.

When the relevant literature is examined, the majority of patients in palliative care centers were elderly people with cancer which is consistent with our results (17-20). In a study conducted by Komaç et al. (21) the result that 33% of patients in the palliative care service had oncology-related problems supports our study results. This may be because palliative care practices were initiated with the aim of reducing the pain and care of cancer patients (22), as well as revealing the similarity of the problems experienced in the palliative care process in different societies.

In our study, disease-specific treatment came to the forefront in the solution of problems arising from chronic diseases, whereas medication and related specialist support came to the forefront in the solution of problems arising from pain, oncology, and the gastrointestinal system. Consistent with these results, in the study conducted by Ylmaz and Bahat, the use of analgesics was the most commonly used strategy in the management of pain in older adults (23). In another study, Ankay Yılbaş and Çelebi stated that analgesics were frequently used with antidepressant drugs to improve the quality of life by reducing the level of pain felt by a terminal patient, and that psychiatric support should be provided to patients without sufficient social and familial support (24).

In our study, it was observed that dietitian support was adopted for the solution of nutrition-related problems, and psychologist or psychiatrist support was mostly adopted as a solution for neuropsychiatry-related problems. In line with this result, the study conducted by Kayasuggested that patients in the palliative service should receive consultation support from other clinicians, and support services should be provided to patients and their relatives with psychiatrists, psychologists, moral support units, physiotherapists, and social workers (25).

Suggesting similar solution proposals in our research and other studies on the problems experienced in the palliative care process shows the consistency of the research results.

Study Limitations

Our study has some strengths and limitations. The strength of our research is that physicians, who are one of the stakeholders of the palliative care team, which is a multidisciplinary health service that includes functional and emotional care and support, reveal their opinions in a holistic and in-depth manner regarding the problems experienced in the palliative care process and solution proposals. On the other hand, the limitation of the research is the scarcity of physicians included in the study and the research findings consisting only of physicians' opinions.

Conclusion

According to the results of our study, patients in the palliative care process experience multiple problems, and an individualized approach should be adopted as a result of a comprehensive evaluation with a multidisciplinary team to solve these problems. Multiple problems experienced in the palliative care process result in multiple solution proposals, which reveals the importance of cooperation between specialists and increasing the number of physicians working in palliative care centers/services. In addition, the acceptance of palliative care as a specialty will make palliative care services more professional and enable patients receive more qualified health care.

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Ethics

Ethics Committee Approval: The study was approved by the Medical Research Ethics Committee of the relevant University (dated: 28/11/2022; number: 22-11.1T/37) and was conducted in accordance with the principles of the Declaration of Helsinki.

Informed Consent: Informed consent was obtained from all participants.

Peer review: Externally peer reviewed.

Authorship Contributions

Concept: AG, AK; Design: AG, AK; Data Collection or Processing: AG, AK; Analysis or Interpretation: AG; Literature Search: AG, AK; Writing: AG, AK.

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