Original Article

Improvements in Physicians' Knowledge, Difficulties, and Self-Reported Practice After a Regional Palliative Care Program

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Abstract

Context. Although several studies have explored the effects of regional palliative care programs, no studies have investigated the changes in physician-related outcomes.

Objectives. The primary aims of this study were to: 1) clarify the changes in knowledge, difficulties, and self-reported practice of physicians before and after the intervention, 2) explore the potential associations between the level of physicians' participation in the program and outcomes, and 3) identify the reasons and characteristics of physicians who did not participate in the program.

Methods. As a part of the regional palliative care intervention trial, questionnaires were sent to physicians recruited consecutively to obtain a representative sample of each region. Physician-reported knowledge, difficulty of palliative care, and self-perceived practice were measured using the Palliative Care Knowledge Test, Palliative Care Difficulty Scale, and Palliative Care Self-Reported Practice Scale (PCPS), respectively. The level of their involvement in the program and reason for non-participation were ascertained from self-reported questionnaires.

Results. The number of eligible physicians identified was 1870 in pre-intervention and 1763 in post-intervention surveys, and we obtained 911 and 706 responses. Total scores of the Palliative Care Knowledge Test, PCPS, and PCPS were significantly improved after the intervention, with effect sizes of 0.30, 0.52, and 0.17, respectively. Physicians who participated in workshops more frequently were significantly more likely to have better knowledge, less difficulties, and better self-reported practice.

Conclusion. After the regional palliative care program, there were marked improvements in physicians' knowledge and difficulties. These improvements were associated with the level of physicians' participation in the program. J Pain Symptom Manage 2015;50:232–240. © *2015 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Physician, knowledge, difficulty, palliative care, regional palliative care

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Introduction

Palliative care is an essential part of integrated cancer treatment.[1] It should be provided throughout an entire region, and several outcome studies have explored the effects of regional palliative care programs on place of death, the use of palliative care services, patient- and family-reported outcomes, and costs.[2–6] More recently, qualitative studies from the U.K. suggest that the most important benefit of the Gold Standards Framework is facilitating communication among health care professionals in the community.[7–9] Multiple studies from Canada, The Netherlands, and Australia revealed the perceived importance of an increase in personal and formal contact among health care professionals.[10–12]

These studies provide important insight into the potential benefits of regional palliative care programs, but, to our best knowledge, no studies have investigated the changes in physician-related outcomes despite the fact that physicians are clearly one of the most important professionals in terms of the quality of palliative care. To date, many surveys have revealed that physicians frequently have inadequate knowledge of cancer pain, opioids, symptom management, and the concept of palliative care; this could result in poor symptom control and late referrals to specialized palliative care services.[13–18] On the other hand, many physicians experience considerable difficulties when providing palliative care in a variety of areas, including symptom control, discussing death and achievable goals with patients and families, communication with multidisciplinary professionals, and obtaining support from palliative care specialists.[19–22] Although some educational intervention trials explored the effects of each program on physicians at an individual level,[23,24] understanding the changes in physician-related outcomes after a palliative care program is implemented at a regional level could be useful in interpreting how physicians should be supported to provide better palliative care for patients.

Thus, the primary aims of this study were to: 1) clarify the changes in knowledge, difficulties, and self-reported practice of physicians before and after the regional palliative care intervention program, 2) explore the potential associations between the level of physicians' participation in the program and outcomes, and 3) identify the self-reported reasons and characteristics of physicians who did not participate in the program. Our hypotheses were after the regional palliative care intervention program the knowledge, difficulties, and self-reported practice of physicians improved and the improvement was significantly associated with the level of physicians' participation in the program.

Methods

This was a part of a mixed-method regional palliative care intervention trial, the Japan Outreach Palliative care Trial of the Integrated Model (OPTIM) study.[25–27] The study methodology and results of primary endpoints of the study were reported in previous papers,[25,26] and this article reports the physician-related outcomes as secondary endpoints. This study was performed according to the ethical guidelines for epidemiological research proposed by the Ministry of Health, Labor and Welfare of Japan, and written informed consent was unnecessary. Ethical and scientific validity were confirmed by the institutional review boards for this study and of all participating hospitals.

Overview of the OPTIM Study[26]

The OPTIM study was performed in four regions of Japan. We obtained pre-intervention data for outcomes before or in the early phase of the intervention period and post-intervention data after or in the late phase of the intervention period. The intervention program was implemented from April 2008 to March 2011. The primary endpoints were home death, use of a palliative care service, and patient-reported and bereaved family-reported quality of palliative care. Secondary endpoints included patient-reported and bereaved family-reported quality of life, pain, caregiving burden, and knowledge, beliefs, and concerns about palliative care. The intervention is a comprehensive program covering four areas: 1) to improve the knowledge and skills of palliative care (i.e., dissemination of manuals and assessment tools with interactive workshops about palliative care), 2) to increase the availability of specialized palliative care services for community patients (i.e., establishment of a new community palliative care team, outreach educational visits), 3) to coordinate community palliative care resources (i.e., regional palliative care centers, whole-region multidisciplinary conferences, patient-held records, discharge-planning systems), and 4) to provide appropriate information about palliative care to the general public, patients, and families (i.e., dissemination of leaflets, posters and DVDs, workshops). During the study periods, as interventions for the main target of physicians, a total of 24,353 pocket-sized manuals and 174,891 assessment instruments were disseminated; 414 interactive workshops about a variety of palliative care topics were held and 22,189 health care workers participated; and 38 outreach visits were performed and 429 patients were referred to community palliative care teams.

After the interventions, the percentage of home deaths increased from 6.8% to 10.5%, and this increase was significantly greater than that in the national data.

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