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# Perceiving the Role of Palliative Care: Insights from Respiratory Physicians in Advanced Respiratory Diseases

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## Abstract

Patients suffering from chronic life-limiting or advanced respiratory disorders frequently have a significant symptom load, necessitating palliative care to relieve symptoms, enhance quality of life, and restore dignity. The objective of this study was to examine the perceptions and current practices of respiratory physicians regarding the integration of palliative care for adult patients with chronic advanced respiratory illnesses. The study received responses from 172 respiratory doctors. The majority of respiratory doctors (n=153; 88.9%) believed that early palliative care integration was advantageous. They did not believe that sending patients to palliative care would result in a loss of control over their treatment (n=107; 62.21%), and 66 (38.37%) strongly disagreed that the referral would result in patients losing hope. In our study, respiratory doctors were more likely to include palliative care into their usual clinical practise. The majority of them stated a desire to improve their palliative care abilities. As a result, collaborative integration efforts and reciprocal information sharing between respiratory physicians and palliative care specialists will ensure that patients with advanced respiratory disorders receive high-quality palliative care.

**Keywords:** Respiratory disorders; Palliative care; Symptom management; Perceptions; Quality of life; Respiratory physicians; Clinical practice; Chronic obstructive pulmonary disease; Holistic treatment

## Introduction

Chronic life-limiting or advanced respiratory disorders are progressive and debilitating in nature, ranking third among the causes of death worldwide [1]. Chronic or advanced respiratory disorders account for 32% of global disability-adjusted life years (DALY) in India [2]. Between 1990 and 2016, the prevalence of chronic life-limiting or advanced respiratory disorders increased dramatically, with chronic obstructive pulmonary disease (COPD) accounting for 29% of cases and asthma accounting for 9%. COPD and asthma were responsible for a significant number of mortality, accounting for 10.9% and 8.7%, respectively. They were also the leading causes of disability-adjusted life years. Non-malignant chronic respiratory disorders are more indolent in character than their malignant counterparts, with acute exacerbations of symptoms necessitating frequent hospitalisations [3]. Patients have a single increasing symptom or a cluster of symptoms that impede their daily activities [4,5], which is exacerbated by comorbidities [6]. The most prevalent and disturbing symptoms were pain (54.4%), dyspnea (84.2%), exhaustion (81.4%), dry mouth (80.3%), sleeplessness (64%), sadness (54.8%), and anxiety (52.5%) [7]. Physical and emotional anguish affects both patients and carers, with carers in particular in need of assistance [8]. This necessitates a comprehensive examination of physical and mental symptoms, as well as the inclusion of palliative care in normal clinical treatment [5,7]. Palliative care focuses on symptom management through an interdisciplinary team and gives patients and families with holistic treatment as a unit. Palliative care has been shown in studies to reduce the burden of healthcare spending while also improving the health of individuals with life-limiting conditions [9,10]. Although it is well established that individuals receiving palliative care for chronic respiratory disorders benefit from professional palliative care inputs, many do not receive it unless referred for terminal care. Physician attitudes and expertise about palliative care impact referral to palliative care [11]. According to the evidence, doctors connected palliative care with the end of life and overestimated the number of their patients who needed it [12,13]. Only a few doctors considered palliative care to be anything other than terminal or end-of-life treatment. Other reasons for referral reluctance included a concern of upsetting their patients, stealing hope, being hesitant to abandon their patients, viewing referral as an admission of failure, and not understanding the advantages of referral.[9] Respiratory physicians act as referral gatekeepers for palliative care. Their understanding of the enablers and obstacles to palliative care referral will impact service usage. The present study aimed to explore how respiratory physicians perceive and incorporate palliative care into their current practice for adult patients diagnosed with chronic advanced respiratory illnesses. It also aimed to learn about the needs, enablers, and hurdles to integration as viewed by respiratory physicians.

## Methodology

An exploratory survey strategy was utilised in the investigation. Participants comprised respiratory doctors who cared for adult patients in hospitals and communities. The questionnaire was created following a thorough review of the literature and consensus among respiratory experts. Multiple-choice questions were included in the questionnaire. After all of the authors mutually agreed on its readability, idea clarity, and user-friendliness, the survey was completed. The survey was made available online and included a permission form. The internet portals utilised to conduct this survey were Google Forms and Survey Monkey. On the first page of the survey form, information about the study and an informed consent form were supplied. The information was gathered

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between December 2020 and May 2021.

**Criteria for inclusion:** Participants that were eligible were respiratory doctors who cared for adult patients in hospital or community settings.

**Methods of study design, sampling, and data collecting:** The questionnaire, which was created using Google Forms, was distributed to all respiratory physicians who were enrolled with the ICS database. Because the permission form was included in the online questionnaire, individuals who consented to participate had to click the necessary submit button (thereby consenting to participate) to continue with the study. The survey questionnaire took 10 minutes to complete.

**Data examination:** Google Forms and Survey Monkey were used to collect and compile the data. Epi Info was used for the analysis. The qualitative variables were reported as percentages and frequencies. Normal quantitative data were represented by the mean and standard deviation, whereas non-normal data were represented by the median and interquartile range.

**Consideration of ethics:** Participation in the study was entirely optional, and only those who clicked the submit button after reading the permission form were eligible to continue. To proceed to the submit button, all fields need a response. Participants may opt out at any moment throughout the survey, and the results generated were null and invalid when they did. The investigator secured participant anonymity by keeping all associated identifiers such as names, places of work, and residential addresses private.

## Results

The survey was distributed to all registered respiratory physicians in the ICS database (n = 2400), and 172 physicians replied. The physicians' demographic information indicated an average age of 44.7 years (SD = 10.4). In all, 119 (69.19%) of those polled were men. One hundred and eighteen (68.6%) of respondents held a postgraduate degree (MD) in respiratory or internal medicine, while 23.88% (n = 41) had a diploma in respiratory medicine. The median number of years of experience as a respiratory physician was 14 (IQR 7.50-23 years). The vast majority of physicians (n = 91; 53.21%) worked in private hospitals or practises. The median number of advanced respiratory illness patients seen by respiratory doctors in the previous month was 27.50 (IQR: 11.50-60). Only 13 (7.56%) clinicians offered their own palliative care. Only 58 (33.72%) of physicians at their institution had access to a specialised palliative care physician. However, within a 50-kilometer radius, 108 (62.79%) had access to a specialist palliative care physician. One hundred thirty-five (78.48%) of the physicians were part of a multidisciplinary team.

The study looked into their perceptions of when integrating palliative care might be suitable. While 153 (88.95%) respiratory physicians thought early integration of palliative care was advantageous, 42 (24.42%) thought it was only necessary for terminal care. The study went on to investigate respiratory physicians' perceptions on the facilitators and barriers of incorporating palliative care into the clinical management of patients with advanced respiratory disorders. Sixty-six (38.37%) clinicians strongly disagreed that the recommendation would cause patients to feel abandoned or lose hope. A total of 114 (66.28%) had a positive relationship with the palliative care team, and 129 (75%) felt the need to improve their knowledge of fundamental palliative care. The researchers were curious in the training needs in palliative care as reported by respiratory doctors. Only 72 (41.86%) of physicians had some training in basic palliative care, and only 28 (16.26%) and 23 (23.35%), respectively, of physicians felt confident in delivering non-malignant and malignant palliative care. Furthermore, the study looked at the areas of palliative care where physicians acknowledged a desire for additional training.

## Discussion

Despite advances in respiratory illness care, many diseases still have a bleak outlook. This is true not just for cancer, but also for non-cancerous chronic respiratory illnesses such as severe COPD, interstitial lung disease, pulmonary hypertension, and neuromuscular disorders that lead to respiratory failure [14]. The impetus for palliative care integration is disease-driven rather than need-driven [15]. Recurrent hospitalisations for acute aggravation of symptoms, poor respiratory function, rising symptom load, worsening in functional status, increased requirement for advanced respiratory therapy, and advancing recalcitrant illness are some of these triggers. Recent randomised controlled studies on early palliative care for patients with chronic life-limiting or advanced respiratory disorders have shown significant decreases in the intensity of dyspnea, improvement in DALY, and relief of depressive symptoms. Patients also reported increased confidence, improved function, and better management of their shortness of breath [16]. Early palliative care implementation has been shown to minimise hospital admissions, emergency room visits, and intensive care unit use [17]. It also helps to realise patients' desires for how they want to spend their final hours of life, as well as the administration of opioids for symptom alleviation [18]. Palliative care integration enhanced their coping strategies by reducing physical and emotional symptoms, increasing prognostic awareness, improving knowledge of the treatment plan, and increasing acceptance of advance care planning [19]. Respiratory physicians play a critical role in providing palliative care for advanced respiratory diseases, so understanding their attitudes towards palliative care integration, challenges in palliative care delivery, and the need for palliative care training, primary palliative care, and referral to specialists is critical [20]. In our study, respiratory physicians cared for a large number of patients with advanced respiratory disorders, and nearly half of them addressed palliative care with their patients and carers. Only one-third were able to provide palliative care. This disparity in the number of patients seen and referrals to palliative care may be driven by variables such as the difficulty to reliably anticipate prognosis, time restrictions, and inadequate resources. The study also found a lack of clarity in the time of starting palliative care. However, our research found conflicting findings. In our study, respiratory doctors clearly distinguished between curative and palliative care and appeared to believe that palliative care should be included early. Another source of disagreement might be patients or families who are unwilling to discuss palliative care with their doctor. Furthermore, because the sickness has a protracted course, they regard it as non-fatal, which allows them to adapt to it. While most respiratory doctors agreed on the importance of early integration, they also agreed on the importance of considering the patient/family's perspective when making such a recommendation. Most respiratory physicians realised the need of early palliative care integration for advanced respiratory disorders, and only a minority felt that palliative care could be offered towards the end of life, indicating an attitudinal shift. The findings are consistent with those, who found that early palliative care might allow communication about patient/family choices in a sympathetic and supportive way, as well as help in decision-making for end-of-life planning. Early integration enables the maintenance of hope and serves to help patients and their families in approaching the life-limiting illness honestly.

This was a positive answer from almost all of the participants who felt comfortable sending their patients to palliative care. They viewed this recommendation positively and had no concerns about losing authority over their patients or taking hope from their patients. These findings contradicted the findings of a research that looked at Australian oncologists' referral patterns to palliative care. In that study, oncologists did not believe it was essential to send their patients to palliative care since they were confident in treating their patients' symptoms and judged their treatment to be non-inferior to a specialised palliative care programme. In the study, oncologists were hesitant to recommend their patients due to a bad relationship with the provider and a perception of low service quality. A physician will see the value of cooperating with the palliative care team if they anticipate or have had a good exchange and if the benefits of this exchange outweigh the expense of the activity. The importance of this connection will improve future collaborative behaviours [21]. The harmonious connection between our physician participants and the specialised palliative care team, as well as their trust in their care provision, appeared to be the grounds for their perspective, and this boded well for the future of respiratory palliative care in the country. Some physicians in our study felt constricted in their referrals due to a scarcity of palliative care experts in their institution or nearby practise. With most services centred in large cancer institutions across the country and the focus of training being palliative oncology, the field's infancy might pose considerable challenges to accepting referrals for non-malignant palliative care.

Despite the fact that most respiratory physicians emphasised the relevance of opioids in pain management, dyspnea, and cough, they all stated a need to improve their palliative care skills. Pain and symptom management were placed first, followed by difficulties with end-of-life care and communication skills. These findings were consistent with previous research on general practitioners' learning needs in basic palliative care. Because of the longer time of meetings with their physicians, patients develop a sense of comfort and closeness with respiratory physicians. This underlines the significance of basic palliative care education for respiratory doctors in order to improve their abilities in delivering primary palliative care and also to know when to commence palliative care and refer to specialists based on established referral criteria [22]. Although this study contributes to our understanding of clinical practise, it has numerous limitations that should be noted. The main limitation was sampling bias, as we chose respiratory doctors from the ICS database. We might have overlooked respiratory doctors who were not registered with them. The study's response rate was unclear because there was no definitive denominator, but the researchers made every attempt to reach out to respiratory specialists using Google Forms, Survey Monkey, and seminars. We sent the emails to respiratory physicians' email addresses and relied on their accuracy. This may have also contributed to the low reaction. The survey was distributed during the COVID epidemic, which may have contributed to the low response rate among research participants. Other possible explanations for the low response rate include disincentivisement, difficulties with accessing online survey portals, or non-response from physicians who were uninterested in palliative care. There might possibly have been a bias in our replies because only physicians who perceived the advantage in integrating palliative care answered to the survey. Future research might compare the perspectives and attitudes of respiratory physicians who have had exposure to palliative care to those who have not. Furthermore, future research should look at the advantages and disadvantages of early palliative care for non-malignant respiratory disorders in a resource-constrained setting.

## Conclusion

Although early palliative care is recognised to help patients with advanced respiratory disorders, and is supported by the majority of our respiratory physicians in the research, referral to palliative care in the nation remains limited. Referral to palliative care will occur only if respiratory doctors consider it helpful, available, and easily accessible. As a result, expanding specialised palliative care services outside cancer and improving respiratory physicians' palliative care education might enhance patient access to palliative care.

## Acknowledgement

Not applicable.

## Conflict of Interest

There are no conflicts of interest.

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