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**ASSESSING THE KNOWLEDGE AND PRACTICE OF
PALLIATIVE CARE FROM DOCTORS PERSPECTIVE:
THE CASE OF THE RIDGE HOSPITAL ACCRA**

BY

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DECLARATION

I, Mariam Abraham hereby declare that apart from references to other people's employment which have been duly acknowledged, this dissertation is a result of my own independent work and has not been submitted for the award of any academic degree in any institution.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ECF	Extended Care Facilities
GARH	Greater Accra Regional Hospital.
GPs	General Practitioners
HIV	Human Immune-deficiency Virus
IRB	Institutional Review Board
KNUST	Kwame Nkrumah University of Science and Technology
PC	Palliative Care
PCKTS	Palliative Care Knowledge Test
PCT	Palliative Care Team
PI	Principal Investigator
PLWHIV	Persons living with HIV
UDS	University for Development Studies
UG	University of Ghana
WHO	World Health Organization

DEFINITION OF TERMS

- i. **Palliative care:** As defined by the WHO is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO, 2015b)
- ii. **Terminally ill patient:** This refers to a patient who is suffering from diseases or illnesses which are either extremely difficult to cure or cannot be cured and eventually causes their death.
- iii. **Life-limiting diseases:** This refers to chronic diseases that stay with their victims for long periods and causes the life of their victims to degenerate to the extent that the victims are incapacitated to achieve any life goals.
- iv. **Life-threatening diseases:** These are diseases which reduce the vitality of its victims and over the long period cause the death of its victims.
- v. **Patient-centered care:** This refers to clinical care which is focused on improving the wellbeing of the patient.



ABSTRACT

There have been concerns on how medical doctors' knowledge on Palliative Care impacts on Palliative Care practice, in the delivery of quality health care in Ghana. Despite the concern above, there is no empirical study to date that attempts to investigate this problem in Ghana. The objective of this study was to assess the knowledge and practices of medical doctors at the Ridge Hospital on Palliative Care. The study adopted the quantitative approach and used non-probability sampling technique to engage 165 respondents all of whom, were medical doctors from various departments at the hospital. Out of this number, 145 questionnaires were retrieved from the survey. The study used Chi-Square statistical tool to establish that, there is a significant relationship between, doctors' knowledge on Palliative Care and the practice of Palliative Care in the delivery of quality healthcare. The study found that there were several pathways through which doctors acquired on Palliative Care. For example, majority of the doctors at the hospital had knowledge in Palliative Care which they acquired from medical school. It was further revealed that, most doctors at the Ridge hospital handle terminally ill patients at least once in a week. This made the knowledge acquired on Palliative Care very essential in their line of duty. Additionally, almost all the doctors surveyed at the hospital do practice pain management which is a very critical component in Palliative Care practice. Also findings showed that doctors at the Ridge hospital were motivated by the knowledge they have on Palliative Care practice and readily assisted patients that required that attention. Based on findings, the study recommended that stakeholders in the healthcare sector should ensure all medical schools at least, incorporate Palliative Care in their curriculum, since it was established that, doctors are motivated by knowledge in Palliative Care in caring for chronically ill patients in their line of duty.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The Worldwide Hospice Palliative Care Alliance (WHPCA) (2015) has argued that the global goal for health, as adopted in September 2015 by the UN, aims at building a better world by 2030 by ending poverty and most emphatically, promoting prosperity and wellbeing for all (United Nations Sustainable Development, 2015). Palliative care is seen as an essential component of promoting good health and wellbeing. It is also seen as a means to ensure healthy lives and promote wellbeing for all ages (WHPCA, 2015). The World Health Organization maintains that palliative care, in particular, is a key component of Universal Health Coverage (WHO, 2015a). Palliative care is defined as “an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO, 2015b). This implies that it addresses the physical, social, psychological, and spiritual issues facing people affected by life-threatening or life-limiting illness. The WHPCA (2015) intimates that palliative care is a holistic approach that aims at meeting the needs of the whole person, and not just to treat their clinical condition.

It is appropriate to provide palliative care at any stage from the time a patient is diagnosed of an illness through to the end of life. Regardless of the stage of an illness, the use of the palliative care approach to care helps improve the quality of life of the individual to the highest possible level. All healthcare professionals can provide palliative care while specialist palliative care services can be accessed when there is some uncertainty regarding

the care an individual needs and this is provided in collaboration with the primary health care team. Significantly it has to be noted that specialist palliative care services can be provided more than once during an illness and discharges may be effective which can vary on individual basis.

According to Mitchell et al. (2010), palliative care has a target of improving higher quality of life, through therapeutic outcomes planned by a multidisciplinary team, for people with chronic diseases or in an extremely terminal state. In the United States, palliative care has evolved from a small care arena into a fairly large health industry and has considerably improved the care given to those at the end of life (Connor, 2007).

In the United Kingdom, palliative care began as hospice care primarily in inpatient settings while in the United States great emphasis was placed on care in the home. United States palliative care is now conceptualized as patient-centered and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering (National Consensus Project for Quality Palliative Care, 2004). In both countries, palliative care provision, albeit imperfect, has resulted in excellent care for some patients. While methodologies to identify patients in need of palliative care face some challenges relative to lack of refinement, the palliative care approach is generally understood (Gomez-Batiste et al., 2014; Murtagh et al., 2014). Many symptoms, problems and needs are shared across conditions (Fitzsimons et al., 2007). Palliative care provided a major source of care for people with chronic non-cancer conditions who are likely older, in need of support due to longer term disability and frailty (Gill, Gahbauer, Han, & Allore, 2010). Studies have shown that a number of countries, for instance, Brazil and Lebanon, have contemplated palliative care as a

solution to the health care needs of people with degenerative diseases and vulnerable groups (Saito & Zoboli, 2015; Mukemo et al., 2017).

Historically, palliative care development in Western Africa has been very low as compared to other part of Africa. The Hayward Medical Communications (2014) attributes this development to the relatively low HIV prevalence. In Nigeria, palliative care nurses are notable group of professionals who provide home care services chiefly for client from the Diaspora. The University College Hospital in Ibadan hosted the first palliative care team. From thence, palliative care is becoming a multidisciplinary team of doctors, nurses, physiotherapists, pharmacists, volunteers and administrators, trained within and outside the country, who provide both hospital and home-based services (Hayward Medical Communications, 2014).

It is documented that in Ghana, palliative care was nonexistent until 2003 when the Minister of Health, then Dr. Kwaku Afriyie, raised the need for palliative care for specialist care to terminally ill patients with cancer, diabetes, stroke and other life-limiting diseases (Modern Ghana, 2003). Ripples Health Care was the first specialist palliative care centre known. Consequently, the Ghana Palliative Care Association was found in 2006, and periodic training of specialists was undertaken. There is however, copious literature suggesting that many health centres in developing country have no palliative care system (Kassa et al., 2014; Silbermann et al., 2012). Palliative care units in Ghana's hospitals only guarantee suboptimal care for patients and are often nonexistent. The Ridge Hospital, which is the area in focus in this study, is considered as one of the major hospitals in Accra, the capital of Ghana, beside the Korle-Bu Teaching Hospital. The ability to practice palliative care in Ghana's hospitals demands that the architecture of the hospitals must provide palliative care unit.

Not only that, but also the health professionals, like medical doctors and nurses need high awareness and knowledge of the relevance of palliative care. Palliative care offers measures to ensure good quality of life for patients and their families confronted with issue related to life limiting illnesses, through the anticipation and alleviation of suffering. The intension of this survey is to assess the Knowledge and practice of palliative care from the perspective of medical doctors, using the Ridge hospital as the study site.

1.2 Statement of Problem

Globally, the burden of chronic and life-limiting illness is on the rise. In 2015, it was estimated that about 39,189 [68.4%] of people died from non-communicable diseases. It was further projected that about 51,792 (73.9%) (World Health Organisation, 2013)of people suffering from non-communicable diseases could die in 2030. Similarly about 1667 HIV deaths were recorded in 2015 with a projection of 1,793 HIV death in 2030(World Health Organisation, 2013).

In 2003, there were 26.6 million individuals in sub-Saharan Africa living with HIV, 3.2 million new contaminations and 2.3 million AIDS-related deaths. Annually about 0.5 million malignancy deaths are recorded.

These people suffering from the above-mentioned diseases or conditions and their families are faced with high symptom burdens ranging from physical, psychosocial and spiritual before their death. This brings suffering to both patients and family.

Therefore there is an urgent need to enhance care for patients with serious, multifarious and potentially life-threatening or life-limiting medical conditions. The WHO estimates that 40 million people need palliative care, of which 78% live in low to middle income countries such

as Ghana. The aim of palliative care is to reduce suffering and improve quality of life, which involves taking care of physical, emotional, spiritual, social and intellectual needs of an affected individual.

Although there are effective and low cost interventions capable of reducing physical and emotional distress in patients with life-limiting illnesses and their caregivers, they are not routinely taught in medical, nursing, and health care givers schools and healthcare professionals globally may not be well-trained in delivering these interventions (Edwardo Burera, 2016). It has been established that not all clinicians are competent in providing basic palliative care and responding to palliative care needs of patients who need it (Weissman & Meier, 2011). This particularly the case given that contemporary medicine focuses more on curative care, meaning, that it is about time palliative care was integrated into curative treatment (Zalaf et al., 2017). Admittedly, there have been some efforts in the past several decades to promote palliative education globally especially in the developed world. Despite these efforts especially in providing specialized palliative care and education, there are still widespread misconceptions about palliative care, with some patients often regarded with pity and stigma (Hanratty et al., 2006)

This problem is more common in developing countries where knowledge about palliative care is not only limited, but more importantly, few professionals have the requisite specialized training to provide palliative services. In Ghana, palliative care has been in existence for 15 years now with formal palliative care being given at the Korle Bu teaching Hospital, Tetteh Quarshie Memorial Hospital and the Komfo Anokye Teaching Hospital. Various palliative care training programs have been organized for doctors and other clinicians in some hospitals with the GARH inclusive. This training was done to aid participants to deliver or initiate basic

palliative care for their patients when the need arises and to also start formal palliative care services at their various hospitals since there is no formal training for doctors in Ghana as compared to their developed counterparts. Regardless of these training programs it is not clear the extent to which this has impacted the quality of palliative care in Ghana. This study seeks to find out the knowledge of doctors at the Greater Accra Regional Hospital (GARH) on palliative care and their ability to initiate or practice some form of palliative care.

1.3 Research Questions

The following fundamental questions serve as a guide to the study:

1. What is the level of knowledge of medical doctors at the Ridge Hospital on palliative care?
2. What is the extent of practice of palliative care at the Ridge Hospital?
3. What is the relationship between doctors' knowledge on palliative care and the practice of palliative care at the Ridge Hospital?

1.4 Objectives

1.4.1 General Objective

The general objective of this study is to assess the knowledge and practices of medical doctors at the Ridge Hospital on Palliative Care.

1.4.2 Specific Objectives of the Study

1. To assess the knowledge of medical doctors at the Ridge Hospital on palliative care services.
2. To determine the extent of practice of palliative care at the Ridge Hospital.
3. To determine the relationship between doctors' knowledge on palliative care and the practice of palliative care at the Ridge Hospital.

1.5 Justification of the Study

Palliative care is an essential part of health delivery to patients and family. As such, improving palliative care by improving upon knowledge and practice has become important. Globally, palliative care is seen to be a new discipline and so there is the need for further studies or research work to be done in this area to improve understanding and delivery of palliative care. This study is justifiable because of the following reasons:

First, medical professionals will be able to assess themselves with regards to palliative care which will inform decisions on updating the knowledge they have on palliative care. This study provides information to inform decisions on the priority areas to consider in updating the knowledge about palliative care. This will in turn benefit the individual patients as they may get improved quality of life when knowledge and practice gaps of doctors are identified and modified.

Secondly, good knowledge and practice of doctors in the delivery of palliative care will help reduce symptom burden on patients and in turn relief their family from having to see their love ones suffer. In this regard, relatives will have sound mind knowing that their love ones have improve quality of life and this will intend benefit the community as a whole.

Moreover, the study will benefit policy makers by helping them identify the gaps in the knowledge and practice of doctors in palliative care, which can influence revision of Medical School Curriculum to incorporate palliative care content in medical training. The attention of educators would be drawn and as such more to importantly be focused on palliative care education for medical school students and result in improved palliative care conveyance.

Lastly, the study findings will aid researchers who will be doing studies in palliative care, serving as a basis for them.

1.6 Conceptual Framework of the Study

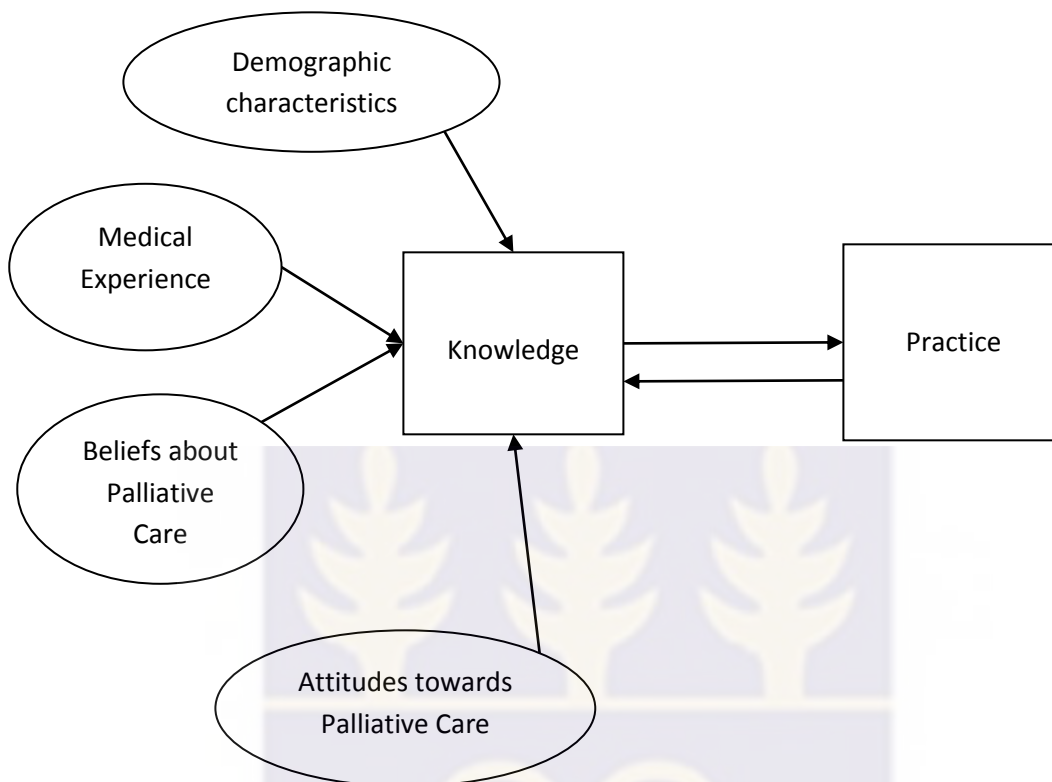
To achieve the goal of improved hospice utilisation when appropriate, some guidelines recommend that palliative care be incorporated into standard-of-care intervention approach (Smith et al., 2012). One validated model that has been proven effective in patients with serious illness includes the following actions: stating the prognosis at the first visit; appointing someone in the physician's office to ensure that advance directives are discussed; scheduling a hospice care visit within the first three visits; and offer to discuss the patient's prognosis, coping strategies, and end-of-life care at each transition (Smith et al., 2012b). Palliative care should be part of a broader continuum of care, thereby avoiding abrupt changes in the medical course. Family doctors are well positioned to discuss advance care planning during office visits; several increasingly nuanced interventions are available to facilitate this discussion. Family physicians should be familiar with disease trajectories of common chronic illnesses, as well as tools that aid in prognostication. Institutions should also consider implementing protocols that trigger hospice referrals based on specific clinical features, for example, repeated or lengthy hospitalizations, insurance, decline in cognitive or functional status, unacceptable pain, emotional distress, and palliative care utilization should be a key quality metric. Physician and nursing education must continue to incorporate these elements in clinical preparation.

From the foregoing and per the focus of this study, palliative care that takes into account the contributions of medical doctors is the main object of the conceptual framework. Knowledge and practice of the medical doctors are the main variables of concern. Practice is offered as

the natural of the ability or confidence of the medical doctors to apply their skill and expertise in delivery of palliative care. The relevant variables in the study are as presented in Figure 2.1 and explained thereafter.



Figure 2.1: Conceptual Framework



In Figure 2.1, the two main constructs for measurement in the study are knowledge and practice. Knowledge is a construct that is based on certain latent variable. These variables are demographic characteristics, medical experience, beliefs about palliative care, and attitudes towards palliative care. Practice of palliative care, on the other hand, is offered as a construct that depends on the knowledge of medical professionals, specifically medical doctors. However, when knowledge causes an action, there is often an outcome which acts as feedback to the actor. In this case, the feedback would be, more or less, processed and incorporated into the knowledge stream for improved future action.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

2.1 What is Palliative Care?

Basically, palliative care may be understood as the kind of care rendered to terminally ill patients whose illness cannot be cured by any known clinical means. Palliative care entails caring for people with incurable life-limiting illnesses, relieving their suffering and supporting them through difficult times (Leng, 2011). According to WHO (2015b), palliative care is defined as, “an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.

Palliative care has the objective of promoting a better quality of life, through therapeutic projects planned by a multidisciplinary team, for people with chronic degenerative diseases or are in a terminal state. In furtherance of this view, WHO (2015a) urged that the composition of the palliative care team will vary depending on the objectives of the programme, and the health-care professional's available.

Studies have shown that doctors play very vital role in providing quality palliative care since they spend more time with patients (Mukemo, et al., 2017). However, the care is not restricted to specific contexts and institutions and must be performed at every level of the health system (Saito & Zoboli, 2015). All health workers should be trained for the palliative care approach, since this kind of attention needs to be established early, from the moment of the diagnosis of

chronic health conditions, and aimed at a good quality of life (Mitchell et al, 2010). Specialized palliative care is an assignment attributed to specialists in hospices, while primary health care provides the overall palliative care. The best results in providing palliative care depend on the integrated operation of services as well as the alliance between specialists, generalists and home caregivers (Saito & Zoboli, 2015).

2.2 The Need for Palliative Care

In 2014, the World Health Organization and the Worldwide Hospice Palliative Care Alliance collaboratively published the Global Atlas of Palliative Care at the End of Life (Global Atlas, 7). In this publication, the need for, and availability of palliative care worldwide was quantified. The publication estimated that the number of people in need of palliative care at the end-of-life was 20 million. Unfortunately, only 14 percent of that need was being met. Not only that, but also research by the International Children's Palliative Care Network (ICPCN) identified that less than 1 percent of children are receiving palliative care (International Children's Palliative Care Network & UNICEF, 2013).

The Global Atlas identified people needing palliative care at the end of life. When including people needing palliative care early in the course of their illness the number doubles to at least 40 million each year. In addition there are several family members and caregivers for each affected person. Therefore the real need far exceeds the estimate published (WHPCA, 2015).

The Global Atlas research, including various other studies, leads to one conclusion; the need for palliative care cannot be underestimated. Many of the Global Goal for Health targets cannot be met without a focus on palliative care. The sections below describe the role of palliative care in relation to each relevant target.

In 2015 5.9 million children under 5 years old died. Neonatal and peri-natal conditions accounted for 45% of these deaths. WHO estimates that 98% of children needing palliative care live in Low- and Middle-Income Countries (LMICs), with almost 50% in Africa, which has only 3% of the world's health staff (WHO, 2015a).

Both adults and children need palliative care for HIV and AIDS. The Global Atlas estimates that over 1.2 million people with AIDS need palliative care at the end of life. Many more people living with HIV could benefit from palliative care from the point of diagnosis. WHO recognizes palliative care as an integral part of care for people living with HIV. It improves quality of life and can also support adherence to HIV treatment. Worldwide 5.7% of adults in need of palliative care at the end of life have HIV and AIDS. The burden is higher in the African Region, where this figure increases to around 42%. About 10.23% of children in need of palliative care at the end of life died from HIV and AIDS. In the African Region, those with HIV and AIDS represent 19% of children in need of palliative care (Connor, 2014). Globally, the burden of chronic and life-limiting illness is on the rise. In 2015, it was estimated that about 39,189 [68.4%] of people died from non-communicable diseases, about 51,792 which is 73.9% have been projected to die in 2030 and an estimate of 1667 HIV death in 2015 with a projection of 1,793 HIV death in 2030 (World Health Organisation, 2013)

These people and their families are faced with high symptom burden ranging from physical psychosocial and spiritual before their death. This brings suffering to both patients and family. Therefore the need to improve care for patients with serious, complex, and potentially life-threatening or life-limiting medical conditions is unquestioned. The WHO estimates that 40 million people need palliative care, of which 78% live in low to middle income countries such

as Ghana. Palliative care aims to alleviate suffering and promote quality of life, and addresses physical, intellectual, emotional, social and spiritual needs (Edwardo Burera, 2016).

2.3 Knowledge, Attitudes, Beliefs and Experiences of Health Care Professionals in Palliative Care Delivery

The important factors that influence successful delivery of palliative health care can be gauged in the area of health care professionals' knowledge, attitude, beliefs and experiences in the delivery of palliative care or any such related care. It is plausible to say that the quality of palliative is based on the knowledge and practice of health care professionals, particularly medical doctors. Furthermore, this knowledge and practice could form the basis for implementation of a sound palliative care system in a given locality. After nurses, the doctors are also the main valuable palliative care team members who address the physical, functional, social, and spiritual dimensions of care.

This shows that the hands that work in clinical settings or hospitals are equally important in palliative care settings. Thomas et al. (2015) indicated that doctors and other health care professionals are unprepared to care for patients in pain. This kind of thinking seeks to show that health care professionals are quite unprepared to take up tasks of palliative care. Several reasons have been identified such as inadequacy, education, absence of curriculum content related to pain management and faculty attitudes and even beliefs related to pain (Thomas et al., 2015).

Whereas there is a paucity of studies on the knowledge and attitudes of medical doctors regarding palliative care, much of the literature has concentrated on knowledge and behaviours of health doctors. Wool (2013) brings the discourse on knowledge and behaviours

regarding palliative care to the context of medical professionals. Wool's (2013) study explains the meaning of difficulty for medical professionals to deliver palliative care as the extra effort or skill which is required but hardly accessible to the professionals to deal with certain clinical situations. The study contends that a lack of knowledge about palliative care and confidence in oneself may create hesitation in providing patients with timely and appropriate care, thus creating difficulty in providing palliative care. Consequently, Hirooka et al. (2014) consider medical professionals' confidence in palliative care as an indicator of their ability. Although confidence in itself does not ensure provision of best care for patients, it does reflect knowledge and previous success. Low confidence in a medical professional would likely be an indicator that they lacked competence. Previous research has investigated difficulties or barriers encountered by medical doctors and registered doctors in providing palliative care (Sasahara et al., 2005; Miyashita, et al., 2007a). These studies indicated that medical professionals lacked knowledge and communication skills relevant to terminally-ill cancer patients and their families. Another study also pointed to a lack of medical professionals specializing in palliative care (Miyashita et al., 2007b). However, these studies were small, involved few institutions and did not include multiple categories of medical professionals.

Even though education and training are required for integrating palliative care into health care systems, there is a well-documented knowledge deficit among doctors and other healthcare providers in the field of palliative care. There is, hitherto, a widespread consensus that doctors' deficient knowledge may be due to the fact that undergraduate medical programmes do not integrate the topic within the curriculum (Adriaansen & van Achterberg, 2008). Abu-Saad et al. (2009) contend that the knowledge deficit about palliative care is one of the main obstacles to the provision of high quality palliative care services. Their study conducted in

Lebanon to evaluate doctors' knowledge, attitudes, and practice found that those doctors without a clinical background have better knowledge of palliative care than clinical doctors. A study examined third-year diploma student-doctors' knowledge about palliative care in India and found that the level of knowledge was lower than average (Karkada et al., 2011).

Another study conducted in the USA found that students' knowledge of end-of-life care tended to increase as they progressed towards the end of their study programme (Wallace et al., 2009). However, it was still considered to be limited, and inadequate to enable them provide a high standard of care once they graduated from medical school (Wallace et al., 2009). In a related study by Prem et al., (2012), it was found that doctors had poor knowledge of palliative care principles. A descriptive study was conducted to assess the knowledge and practice of staff doctors on palliative care in selected hospitals of Guwahati city, Assam. A self-administered structured questionnaire was used to collect data from 100 doctors. The study revealed that 79% of the staff doctors have inadequate knowledge, 21% have moderately adequate knowledge and no one has adequate knowledge on palliative care. In relation to the levels of practice, 48% of the doctors practiced adequately while 43% of the doctors practiced moderately adequate. Only 9% of the doctors practiced inadequately. A positive correlation ($r= 0.30$) was found between knowledge and practice scores of palliative care by the staff doctors. It was, however, observed that there **was** an inverse correlation between knowledge and practice of the doctors with the lowest and highest years of experience selected for this study. This implies that the higher the years of experience the lower the score that the doctors are likely to obtain for their knowledge and practice of palliative care and vice versa (Anila & Haseena, 2015).

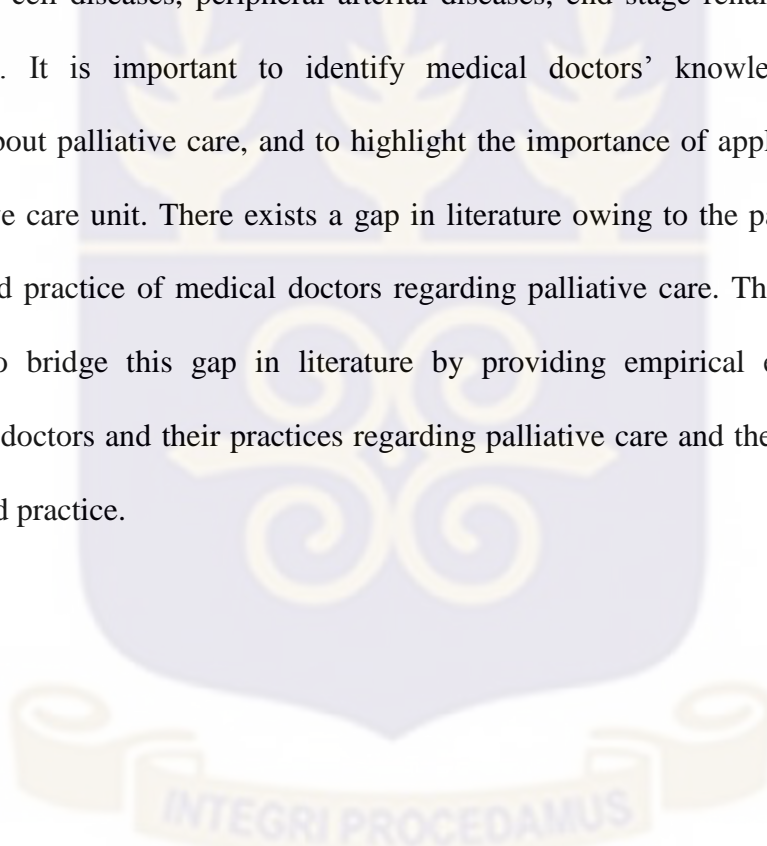
Another study conducted in 2013 in the paediatric medical ward and intensive care unit at Menoufiya University Hospital in Egypt aimed to evaluate the impact of palliative care education on doctor's knowledge, attitude and practice in the care of chronically-ill children. The tool of data collection was an interviewing questionnaire which included Socio-demographic data, Doctors' knowledge; Doctors' attitude and Doctors' experience. Results of the study revealed that less than two thirds (63.3%) of doctors have bachelor degree, and none of them gave care for dying children in the past year. Regarding Doctors' knowledge, less than one third of them (30%) in pre-test correctly know the philosophy of palliative care compared to 60% in post-test. Also, there were statistically significant difference between pre and post-test relating to doctors' attitude towards palliative care (Anila & Haseena, 2015).

Doctors need evidence based knowledge to perform the care. Doctors gain their knowledge through different sources, for example, through academic sources, personal experiences and practices. The academic source of knowledge includes theories and research which represent the scientific side of medicine (MeEwen & Wills, 2011). Medical knowledge is classified in four types, which are empirical knowledge, personal knowledge, esthetics knowledge and ethical knowledge. Empirical knowledge is the scientific knowledge that can be obtained from observations and tests.

Personal knowledge is based on individual's thoughts. Esthetics knowledge is related to the art of creativity and values. Ethical knowledge is the knowledge that is used to distinguish between right and wrong actions (Carper, 1978). Carper's work was criticized by Schultz and Meleis (1988). As a result of this critique, medicine knowledge was identified as clinical, conceptual and empirical knowledge. Clinical knowledge results from combining personal and empirical knowledge while providing care and solving patient problems. Conceptual

knowledge is a reflective knowledge that defines concepts and examines the relationship between the concepts within a theory. Empirical knowledge is the use of tests, experiments and study phenomena, to measure the effectiveness of action in the practices (MeEwen & Will, 2011).

According to Ganem et al. (2011), patients with cancer are not the only ones who need palliative care. There are other conditions rather than cancer to be treated with palliative care such as sickle cell diseases, peripheral arterial diseases, end stage renal diseases and acute liver diseases. It is important to identify medical doctors' knowledge, thoughts and experiences about palliative care, and to highlight the importance of applying palliative care in the intensive care unit. There exists a gap in literature owing to the paucity of studies on knowledge and practice of medical doctors regarding palliative care. This study contributes enormously to bridge this gap in literature by providing empirical evidence about the knowledge of doctors and their practices regarding palliative care and the nexus between the knowledge and practice.



2.4 Palliative Care in Africa in General and Ghana in Particular

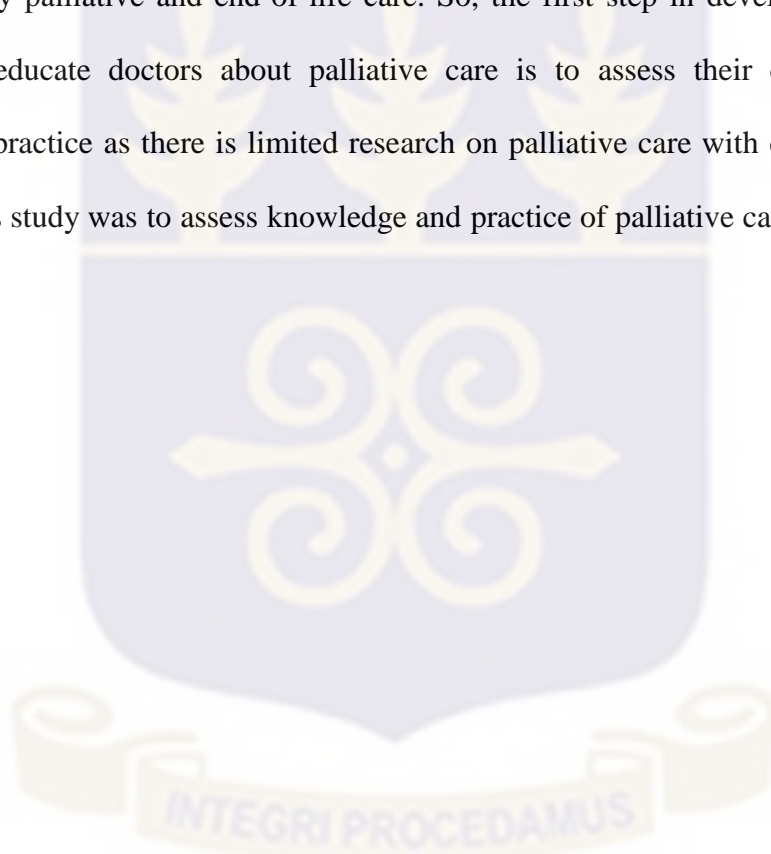
Palliative care is a relatively new concept in many countries: chiefly in developed countries and is absent in several African countries. There are a number of potential approaches that may be suitable in Africa but due to scarceness of data in this field of care, it becomes difficult to choose such approach based on evidence. However, The World Health Organization has recommended a public health strategy as the best approach for establishing and/or integrating palliative care into a country. The public health approach is the science and art of preventing disease, prolonging life and promoting the health to the entire populations through the organized efforts of society (Gopal & Archana., 2016; Garcia et al, 2007).

Only four out of 53 African countries have integrated palliative care into their healthcare policy and used it as a part of a strategic plan focusing on cancer treatment. They are: Kenya, South Africa, Tanzania, and Uganda; while Rwanda and Swaziland have taken a different approach by developing stand-alone national palliative care policies (Ntizimira et al., 2014). In Ghana, the best attempt at palliative care has been a suboptimal end-of-life care for patients with cancer at the Korle-Bu Teaching Hospital. This, however, is fraught with recurring problems resulting in complaints from patients and families in many instances.

Although end-of-life conversations need to become a routine structured intervention, they are not (Larson & Tobin, 2000; Kyerewaa et al., 2014). The Korle-Bu Teaching Hospital established a palliative care team (PCT) in May 2012 to address these deficiencies in the quality of care delivered to terminally-ill patients. The PCT instituted a structured approach to end-of-life decision making to improve the quality of care for patients with terminal illness. Although patients may have little hope of survival, it is imperative that they are given proper care. Yet, too many dying patients suffer unnecessarily. Doctors are central figures in

advocating interventions that minimize burden and distress and enhance quality of life for their patients who are terminally ill (Fox, 2007) and they spend a lot of time caring for patients who finally die . Doctors take part in the decision process related to those patients (Puntillo & McAdam, 2006).

Therefore, the value of palliative care to doctors who deliver majority of care to chronically ill patients is unquestionable, and there is a need to support and educate doctors for the provision of high quality palliative and end-of-life care. So, the first step in developing a strategy to support and educate doctors about palliative care is to assess their current knowledge, attitudes and practice as there is limited research on palliative care with doctors. Rightly so, the aim of this study was to assess knowledge and practice of palliative care among doctors at the GARH.



CHAPTER THREE

METHODOLOGY

3.0 Introduction

3.1 Research Design

The present study was a case study, and as stated by Morris and Wood, 1991 and cited in Saunders *et al.* (2007), a case study involves a study of a particular situation and its impact in order to have a more accurate detail and in-depth understanding of the nature of the phenomenon as it relates to a specific environment, which in this case, is the Ridge hospital, Accra. This approach is adopted because, the purpose of the study was to gain a rich and in-depth understanding of the knowledge and practices of medical doctors at the Ridge Hospital on Palliative Care. The study also adopted the quantitative approach, from which primary data was collected from doctors of the Ridge Hospital. Quantitative methods fall within the positivist school of thought and as such, is strong in generating ideas for the purpose of generalization, (Saunders et al., 2009). Therefore, primary data was collected through the integration of quantitative techniques, from which data were obtained through questionnaires administered to doctors.

3.2 Scope of the Study

The scope of this study spans the knowledge and practices of medical doctors on Palliative Care in the Ridge Hospital, Accra. In evaluating the knowledge and practice of Palliative Care in the Ridge hospital, the study focused on, assessing the knowledge of medical doctors in the Ridge Hospital on Palliative Care, secondly it examined the extent to which Palliative Care is practiced, in the Ridge Hospital by the medical doctors. While the third part, examined the

effect of doctors' knowledge of Palliative Care on the practice in Ridge Hospital. Limiting the study to this scope makes it more measurable, from the research point of view.

3.3 Study Area

The study area for the study was the Ridge Hospital, Accra. The decision to choose this facility is that, the hospital is one of the major health care facilities apart from the Korle-Bu Teaching Hospital in the Greater Accra Metropolis. The hospital is also one of the hospitals earmarked to provide top notch health care in the capital city, Accra. The hospital provides the environment from where Palliative Care can be examined in terms of the knowledge and practice of it. Ridge Hospital which is also known as the Greater Accra Regional Hospital (GARH), serves as a referral point for all the district hospitals in the Greater Accra metropolis, which include Ga Central Municipal, Adenta Municipal, Ga East Municipal, La Nkwantanang Madina and various district hospitals in the greater Accra Region. The hospital is divided into departments which helps to organize its service delivery. Some of these departments include the medical, Pediatrics, obstetrics, Gynecology Orthopedics Allied Health and many other department which are allocated with respect to various specialties.

3.4 The Study Population

The target population for the study was the doctors working at the Greater Accra Regional Hospital, with a total number of 280 doctors.

3.5 Variables

3.5.1 Dependent/Outcome

- Knowledge on palliative
- Practice of palliative

3.5.2 Independent Variables

- Age
- Sex
- Nationality
- Institution of training
- Palliative care education
- In-service palliative care training
- Level of education
- Years of experience
- Experience in care of chronically ill patient
- Department of work (Medical, surgical, pediatric, Oncology, Orthopedics)

3.6 Inclusion Criteria

Doctors who were present at post at the GARH during the study period who consented.

3.7 Exclusion Criteria

Doctors on leave or on other official duties outside the facility during the data collection period.

3.8 Sampling Procedure

This study employed a purposive and convenience sampling procedures in collecting data. These sampling strategies preserve time and provides clearly defined steps through which participants of the study are selected in an unbiased fashion (Bryman, 2007).

The first stage was purposive sampling which was used to identify the doctors in their offices of work. This sampling method was also used to identify the medical doctors for the purpose of the study. At the second stage, convenience sampling was used to select doctors for the purpose of administering the questionnaires. This was chosen because doctors often work under intense atmosphere where, they may not have the time to spare off their routine. This method, however, allows doctors who were available and ready at the periods of data collection to be contacted to complete the questionnaires.

3.9 Sample Size

The questionnaires were completed by a number of doctors whose total was calculated using the sample size calculation formula attributed to Yamane (1967). The formula is given by:

$$n = \frac{N}{1+Ne^2}$$

Where 'n' is the sample size, 'N' is the sample frame (study population) and 'e' is the margin of error which is normally taken as 0.05, indicating a 95% confidence interval.

Therefore with a population of 280 doctors, given the sample size formula $n = \frac{280}{1+280(0.05)^2} =$

$\frac{280}{1+0.7} = \frac{280}{1.7} = 164.7$, therefore the sample size determined for the study is 165 doctors from the

Ridge Hospital.

3.10 Study Instrument for Data Collection

A self-administered questionnaire was issued to the study participants for data collection. Questions were asked on social demographic, on Palliative care practices and on knowledge which was adopted and modified from the Palliative Care knowledge Test (PCKT). The data collection instrument was in three section, which sought to address the objectives of the study.

- Section one: A socio demographic variables included, Age, Sex, Department, and Institution of training, country of origin, and level of education, work experience, experience of caring for chronically ill patients, formal palliative education and Palliative care in-service.
- Section two: Knowledge questions were adopted from the Palliative Care Knowledge Test (PCKT). A composite score was obtained for the knowledge variable which was measured by creating a composite score for all the 12 knowledge indicators from the questionnaire and further categorized into;
Low ≤ 4 , Moderate >4 to ≥ 8 , High > 8
- Section three: This section was made up of practice questions which was constructed from guidelines and various literatures related to PC practice which sought to address the specific objectives of practice.

3.11 Data Collection Procedure

Series of visits to the Ridge Hospital was made by two (2) data enumerators, to familiarize with the doctors to facilitate easy data collection from the study area.

3.12 Data Collection Method/Approach

A quantitative approach of data collection was used for collection of data from study participants. This included distribution of structured questionnaires which sought to collect data on all available variables and which answered the set objectives. The questionnaires were distributed to participants where ever they were located at their facility with clear emphasis on area of approved convenience and each participant was given a maximum of an hour to complete the questionnaire. Opportunity was given to the participants who for one reason cannot answer questionnaire within the stipulated time to answer and this was within the data collection period.

3.13 Data Collection Technique

Research Assistants were trained and given the responsibility of delivering the structured questionnaires to the study participants who were present at their various locations with the given period and collection of answered questionnaires. Participants were told the purpose of the study, their consent sought and they were encouraged to answer all items on the questionnaires within the time limit as much as possible to minimize large non-response rate.

3.14 Reliability Test

Data was analyzed using reliability analysis, descriptive statistics and other inferential statistical tool in the form of regression and correlation analysis. Reliability analysis was assessed by the Cronbach's alpha ' α '. Cronbach's alpha provides an estimate of the internal consistency of the measures (Brown, 2001) and normally ranges from 0 to 1. As a general rule, a coefficient greater than or equal to 0.7 is considered acceptable and a good indication of construct reliability, the lower limit of acceptability is 0.6 (Sekaran, 2003).

3.15 Data quality control

To ensure data quality control research assistants with adequate knowledge and understanding, confident and has good communication skills were recruited and trained. The training was on the study, the questionnaire and the data collection procedure which was done by the PI and lasted for two days. After the training pretesting was done at the Korle Bu Teaching Hospital. Data collected was checked every day by the principal investigator who was also supervising the data collection process, for its completeness. Discussion of Problems faced during the day of data collection was done with the research assistants overnight and addressed.

To ensure confidentiality the names or personal identities of the study respondents was not recorded and the data collected was kept in files in a secured place where no one can have access to except the PI and the research team.

3.16 Ethical Considerations

Ethical clearance was obtained from the Ethics Review Committee, of the Ghana Health Service. In addition, an official letter from the School of Public Health, University of Ghana was sent to the Ridge hospital's administration in this case the director, to seek for their permission and consent to conduct the research in the hospital. Furthermore, the consent of participants, were obtained through the provision of informed consent forms, for them to sign voluntarily as an indication of, their acceptance to be engaged for the study, for the administration of questionnaires without persuasion, and were at liberty to refuse or stop answering the questionnaire at any moment they so wish for reasons best known to them.

As part of addressing the issue of confidentiality, the identity of respondents were kept anonymous without seeking for their names or staff identity numbers. In addition, data were collected by enumerators who were not staffs of the hospital and as such were not familiar with the identity of the doctors of the hospital. Furthermore, questionnaires were self-administered by the respondents and collected in sealed envelopes by the enumerators as part of ensuring confidentiality. Also the questionnaires were distributed based on the convenience of the respondents, devoid of any method, that could lead to their easy identification. Most importantly, all other ethical consideration were strictly deployed, without any breach of privacy and confidentiality.

3.17 Data Analysis

Data collected was entered into excel and exported to Stata version 15 for analysis and also checked for missing values. Descriptive statistics was done to describe the frequency and percentages which was displayed in tables, graphs and charts. The scores on the various scales were calculated and converted to proportions. To test for association of the predictor variables to the outcome variables a Chi square test statistic was used. Multivariable and Univariable logistic regression analysis was performed. In testing for the level of significance in both test the confidence interval was set at 95 percent with an alpha level of 0.05 and at p-value less than 0.05.

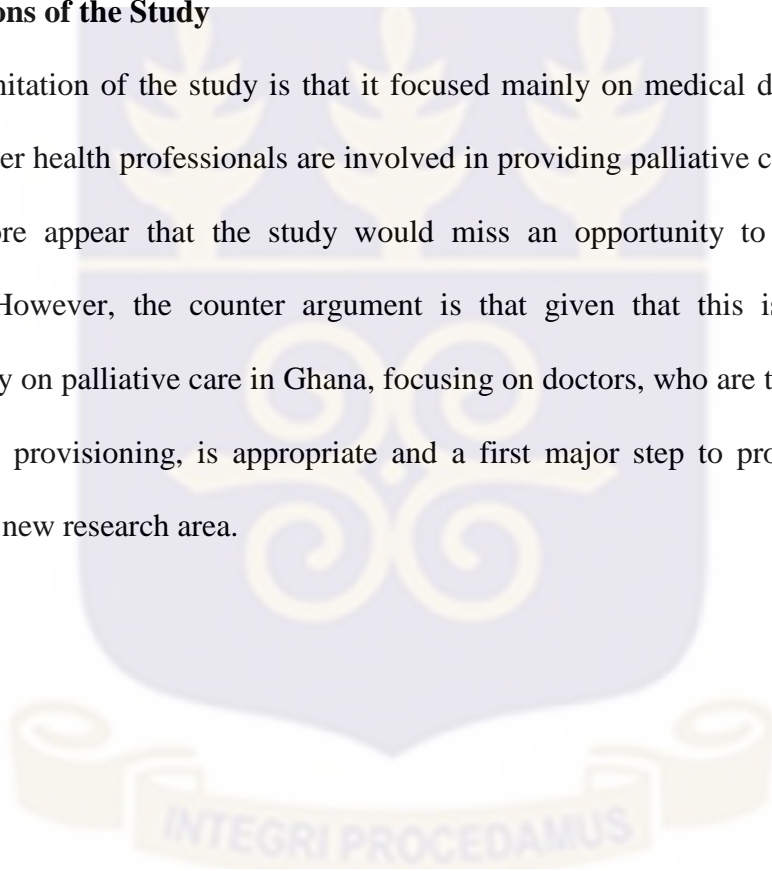
3.18 Pre-test or Pilot Study

A pilot study was conducted before the main data collection period which was earlier. Key informant interviews was conducted for five doctors at the Korle Bu Teaching hospital to identify other factors influencing the outcome variable; knowledge, practice and the relationship between knowledge in palliative care and practice of palliative care. The

identified variables were used to reconstruct semi structured questionnaires for the quantitative part of the study. This pretesting was done to test for the clarity and to eliminate errors from the questionnaire and to check for the performance of the research assistants and the necessary corrections done before the main data collection period. The pilot study was done within a day after which the data collected was reviewed and discussion held between the research assistants and the PI.

3.19 Limitations of the Study

A possible limitation of the study is that it focused mainly on medical doctors even though admittedly other health professionals are involved in providing palliative care at the GARH. It would therefore appear that the study would miss an opportunity to draw from varied experiences. However, the counter argument is that given that this is perhaps the first empirical study on palliative care in Ghana, focusing on doctors, who are the leading actors in palliative care provisioning, is appropriate and a first major step to providing preliminary insights into a new research area.



CHAPTER FOUR

RESULTS

4.0 Introduction

4.1 Background characteristics of study respondents

A total of 142 doctors were interviewed in this study. Females were 50.7% (72/142). Majority of the doctors (68.3%) were below 30 years of age while 23.9% (43/142) were between 31 – 45 years and only 1.4% (2/142) represented doctors at 50 years or above. Doctors with first degree were 64.5% (91/142) while those with masters and PhD were 31.2% (44/142) and 4.3% (6/142) respectively (Table 4.1).

About forty-eight percent (47.9%) 68/142 of the doctors interviewed were residents in their respective fields of practice. There were 38.7% (55/142) house officers and 11.3% (16/142) being specialists with only 2.1% (3/142) were consultants. Majority 132/142 (93.6%) were Ghanaians and 9/142(6.4%) of the doctors were non-Ghanaians. Forty-one percent (41%) 58/142 were trained in Kwame Nkrumah University of Science and Technology (KNUST), 31.91% (45/142) were trained in the University of Ghana and 19.2% (27) were trained outside Ghana.

Nearly seventy percent (69.7%) 99/142 of the doctors had less than 5 years of working experience with 19.7% (28/142) having 6-10 years working experience. Among participants 7.8% (11/142) had 11-15 years of working experience while doctors with 16-20 years' work experience was 1.4% (2/142).

Table 4.1: Socio-demographic characteristics of respondents.

Characteristics	Frequency	Percentage (%)
Sex (n=142)		
Male	70	49.30
Female	72	50.70
Age		
Below 30 years	97	68.31
31 – 45 years	34	23.94
46 – 50 years	9	6.34
50 and above	2	1.41
Highest level of Education (n=141)		
First degree	91	64.54
Masters	44	31.21
PhD	6	4.26
Professional rank (n=142)		
House Officer	55	38.73
Resident	68	47.89
Specialist	16	11.27
Consultant	3	2.11
Years of service (n=142)		
Below 5yrs	99	69.72
6-10yrs	28	19.72
11-15yrs	11	7.75

16-20yrs	2	1.41
21 above	2	1.41
University trained (n=141)		
Outside Ghana	27	19.15
University of Ghana	45	31.91
KNUST	58	41.13
UDS	8	5.67
UCC	3	2.13
Country of origin (n=141)		
Ghana	132	93.62
Outside Ghana	9	6.38

Source; field survey, 2018

Regarding the department from which, each respondent work at the Ridge hospital, table 4.2 below reveals that a majority (35.8%) of the respondents were in the medical department, (24.8%) in the surgical department, (19.7%) formed those in the pediatrics department, (7.3%) were in emergency, (5.8%) were in the orthopedics department, while (3.6%) and (2.9%) formed those in the anesthesia and oncology department respectively.

Table 4.2: Department of Work

Departments	Frequency	Percent
Medical	49	35.8
Surgical	34	24.8
Pediatrics	27	19.7
Oncology	4	2.9
Orthopedics	8	5.8
Emergency	10	7.3
Anesthesia	5	3.6
Total	137	100

Source: Survey data (2018)

4.2 Assessment of palliative care knowledge

From table 4.3a below, the study revealed with a mean of 4.16 that, the respondents held the view that Palliative care is a multidisciplinary approach to quality healthcare delivery, also the mean of 4.09 indicates that, the respondents were of the view that, Palliative Care should be provided along with Anti-Cancer treatment. Also the mean of 3.73 confirms that, respondents shared the view that, Palliative Care should only be provided for patients who have no curative treatments available. In addition, the mean of 3.25 affirms a neutral view of the respondents that, Pentazocine should be used more often than an Opioid in Palliative Care, while the mean of 3.03 indicates a neutral view of the respondents that, the use of opioids does not influence survival time of patients.

Table 4.3a: Knowledge on Palliative Care

Statements	N	Mean	Std. Deviation
Palliative care is a multidisciplinary approach to quality healthcare delivery	141	4.16	.973
Palliative care should only be provided for patients who have no curative treatments available	142	3.73	.967
Should Palliative Care be provided along with Anti-Cancer treatment	141	4.09	.751
Pentazocine should be used more often than an Opioid	141	3.25	1.17
The use of opioids does not influence survival time of patients	141	3.03	1.01

Scale: 1-Strongly disagree, 2-Disagree, 3-Neutral, 4- Agree, 5-Strongly agree

Source: Survey data (2018)

The study also reveals in table 4.4b below that, the respondents shared the view that one of the goals in Pain Management is to allow patients to get a good night's sleep. This is confirmed by the mean of 3.91. Also the respondents shared a neutral view with respect to the fact that, some dying patients require continuous sedation to alleviate suffering during Palliative Care. This is confirmed by the mean of 3.45. In addition, the mean of 3.18 indicates a neutral view of the respondents to the fact that, at terminal stages of cancer, higher calorie

intake is needed compared to early stages, while the mean of 3.14 also indicates a neutral view as held by the respondents that, during the last days of life, drowsiness associated with electrolyte imbalance should decrease patient discomfort.

Table 4.3b **Knowledge on Palliative Care**

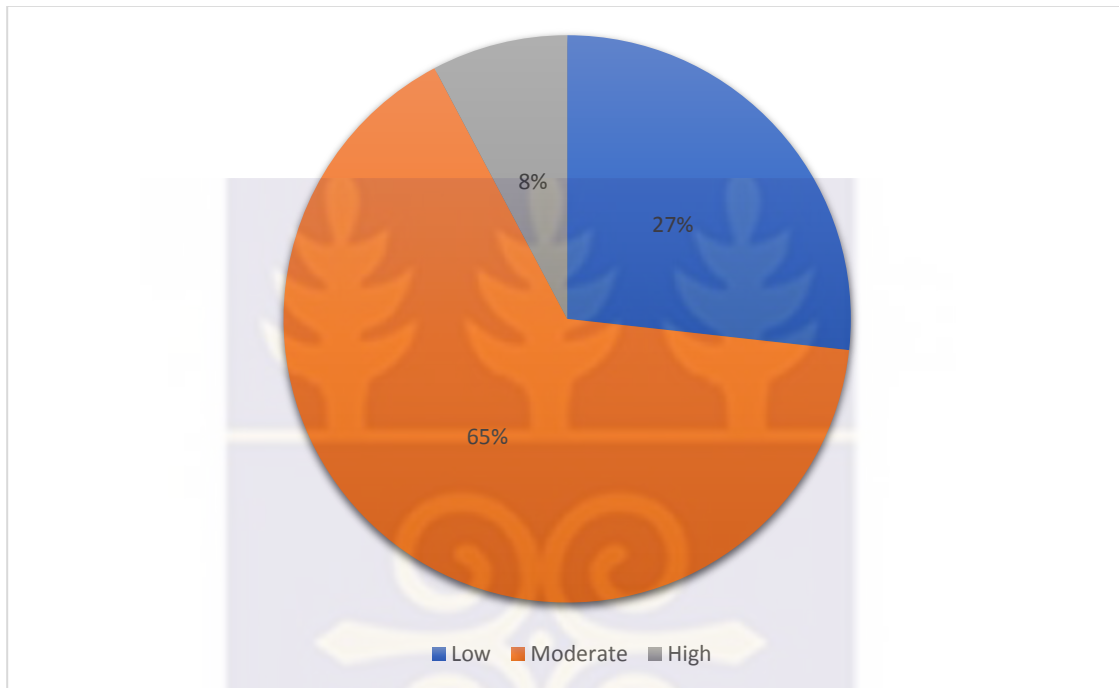
Statements	N	Mean	Std. Deviation
During last days of life, drowsiness associated with electrolyte imbalance should decrease patient discomfort?	139	3.14	.913
Do you share the view that, some dying patients require continuous sedation to alleviate suffering during Palliative Care?	141	3.45	.952
At terminal stages of cancer, higher calorie intake is needed compared to early stages?	140	3.18	.976
One of the goals in Pain Management is to allow patients to get a good night's sleep?	141	3.91	1.04

Scale: 1-Strongly disagree, 2-Disagree, 3-Neutral, 4- Agree, 5-Strongly agree

Source: Survey data (2018)

From the chart below, 65% of the doctors had moderate knowledge on palliative care. While 38 out of the 142 (27%) had low knowledge, the remaining 8% showed high level of knowledge on palliative care practices

Figure 4.1: Proportion of doctors’ level of knowledge on Palliative Care Services



4.3 Assessment of doctors’ practices for palliative care services.

Table 4.4 also reveals that, respondent’s **addresses** psychological issues as well in practicing Palliative Care, as confirmed with the mean of 4.05. Also respondents do communicate to the family members of terminally ill patients about their diagnosis. This is confirmed by the mean of 3.96. The study further confirmed with a mean of 3.95 that, respondents do initiate discussions with patients during Palliative Care. In addition, the mean of 3.68 confirms that, in dealing with Palliative Care practice, respondents do address spiritual issues by connecting with a spiritual counselors.

Table 4.4: Practice of Palliative Care in Ridge Hospital

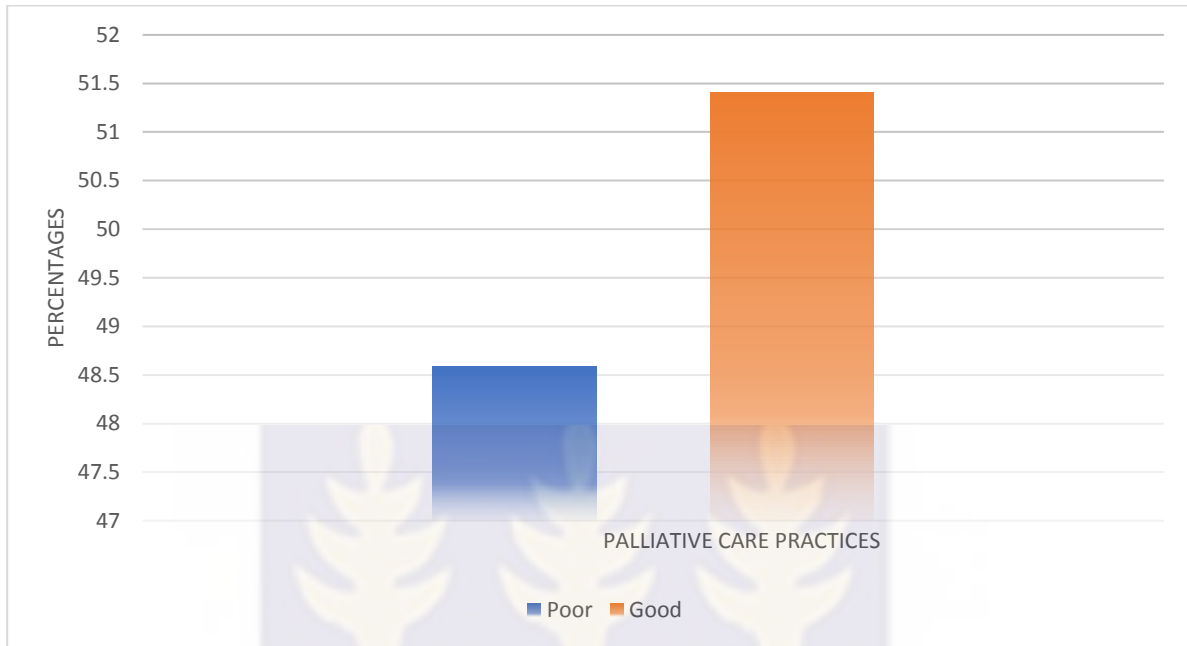
Statements	N	Mean	Std. Deviation
Do you initiate discussion with patients?	142	3.95	.737
In dealing with Palliative Care practice, do you address spiritual issues by connecting with a spiritual counselor	142	3.68	.942
Do you communicate to the family members of terminally ill patients about their diagnosis	142	3.96	.794
Do you address psychological issues as well in practicing Palliative Care	141	4.05	.730

Scale: 1-Strongly disagree, 2-Disagree, 3-Neutral, 4- Agree, 5-Strongly agree

Source: Survey data (2018)

Results from table 4.5 showed that majority (51.41%) doctors practiced good palliative care services. However, quite a number of the doctors (48.59%) practiced poor palliative care services.

Figure 4.2: Proportion of doctor’s practice for palliative care services



4.4 Relationship between predictor variables and palliative care practices.

The Chi square test of association was used as a measure of assessing the relationship between the predictor variables and palliative care practice. Predictor variables included sex, level of education, professional rank, and years of service, country of origin, university trained and level of knowledge. The outcome variable was palliative care practice set at 95% confidence interval and an alpha level of 0.05.

Among the predictor variables analyzed, level of knowledge on palliative care services was found to be significantly associated with the outcome ($Chi\ square(X^2) = 8.29, p\text{-value} = 0.02$). All other variables were not significantly associated, (Table 4.6).

Table 4.5: Chi square test of association of socio-demographic characteristics of doctors and Palliative Care Practices.

Variables	Palliative Care Practices				χ^2	p-value
	Poor		Good			
	Frequency	%	Frequency	%		
Sex	N=69		N=73			
Male	34	48.57	36	51.43	0.00	0.99
Female	35	48.61	37	51.39		
Level of Education	N=69		N=72			
First degree	49	53.85	42	46.15		
Masters	17	38.64	27	61.36	2.75	0.26
PhD	3	50.00	3	50.00		
Professional Rank	N=69		N=73			
House officer	32	58.18	23	41.82		
Resident	29	42.65	39	57.35	3.42	0.33
Specialist	7	43.75	9	56.25		
Consultant	1	33.33	2	66.67		
Years of Service	N=92		N=41			
Below 5 years	51	51.52	48	48.48		
6 – 10 years	9	32.14	19	67.86		
11 – 15 years	7	63.64	4	36.36	8.37	0.08
16 -20 years	3	60.00	2	40.00		
21 years and above	0	00.00	2	00.00		
Country of origin	N=68		N= 73			
Ghana	64	48.48	68	51.52	0.06	0.81
Non-Ghana	4	44.44	5	55.56		
Knowledge	N=69		N=73			
Poor	26	68.42	12	31.58		
Moderate	39	41.94	54	58.06	8.29	0.02*
High	4	36.36	7	63.64		
University of training	N=68		N=73			
Outside Ghana	14	51.85	13	48.15		
UG	18	40.00	27	60.00		
KNUST	31	53.45	27	46.55	2.27	0.69
UDS	4	50.00	4	50.00		
UCC	1	33.33	2	66.67		

4.5 Strength of Association

A multivariable logistic regression model was run between independent variables and the outcome variable (palliative care practices). The crude as well as the adjusted odds ratios were found and are shown in *table 4.7 below*;

Table 4.6: Univariable and multivariable logistic regression analysis for the association between independent variables and palliative care practice.

Variable	Crude OR (95% CI)	p – value	Adjusted OR (95% CI)	p- value
Sex				
Male (reference)	1	-	1	-
Female	1.00(0.52-1.93)	0.99	1.24(0.55-2.79)	0.60
Age				
30 years and below (reference)	1	-	1	-
31 – 45 years	0.95(0.43-2.07)	0.89	0.74(0.18-3.03)	0.67
46 – 50 years	8.51(1.02-70.66)	0.05*	1(omitted)	
50 and above	1	-	1(omitted)	
Level of Education				
First degree (reference)	1	-	1	-
Masters	1.85(0.89-3.86)	0.09	2.60(0.72-9.35)	0.14
PhD	1.17(0.22-6.09)	0.86	1.11(0.06-20.23)	0.94
Years of service				

5 years and below(reference)	1	-	1	-
6 – 10 years	2.24 (0.93-5.43)	0.07	0.87(0.17-4.38)	0.87
11 – 15 years	0.61 (0.17-2.21)	0.45	0.27(0.03- 2.19)	0.22
16 -20 years	1(omitted)	-	1(omitted)	
21 above	1(omitted)	-	1(omitted)	
Country of origin				
Ghana (reference)	1	-	1	-
Non-Ghana	1.18(0.30-4.58)	0.81	0.92(0.13-6.38)	0.93
Knowledge				
Poor (reference)	1	-	1	-
Moderate	3.00(1.35-6.66)	0.01*	2.50(1.02-6.06)	0.04*
High	3.79(0.93-15.47)	0.06	2.87(0.63-13.06)	0.17
University of training				
Outside Ghana	1	-	1	-
UG	1.62(0.62-4.23)	0.33	1.78(0.52-6.10)	0.36
KNUST	0.94(0.38-2.34)	0.89	1.03(0.30-3.60)	0.95
UDS	1.08(0.22-5.22)	0.09	1.12(0.16-7.67)	0.91
UCC	2.15(0.17-26.67))	0.60	2.37(0.17-33.70)	0.53

Source: Survey Data 2018

4.6 Relationship between knowledge and palliative care practices

From table 4.7, knowledge and age significantly predicted palliative care practice. Doctors who had moderate level of knowledge on palliative care services were 3.00 times more likely to practice good palliative care as compared to those who had poor knowledge on palliative care ($COR = 3.00$ 95% $CI= 1.35-6.66$, $p-value= 0.01$). In furtherance, doctors who were between ages 46-50 years were 8.51 times more likely to provide good palliative care services to their patients compared to those below 30 years of age ($COR = 8.51$ 95% $CI= 1.02-70.66$, $p-value= 0.05$).

However, after controlling for all other variables, doctor's knowledge on palliative care was found to be significant in predicting palliative care practice. Doctors with moderate knowledge on palliative were 2.50 times more likely to exercise good palliative care practice relative to those with poor knowledge on palliative care ($AOR = 2.50$ 95% $CI= 1.02-6.66$, $p-value= 0.01$).

4.6.1 Relationship between doctors' knowledge and Practice of Palliative care.

From table 4.8 the study showed with a majority of (47.5%) that, respondents initiates discussions during Palliative Care at the diagnosis stage, (44.6%) represents those who initiates the discussions as the disease progress. While (7.9%) initiates the discussions at the end of life?

Table 4.7: Which of the following stage, do you initiate Palliative Care discussion?

	Frequency	Percent
During diagnosis	66	47.5
When disease progress	62	44.6
At the end of life	11	7.9
Total	139	100

Source: Survey data

In handling patients during Palliative Care practice, the study revealed in table 4.9 that, majority of the respondents (82.0%) do listen with empathy when handling patients. While (18.2%) shows concern by understanding patients during care.

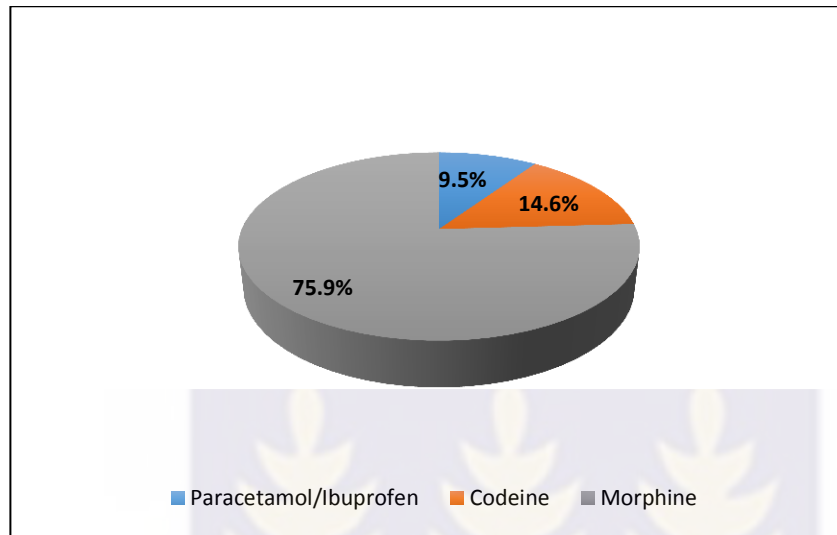
Table 4.8: How do you handle patients during palliative care?

	Frequency	Percent
Listen with empathy	100	82.0
Understand patient reaction	22	18.0
Total	122	100

Source: Survey data

Figure 4.8 below also reveals that a majority of (75.9%) indicated, Morphine is the commonly used medication in severe pain management by the respondent, followed by Codeine with a representation of (14.6%), while (9.5%) represents the use of Paracetamol /Ibuprofen.

Figure 4.3: What is the commonly used medication in your practice of severe pain management?



Source: Survey data (2018)

The study further indicated in table 4.10 that, the respondents shared the view that providing palliative care is a collaborative effort between specialists, generalists and home caregivers/family members, as confirmed by the mean of 4.36. Also the mean of 4.07 confirms that, in-service training of medical officers' impact positively on the practice of Palliative Care.

Table 4.9: Association between Doctors' knowledge and practice of Palliative Care

Statements	N	Mean	Std. Deviation
Do share the view that, in-service training of medical officers' impact positively on the practice of Palliative Care?	140	4.07	.746
Do you share the view that providing palliative care is a collaborative effort between specialists, generalists and home caregivers/family members?	140	4.36	.681

Scale: 1-Strongly disagree, 2-Disagree, 3-Neutral, 4- Agree, 5-Strongly agree

From table 4.11a below it is established that, there is a relationship between formal Palliative Care education of doctors and the use of Pentazocine when cancer pain is mild as the expected values, which are values expected by chance and the actual counts are different from each other. Furthermore, table 4.11b on the Chi-square of independence, testing the null hypothesis that, there is no relation between a doctor's knowledge on the use of Pentazocine when cancer pain is mild and the doctor's formal education on Palliative Care. The large Chi-Square statistic of (28.945) and its small significance level ($p < .001$) indicates that, it is very unlikely for a doctor to have knowledge on the use of Pentazocine when cancer pain is mild, if he/she has not been formally trained in Palliative Care. In other words, there is a relationship between a doctor's knowledge on the use of Pentazocine when cancer pain is mild and formal training of doctors in Palliative Care practice.

Table 4.10a: Cross tabulation between formal Palliative Care Training and the often use of Pentazocine

			Pentazocine should be used often when cancer pain is mild					Total
			strongly disagree	disagree	neutral	agree	strongly agree	
formal Palliative Care education	yes	Count	18	10	17	39	13	97
		Expected Count	13.3	7.7	29.3	37.0	9.8	97.0
	no	Count	1	1	25	14	1	42
		Expected Count	5.7	3.3	12.7	16.0	4.2	42.0
	Total	Count	19	11	42	53	14	139
		Expected Count	19.0	11.0	42.0	53.0	14.0	139.0

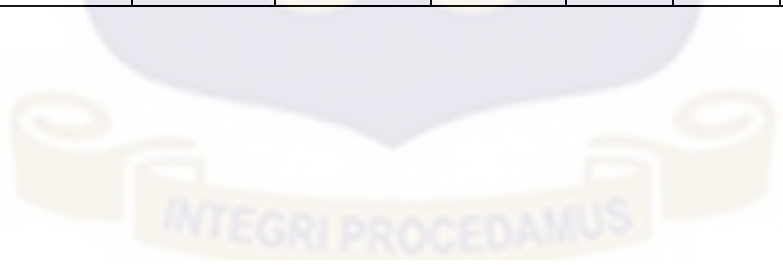


Table 4.11b **Chi-Square Tests**

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	28.945 ^a	4	.000
Likelihood Ratio	30.693	4	.000
Linear-by-Linear Association	.277	1	.599
N of Valid Cases	139		

p = 0.05

From table 4.11c below indicates that, there is a relationship between formal Palliative Care education of doctors and their knowledge on whether, the use of opioids does not influence survival time of Patients or not. As the expected values, which are values expected by chance and the actual counts are different from each other. Furthermore, table 4.11b on the Chi-square of independence, testing the null hypothesis that, there is no relationship between a doctor's knowledge on whether, the use of opioids does not influence survival time of Patients and the doctor's formal training on Palliative Care practice. The large Chi-Square statistic of (18.448) and its small significance level ($p < .001$) indicates that, it is very unlikely for a doctor to have knowledge on whether, the use of opioids does not influence survival time of Patients, if he/she has not been formally trained in Palliative Care practice. This suggests that, for a doctor to know whether the use of opioids does not influence survival time of Patients, he/she might have formally been trained in Palliative Care practice.

Table 4.11c **Cross tabulation between whether the use of opioids does not influence survival time of Patients and formal education of doctors in Palliative Care Practice.**

			use of opioids does not influence survival					Total
			strongly disagree	disagree	neutral	agree	strongly agree	
formal Palliative Care education	Yes	Count	7	34	23	27	6	97
		Expected	4.9	27.2	32.8	26.5	5.6	97.0
	no	Count	0	5	24	11	2	42
		Expected	2.1	11.8	14.2	11.5	2.4	42.0
		Count						
		Expected						
Total	Count	7	39	47	38	8	139	
	Expected	7.0	39.0	47.0	38.0	8.0	139.0	
	Count							



Table 4.11d **Chi-Square Tests**

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.448 ^a	4	.001
Likelihood Ratio	20.595	4	.000
Linear-by-Linear Association	3.232	1	.072
N of Valid Cases	139		

p = 0.05



CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Background of the Study

The study had more female doctors as compared to males. Also respondents below age 30years formed the majority. Which is an indication that, most of the doctors are in their youthful stage as of the time of the study. Furthermore, respondents engaged in the study had at least a first degree and had served as **doctors** for at least below a period of five (5) years as medical doctors and were resident doctors at the Ridge hospital.

5.1 Knowledge of Medical Doctors at the Ridge Hospital about Palliative Care Services

The study revealed that, most of the doctors at the Ridge hospital in Accra, had moderate knowledge on palliative care. Also majority of them have had formal training in Palliative Care practice during their training at medical school. In addition the doctors held the view that, Palliative Care is a multidisciplinary approach to quality health care delivery. This results implies clearly that, doctors at the Ridge hospital have adequate knowledge on Palliative Care practice and this is so because, they have had formal training in Palliative Care during medical school training, which enables them to handle chronically ill patients at least once in a week.

Their knowledge in Palliative Care affirms the view of Mukemo et al. (2017) that doctors play very vital role in providing quality palliative care since they spend more time with patients. Which means that, a doctor's knowledge on Palliative Care practice is very critical given the vital role they play in providing quality health care. This results also implicate the view that, all health workers should be trained in the palliative care approach, since this kind of attention

needs to be established early, from the moment of the diagnosis of chronic health conditions, and aimed at a good quality of life, as stated by Mitchell et al. (2010).

5.2 Practice of Palliative Care in Ridge Hospital

Contrary to previous studies (Sasahara et al., (2005) ; Miyashita, et al., (2007a) which indicated that medical professionals lacked knowledge and communication skills relevant to terminally-ill cancer patients and their families, this study showed that, doctors at the Ridge hospital do initiate discussion with patients and their family members when caring for terminally ill patients, as well as address psychological issues. This practice at the Ridge hospital by doctors could highly be attributed to the fact that the formal training they gained in Palliative Care practice during their medical school, reflects in their line of duty and can imply that, formal training of medical doctors in palliative care practice impacts positively in their practice as medical doctors.

Again this results as compared to the view of Thomas et al. (2015) indicates that doctors and other health care professionals are unprepared to care for patients in pain. This may be concluded that, a doctor's preparedness to care for patients in pain or terminally ill patient, depend on his/her formal training in Palliative Care practice.

5.3 Relationship between Doctors Knowledge and Practice of palliative care

The study also confirmed that, there is a relationship between doctor's knowledge on Palliative Care and the practice of palliative care, which affirms the view of Wool (2013) that, lack of knowledge about palliative care and confidence in oneself may create hesitation in providing patients with timely and appropriate care, thus creating difficulty in providing palliative care. This as compared to the findings of this study indicates that, formal training of

doctors in Palliative Care boost their confidence in providing timely and proper care to patients with terminally ill conditions, which results mainly in the delivery of quality health care. And also confirms the views of Hirooka et al. (2014) that, medical professionals' confidence in palliative care is an indicator of their ability in providing best care for patients, which is mainly a reflection of the knowledge acquired formally during training as a medical doctor.



CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Regarding the knowledge of Palliative Care by medical doctors at the Ridge hospital the study showed that, most of the doctors have had formal education on Palliative Care practices during their training in medical school, which makes them capable of handling chronically ill patients. Also the study showed that, most doctors at the Ridge hospital handles terminally ill patients at least once in a week.

The study further indicated that, doctors at the Ridge hospital do practice Palliative Care and in so doing, they communicate to family members of terminally ill patients about their diagnosis, initiate Palliative Care discussion with patient, address psychological issues as well and also manage the pain of patients with the right medications to ease their pain. Which is an indication that, they do practice pain management.

Finally, the study indicated that, doctor's knowledge on Palliative Care at the Ridge hospital, reflects strongly in the way they handle chronically ill patients.

6.2 Recommendations

Based on the findings of the study, the following recommendations are suggested in promoting quality healthcare in Palliative Care practice:

- Management of health facilities should endeavor to, organize some sort of in-service training on Palliative Care practice to bring all of their doctors up to speed on Palliative Care, since knowledge on Palliative Care has been established as a key factor in its practice.

- All medical schools in the country, should be encouraged to incorporate Palliative Care in their curriculum.
- Future studies in this area, should determine whether the source of a doctor's medical training impacts strongly on the practice of Palliative Care.
- Government should endeavor to create Palliative Care Units in all of its major health facilities, to promote the delivery of quality healthcare in the practice of Palliative Care.



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APPENDICES

Appendix I

PARTICIPANTS INFORMATION SHEET

Introduction

I am Mariam Ibrahim, currently pursuing a Masters in Public Health at the School of Public health, University of Ghana, Legon. I am conducting a study to ascertain the Knowledge, Practices of doctors on palliative care and their perspective on the need for formal palliative care services at the GARH.

Background of the study

Persons faced with terminal illnesses go through a lot of suffering as a results of their infirmity and as a results have impaired quality of live. This affects all aspects of their lives [psychologically, physically, spiritually and emotionally] as well as their families. During these period patients' management needs to be channeled to a direction which will help improve their quality of life and that of their families, which is the main target of palliative care.

Purpose

This study seeks to assess the knowledge and practice of palliative care by doctor at the GARH and to find out doctors perspectives on the need for a formal palliative care service at the hospital

Procedure

Information on the knowledge and practices of palliative care as well as the perception of

doctors on the need for formal palliative care will be sought from all doctors in various departments of the hospital. This will involve responding to some questions. I believe that the information obtained from this study will help identify the gap in the knowledge and practices of palliative care and will go a long way to benefit the delivery of care to patients with life limiting illnesses and Family.

Risks and Discomfort.

There are no foreseen major risks associated with participating in this study. The procedure for this study which involves responding to some questions may cause some form of discomfort to you. However you are free to opt out at any point of the study if you wish to. This is purely an academic exercise and forms part of a research work towards the award of a Master of Public Health.

Benefits

There are no direct benefits to you. However, the information that will be obtained from this study may help improve health care delivery in the hospital and the nation as a whole.

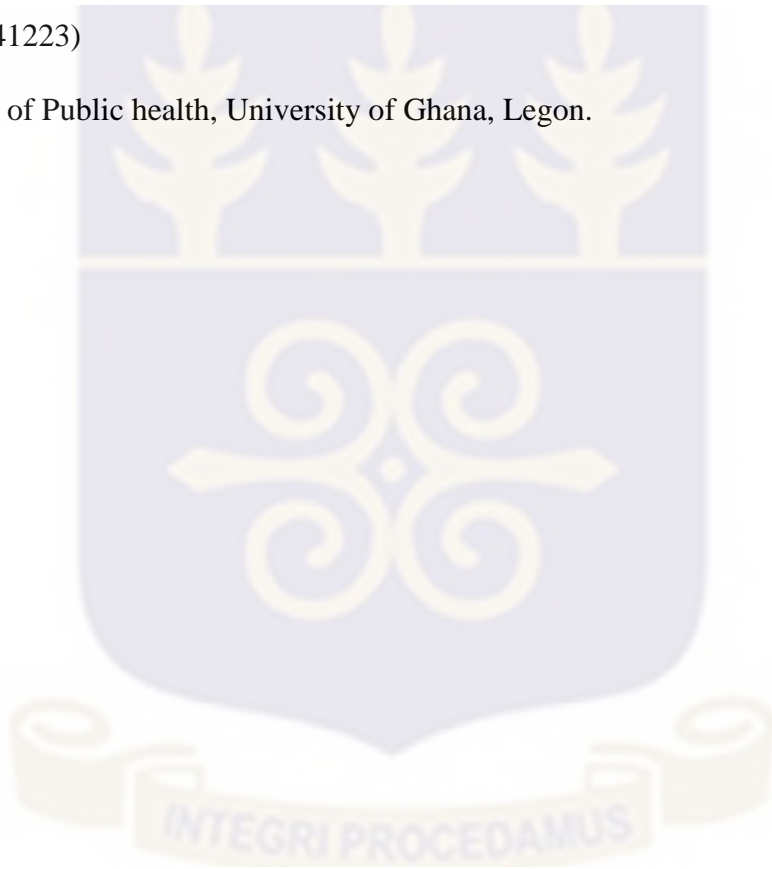
Confidentiality

Information gathered from the study would be used purposely for research. Study participants are assured of confidentiality, no personal identifying information concerning you will be presented in the analysis or publications of this study. The information gathered from the study will not be disclosed to anyone without participant's permission.

Contacts for additional information

Please call the Principal Researcher Mariam Ibrahim on 0203141270 if you have questions about the study. If you have any questions about your rights as a research participant or feel you have been treated unfairly, you may contact any of the following for further clarification or redress.

- GHS/ Ethical Review Committee Administrator, Hannah Frimpong (mobile: 0507041223)
- School of Public health, University of Ghana, Legon.



CONSENT FORM

Participants Statement

I have read the information given, have had the opportunity to ask questions which has been well answered and I have understood the purpose of this exercise. I voluntarily agree to be a participant of this study.

PARTICIPANT SIGNATURE:

DATE:

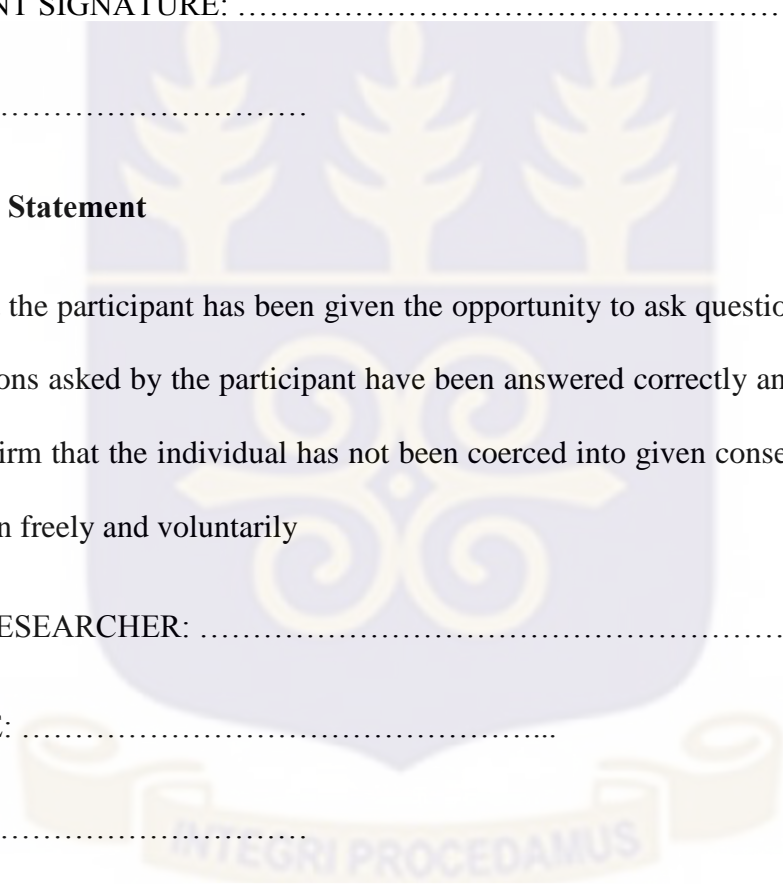
Researcher's Statement

I confirm that the participant has been given the opportunity to ask questions about the study, and all questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into given consent, and the consent has been given freely and voluntarily

NAME OF RESEARCHER:

SIGNATURE:

DATE:



Appendix II

UNIVERSITY OF GHANA

SCHOOL OF PUBLIC HEALTH-COLLEGE OF HEALTH SCIENCES



Dear Respondent,

This study is part of an academic requirement by the above mentioned school in the pursuit of a Master of Public Health Degree, in relation to the study on the Knowledge and Practice of Palliative Care at the Ridge Hospital, from the doctor's perspective. Please be assured that data collected will be treated as **Strictly Confidential and will be used for an academic purpose ONLY.**

Section A: Demographical Data

1. Gender : Male [] Female []
2. Age: below 30years [] 31-45years [] 46-50years [] 50 and above []
3. Level of Education: First Degree [] Masters [] PHD [] Others Specified.....
4. Years of Service:
Below 5years [] 6-10 [] 11-15 [] 16-20 [] 21 and above []
5. Rank: House Officer [] Resident [] Specialist [] Consultant [] Other specify.....

6. Department of Work: Medical [] Surgical [] Pediatrics []
Oncology []

Orthopedics [] Emergency [] Anesthesia [] others
specify.....

7. Place of Medical School Training; UG [] KNUST [] UDS [] Others
Specify.....

8. Country of Origin ; Ghana [] Others
specified.....

Place of Medical School Training; UG [] KNUST [] UDS [] Others
Specify.....

Section B: Knowledge of Medical Doctors in the Ridge Hospital about Palliative Care Services

9. Have you ever managed chronically ill patients before in your line of duty?

Yes [] No []

10. If yes, how often do you manage chronically ill patients?

Daily [] Once a week [] Once a month [] Once a year [] Never []

11. Do you share the view that, palliative care is a multidisciplinary approach to quality health care delivery?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

12. Have you ever had any formal Palliative Care education as a medical doctor?

Yes () No ()

13. If your answer to Question 10 above is Yes, was the education in the form of In-Service training or it was during your training as a medical doctor?

In-Service training () Medical School () Not Applicable ()

14. In your estimate, how would you rate your overall knowledge on Palliative Care practice?

Excellent [] very Good [] Good [] Average [] below Average []

15. Do you share the view that, Palliative Care should only be provided for patients who have no curative treatments available.

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

16. Should Palliative Care be provided along with Anti-Cancer treatments?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

17. When cancer pain is mild, Pentazocine should be used more often than an Opioid?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

18. Do you share the view that, the use of Opioids does not influence survival time of patients?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

19. During the last days of life, drowsiness associated with electrolyte Imbalance should decrease patient discomfort?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

20. Do you share the view that, some dying patients require continuous sedation to alleviate suffering during Palliative Care practice?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

21. At terminal stages of cancer, higher calorie intake is needed compared to early stages

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

22. One of the goals in Pain Management is to allow patients to get a good night's sleep?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

Section C: Practice of Palliative Care in Ridge Hospital

Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
23. Do you initiate Palliative Care discussion with patient?					
24. In dealing with Palliative Care practice, do you address spiritual issues by connecting with a spiritual counselor					
25. Do you communicate to the family members of terminally ill patients about their diagnosis					
26. Do you address psychological issues as well in practicing Palliative Care					

27. What is the commonly use medication in your practice for severe pain?

Paracetamol/Ibuprofen [] Codeine [] Morphine [] Other specify.....

Section D: Association between Doctors Knowledge and Palliative Care Practice

28. Which of the following stage, do you initiate Palliative Care discussion?

During diagnosis [] When the disease progress [] At the end of life [] Other specify.....

29. How do you handle patients during Palliative Care?

Listen with empathy Impose your own view Understand patient reaction

30. What other effective interventions capable of reducing physical and emotional distress in patients with life-limiting illnesses?

.....

31. Do you share the view that providing palliative care is a collaborative effort between specialists, generalists and home caregivers/family members?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

32. Do share the view that, in-service training of medical officers' impact positively on the practice of Palliative Care?

1-Strongly disagree () 2- Disagree () 3- Neutral () 4- Agree () 5-Strongly agree ()

Thank you for the Assistance!!!