‘Completely by accident’: a qualitative analysis of service providers motivations to practice palliative care

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Abstract

Background: The lack of clarity about the factors that motivate service providers to take a career in palliative care presents a significant knowledge gap that must be filled. This is because gaining knowledge about the motivations for taking a career in palliative care would provide valuable insights that can potentially increase buy-in and interest among prospective healthcare professionals. By elucidating the motivations of service providers, the study aims to contribute to the broader field of palliative care research and inform the development of tailored interventions and training programmes to increase the pool of specialized palliative care providers.

Objective: To explore palliative care service providers’ motivations to practice palliative care.

Design: Exploratory descriptive design.

Methods: In all, seven in-depth interviews were conducted using a semi-structured interview guide. Data were managed using NVivo-12. Inductive thematic analysis was performed by following Hasse’s adaptation of Colaizzi’s approach to qualitative thematic analysis.

Results: Two main factors motivated service providers to take a career in palliative care. The first was the influence of professional training while the second motivation was from their personal experiences regarding providing care to a family member with palliative care needs.

Conclusion: The study concludes that personal experiences with caring for a loved one with palliative care needs play a pivotal role in shaping the decision of service providers to pursue a career in palliative care. Also, investment in palliative care education and training is crucial to ensure a skilled workforce capable of meeting the growing needs of patients and families facing serious illnesses.

Keywords: health services research, motivation, palliative care, qualitative research

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Background

In Africa, where AIDS mortality remains high and rates of non-communicable diseases such as cancer and end-stage kidney disease are rising,[1,2] there is a high demand for healthcare services that emphasizes an improvement in the quality of life by touching on all aspects of the individual including their physical, psychosocial, cultural and spiritual needs. Palliative care encompasses a comprehensive approach aimed at enhancing the quality of life for patients and their families facing the complexities associated with terminal illnesses.[3] This approach involves the identification and early treatment of pain, along with addressing psychological and spiritual symptoms that may arise in the context of terminal illness.[4–7]

Despite the importance of palliative care service provision, nearly 86% lack access to this care.[8] The high unmet need for palliative care has been attributed to several factors including poor referral system, lack of national policies and frameworks on palliative care, lack of

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funding or reimbursement for palliative care and patients' misperceptions about palliative care.[9,10] Beyond these barriers, issues relating to the education, staffing and knowledge of palliative service providers have been documented as key challenges. For instance, Aldridge *et al.*[9] reported in their study that lack of adequate education/training and perception of palliative care as end-of-life care, as well as the low staff size of palliative care teams were significant barriers to the provision of this care to those who need it. In Ghana, some studies[11,12] have found that there is a general misperception about palliative care and an inadequately trained workforce to support palliative care service provision. Additionally, an earlier study by Okyere and Kissah-Korsah has revealed that there is currently some level of palliative care education in Ghana; however, this pre-service training is accessible only to medical students in their fifth year.[11] This implies that other health and allied health service providers including nurses, radiologists, anaesthesiologists, social workers and among other cadres lack pre-service training in palliative care service delivery.

While many studies have explored the barriers to palliative care provision,[9–12] these studies fail to explore other perspectives including why service providers take a career in palliative care provision. As such, the question remains unanswered: what motivates service providers to take a career in palliative care provision? The lack of clarity about the factors that motivate service providers to take a career in palliative care presents a significant knowledge gap that must be filled. This is because gaining knowledge about the motivations for taking a career in palliative care would provide valuable insights that can potentially increase buy-in and interest among prospective healthcare professionals. Additionally, appreciating the service providers' motivations to practice palliative care has the potential to facilitate better collaboration and coordination among team members, leading to more holistic and patient-centred care. By elucidating the motivations of service providers, the study aims to contribute to the broader field of palliative care research and inform the development of tailored interventions and training programmes to increase the pool of specialized palliative care providers. The study, therefore, aims to explore palliative care service providers' motivations to practice palliative care.

Methods

Design

This study utilized an exploratory descriptive qualitative research design. The primary objective was to gain insights and understand perspectives related to the research topic. This study design was chosen to capture the richness and depth of individual perspectives, rather than aiming for generalization of the results to a larger population.[13] The study was conducted between 1 October and 31 December 2021.

Setting

The study was conducted at the Korle Bu Teaching Hospital (KBTH), Ghana. KBTH is renowned as the largest tertiary health facility in the country and is recognized as a major referral centre for various medical conditions, including cancer. One notable aspect of the hospital is its provision of specialist palliative care services. This reflects the hospital's commitment to providing comprehensive care and support to individuals with life-limiting illnesses. Services provided at KBTH's palliative care unit include in-patient, out-patient and home care. This is provided by a dedicated team consisting of family physicians, nurses and a pharmacist.[14]

Sample

The study employed a purposive sampling technique to ensure diversity among the participants in terms of their professional backgrounds, years of seniority, experience in providing palliative care services and depth of knowledge related to the subject of study. Out of the nine palliative care service providers at the unit, only seven of them were available at the time of the study. This included a geriatric nurse, community health nurse, palliative care nurse specialist, pharmacist, family palliative care resident (i.e. a resident with a family medicine background who is specializing in palliative care), general nurse, clinical psychologist and a social worker.[5] The selection criteria for recruitment included two key factors: (a) being a member of the palliative care team at KBTH and (b) having a minimum of 2 years of experience in the field of palliative care.[5] By selecting participants who met these inclusion criteria, the study aimed to gather insights and perspectives from experienced palliative care professionals within the specific context of KBTH's palliative care unit. The study

participants had all received a 6-week intensive training from the Institute of Hospice and Palliative Care in Africa, based in Kampala, Uganda.[5]

Data collection

Face-to-face interviews were conducted at the palliative care unit office which is located within the Department of Family Medicine. To guide the data collection process, a semi-structured interview guide was used. This interview guide was developed based on previous studies[15,16] and included main questions as well as probing questions to delve deeper into specific topics. Prior to the interviews, participants were provided with an information sheet that outlined the study's objectives, procedures, potential benefits and risks of participation, the expected length of the interview, as well as an emphasis on protecting their identities. Participants were required to provide both written and oral consent. All seven interviews were conducted by the author to ensure familiarity with the data and facilitate the richness of the analyses. Each interview was audio recorded and conducted in English. Overall, the interviews lasted between 24 and 54 minutes, allowing for a comprehensive exploration of the participants' perspectives and experiences.

Analyses

Following the interviews, all seven audio data were transcribed verbatim. The transcriptions were then imported into QSR NVivo-12 (QSR International Pty Ltd.), a software tool used for data management and analysis. For the analysis of the data, the author employed an inductive thematic analysis approach. Specifically, the researcher relied on Haase's version of Colaizzi's method for qualitative research analysis.[17,18] The imported transcripts were thoroughly read three times to develop familiarity with the data. Using the 'nodes' function within QSR NVivo-12, the author coded extracts and narrations that reflected particular responses to the research questions. The author then identified patterns across the coding of the various transcripts. This process involved identifying meaningful connections and relationships within the data. Identified patterns were categorized into themes for further interpretation. To reduce potential bias, the author shared the coding and findings with two qualitative experts – one from the University of Cape Coast and the other from Kwame Nkrumah University of Science and Technology to obtain their feedback and alternative perspectives. This helped to overcome the limitations of not performing inter-rater reliability.

Rigour

Ensuring rigour and trustworthiness is an important aspect of qualitative studies. To ensure confirmability, member checking was done a week following the interview to make sure the results reflected the intentions of the participants. However, none of the participants raised objections following the member-checking exercise. For confirmability purposes, copies of the interview guide, information sheet and informed consent forms were kept. Transferability was ensured by providing a full explanation of the study's background and sample characteristics. In terms of credibility, the study adhered carefully to the methodology. Additionally, participants' exact words were used exclusively in the extracted narrations that were coded. The study relied on O'Brien's Standards for Reporting Qualitative Research (SRQR)[19] to report the study (Supplemental Material 1).

Results

The distribution of the participants' sociodemographic characteristics is summarized in Table 1. Their ages ranged between 30 and 59 years. There was diversity in the years of experience with the minimum being 2 years while the maximum years of experience was 9 years. It should be noted that all the participants identified as females. Hence, their gender is not reported in Table 1.

Two main factors motivated service providers to take a career in palliative care. The first was the influence of professional training while the second motivation was from their personal experiences regarding providing care to a family member with palliative care needs.

Through professional training

It is evident from the study that professional training plays a critical role in determining the service providers' decision to take a practice in palliative care. According to the participants, prior to receiving professional training on palliative care, they lacked an understanding of what this approach to healthcare constituted. However, the professional training received introduced them to

Table 1. Participants' sociodemographic characteristics.

Participant ID	Age (years)	Specialty	Years of experience
SP1	30–34	Geriatric nurse	2
SP2	30–34	CHN	8
SP3	55–59	PC nurse	9
SP4	50–54	Pharmacist	9
SP5	35–39	Family PC resident	9
SP6	35–39	General nurse	9
SP7	30–34	PC nurse	2.5

PC, palliative care; CHN, Community health nurse.

palliative care approaches and further increased their knowledge, skills and interest to practice as palliative care service providers. The following extracts reflect the participants' perspectives:

> I became a palliative care nurse after receiving professional training from Uganda. So, I travelled to Uganda in 2017 for my palliative care training. It was a certificate course. So, I am a certified palliative care nurse. That was how I gained the knowledge, skills and passion for delivering palliative care services (SP2).

> I would say that taking a career in palliative care was completely by accident. This is because I worked in the hospital in the orthopaedic unit. So, there was this workshop that was ongoing and as a nurse I want to get professional development points, and so I decided to join them. After the training, they formed the palliative care team. Because we had to form a team, I joined the team as a secretary. Upon several meetings, palliative care started and then with a patient that we saw, I said, 'hey. . .this is something that I want to be', even though my interest was in emergency medicine and all that. But I developed interest for palliative care based on the humanity part. I have grown to love it so much. (SP6)

Personal experiences with caring for a relation with palliative care needs

This study revealed that service providers took cues from the personal experiences that they had with respect to a loved one who passed away due to a chronic disease, or close relation who benefited from palliative care services before dying. The participants indicated that they became more appreciative of supportive care and palliative care after their close relations (i.e. parents, uncles) had succumbed to death after battling with a chronic disease. In their view, this experience motivated them to want to be in a position that will enable them to provide empathy and care as they would have done for the deceased relation, hence influencing their decision to become palliative care service providers:

> I had an uncle who had cancer of the jaw and was in Kumasi. He was in so much pain because in those days, they weren't managing it [the pain] well. So, I usually leave here for Kumasi every Friday to dress his wounds and manage his pain, then I will come back. When it got to a time, I realised I couldn't do it alone so I got assistance from a nurse who could fill in for me on the weekdays when I am not there. Then I had an incident with my dad who had multiple organ failure. These experiences helped me to understand and appreciate the importance of supportive care. In the long run, it influenced my decision and passion to be palliative care service provider. (SP3)

> I had a personal experience where a family member needed palliative care. That gave me more exposure to palliative care. I felt that it was quite a deprived area; not a lot of physicians were into it. So, I could offer my services so that others could benefit from what my family members and I benefited. So, that was the main motivation for engaging in palliative care. (SP5)

Discussion

The findings from the research shed light on the significant role that professional training plays in shaping the decision of service providers to pursue a career in palliative care. Prior to receiving professional training, participants in the study expressed a lack of understanding of what palliative care entailed. This suggests that palliative care may not have been adequately emphasized in their pre-service education or clinical experiences. Similar findings have been reported in previous studies that have found the lack of adequate education/training to be a significant challenge in palliative care service delivery.[9,11,12] However, the professional training they received in palliative care proved to be transformative. Participants reported that the training introduced them to the principles, approaches and skills required in palliative care. It not only increased their knowledge

about the field but also ignited their interest and passion to provide palliative care services. This result affirms existing literature that suggests that adequate training and education is an opportunity for increasing the pool of specialist palliative care providers.[20–22]

It is evident from the study that the personal experiences of service providers served as a motivating factor that drew them to pursue palliative care. The participants in the study shared their experiences of witnessing the challenges faced by their close relatives who battled chronic diseases and ultimately succumbed to death. These personal encounters served as cues to action, prompting the participants to seek roles in palliative care where they could provide empathy and support to others facing similar situations. Similar findings have been reported in a study that found that personal experience with a family member with cancer was a motivating factor for individuals to volunteer and pursue palliative care service provision.[23] It is possible that the first-hand experience with the challenges of caring for a loved one with a chronic disease instilled in the participant an appreciation of the relevance of palliative care. Moreover, it is likely to bring about intrinsic feelings of satisfaction, fulfilment and joy which are all key characteristics that motivate individuals to pursue career pathways including a career in palliative care.

Implications for policy and practice

The implications of these findings extend to the recruitment and retention of palliative care providers. Understanding the role of personal experiences as cues to action can help in identifying individuals who may be more inclined to choose palliative care as a career path. It also emphasizes the importance of creating supportive environments and educational opportunities that allow individuals to translate their personal experiences into meaningful contributions in palliative care. The findings also underscore a need for Ghana and other countries categorized as having limited palliative care to invest in palliative education. This education should be introduced at the pre-service training for all health and allied healthcare courses to ignite interest and passion for palliative care. Additionally, prioritizing pre-service palliative care training could potentially increase the country's capacity to have primary palliative care, which is necessary for early initiation of palliative care, timely referral of patients to specialist palliative care providers, and contribute significantly to reducing the unmet need for palliative care.

Strengths and limitations

Using a descriptive phenomenological design was appropriate in eliciting the perspectives and lived experiences of palliative care service providers. Moreover, the use of Hasse's adaptation of Colaizzi's analytical framework ensured a comprehensive exploration of the emerging issues from the transcript. Notwithstanding, there were some limitations. The study was limited to only members of the palliative care team. Furthermore, due to the exclusive reliance on in-depth interviews in this study, the findings may not necessarily represent the collective viewpoint of the group but instead predominantly portray individual perspectives.

Conclusion

The study concludes that personal experiences with caring for a loved one with palliative care needs play a pivotal role in shaping the decision of service providers to pursue a career in palliative care. Also, investment in palliative care education and training is crucial to ensure a skilled workforce capable of meeting the growing needs of patients and families facing serious illness.

Declarations

Ethics approval and consent to participate

The study adhered to the guidelines set forth by the International Committee of Medical Journal Editors (ICMJE) and the Helsinki Declaration. Ethical approval was obtained from the University of Cape Coast Institutional Review Board (ID#: UCCIRB/CHLS/2021/18) and the Korle Bu Teaching Hospital Scientific and Technical Committee (ID#: KBTH-STC 000108/2021). Prior to their participation, each participant provided both verbal and written consent.

Consent for publication

Not applicable.

Author contributions

Joshua Okyere: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Software; Writing – original draft; Writing – review & editing.

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Competing interests
The author declares that there is no conflict of interest.

Availability of data and materials
The data underpinning the findings of this study are accessible upon request from the corresponding author. However, it should be noted that the data are not publicly available in accordance with privacy and ethical restrictions.

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Supplemental material
Supplemental material for this article is available online.

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