PERSPECTIVES FROM PRACTICE AND PRIMARY CARE INTEGRATION: THE IDEAL PALLIATIVE GP

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Background

Palliative care is increasingly recognized as a critical component of primary healthcare, yet its integration remains underdeveloped (den Herder-van der Eerden et al., 2017). General practitioners (GP) in Czechia do not undertake a specific training reagrding palliative care aspects in their work. An educational program covering this gap launched in 2024 with a goal to educate “paliative GPs”. It covers topics of communication, palliative patient identification, goal and plan of care, assessment of patient values, symptom management, pharmacotherapy, specifics of geriatric patients, patients with dementia, and patient in specialist's outpatient clinic, specialized palliative care, home hospice, inpatient hospice, hospital palliative team, palliative outpatient clinic, home care, legal and ethical aspects in end-of-life care in the GP's office. Psychological aspects (such as trauma, spirituality, caring for carers, self-care techniques, maintaining safe capacity).

The aim of our study was to explore which key competences or characteristics are thought to constitute a good paliative GP according to the study programme attendees. To evaluate the course effectiveness, we explored if and how the participants self-report the change in these competences and their ability to integrate a palliative care in their everyday practice of GPs’.

Methods

The study uses a mixed-methods approach, combining self-reports from practitioners on their competence development over the educational programme with focus group data gathered at the beginning (FG1) and end of the program (FG2). Through a thematic analysis (Braun & Clarke, 2006) of the focus groups data, we identified the key characteristics and competencies the trainees thought a palliative practitioner should ideally have.

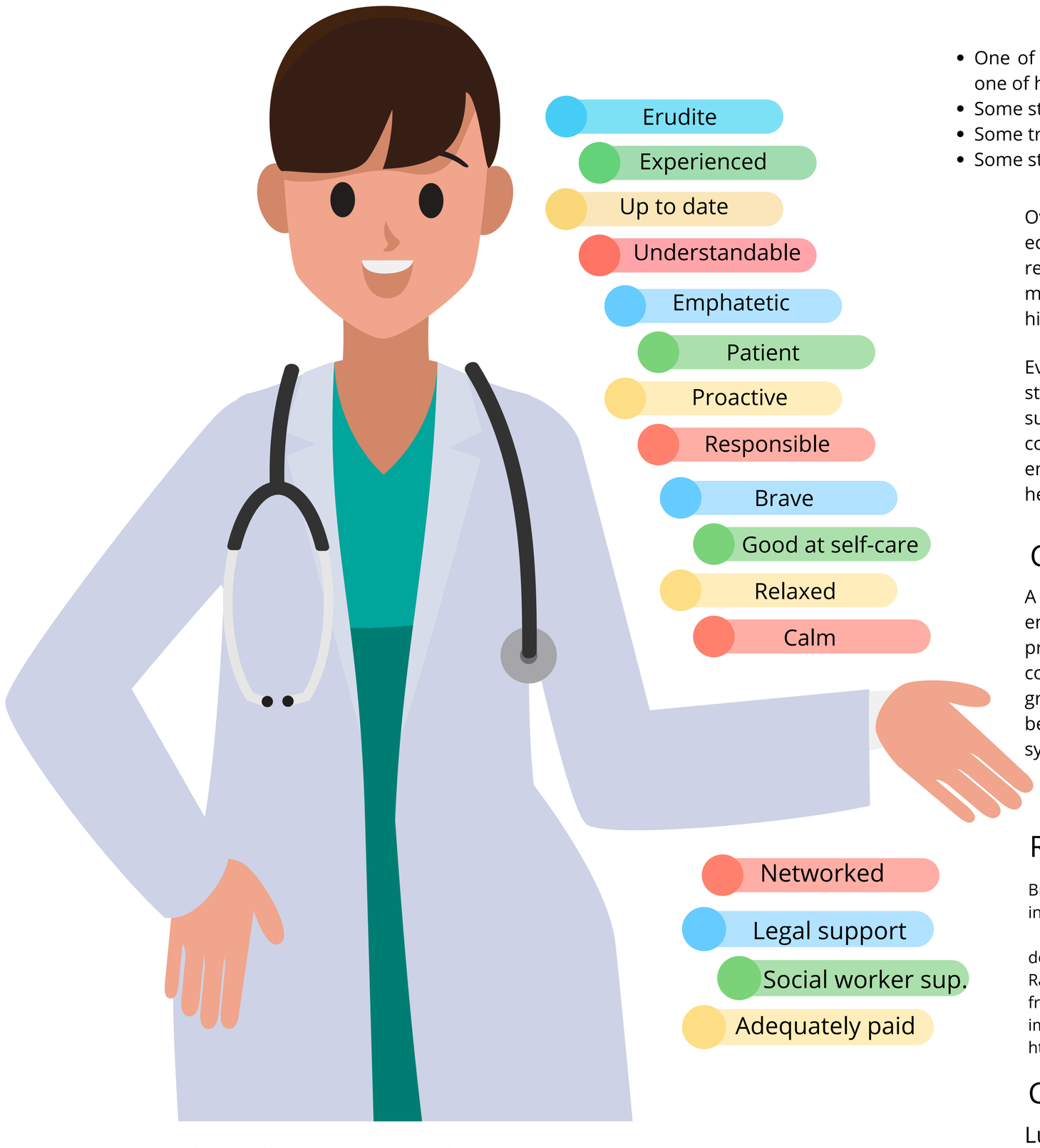

Figure 1. Who is an ideal paliative GP according to the primary care practitioners.

The participants then self-reported how they meet a specific competences on a Likert scale from 1 (not at all) to 7 (very much); and they were asked to express (as a percentage) how close they thought they were to the ideal paliative GP (i. e. a person, who whould meet all these criteria) in 4 timepoints - before the educational program started and after each course.

Participants

13 female and 2 male trainees of the educational program filled in the self-reported scales; 6 of them participated in the focus groups. All were certified GPs, mostly experienced - 10-14 years (N=8) in a primary care but also novices working less then 5 years (N=2).

Results

The qualitative analysis of the FG1 showed that next to the personal erudition, soft skills, and practical competencies, the external factors are thought to allow an integration of the palliative care in a GP’s practice (see Figure 1).

While individual practitioners demonstrated **improvements in soft skills**, particularly in communication with a patient and setting boundaries; and **practical competencies** such as better knowledge of pain management after the course, they also reported how **the broader structural changes are needed** to support these advancements.

However, some women talked about their ability to better deal with a system after the course, which help their motivation in their everyday practice.

- One of the participants for example decided not to fight with a system within one of her employes and started to work full time at her own practice.
- Some started networking within the system of palliative care
- Some try to set up and guard their boundaries better.
- Some started to talk about palliative care to change the views in the society.

Overall, the participants of the FG2 felt empowered after completing the education, and reported a positive impact on their everyday practice. They reported to be more informed, less uncertained, provide better care, feel more brave and confident in their communication towards the patient or his/her family.

Even if part of the participants report better competencies or self-care, they still feel uncertain in their practice, which leads them to thing about supervision and also a further education. Some felt they need more communication trainings, self-growth courses aimed at dealing with ones emotivity or even psychoherapy training as a complex education, which could help provide better paliative care in their setting.

Conclusion

A sustained focus on education and practitioner development can greatly enhance the percieved competence of the GP and the quality of palliative care provided. Except of the education, policy changes, such as adequate financial compensation (reporting a signal code to insurance companies) or enabling greater coherence between practitioners and the palliative care system, would be beneficial for a better integration of palliative care in a primary care system.

References

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