



THE ROLE OF FAMILY PHYSICIANS IN END-OF-LIFE CARE: A REVIEW OF BEST PRACTICES

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Abstract:

End-of-life care is a pivotal component of healthcare, demanding specialized attention and empathy. Family physicians are at the forefront of providing support, comfort, and medical expertise to patients and their families during this delicate stage. This review seeks to consolidate the most effective strategies for family physicians in end-of-life care, encompassing communication, symptom management, advance care planning, and the facilitation of collaborative efforts with other healthcare professionals. Additionally, the review delves into the obstacles and challenges that family physicians may face in delivering end-of-life care, offering actionable recommendations to enhance the quality of care provided. The review's insights underscore the indispensable role of family physicians in ensuring the delivery of exceptional end-of-life care. It emphasizes the necessity for continuous education and support to empower family physicians in this critical realm of healthcare, ultimately aiming to enhance the standard of care for patients and their families during this poignant phase of life.

Keywords: endo of life care, palliative care, family medicine

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Introduction:

Care given during the "last year of life" is referred to as end-of-life care; but, for certain diseases, this may extend to months or even years. End of life care refers to the support and medical care provided to individuals who are in the final stages of a terminal illness or nearing the end of their life. This type of care focuses on helping patients manage pain and symptoms, as well as providing emotional and spiritual support for both the patient and their loved ones. End of life care may also include discussions about the patient's wishes for their care and end-of-life decisions, such as advance directives and palliative care options. The goal of end of life care is to ensure that the patient is as comfortable and peaceful as possible during their final days, and to support their loved ones through the grieving process [1, 2].

One of the primary responsibilities of family physicians in end-of-life care is to provide comprehensive and compassionate care to patients who are nearing the end of their lives. This includes managing pain and other symptoms, addressing emotional and psychological needs, and coordinating care with other healthcare providers. Family physicians also play a key role in helping patients and their families make informed decisions about their care, including end-of-life treatment options and advance care planning [3].

In addition to providing direct medical care, family physicians also serve as advocates for their patients in end-of-life care. They work to ensure that patients' wishes and preferences are respected and that they receive the support and resources they need to have a comfortable and dignified end-of-life experience. This may involve collaborating with other healthcare professionals, such as palliative care specialists, social workers, and spiritual care providers, to address the holistic needs of patients and their families [4].

One of the challenges that family physicians face in end-of-life care is navigating the complex and often emotionally charged dynamics that can arise when caring for patients who are nearing the end of their lives. This includes addressing the needs and concerns of family members, who may be struggling with grief, guilt, and difficult decisions about their loved one's care. Family physicians must be skilled communicators and empathetic listeners, as they work to support patients and their families through this challenging time [5].

Despite these challenges, family physicians have a profound impact on patients and their families in end-of-life care. They provide continuity of care and a familiar presence for patients and their families, which can offer comfort and reassurance during a difficult time. Family physicians also help

to facilitate important conversations about end-of-life care and ensure that patients' wishes are honored, which can lead to a more peaceful and meaningful end-of-life experience for patients and their loved ones [6].

The objective of this study is to review and consolidate the best practices for family physicians in providing end-of-life care. The study aims to identify and summarize the most effective strategies for family physicians in areas such as communication, symptom management, and collaboration with other healthcare professionals.

Plan of Care

It is difficult to plan and provide care for patients who are nearing the end of their lives. When a patient receives a terminal diagnosis, or shortly after, is the best time to prepare their end-of-life care. "To ensure that the patient's individual preferences are maintained during end-of-life care, frequent clinician-patient conversations are necessary." In order to allow for advance planning, the Institute of Medicine advises having these discussions as soon as possible once an illness has been diagnosed. Drafting advance directives and having formal discussions about death are both parts of this preparation process. Planning aids in ensuring that the dying patient's objectives, values, and preferences are taken into consideration while providing care. Research indicates that when a dying patient receives personalised end-of-life care, their quality of life is improved [7].

Healthcare team members have several tools at their disposal to assess and optimise the quality of life of a patient nearing death. It is advised that healthcare professionals use the instrument that best suits the needs of each patient. Certain patient populations, such as individuals with heart disease (Cardiac Health Profile) and breast cancer (QOL-BC), were the focus of specific quality of life scale design. A more general tool, however, would be more helpful as many members of the healthcare team frequently treat patients with a range of diseases. Regardless of a patient's diagnosis, the WHOQOL-BREF was created by the World Health Organisation to be used by all patients. The patient's quality of life is assessed across four dimensions using the WHOQOL-BREF [8]. Environmental resources, social relationships, psychological well-being, and physical health are these domains. Patients are asked to answer questions on daily activities, discomfort, sleep and rest, energy levels and weariness, and physical health. Self-esteem, spirituality and religiosity, as well as happy and negative emotions, are all measured in the psychological health category. Personal relationships, social support, and sexual

activity are among the aspects examined in the social relationships category. The domain of environmental resources includes measurements for financial resources, home environment, healthcare accessibility, and leisure activity participation. A member of the healthcare team can assign the patient to complete the WHOQOL-BREF, which consists of 26 questions that assess all four categories. The patient's responses to these domain questions can subsequently be used by the healthcare team member to guide their treatment approach [9, 10].

The treatment strategy ought to be based on the patient's quality of life evaluation. Studies indicate that the best care delivery models to maximise a patient's quality of life towards the end of their life are those that incorporate services "across the care continuum with service involvement triggered by the patient's needs." Social work, physical and occupational therapy, mental health services, respiratory therapy, palliative care, and spiritual care are just a few examples of the integrated services that may be provided. A dying patient has a much higher quality of life when their requirements are met via integrated care [11].

Pain and Symptom Management

Patients experience a wide range of symptoms near the end of their lives, which may lower their quality of life. Healthcare team members can improve their dying patients' quality of life by managing their symptoms properly. Mobility problems, discomfort, and GI, respiratory, and other symptoms are among those that impact the physical domain. Anxiety and depression are examples of symptoms that impact the psychological health domain. All members of the healthcare team have an obligation to evaluate these symptoms and collaborate with the patient to achieve optimal control over them [11].

According to the research, one of the most frequently discussed issues for people nearing the end of their lives is appropriate pain management. Given that pain management regularly varies, members of the healthcare team are encouraged to conduct thorough assessments of the patient's pain on a regular basis and to organise the patient's care around these assessments. The patient's cognitive and developmental level determines which evaluation instrument is best for quantifying their discomfort [12].

Members of the healthcare team should be aware that some people cannot vocally communicate their demands, hence there are scales available for them. When a patient has a diagnosis that prevents them from self-reporting their pain, like expressive aphasia or dementia, scales like the PAINAD can

be employed. Regardless of the scale utilised, the patient must provide a comprehensive self-report, which should guide the healthcare team member's physical examination. The member of the healthcare team should utilise this thorough data collection to help regulate pain sensations by differentiating between the many forms of pain the patient is experiencing (such as visceral vs. neuropathic pain) [13]. Pain can be managed in a number of ways. Administering opioids, non-opioids, and adjuvants such corticosteroids and antidepressants are examples of pharmaceutical interventions. Massage, music therapy, meditation, and heat/cold therapy are examples of non-pharmacological pain management techniques. The kind of care selected ought to be determined by a thorough evaluation of the patient, taking into account both needs and preferences. Additionally, medical marijuana is a successful pain management treatment, depending on the state regulations where the patient obtains end-of-life care [14].

Dyspnea, or difficulty breathing, is one of the most prevalent respiratory symptoms that patients may have when receiving end-of-life care. According to research, during end-of-life treatment, up to 70% of all patients who are dying report having dyspnea symptoms. The members of the medical team must perform a comprehensive assessment of dyspnea symptoms, just like they do for pain. This entails evaluating the breathing's depth, rhythm, pattern, pace, and effort [11].

Anorexia and constipation are two GI symptoms that might arise in the latter stages of life. Either one or both may be signs of the patient's terminal illness, adverse drug reactions, or both. The first step in addressing these symptoms is accurately determining their aetiology. Non-pharmacological treatments for anorexia include calorie-rich diets, foods the patient enjoys, and odour control. Pharmacological treatments for anorexia include antipsychotics like olanzapine and corticosteroids [13].

Opioids and bronchodilators are two pharmacological therapies for dyspnea. Strategies for conserving energy, changing positions, and oxygen treatment are examples of non-pharmacological interventions. In order to adjust therapy options in response to changing patient status and symptoms, thorough and frequent assessments of dyspnea are necessary [11].

Fatigue is one of the most prevalent mobility complaints that people may encounter in the final stages of their lives. Patients describe fatigue as incapacitating weariness rather than simply just being tired all the time. The dying patient's quality of life may be impacted in a number of ways by this weariness. Members of the healthcare team should

be aware that patients' weariness can be measured using a number of proven instruments. Prior to using medication to treat exhaustion, the reason should be investigated [13]. There are several well-established causes of weariness, such as depression, anaemia, dehydration, and infections. Fatigue is one of the most prevalent mobility complaints that people may encounter in the final stages of their lives. Patients describe fatigue as incapacitating weariness rather than simply just being tired all the time. The dying patient's quality of life may be impacted in a number of ways by this weariness. Members of the healthcare team should be aware that patients' weariness can be measured using a number of proven instruments. Prior to using medication to treat exhaustion, the reason should be investigated. There are several well-established causes of weariness, such as depression, anaemia, dehydration, and infections [12].

The dying patient's psychological wellbeing is impacted by psychiatric disorders including anxiety and depression. To guide treatment, these symptoms, which can range in severity from moderate to severe, should be evaluated using reliable instruments. Numerous instruments are available to quantify anxiety and depression symptoms. SSRIs and NDRIs, like bupropion, are examples of pharmacological therapies. Exercise and cognitive behaviour therapy are two non-pharmacological treatments for depression. Benzodiazepines are among the most often prescribed medications used to treat anxiety disorders. Anxiety symptoms can be effectively reduced by both meditation and cognitive-behavioral therapy [15].

Pain, dyspnea, anorexia, constipation, exhaustion, sadness, and anxiety are some of the most typical symptoms that patients nearing the end of their lives may experience. In addition to any additional symptoms the patient may have, members of the healthcare team must screen for these. A plan of care that will improve the patient's quality of life can be developed by the patient and the member of the healthcare team after a thorough assessment has been completed [16].

Ethics

There are often many moral conundrums at the end of life. Members of the healthcare team must have a thorough understanding of bioethics in order to handle any moral conundrums that may arise for their patients' families as they near death. When assisting the patient and family with moral quandaries, the members of the healthcare team must never forget that the purpose of end-of-life

care is to improve the quality of life for the dying individual [17].

Autonomy, or the patient's capacity for free will and self-determination, is the fundamental ethical premise in biomedicine. Healthcare team members need to evaluate if the patient is capable of making decisions on their own while considering ethical quandaries that can arise in the final stages of life. To ensure that the patient is able to make educated decisions regarding their care, the team member must evaluate the patient's cognitive and developmental abilities in relation to the disease and available options [18].

Concurrent study of the ethical principles of beneficence and non-maleficence is warranted. It is believed that non-maleficence—not harming the patient—and beneficence—doing what is best for the patient—balance one another. While taking the required steps to ensure that the dying person's pain is not prolonged, the members of the healthcare team have a duty to act in the patient's best interest and refrain from malice. Justice is the last ethical precept to be taken into account when providing end-of-life care. The member of the healthcare team must act in the best interests of the dying patient by weighing what is fair or just in light of the justice principle. A member of the healthcare team who adheres to all four of these principles is likely to improve the patient's and family's quality of life by assisting them in making morally right decisions [19].

When a patient who was once part of the healthcare team is dying and is no longer able to make decisions for themselves, there may be ethical conundrums for the team. An advance directive must be consulted by the member of the healthcare team if the dying patient is incapable of expressing their desires. An advance directive is a legal instrument that expresses a patient's preferences and, in some situations, appoints a durable power of attorney—someone who is authorised to make choices regarding the patient's medical treatment [17]. The best method to uphold the ethical principle of autonomy is to follow the wishes expressed in the advance directives. But according to studies, only 26% of Americans presently have an advance directive in place. The most common excuse given for not having an advance directive is ignorance of the necessity of this paperwork. Early end-of-life discussions with the patient and family members are made even more important when advance directives are in place for terminally ill patients. During these discussions, the individual who is dying is asked to choose an individual, who may or may not be a family member, who will honour their desires, make choices that are consistent with those desires, and speak up in

support of those wishes in the event that conflicts arise [20].

Healthcare team members may also encounter an ethical conundrum when providing care for patients who are near death, such as when the patient's options for treatment or the durable power of attorney result in needless suffering or are medically pointless. Healthcare team members should keep in mind that all end-of-life care should be patient-centered and that ineffective medical treatment can take many different "forms and be defined as futile only in the context of each patient's situation." [19] Cardiopulmonary resuscitation for elderly and frail patients who are dying, screening tests that don't affect the comfort care provided, and invasive procedures like endotracheal tube implantation and surgeries that don't prolong the patient's life are a few examples of these care options that have been documented in medical literature. It's possible that these innovations will be successful in "producing physiological effects while offering the patient no benefit." Naturally, every action should be taken into account in light of the patient's diagnosis and course of sickness. Health team members should also be aware that decisions about end-of-life care are frequently influenced by the patient's culture. Consequently, a thorough cultural assessment carried out early on in the end-of-life care process may aid in clarifying expectations of care for the dying patient, their family, and the healthcare staff [20].

Ethics committee meetings can be called in situations where moral conundrums arise and there is dispute about how to handle the dying patient's final care. Ethics committees are not meant to take over or control patient care; rather, their role is to advise medical personnel. Medical professionals, nurses, chaplains, social workers, and case managers make up the interprofessional ethics committees, which provide professional guidance in cases when conflicts arise, even if their recommendations are not legally binding [21].

Termination of Care

Termination of care must be considered when symptoms are too severe or unmanageable for the patient. The decision to terminate care is made as part of the preliminary end-of-life discussions, not on a whim. It is important to end the patient's care and let them die when the medical team's recommended course of action is medically pointless or is causing the patient more agony. When it comes time to end care, the patient should make the decision if they are capable of doing so. This duty falls to a power of attorney if the patient is developmentally or cognitively competent of making such decisions [22].

When there are moral conundrums, ethics committee suggestions can also be taken into consideration when making judgements about ending care. Healthcare team members are advised to keep in mind the previously described concerns, such as communication styles, cultural considerations, and quality of life, when proposing termination of treatment for the dying patient. The patient and their quality of life should be the focal point of any discussion regarding the end of care [23].

Conclusion:

Family physicians play a vital role in end-of-life care, providing comprehensive and compassionate care to patients and their families as they navigate the final stages of life. Their responsibilities include managing symptoms, advocating for patients' wishes, and supporting patients and their families through the emotional and practical challenges of end-of-life care. Despite the challenges they face, family physicians have a profound impact on patients and their families, helping to ensure that they receive the care and support they need to have a dignified and comfortable end-of-life experience.

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