Introduction: The integration of palliative care (PC) services is characterized by several barriers and challenges, which may include misperception of PC services as end-of-life care, poor referral systems, inadequate financial support, regulatory barriers, and the small size of PC professional workforce. Beyond these barriers, the question remains: what opportunities exist to facilitate the integration of PC in managing patients’ conditions? Notably, for a resource-constrained country like Ghana, unearthing existing facilitating factors would enable the country to leverage the opportunities these factors present to promote PC integration.

Objective: The aim of this study is to explore opportunities that exist to facilitate PC integration from the perspective of PC service providers.

Methods: An exploratory descriptive qualitative research design was used. Using semi-structured interview guides, seven face-to-face interviews were conducted with PC service providers in a tertiary hospital in Ghana. Data were managed using QSR NVivo-12. Inductive thematic analysis was carried out following Haase’s modification of Colaizzi’s approach to qualitative research analysis.

Results: From the inductive thematic analysis, it was revealed that four main opportunities exist to facilitate PC integration. These included the availability of a PC team and teamwork, knowledge level of service providers, enabling attitudes of service providers, and the incorporation of PC in the medical school curriculum.

Conclusion: The study concludes that to facilitate the integration of PC in a tertiary health facility, there is a need to leverage on the supportive attitudes of service providers. Also, there is a need to expand the incorporation of PC education in the curriculum of all health and allied health courses. This could help create a pool of primary healthcare providers who can provide generalist PC services promptly. The study also underscores a need for continuous professional development.

Keywords: palliative care, nursing, health services, qualitative research
management of physical pains and symptoms (Afolabi et al., 2022). This is where palliative care (PC) comes to play.

By definition, PC refers to “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, 2002), indicating that this approach to healthcare is critical to provide support to individuals with life-threatening illnesses (Radbruch et al., 2020). Healthcare providers have a critical role to play in the implementation and integration of PC services. Given that nurses constitute the largest workforce in the healthcare system, their strategic position is quintessential to the quality and effectiveness of PC service provision and integration (Fitch et al., 2015). The role of nurses in PC is reinforced by the point that PC service provision is strongly aligned to the basic tenants of nursing in providing holistic care to individuals and family members (Engberink et al., 2020; Fitch et al., 2015). Nurses play a role in ensuring early referral and early initiation of palliation, as well as contributing to effective symptoms management (Fitch et al., 2015). Hence, understanding their perspectives as the opportunities available for the integration of PC services is imperative to inform the effective implementation and integration of PC services especially in resource-constrained populations.

**Review of Literature**

Available evidence shows that PC improves the quality of life of not only the person living with a life-limiting health condition, but also provides closure and psychological support to their families (Çalk et al., 2022; Collins et al., 2016; Rodin et al., 2022). Yet, there is a high unmet need for PC service worldwide as only 14% in need of this service receive it (WHO, 2020). Within the African context, only 5% to 11% of people in need of PC services have access to it (Afolabi et al., 2021). To narrow the high unmet need of PC service, scholars have proposed an integration of PC services to ensure that there is wider reach to those who may require such services (Afolabi et al., 2021; Hui & Bruera, 2016; Payne et al., 2017). In this context, integration of PC services refers to bringing together the different components of the care (administrative, organizational, clinical, and service) to work in a collaborative way to improve the health outcomes of patients and their families (Van Beek et al., 2016).

Available evidence has shown that the integration of PC services in the management of patients’ diseases has a greater likelihood of improving the overall quality of life of the patient and their families (Meier, 2011). Despite the benefits of PC integration, its implementation is characterized by several barriers and challenges that may include misperception of PC services as end-of-life care, poor referral systems, inadequate financial support, regulatory barriers, and small size of PC professional workforce (Aldridge et al., 2016; Davis et al., 2015). Beyond these barriers, the question remains: what opportunities exist to facilitate the integration of PC into managing patients’ conditions? Notably, for a resource-constrained country like Ghana, it might be difficult to overcome the many barriers to PC integration. However, by unearthing existing facilitating factors, the country would be able to leverage the opportunities these factors present to promote PC integration. Notwithstanding, there is sparse empirical evidence from Ghana that explores the opportunities that exist to facilitate PC integration. To narrow this literature gap and contribute to the advancement of PC integration in Ghana, the present study explores opportunities that exist to facilitate PC integration from the perspective of PC service providers.

**Methods**

**Study Design**

An exploratory descriptive qualitative research design was used. With this research approach, the emphasis was on utilizing text to describe the data and give interpretation to the results, rather than to seek the generalizability of the study findings (Bernard, 2017). The study was conducted between October 1 and December 31, 2021. The main research question in this study was that, “what are the existing opportunities that facilitate the integration of PC?”

**Setting**

This study was carried out at the Korle Bu Teaching Hospital (KBTH), Ghana. Specifically, the study was conducted at the palliative care unit, which is located within Department of Family Medicine at the Korle Bu Polyclinic (Okyere et al., 2022). KBTH is the first tertiary hospital in Ghana to operate specialist PC services and has since been the main health facility providing PC services to the country’s most populous city, Accra, and its peripheral regions. The facility also doubles as the leading referral hospital in the country (Sackey, 2015). The PC unit has a team that offers both out-patient and in-patient consultation to clients as well as home visits. In-patient consultations are organized three times a week whereas home visits are done every Wednesday (Okyere et al., 2022).

**Sample**

Seven of the nine PC service providers that make up KBTH’s PC team consented to participate in this study. The composition of the PC team included a geriatric nurse, community health nurse (CHN), PC nurse specialist, pharmacist, family PC resident, general nurse, clinical psychologist, and a social worker (see Table 1). It is important that every member of the PC team had received a 6-week intensive training from the Institute of Hospice and PC in Africa,
based in Kampala, Uganda. This training program is a certificate course that has several modules. During this program, participants are provided training on symptoms and pain management, spiritual assessments, and dealing with patients’ or caregivers’ psychological distress. This training program held in Kampala, Uganda is entirely financed by healthcare professionals. As such, the participants received their training at different time points. In addition, members of the PC team received other forms of training including a master’s program in PC and other specialist courses in PC.

Inclusion Criteria

Healthcare professionals were recruited based on the inclusion criteria that: (a) they must be a member of the PC unit and (b) they must have been working with the PC unit for at least 2 years (Munkombwe et al., 2020).

Table 1. Participants’ Sociodemographic Characteristics.

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

Source: Fieldwork, 2022.

The ages of the participants ranged between 30 and 59 years, with nearly half of the participants (3/7) being within the age group 30–34 years. The participants from the study included a geriatric nurse, community health nurse, PC nurse, pharmacist, general nurse, and a family PC resident. It should be noted that these are all members of the established PC team at KBTH. Regarding their years of experience with the PC team, it ranged between a minimum of 2 years and a maximum of 9 years. Thus, those with 9 years’ experience have been with the PC team since its inception.

Data Analysis

Inductive thematic analysis was carried out following Haase’s modification of Colaizzi’s approach qualitative research analysis (Liu et al., 2020; Morrow et al., 2015). The transcribed narrative texts were read independently by the authors. To fully understand the intended meaning included in the transcripts, each author read them at least three times. Using the "nodes" feature of QSR NVivo 12, relevant quotes were extracted from the transcript, followed by the assignment of codes. Where there were overlapping codes, the researchers held team discussions to reach an agreement and substantiate the study’s emergent concepts.

Trustworthiness and Rigor

The researchers meticulously followed the study methodology and only used participant quotations that were taken verbatim to assure credibility. A week following the data collection, member verification was conducted with two of the respondents so they could confirm the findings. Credibility was further enhanced by structuring the interview guide to reflect the goals. Also, the researchers gave a thorough description of the study’s setting and the procedures used for selecting the participants to ensure transferability.

Results

Sample Characteristics

The ages of the participants ranged between 30 and 59 years, with nearly half of the participants (3/7) being within the age group 30–34 years. The participants from the study included a geriatric nurse, community health nurse, PC nurse, pharmacist, general nurse, and a family PC resident. It should be noted that these are all members of the established PC team at KBTH. Regarding their years of experience with the PC team, it ranged between a minimum of 2 years and a maximum of 9 years. Thus, those with 9 years’ experience have been with the PC team since its inception.

Main Findings

From the inductive thematic analysis, it was revealed that four main opportunities exist at the KBTH to facilitate PC integration. These included the availability of a PC team and teamwork, knowledge level of service providers, enabling attitudes of service providers, and the incorporation of PC in the medical school curriculum.
Incorporation of PC in Medical School Curriculum

The participants’ responses revealed that there is currently some level of incorporation of PC education in the curriculum for medical school. Participants asserted that fifth-year medical students had to take up a course in PC as part of their training in family medicine. Also, resident physicians and other service providers on rotation were given the opportunity to learn and practice PC during their period of residency and rotation respectively. This current action was deemed an important step to support the future of PC integration. The following narratives present the participants’ perspectives about how the incorporation of PC into the medical school curriculum is an opportunity to support PC integration:

“We now have all the colleges also passing through, that is, the physicians, surgeons and pharmacists. They do their rotation with us. Those doing family medicine also come here for their rotation. Those doing pharmacy also come for here for their rotation because of the medical aspect and the drug aspect. They need to know the opioids that we provide for pain management. That is helping with the integration.” (SP3_IDI_55–59 years).

“I think for the past five or six years, the medical students in the final year are introduced to palliative care during the family medicine sessions. We always expose them to pain management, and that is helping them to appreciate the role of palliative care in cancer management. So, in the near future, our primary service providers will be integrating care right at the point of diagnosis and through early referrals.” (SP4_IDI_50–54 years).

Notwithstanding the importance of incorporating PC in the medical school curriculum, some service providers were of the view that holistic integration of PC is likely to happen when PC is incorporated in the curriculum of all health and allied health curriculum. This suggestion is exemplified in the quote below:

“I think that including palliative care in pre-service curriculum for health providers would be necessary for promoting full integration. All the health care providers must have baseline knowledge on palliative care. If all health care providers have baseline knowledge, then some level of palliative care will be provided at all the levels before we see the more complicated cases. But generally, anybody at all should be able to provide some level of basic palliative care. If you don’t introduce it at the curriculum level, then it will be very difficult achieve the basic generalist approach to palliative care.” (SP4_IDI_50–54 years).

Knowledge Level of Service Providers

This study suggests that the knowledge level of service providers was a factor that facilitated PC integration at KBTH. The participants asserted that service providers had the requisite skills and knowledge needed to provide palliation to patients. This was evident in how some service providers engaged in personal research and organized training sessions to hone their knowledge and skills to deliver PC to patients. The voices of the participants about this issue are exemplified in the following quotes:

“I think that the service providers are very knowledgeable about cancer as well as the various ways of delivering palliative care, and that help us to integrate different aspects of the palliative care to patients. Our doctors here also do a lot of research which helps to provide new insight on how to improve cancer palliative care.” (SP1_IDI_30–34 years).

“Yes. I think that the service providers’ knowledge and understanding about palliative care is by far one of the greatest opportunities that exist here at Korle Bu which is facilitating palliative care integration. Based on the training that we have received; we are all knowledgeable and know when and exactly what to do to support palliative care to cancer patients. So, there is no delay in service provision at all on the part of palliative care team.” (SP2_IDI_30–34 years).

Enabling Attitudes of Service Providers

According to the study participants, the attitude of service providers is an opportunity that can be leveraged to facilitate PC integration. The participants opined that they showed respect and upheld the dignity of patients. Service providers further asserted that they were non-judgmental in their care provision to patients. They encouraged and reassured patients. This is what some of the participants had to say:

“Oh, for us we do not judge. Even when you have delayed in seeking care after referral, we do not judge the patient. You will not hear us saying that you have kept too long at home before coming. Neither do we judge you for delaying. We rather encourage them because they often feel disappointed and guilty for not reporting early.” (SP3_IDI_55–59 years).

“We provide palliative care to patient in a respectful and friendly manner. So, I think that is an important factor that is facilitating the integration of palliative care.” (SP1_IDI_30–34 years).

Reflecting on the enabling attitudes of service providers, one of the participants asserted that the commitment shown by service providers was unparalleled. This commitment exhibited by service providers was manifested in their
decision to participate in professional PC training programs that would enlighten them on how to better integrate care to patients. The cost of these training programs is borne by the service providers. The quote below reflects this perspective:

“Our commitment to the work is an enabling factor that facilitates integration of palliative care. Personally, I will say that the commitment I have for palliative care is what motivated me to pay $2,500 to receive special training in palliative care. I could have said that I will not go but being in the unit for four years, I realised that I had found my calling.” (SP2_IDI_30–34 years).

**Availability of PC Team and Teamwork**

In the view of the participants, the mere availability of a PCT or unit meant that the hospital was ready to integrate PC services, and that was an opportunity to encourage other health professionals to refer cases that demand palliation. The participants also asserted that teamwork was elemental in their quest to integrate PC. To service providers, teamwork is significant in building trust with patients. The following excerpts reflect participants’ perspectives about the availability of PCT being a factor that facilitated PC integration:

“The fact that the hospital acknowledges that there is a palliative care unit for them to refer patients with palliative care need is a facilitator for promoting its integration. Because, at least they acknowledge the presence of something like that and they refer to us.” (SP6_IDI_35–38 years)

“Teamwork is very important when it comes to integrating palliative care. If there is no teamwork, then it will be difficult for us to work together and refer early. So, we have built our team in such a way that it is ‘patient first’. Normally, oncology will schedule patients in three months or four months’ time. By then you may even be dead already or the cancer might have spread so much that you cannot come to the hospital. But with our teamwork, we are able to integrate care much better. So, teamwork is number one.” (SP3_IDI_55–59 years).

**Discussion**

The present study explored the opportunities that exist to facilitate PC integration from the perspective of PC service providers. The findings revealed four main opportunities to support PC integration: the availability of a PC team and teamwork, knowledge level of service providers, enabling attitudes of service providers, and the incorporation of PC in the medical school curriculum.

Consistent with the findings of Centeno et al. (2016), participants in this study allude to the assertion that the incorporation of PC into the medical school curriculum is an important endeavor for a young physician who helps to build their interest in PC, enhance their appreciation about the role of PC in the continuum of cancer care, and orient them about the best practices for integrating PC including early referrals. This result aligns with Schulz et al. (2013) whose study emphasized that incorporating PC into the curriculum of medical and health science curriculum broadens the students’ knowledge about pain and symptoms management, opioids, and medications, and prepares them for the actual PC service provision. Relatedly, the result is consistent with Fitch et al. (2015) postulation that introducing PC contents in health curriculum is necessary to build the capacity of health providers, particularly nurses to provide PC services. Thus, the findings imply that when appropriately leveraged, the inclusion of PC in the health school curriculum can create a pool of primary healthcare providers who can provide basic, generalist PC services to patients.

This study also revealed that service providers’ knowledge is an opportunity to advance PC integration. The result is consistent with previous studies. For instance, this perspective is consistent with the findings of Donkor et al. (2018) study that found service providers’ knowledge as an important facilitator in the provision and integration of PC for cancer patients. The result is further corroborated by a systematic review that found similar findings (Carey et al., 2019). Thus, with high level of knowledge about PC, members of the PC team and primary service providers would appreciate the need to integrate care at the point of diagnosis rather than referring at the end-of-life. From a nursing perspective, the findings imply that building the knowledge level of nurses has the potential to enhance the self-efficacy of nurses to move out of the curative paradigm and anticipate PC needs of patients (Engberink et al., 2020). This would eventually contribute to early referral and initiation of PC services.

This study also revealed that enabling attitudes of service providers is an opportunity to be leveraged in facilitating PC integration. It is indicative from the present study that respect, dignified care, and commitment to work were attitudes that support the integration of PC. This result is consistent with the findings of a related study conducted in Sweden that documents the role of dignified care in facilitating PC integration (Östlund et al., 2019). Similarly, the findings corroborate an earlier study from Thailand that emphasizes how essential respectful communication, empathetic listening, and dignity-conservation care are critical to the integration of PC (Doorenbos et al., 2013). The result could be explained from the perspective that the exhibition of supportive attitudes creates an enabling environment that would encourage patients and their families to go through the PC continuum. Moreover, the study showed that service providers’ commitments can motivate them to take up professional and specialist courses at their own expense to sharpen their competence to provide PC services. This is an important finding given...
that in Ghana like many resource-constrained countries, it is a challenge for the State to fund professional and specialist PC training.

From the perspectives of PC service providers, the availability of an interdisciplinary PC team and teamwork is an important opportunity that can be leveraged to facilitate the integration of PC. This result is consistent with previous studies that have found the availability of an interdisciplinary team to carry out PC services as a key facilitating factor to promote PC integration (Fernando & Hughes, 2019; Hui et al., 2015; Hui et al., 2018). A person who requires PC services has physical, psychosocial, and spiritual or metaphysical needs (Rego et al., 2018). Therefore, it is imperative to have a pool of service providers who can meet the distinct, yet interconnected dimensions of care that patients and their families. The existence of an interdisciplinary team to handle PC supports advocacy, sharing of knowledge and experiences, thereby enhancing individual and collective competencies (Johansen & Ervik, 2018). Another plausible explanation could be that, teamwork enables members of the PC team to effectively collaborate to meet the different needs of patients while functioning in cohesion and resolving conflicts (Johansen & Ervik, 2018; Nancarrow et al., 2015). From a nursing point of view, the findings imply that the availability of a PCT and teamwork could optimize information sharing, which is necessary for making critical decisions about the patient and their PC needs (Engberink et al., 2020; Pype et al., 2014).

**Strengths and Limitations**

The use of an exploratory descriptive design provides a rich in-depth exploration of the opportunities that exist to support the integration of PC services in a tertiary health facility in Ghana. Also, the use of member checking to authenticate the findings is a core strength of this study. Notwithstanding, there were some limitations. The perspectives of patients were not captured by the scope of this study. Similarly, the study was restricted to only PC service providers. Hence, the perspectives of primary healthcare providers who are central to PC integration were not captured in this study.

**Implications for Practice**

Mainly, the findings have an implication for PC education. The findings from this study underscore a need for policy-makers to support the incorporation of PC education into the curriculum of all health and allied health courses. Also, the findings highlight a need for healthcare facilities to invest in capacity-building sessions to leverage the availability of the interdisciplinary PC team. A conscious effort must be made to ensure cohesion and teamwork to facilitate PC integration.

**Conclusion**

The study concludes that to facilitate the integration of PC in a tertiary health facility, there is a need to leverage the supportive attitudes of service providers. Also, there is a need to expand the incorporation of PC education in the curriculum of all health and allied health courses. This could help create a pool of primary healthcare providers who can provide generalist PC services promptly. This study also underscores a need for continuous professional development.

**Abbreviations**

| Abbreviation        | Description                                      |
|---------------------|--------------------------------------------------|
| KBTH                | Korle Bu Teaching Hospital                       |
| KBTH-STC            | Korle Bu Teaching Hospital Scientific and Technical Committee |
| PC                  | Palliative Care                                  |
| PCT                 | Palliative care team                             |

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**Author Contributions**

JO conceived and designed the study. JO collected and analyzed the data. JO and KKK drafted, reviewed, and commented on the manuscript and approved the final draft. KKK supervised this work.

**Availability of Data and Materials**

All data generated and/or analyzed are available from the corresponding author upon reasonable request.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Ethical Statement**

We sought ethical approval from the KBTH Scientific and Technical Committee [KBTH-STC] (approval ID number: KBTH-STC 000108/2021). We ensured that all participants accepted to voluntarily participate in this study after having read the information and consented to it. Also, we adhered strictly to the Declaration of Helsinki and the Belmont Declaration.

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