

General Practitioners' experiences with palliative and end of life care: a qualitative study in Norway

Background: Providing palliative care in the municipal health care services requires participation from the regular general practitioners (RGPs). The Norwegian guideline for palliative care is a tool to ensure quality and equality in the services. It designates RGPs as key workers, mastering specific skills. Evaluations of the palliative care services describe the RGPs as “put on the sideline”. We previously performed a questionnaire survey among Norwegian RGPs, showing variable RGP involvement, and unawareness of elements in the guideline.

Aim: To explore RGPs' experiences of palliative and terminal care, how they understand their role, and gain a deeper understanding of factors influencing RGP involvement.

Methods: Focus group interviews with RGPs, using a semi-structured interview guide. The interviews were transcribed verbatim. Transcripts were analyzed using interpretative phenomenological analysis (IPA) looking for emergent themes. Data were handled with the NVIVO software.

Results: We conducted four focus group interviews, with 26 RGPs. The informants were of varying age and gender, and from both urban and rural areas. A preliminary analysis shows that all of the RGPs had some experience with palliative care, whereas the amount varied. Most RGPs had little experience with terminal care at home. RGPs in rural areas seemed to be more involved than those in urban areas. The RGPs most involved seemed confident about their role as key workers. RGPs less involved appeared unsure of their role and ambivalent towards the RGP being the key worker. They perceived that other professionals were in charge, and described a discontinuation of the doctor-patient relationship. In all focus groups, palliative care was deemed meaningful, but also demanding. Time and resources were identified as the most constraining factors. The RGPs seemed confident about their central role in follow-up of relatives and providing psychosocial support. They also felt that they would be able to provide patients with basic medical treatment for symptom control. For the more advanced tasks, there was more diversity of opinions of whether or not these should be the responsibility of the RGP. The majority were unfamiliar with the guideline itself.

Short discussion: The varying participation of RGPs in palliative care might reflect differences in culture, perhaps accounting for the difference between rurally and urbanly based RGPs. However, possible differences in organization and specialist health care provision must also be considered. Whereas time and resources were described as the most constraining factors, the RGPs revealed strategies to handle lack of both experience and knowledge, pointing towards an ability to participate in palliative care.

Conclusion: The RGPs do not have a uniform view of their role, but although experiencing varying degrees of involvement in palliative care, they value participation in this work. Time issues, rather than lack of skills, seem to be the most important barrier to participation. Our findings indicate that the RGP does not need to be put on the sideline in palliative care.