Scholars Academic Journal of Biosciences
Abbreviated Key Title: Sch Acad J Biosci
ISSN 2347-9515 (Print) | ISSN 2321-6883 (Online)
Journal homepage: https://saspublishers.com

OPEN ACCESS

Medicine

Family Doctors Facing Break-Point Decision: A Cross-Sectional Study

Dalea Radhwan[1]*, Ahmed Alkhazraji[2]

[1]Consultant Family Medicine, Ostergotland County, Linkoping, Sweden
[2]Consultant Family Medicine, PHCC, Doha, Qatar

DOI: 10.36347/sajb.2024.v12i04.004 | **Received:** 03.04.2024 | **Accepted:** 06.05.2024 | **Published:** 13.05.2024

***Corresponding author:** Dalea Radhwan
Consultant Family Medicine, Ostergotland County, Linkoping, Sweden

Abstract

Original Research Article

Health professionals, especially working physicians, experience terrible psychological effects from their work since they see patients' conditions worsen till they pass away. Gaining a thorough grasp of the experiences of general practitioners working in Ostergotland County, Sweden, was one of the primary goals of the current study. To gather information from study participants, a cross-sectional study was carried out. This survey comprised 121 health professionals in total. Participants were given a 19-question questionnaire. The results of the study indicated that the majority of doctors have more than 20 years of experience, more than half of the sample said that making a break-point decision is difficult, and the majority of doctors (n=46, 79%) said they felt more confident in their ability to make decisions when multiple doctors were involved in the process. About 79% of the sample had graduations from within the European Union, with 65% of those degrees coming from Sweden. About 50% of the doctors who made decisions did so based on their own experiences, while the majority of doctors (67%) think that patient relatives' input is important when making decisions. Together, these factors make break-point decision-making for physicians a challenging and intricate undertaking, even with their vast medical knowledge. Involving patients and consulting with colleagues can boost trust in the decision-making process.

Keywords: Family doctors, health professionals, Sweden, decision, break-point decision, cross-section.

INTRODUCTION

The inevitability of death is a universal truth that transcends age, gender, and social strata (Saitta-Ringger, 2024). Regardless of one's standing in life, the prospect of falling ill or meeting with a fatal accident is a reality that confronts all individuals and their families (Testoni *et al.*, 2020). The experience of death can vary widely among different people, as each individual copes with the associated emotions in their own way (Betriana and Kongsuwan, 2020).

In the realm of healthcare, professionals are often confronted with the reality of mortality (Sathiananthan *et al.*, 2021). As per the National Board of Health and Welfare, in Sweden, the year 2017 saw a considerable number of deaths, amounting to approximately 92,000, of which nearly 90% were individuals aged 65 or above. It is a well-known fact that healthcare practitioners are frequently exposed to situations involving death (Andersson *et al.*, 2018; Statistics on causes of death, 2018).

The National Board of Health and Welfare in Sweden is responsible for maintaining records of vital statistics, including the number of deaths that occur in hospitals versus outside of hospitals. However, the accuracy of these records has been called into question, as a study conducted in 2012 revealed that the Board's statistics on where people die are not fully reliable. Despite the lack of accurate data, the study did provide some insight into end-of-life care in Sweden. It revealed that among people aged 65 years or older, 30,000 individuals died in the hospital, while 50,000 passed away outside of it. This includes deaths that occurred in nursing homes or private residences. The findings of the study highlight the importance of accurate record-keeping in the healthcare system, particularly when it comes to end-of-life care. Understanding where people die and under what circumstances can help healthcare providers improve the quality of care they provide and ensure that patients receive the support and resources they need during their final days and (Åhsberg and Fahlström, 2012).

In the field of healthcare, there are generally two types of care available to patients: curative care and palliative care (Parry, 2024). Curative care, as the name suggests, focuses on treating the underlying causes of a disease or medical condition to cure or manage it. This type of care is typically employed when a patient's condition is reversible or treatable through medical intervention (Babatunde *et al.,* 2021). On the other hand, palliative care is a type of care that focuses on relieving symptoms and improving the quality of life for patients with serious illnesses or chronic medical conditions. This type of care is often used to manage pain, alleviate discomfort, and provide emotional and spiritual support to patients and their families (Etik, 2018).

In Sweden, when a patient is transitioning from curative care to palliative care, the process is marked by a crucial conversation involving the doctor, the responsible nurse, the patient, and, if the patient so desires, their family members or close relatives (Löfmark *et al.,* 2007; Henoch *et al.,* 2016). This conversation is of utmost importance, as it forms the basis for the patient's future care and treatment plan (Henoch *et al.,* 2016). The doctor and nurse will provide the patient with all the necessary information about the palliative care process, including its goals, expected outcomes, and potential risks. They will also discuss the patient's preferences and values, as well as their physical, emotional, and spiritual needs, to create a personalized care plan that meets the patient's individual needs. The involvement of family members in this conversation can help provide emotional support to the patient and ensure that their wishes are respected throughout the palliative care process (Hagan *et al.,* 2018).

When communicating with patients, it is important to make sure that the conversation is tailored to the patient's unique situation and preferences. This way, the patient feels heard and understood, which can help to establish trust and build a positive relationship between the patient and their doctor (Kwame and Petrucka, 2021). Additionally, it is crucial to consider the patient's level of understanding and background when communicating with them. By doing so, the doctor can minimize the risk of misunderstandings and ensure that their message is conveyed accurately and effectively (Mohd Salim *et al.,* 2023). The National Board of Health and Welfare has recently published a report titled "Palliative care - Clarification and concretization of concepts", where they shed light on the topic of palliative care. In this report, the Board delves into what can be discussed during a break-point conversation. The report provides detailed examples that can help healthcare providers better understand how to approach the sensitive topic of end-of-life care with their patients and their families (Palliative care, 2018):

- Find out if the patient wishes relatives to be present
- Check off how much information the patient wishes to receive about the disease
- Ask how the patient perceives the disease situation
- Adapt the conversation to the patient's ability to take in information
- Inform about the medical assessment and that the patient no longer benefits from life-prolonging treatments
- Ask what is important to the patient and where he/she wants to be cared for.

During this conversation, it is essential to collaboratively develop a comprehensive plan for continued care and treatment. This plan must also include a well-thought-out decision regarding emergency measures that can be taken in the event of infection or cardiac arrest. By discussing and deciding on these matters, we can ensure that the patient's health and well-being are given the utmost priority and that they receive the best possible care (Palliative care, 2018).

One of the most important aspects of healthcare is the documentation of all patient information in their records. However, this must be done while maintaining the patient's autonomy and privacy. The Patient Act 2014:821 ch. 4 provides guidelines for communication between healthcare staff and patients, emphasizing the importance of respecting the patient's self-determination and integrity. This means that healthcare providers must always take into account the patient's preferences and values when making decisions about their care. Chapter 3 of the same law further emphasizes the patient's rights, specifically their right to receive information about their current health status and any interventions planned by healthcare providers. This information must be presented in a way that is tailored to the patient's needs and level of understanding, ensuring that they are fully informed and involved in their own care (The Riksdag administration, 2014).

In the field of medicine, doctors are often faced with ethical dilemmas that arise from balancing the principle of doing good and respecting patient autonomy. These dilemmas may occur when a patient refuses a treatment that the doctor deems necessary for their well-being, or when the doctor's treatment choice prolongs the patient's suffering instead of improving their condition (Gedge *et al.,* 2007). In such situations, the doctor must carefully evaluate the options available and make a decision that is in the best interest of the patient while respecting their autonomy (Harkin, 2020). This requires a delicate balance between the doctor's duty to provide care and the patient's right to make decisions about their own body and health (Palliative care, 2018).

In the context of palliative care, one of the most complex issues centers around an individual's right to autonomy (Gómez-Vírseda *et al.,* 2020). While it is widely accepted that every person has the ethical and legal right to self-determination, this right is not always straightforward to implement (Milossi *et al.,* 2021). Instead, it varies depending on a range of factors, such as the individuals' cognitive, physical, and social abilities. These factors collectively shape the extent to which they can exercise their right to self-determination and make decisions that align with their values and preferences (Teixeira *et al.*, 2012). As such, healthcare providers must carefully balance their duty to respect patients' autonomy with their obligation to promote their overall well-being and safety (Palliative care, 2018).

In a situation where the patient's own ability to handle information has deteriorated to a certain degree, that person cannot therefore be seen as capable of self-determination.

Chapter 3 of the Patient Act 2014:821 outlines a crucial provision regarding the sharing of medical information of patients suffering from advanced illnesses. In such cases, the Act mandates that the patient's information be disclosed to a designated family member, rather than the patient themselves (Bergh *et al.*, 2015). This provision serves as a protective measure for patients who may be unable to make informed decisions concerning their health due to their medical condition (media.palliativ.se, 2015).

In situations where a patient is not deemed fully autonomous and expresses the desire not to share their medical condition with their family members, it is vital to remember that the patient's relatives are still entitled to receive information about their loved one's condition (Scharf *et al.*, 2021). This is not only an ethical obligation but also a legal one. As such, it is of utmost importance for healthcare personnel to acquire the necessary skills to communicate with the patient's relatives in a sensitive and respectful manner. This includes knowing how to handle the situation during care and break-point conversations, while ensuring that it does not have a detrimental effect on the patient's well-being (Pivodic *et al.*, 2016).

MATERIAL AND METHODS

This research aimed to gain a comprehensive understanding of the experiences of general practitioners operating in Ostergotland County, Sweden. To achieve this, an email notification was sent to all 121 practitioners on the same day, containing a 19-question document. The document consisted of 16 guided questions and 3 open-ended questions, designed to delve into the practitioners' experiences and insights. To maintain confidentiality, practitioners were given a one-week deadline to respond to the questions, and they were not required to reveal their names or workplaces.

The researcher carefully collected and organized the data, saved it in a database, and used Microsoft® Excel® to generate graphical representations and calculate percentages. The data was presented as collective statistics without any personal information, making it unnecessary to seek approval from the local ethical committee.

The primary objective of this study is to provide valuable insights into the experiences of general practitioners in Ostergotland County. The findings of this study can prove to be beneficial in guiding future policies and practices in the region, which can ultimately enhance the quality of healthcare services provided to the public.

RESULTS

Results were obtained from 58 physicians who answered the questionnaire and are illustrated in table (1):

Table 1: Difficulty vs confidence in making break-point decision

	Feeling confident about decision n (Percentage)	**Break-point is a difficult decision n (Percentage)**
Always	6 (10%)	4 (7%)
Often	48 (83%)	26 (45%)
Rarely	2 (3%)	22 (38%)
No	2 (3%)	6 (10%)

Most physicians have experience of more than 20 years (n=26, 45%), while those with 16-20 years represent 21%. Approximately 10% (n=6) have experience of less than 10 years (figure 1).

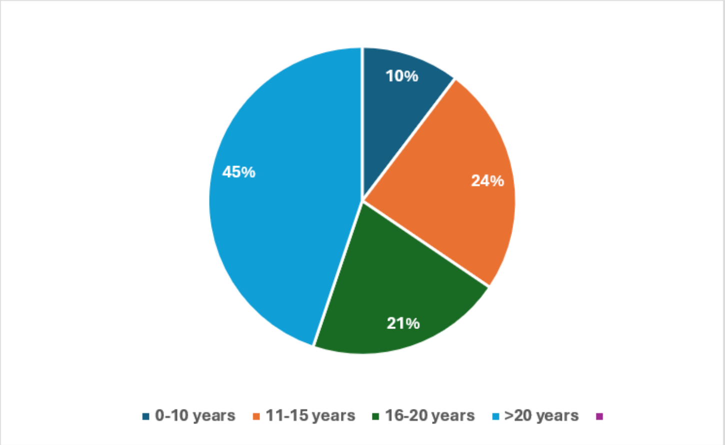

Figure 1: Years of experience

More than half of our sample answered that the break-point decision is a difficult decision to make (table 1). Within this cohort, where a group of physicians is being studied, only a small number, specifically two doctors, who equates to 3% of the total group, have expressed a lack of complete confidence about their break-point decision. On the other hand, most participants regularly feel confident with their decision as indicated in table (1). It's interesting to note that approximately three-quarters of physicians have no feelings of regression about their decision after it's been made. However, the remaining quarter may have thoughts about the suitability of their decisions afterward.

The study found that most physicians (n=46, 79%) expressed a higher level of confidence in their decision-making abilities when multiple doctors were involved in the process (Figure 2).

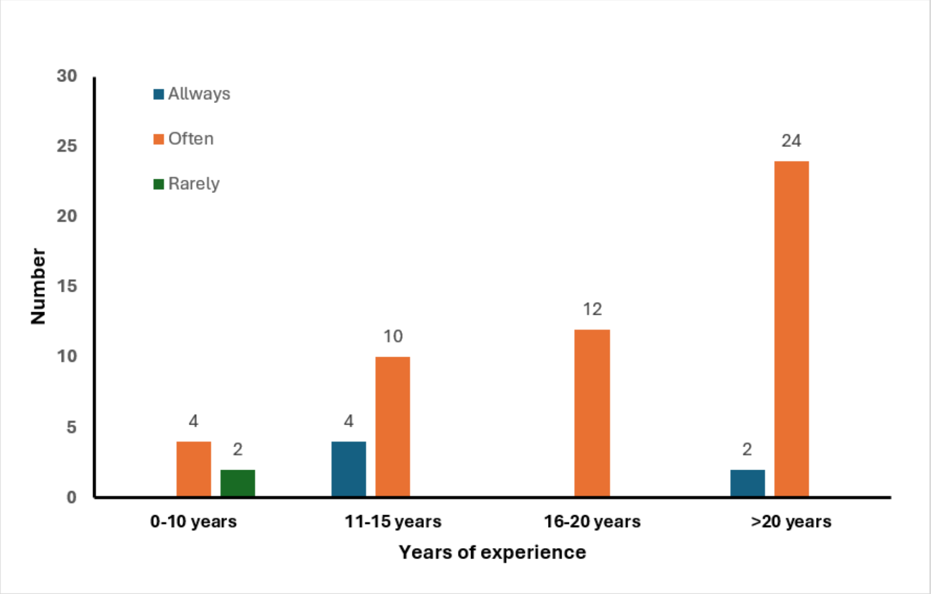

Figure 2: Years of experience in correlation to confidence level

Graduation within the European Union represents about 79% of the sample, of which 65% were graduated in Sweden (Figure 3).

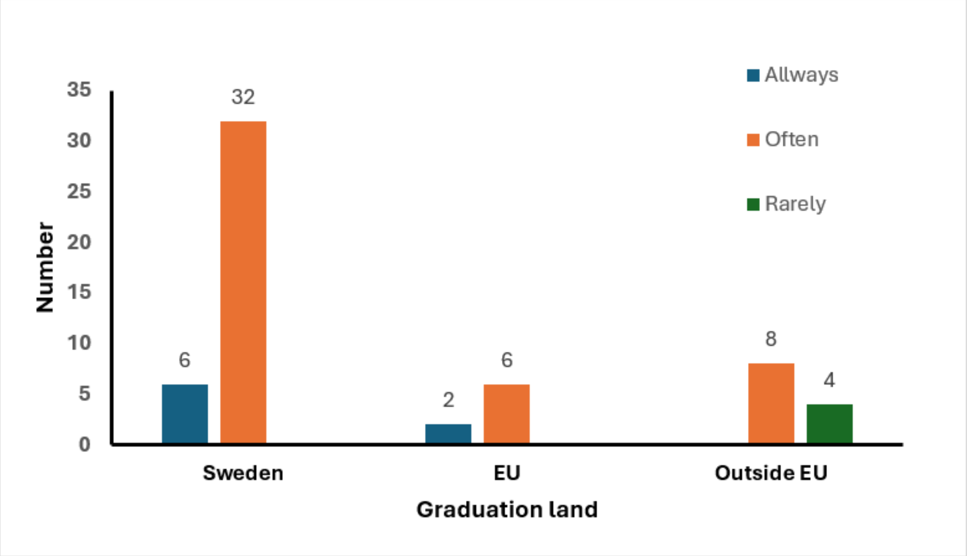

Figure 3: Graduation land in correlation to confidence level.

According to the data, most physicians (n=34, 59%) hold specialized competence for over 10 years. Additionally, about 76% (n=44) have another specialization besides family medicine. An equal percentage of physicians (76%) have regular on-call duty, which puts them in charge of making break-point decisions.

According to the available data, approximately half of the physicians who made decisions relied on their personal experience, while the remaining half sought guidance from the relevant local or national medical guidelines.

According to the findings of this study, a significant proportion of physicians expressed their willingness to reconsider their decision after a certain period of time. The majority of physicians (55%) stated that they would be open to reconsidering their decision after six months, while 31% would be willing to do so after a year. Interestingly, only 14% of physicians reported that they would not reconsider their decision at all.

According to the survey, the majority of doctors (67%) believe that the involvement of patients' relatives is significant in the decision-making process. They consider the opinions and preferences of the patients' families while providing medical care. However, about one-third of the doctors do not consider the views of the relatives and make their decisions independently.

DISCUSSION

The decision to establish the break-point is one of the most contentious and complex decisions in medical practice (van Wee *et al.*, 2023). Our study has revealed that there is no direct relationship between the number of years of experience a physician possesses and their level of confidence when confronted with this dilemma. Paradoxically, physicians with 11-15 years of experience demonstrate the highest level of confidence in making decisions regarding the break-point when compared to their counterparts with more than 20 years of experience (figure 2).

Initiating palliative care is an extremely difficult communicative task (Goni-Fuste *et al.*, 2023). There are many possible scenarios for why the patient is assessed as palliative, as are possible dynamics between the patient and relatives (Scotté *et al.*, 2023). It is important to realize that there is no single strategy for how to discuss these things. The literature indicates the importance of emotional support in a palliative situation (Weston *et al.*, 2023; Yoong *et al.*, 2023).

The data presented herein highlights that physicians who have graduated from institutions within the European Union, including Sweden, appear to be more adept at making ethical decisions (Banta, 2023). This capability may be attributed to the exposure that they received to such ethical quandaries during their undergraduate studies. Specifically, in Sweden, early-course medical students frequently accompany family medicine specialists within primary healthcare settings, where they undertake various responsibilities, such as senior-house visits and on-call duties (Watari *et al.*, 2018). As opposed to this, medical practitioners who graduated from institutions outside of the European Union appear to have less experience in making such ethical decisions (Matei and Cocosatu, 2023). This could be attributed to the fact that their curricula lack an emphasis on practical training and decision-making abilities in this regard (figure 3).

Effective decision-making is essential for physicians in providing optimal care for their patients (Chu *et al.*, 2024). While personal experience and expertise are undoubtedly important in such decision-making, it is equally crucial to have clear and reliable guidelines to follow (Chu *et al.*, 2024). These guidelines not only provide a framework for decision-making but also help doctors to make more confident decisions. Additionally, it was found that most doctors feel more confident when they can consult with a colleague, and the responsibility is shared by more than one doctor. Collaborative decision-making can provide valuable insights, perspectives, and support in complex cases, ultimately leading to better patient outcomes (Reddy, 2024).

The provision of patient care is a complex and multifaceted process that involves various factors that are continuously evolving. As such, healthcare providers must frequently review and re-evaluate their decisions to ensure that they are providing the best possible care to their patients (Bhati *et al.*, 2023). This requires healthcare professionals to stay up-to-date with the latest developments in their respective fields and to remain adaptable to changes in their patients' conditions. The findings suggest that physicians acknowledge the importance of regularly reviewing their decisions and are committed to providing the highest quality of care to their patients.

Prior research indicates that the relatives of palliative patients experience a cognitive and emotional dilemma when it comes to treatment options and prognosis (Latham *et al.*, 2024). The tension arises from the conflict between rationality and emotions, which can influence decision-making. This issue has been documented in various studies and highlights the need for healthcare providers to provide support to family members during the decision-making process (Jones *et al.*, 2024). This may be a possible part of the explanation, together with the authority of the position, why certain medical decisions are not questioned by the family in the palliative stage. The doctor in this case acts as an emotional safety net for the loved ones, so they can focus on the emotional aspect of dying instead of the practical aspects of the illness (Parry *et al.*, 2024).

In certain scenarios, the engagement of family members is vital, particularly when the patient is suffering from a terminal illness or lacks the mental capacity to communicate with medical professionals (Iyer *et al.*, 2024). In these circumstances, physicians find it advantageous to have the input of relatives when making decisions. However, our research revealed that about one-third of physicians did not take into account the opinions of family members (Akkermans *et al.*, 2021). This could be due to their previous experiences where the patient's condition was evident and met the criteria for a decisive moment, and the family members were unavailable. Bhattacharyya and Benbow (2024) found evidence that a person-centred communication is not necessarily the best on all occasions, provided that the doctor has a previous good relationship with the patient.

CONCLUSION

Making break-point decisions is a complex and difficult task for doctors, despite their extensive medical expertise. Patient involvement and consultation with colleagues can help increase confidence in decision-making. Additionally, these decisions should be regularly reviewed based on the patient's medical condition. Doctors who have received education and training in ethical dilemmas are better equipped to handle such situations. For doctors lacking experience or in societies where these decisions are not common, proper training and guidance in local and national guidelines is crucial.

Regardless of whether there is a personal or relational basis for the patient's autonomy, the data suggest that a high flow of information to relatives leads to easier handling of the situation, regardless of whether relatives have a decision-making capacity or not.

REFERENCES

- Åhsberg, E., & Fahlström, G. (2012). Changes in place of death among elderly in Sweden—a register study. *Vård i Norden*, *32*(2), 21-24.
- Akkermans, A., Lamerichs, J. M. W. J., Schultz, M. J., Cherpanath, T. G. V., van Woensel, J. B. M., van Heerde, M., ... & de Vos, M. A. (2021). How doctors actually (do not) involve families in decisions to continue or discontinue life-sustaining treatment in neonatal, pediatric, and adult intensive care: a qualitative study. *Palliative medicine*, *35*(10), 1865-1877.
- Andersson, S., Lindqvist, O., Fürst, C. J., & Brännström, M. (2018). Family members' experiences of care of the dying in residential care homes where the Liverpool care pathway was used. *International journal of palliative nursing*, *24*(4), 194-202.
- Babatunde, A. O., Shobanke, H. A., Akinade, A. A., Michael, A. J., Osadare, M., Akanbi, O. K., ... & Adebisi, Y. A. (2021). Enhancing preventive medicine over curative medicine: Role of telemedicine. *Public Health in Practice*, *2*, 100130.
- Banta, D. (2003). The development of health technology assessment. *Health policy*, *63*(2), 121-132.
- Bergh, A. L., Friberg, F., Persson, E., & Dahlborg-Lyckhage, E. (2015). Registered Nurses' Patient Education in Everyday Primary Care Practice: Managers' Discourses. *Global qualitative nursing research*, *2*, 2333393615599168. https://doi.org/10.1177/2333393615599168.
- Betriana, F., & Kongsuwan, W. (2020). Grief reactions and coping strategies of Muslim nurses dealing with death. *Nursing in critical care*, *25*(5), 277-283.
- Bhati, D., Deogade, M. S., & Kanyal, D. (2023). Improving Patient Outcomes Through Effective Hospital Administration: A Comprehensive Review. *Cureus*, *15*(10), e47731. https://doi.org/10.7759/cureus.47731.
- Bhattacharyya, S., & Benbow, S. (2024). Context: The Importance of Communication. *Handbook of Old Age Liaison Psychiatry*, 44.
- Breakpoint20111.pdf [Internet]. [cited 2019 May 5]; Available from: http://media.palliativ.se/2015/08/Brytpunkt20111.pdf.
- Chu, X., Wu, S., Sun, B., & Huang, Q. (2024). Data-driven quantification and intelligent decision-making in traditional Chinese medicine: a review. *International Journal of Machine Learning and Cybernetics*, 1-16.
- Etik: en introduction (in Swedish), 2018.
- Gedge, E., Giacomini, M., & Cook, D. (2007). Withholding and withdrawing life support in critical care settings: ethical issues concerning consent. *Journal of medical ethics*, *33*(4), 215–218. https://doi.org/10.1136/jme.2006.017038.
- Gómez-Vírseda, C., De Maeseneer, Y., & Gastmans, C. (2020). Relational autonomy in end-of-life care ethics: a contextualized approach to real-life complexities. *BMC Medical Ethics*, *21*, 1-14.
- Goni-Fuste, B., Pergolizzi, D., Monforte-Royo, C., Julià-Torras, J., Rodríguez-Prat, A., & Crespo, I. (2023). What makes the palliative care initial encounter meaningful? A descriptive study with patients with cancer, family carers and palliative care professionals. *Palliative Medicine*, *37*(8), 1252-1265.
- Hagan, T. L., Xu, J., Lopez, R. P., & Bressler, T. (2018). Nursing's role in leading palliative care: A call to action. *Nurse education today*, *61*, 216–219. https://doi.org/10.1016/j.nedt.2017.11.037.
- Harkin, D. W. (2020). Ethics for surgeons during the COVID-19 pandemic, review article. *Annals of medicine and surgery*, *55*, 316-319.
- Henoch, I., Carlander, I., Holm, M., James, I., Kenne Sarenmalm, E., Lundh Hagelin, C., ... & Öhlén, J. (2016). Palliative care research–a systematic review of foci, designs and methods of research conducted in Sweden between 2007 and 2012. *Scandinavian journal of caring sciences*, *30*(1), 5-25.

- Iyer, S., Sonawane, R. N., Shah, J., & Salins, N. (2024). Semiotics of ICU Physicians' Views on End-of-life Care and Quality of Dying in a Critical Care Setting: A Qualitative Study. *Indian Journal of Critical Care Medicine*, *28*(5), 424-435.
- Jones, L., Rhyner, F., Rutz Voumard, R., Figari Aguilar, F., Rubli Truchard, E., & Jox, R. J. (2024). "What Is the Most Important to Them?" Swiss Health Care Proxies, Nurses, and Physicians Discuss Planning Practices for Aged Care Residents Who No Longer Have Medical Decision-Making Capacity. *Gerontology, 70*(2), 173-183.
- Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. *BMC nursing*, *20*(1), 158. https://doi.org/10.1186/s12912-021-00684-2.
- Latham, J. S., Butchard, S., & Mason, S. R. (2024). Physician emotional experience of communication and decision making with end-of-life patients: Qualitative studies systematic review. *BMJ Supportive & Palliative Care*, *14*(e1), e99-e119.
- Löfmark, R., Nilstun, T., & Bolmsjö, I. A. (2007). From cure to palliation: concept, decision and acceptance. *Journal of medical ethics*, *33*(12), 685–688. https://doi.org/10.1136/jme.2006.018895.
- Matei, A., & Cocosatu, M. (2023). Administrative System of the European Union. In *Global Encyclopedia of Public Administration, Public Policy, and Governance* (pp. 401-411). Cham: Springer International Publishing.
- Milossi, M., Alexandropoulou-Egyptiadou, E., & Psannis, K. E. (2021). AI ethics: algorithmic determinism or self-determination? The GPDR approach. *IEEE Access*, *9*, 58455-58466.
- Mohd Salim, N. A., Roslan, N. S., Hod, R., Zakaria, S. F., & Adam, S. K. (2023). Exploring Critical Components of Physician-Patient Communication: A Qualitative Study of Lay and Professional Perspectives. *Healthcare (Basel, Switzerland)*, *11*(2), 162. https://doi.org/10.3390/healthcare11020162.
- Palliative care – clarification and concretization of concepts. : www.socialstyrelsen.se, August 2018.
- Parry, R. (2024). Communication in Palliative Care and About End of Life: A State-of-the-Art Literature Review of Conversation-Analytic Research in Healthcare. *Research on Language and Social Interaction, 57*(1), 127-148.
- Parry, R. (2024). Communication in Palliative Care and About End of Life: A State-of-the-Art Literature Review of Conversation-Analytic Research in Healthcare. *Research on Language and Social Interaction*, *57*(1), 127-148.
- Pivodic, L., Harding, R., Calanzani, N., McCrone, P., Hall, S., Deliens, L., Higginson, I. J., Gomes, B., & EURO IMPACT (2016). Home care by general practitioners for cancer patients in the last 3 months of life: An epidemiological study of quality and associated factors. *Palliative medicine*, *30*(1), 64–74. https://doi.org/10.1177/0269216315589213.
- Reddy, S. (2024). Generative AI in healthcare: an implementation science informed translational path on application, integration and governance. *Implementation Science, 19*(1), 27.
- Saitta-Ringger, D. (2024). Periodization as Metaphor: Transcending Time in Toni Morrison's Sula and" Recitatif". South Central Review, 41(1), 9-27.
- Sathiananthan, M. K., Crawford, G. B., & Eliott, J. (2021). Healthcare professionals' perspectives of patient and family preferences of patient place of death: a qualitative study. *BMC palliative care*, *20*, 1-11.
- Scharf, A., Voigt, L., Vardhana, S., Matsoukas, K., Wall, L. M., Arevalo, M., & Diamond, L. C. (2021). What Should Clinicians Do When a Patient's Autonomy Undermines Her Being Treated Equitably?. *AMA journal of ethics*, *23*(2), E97–E108. https://doi.org/10.1001/amajethics.2021.97.
- Scotté, F., Taylor, A., & Davies, A. (2023). Supportive care: The "Keystone" of modern oncology practice. *Cancers, 15*(15), 3860.
- Statistics on causes of death [Internet]; Available from: https://www.socialstyrelsen.se/statistik/statistikefteramne/dodsorsaker].
- Teixeira, P. J., Carraça, E. V., Markland, D., Silva, M. N., & Ryan, R. M. (2012). Exercise, physical activity, and self-determination theory: a systematic review. *The international journal of behavioral nutrition and physical activity*, *9*, 78. https://doi.org/10.1186/1479-5868-9-78.
- Testoni, I., Franco, C., Palazzo, L., Iacona, E., Zamperini, A., & Wieser, M. A. (2020). The endless grief in waiting: A qualitative study of the relationship between ambiguous loss and anticipatory mourning amongst the relatives of missing persons in Italy. *Behavioral sciences*, *10*(7), 110.
- The Riksdag administration. Patient Act (2014:821) Swedish Constitution 2014:2014:821 tom SFS 2018:554 - Riksdag [Internet]; Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningsamling/patientlag-2014821_sfs-2014-821.
- van Wee, B., Annema, J. A., & van Barneveld, S. (2023). Controversial policies: growing support after implementation. A discussion paper. *Transport policy*, *139*, 79-86.
- Watari, T., Hirose, M., Midlöv, P., Tokuda, Y., Kanda, H., Okayama, M., Yoshikawa, H., Onigata, K., & Igawa, M. (2018). Primary care doctor fostering and clinical research training in Sweden: Implications for Japan. *Journal of general and family medicine*, *20*(1), 4–8. https://doi.org/10.1002/jgf2.211.

- Weston, E. J., Jefferies, D., Stulz, V., Glew, P., & McDermid, F. (2023). A global exploration of palliative community care literature: an integrative review. *Journal of Clinical Nursing*, *32*(17-18), 5855-5864.
- Yoong, S. Q., Wang, W., Seah, A. C. W., Kumar, N., Gan, J. O. N., Schmidt, L. T., ... & Zhang, H. (2023). Nursing students' experiences with patient death and palliative and end-of-life care: a systematic review and meta-synthesis. *Nurse Education in Practice*, 103625.