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Original Study

Nursing Home Physicians' Assessments of Barriers and Strategies for End-of-Life Care in Norway and The Netherlands

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A B S T R A C T

Objectives: Working conditions in nursing homes (NHs) may hamper teamwork in providing quality end-of-life (EOL) care, especially the participation of NH physicians. Dutch NH physicians are specialists or trainees in elderly care medicine with NHs as the main workplace, whereas in Norway, family physicians usually work part time in NHs. Thus, we aimed at assessing and comparing NH physicians' perspectives on barriers and strategies for providing EOL care in NHs in Norway and in The Netherlands.
Design: A cross-sectional study using an electronic questionnaire was conducted in 2015.
Setting and Participants: All NH physicians in Norway (approximately 1200–1300) were invited to participate; 435 participated (response rate approximately 35%). Of the total 1664 members of the Dutch association of elderly care physicians approached, 244 participated (response rate 15%).
Measurements: We explored NH physicians' perceptions of organizational, educational, financial, legal, and personal prerequisites for quality EOL care. Differences between the countries were compared using χ^2 test and t-test.
Results: Most respondents in both countries reported inadequate staffing, lack of skills among nursing personnel, and heavy time commitment for physicians as important barriers; this was more pronounced among Dutch respondents. Approximately 30% of the respondents in both countries reported their own lack of interest in EOL care as an important barrier. Suggested improvement strategies were routines for involvement of patients' family, pain- and symptom assessment protocols, EOL care guidelines, routines for advance care planning, and education in EOL care for physicians and nursing staff.
Conclusions: Inadequate staffing levels, as well as lack of competence, time, and interest emerge as important barriers to quality EOL care according to Dutch and Norwegian NH physicians. Their perspectives were mostly similar, despite large educational and organizational differences. Key strategies for improving EOL care in their facilities comprise education and incorporating available palliative care tools and systems.

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Many elderly spend their last period of life in a nursing home (NH).[1,2] Patients and families expect NH physicians to be involved in end-of-life (EOL) care.[3] Previous research suggests that working conditions in NHs may hamper the quality of EOL care, especially participation of the NH physician.[4] EOL trajectories are heterogeneous, posing challenges to NH physicians regarding prognostication, treatment decisions, hospital admissions, and ethical concerns.[5] A survey in Canadian NHs revealed facility staffing and EOL care training as important challenges, as well as possible strategies to improve palliative care.[6]

The organization of medical services and NH physicians' competence vary between countries and may possibly influence the

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provision of EOL care. Norway and The Netherlands are 2 countries in northern Europe with many similarities regarding standard and organization of healthcare services, but different ways of organizing NH care. NH physicians in Norway are mainly family physicians working part time in NHs,[7] similar to Canada.[6] In The Netherlands, medical services in NH are provided by employed specialists or trainees in elderly care medicine with NH as their main workplace.[8,9]

EOL care constitutes an important part of NH physicians' work, yet knowledge about key factors influencing quality and content of this task remains scarce. We aimed at comparing NH physicians' perspectives on barriers and possible strategies to providing EOL care in NH in Norway and in The Netherlands.

Methods

Setting, Design, and Participants

In Norway there are approximately 1000 NHs comprising approximately 40,000 beds.[10] The exact number of NH physicians is not known but estimated at approximately between 1200 and 1300. In The Netherlands, there are 2057 NHs/care homes (approximately 130,000 beds) employing approximately 1913 NH physicians, 345 of which are trainees.[11]

We aimed at inviting all NH physicians in Norway and The Netherlands to participate in an electronic survey. An e-mail invitation to Norwegian NH physicians was conveyed by the chief medical officer in all 428 municipalities in November 2015, including a link to the electronic questionnaire. A reminder was sent after 3 weeks. In The Netherlands, the invitation with link to the questionnaire was published twice during October and November 2015 in the weekly electronic newsletter sent to all 1664 members of the Dutch Association of Elderly Care Physicians and Social Geriatricians, comprising approximately 90% of elderly care specialists and all trainees. One reminder was sent via 4 regional NH research networks after 3 weeks.

Survey Questionnaire

Our questionnaire was derived from a tool developed by Brazil et al[6] for a similar study among medical directors in NHs in Ontario, Canada in 2006. The Brazil et al[6] tool included questions regarding the importance of suggested barriers and strategies for palliative care in NHs, as well as respondents' demographic and practice characteristics, and training received in palliative care. We adjusted the questionnaire to organizational conditions in Norwegian and Dutch NHs and added questions regarding advance care planning, communication with patient's family, and physicians' interest in EOL care (Tables 1–3 and Supplementary Table 1). The adapted questionnaire was translated

Table 1
Characteristics of Responding NH Physicians in Norway and The Netherlands (Number, Percentage, and χ^2 Test if Not Indicated Otherwise)

	Norway N = 435*		The Netherlands N = 244*		*P* Value
	N	%	N	%	χ^2 Test
Sex					
Female	208	48.3	167	68.4	<.01
Male	223	51.7	77	31.6	
Age, y (mean, SD, *t*-test)	45.1	12.2	47.0	12.2	.54
Main workplace					
NH	174	40.2	227	93.0	<.01
General practice	223	51.5	2	0.8	
Other	36	8.3	15	6.2	
Salary					
Fixed	265	96.7	126	91.3	.02
Fee-for-service/other	9	3.3	12	8.7	
Specialty (including trainees)					
General practice/public health	285	85.3	25	10.2	<.01
Elderly care medicine	1	0.3	190	77.9	
Relevant hospital specialty†	27	8.1	0	0	
Other/none	21	6.3	29	11.9	
Specialist status (any specialty)‡					
Specialist	212	69.3	193	79.1	<.01
Trainee	123	36.7	51	20.9	
Work as NH physician					
Experience as NH physician, y (mean, SD, *t*-test)	7.8	8.6	14.0	10.1	<.01
Working h/wk in NH (mean, SD, *t*-test	17.2	13.1	29.4	7.8	<.01
NHs					
No. of beds (mean, SD, *t*-test)	60.7	41.0	288.5	192.0	<.01
No. of physician h per bed per wk (mean, SD, *t*-test)	0.63	0.74	0.59	0.38	.02
Special interest in EOL care/palliative medicine	153	52.8	136	56.9	.34
Education in EOL care/palliative medicine perceived as good§					
Undergraduate education	39	13.6	13	8.2	.09
Postgraduate education	177	62.1	104	66.2	.39
Possibility for CME	147	51.6	120	75.9	<.01
Feeling confident in EOL care	200	69.9	133	84.2	<.01
Availability as NH physician§					
Afternoon/evening	141	51.6	14	10.0	<.01
Weekend	116	42.5	20	14.3	<.01
Out-of-hours NH emergency service	37	13.6	131	93.6	<.01

CME, continuing medical education.
*Valid cases: number varies owing to missing data (Norway N = 287–435. The Netherlands N = 159–244).
†Geriatrics, palliation, rehabilitation, internal medicine.
‡Some specialists in Norway were trainees in another specialty, percentages exceed 100.
§Several choices possible, percentages exceed 100.

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