



# Palliative Care Practices among Physicians Providing Palliative Care to Terminally Ill Cancer Patients – A Cross Sectional Study in A Tertiary Care Hospital of Eastern India

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## ABSTRACT

**Introduction:** To find out palliative care practices among physicians providing care to terminally ill cancer patients.

**Methods:** The study was cross-sectional in nature, conducted in a tertiary care hospital from July 2015 to September 2017 using a predesigned and pretested questionnaire among physicians providing care to terminally ill cancer patients. A universal sample of 42 doctors involved in providing health services to terminally ill cancer patients were included in. The analysis was done using SPSS v. 20.0.

**Results:** Most of the physicians involved in care giving to the terminally ill were specialist care providers (67%) and only 1/5<sup>th</sup> of the physicians had received training on palliative care. Physicians who had either had training or had a personal loss of near and dear one through the state of terminal illness showed much compassionate care giving attitude. 83% physicians had a positive care giving attitude towards their patients.

**Conclusion:** Family and physician interactions need to be improved so as to facilitate better care for the terminally ill patients. There should be regular trainings organised for physicians and other health care providers dealing with terminal illness so they can provide best palliative care to their patients.

**Key Words:** Doctors, Health Care providers, Hospital palliative care, End of life care

## INTRODUCTION

The goal of palliative care is the achievement of optimal symptom control, the best possible quality of life, as well as appropriate rehabilitation for the patients, their family, friends and carers.<sup>1</sup> As suggested by World Health Organisation, palliative care should be available over the spectrum of disease stages, and the availability of palliative care services should be based on need, not on life expectancy. It should not be associated exclusively with terminal care or with cancer care. Many patients need palliative care in the

beginning of the disease, sometimes from the time of diagnosis.<sup>2,3</sup> Improvement of the quality of life and quality of death is the aim of the palliative care. High quality care and a comfortable and peaceful death may relieve grief and decrease the demand on health care services.<sup>4,5</sup> Each year an estimated 40 million people need palliative care, 78% of whom live in low- and middle-income countries.<sup>6,7</sup>

Out of one million newly diagnosed Indian cancer patients each year, more than 50% will die within 12 months of diagnosis and another one million cancer

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survivor's show progressive disease. Out of these 1.5 million in need of palliative care but less than 0.1 million patients can be covered by the existing facilities.<sup>8,9</sup> Palliative care services are usually concentrated in large cities and regional cancer centres, except for Kerala, where services are more widespread.<sup>10</sup>

Community health care professionals like general Practitioners and nurses need to provide general palliative care in the community. Palliative care affirms that death should be dignified and the existing is to be fulfilled by a joint commitment of the medical fraternity and family members, and appropriate government policy.<sup>11,12</sup> In Odisha, the paucity of palliative care units has severely affected thousands of cancer patients and their family members. Treating the clinical symptoms will alleviate the suffering of the terminally ill but even concerning for other domains like spiritual care, holistic care, concerning for autonomy of the terminally ill, looking into social and familial issues of the patients will definitely add up to the care and bring about a dramatic change in the lives of the terminally ill patients. This study was conducted to find out palliative care practices among physicians providing palliative care

## MATERIALS AND METHODS

This study was a hospital based Cross-sectional study, conducted in Oncology (Medical and Surgical) and Haematology departments of a tertiary care hospital of Eastern India from July 2015 to September 2017. A universal sample of all doctors who are directly or indirectly involved in providing health services to terminally ill cancer patients.

A total of 62 physicians were identified (who were involved in providing healthcare to terminally ill cancer patients) out of which only 42 participated in our study. A complete list of physicians who were actively involved in care giving for the terminally ill patients was prepared. They were approached and explained in detail about the study and the expected outcome. The questionnaire was given to them but only 42 were returned in complete form.

The data were entered in Microsoft excel spreadsheet and analyzed using IBM SPSS Statistics software version 20 licensed to the institute. Descriptive statistics were expressed as frequencies (percentages), means, median, standard deviations and Fisher's exact test for associations.

**Study tool:** The questionnaire aimed at evaluating the role of physicians in care giving for the terminally ill alongside investigating the further needs that could strengthen palliative care services in the region. First part intended to obtain information regarding physicians dealing with terminally ill cancer patients which included socio-demographic characteristics like age, gender, education, palliative care training status and their personal experiences in dealing with terminal illnesses. Second part was

'Frommelt attitudes toward care of the dying scale' (FATCOD). In these items, the purpose was to know how caregivers feel about certain situations in which they were involved with patients. The statements concerned about providing care to the dying person and/or, his/her family. Scores less than 75 indicated a negative attitude and score above 75 indicated positive attitude.<sup>13</sup> Third part was designed to assess perception and practice of palliative care among physicians working in specialist palliative care services.

**Practice** included 12 statements of how well the physicians caring for the terminally ill were capable to face certain scenarios that are encountered while intermingling with patients and their family members and how much support they do need while facing such scenario in a scale ranging from 1 to 4 i.e. "1 = Need further basic information, 2 = Confident to perform with close supervision, 3 = Confident to perform with minimal consultation, 4 = Confident to perform independently" which also assessed their confidence of providing palliative care. Perception of physicians was assessed by importance of specific issues in terms of the problems which are experienced by the physician while caring for a dying patient in a 5 point likert scale from very important to not important.<sup>14</sup>

**Ethical considerations:** The study was approved by the Institutional Ethics Committee.

## RESULTS

A total of 62 physicians were identified who were involved in providing healthcare to terminally ill cancer patients, out of which 42 doctors participated in our study.

Out of all the study participants, only 16.7% had received formal training or additional learning related to palliative care. About 90.5% had previous experience/s in dealing with terminally ill patients and 64.3% of the physicians have had an experience of dealing with the terminal illness of their family members/loved ones. Currently, 9.5% of them are dealing with the terminal illness of their family members or loved ones. (Table 1)

FATCOD tool was used to assess the care giving attitude of physicians towards their patients. It was observed that 83.33% of physicians had a positive care giving attitude towards their patients.

Maximum proportion of General practitioners (92.3%) and specialist (96.6%) had a positive care giving attitude towards the terminally ill patient, with no significant difference ( $P = 0.528$ ). All doctors (100%) who had previous training on palliative care shown positive care giving attitude as compared to 94.3% of physicians who did not have training shown positive attitude ( $P = 1.00$ ). Experience in dealing with terminally ill or experience of losing terminally ill family members had no significant association with care giving attitude. (Table 2)

**TABLE 1: Socio-demographic characteristics and basic information of the physicians (in milieu of dealing with terminally ill patients)**

Characteristics	Physicians (%)
<b>Age in years</b>	
Mean ± SD	40.36 ± 6.506
Minimum-Maximum	26-59
<b>Gender</b>	
Men	29 (69)
Women	13 (31)
<b>Educational qualification</b>	
MBBS	13 (30.9)
M.D./M.S.	18 (42.9)
D.M./Mch.	11 (26.2)
<b>Additional training in Palliative care</b>	
Yes	7 (16.7)
No	35 (83.3)
<b>Current department (Specialization)</b>	
Haematology	8 (19)
Critical care/ICU	9 (21.4)
Urology	2 (4.8)
Surgical Oncology	6 (14.3)
Gastro surgery	2 (4.8)
Anaesthesia	8 (19)
Oncology	7 (16.7)
<b>Previous experience in dealing with terminal illness</b>	
Yes	38 (90.5)
No	4 (9.5)
<b>Previous experience with loss of family member/ loved one</b>	
Yes	15 (35.7)
No	27 (64.3)
<b>Present state of affairs</b>	
Presently anticipating	7 (16.7)
Presently experiencing	4 (9.5)
Presently no loss	31 (73.8)

**Table 2: Association of socio demographic characteristics with care giving attitude**

Socio demographic characters	Negative attitude (n=2) (%)	Positive Attitude (n=40) (%)	p value*
<b>Education</b>			
General practitioner	1 (7.7)	12 (92.3)	0.528
Specialist	1 (3.4)	28 (96.6)	
<b>Additional training on palliative care</b>			
Yes	0 (0)	7 (100)	1
No	2 (5.7)	33 (94.3)	
<b>Experience in dealing with terminal illness</b>			
Yes	2 (5.3)	36 (94.7)	1
No	0 (0)	4 (100)	
<b>Experience with loss of loved one</b>			
Yes	1 (6.7)	14 (93.3)	1
No	1 (3.7)	26 (96.3)	

\*p value was calculated using Fischer's exact test.

Table 3 depicted how well the physicians caring for the terminally ill are capable to face certain scenarios that are encountered while intermingling with patients and their family members and how much support they do need while facing such scenario. Only 35.70% feel confident in dealing with certain questions that are asked by patients on issues like death

wishes and the dying process. Majority of physicians (59.6%) were confident to handle the upset behavior of the patients, but they still feel that it would be easier to handle such situation if there is either a close supervision or minimal support by an expert/senior in the respective field. 26.2% participants were unsure and needed further basic information on issues like informing people about various support services available for their treatment. Only 11.9% were confident in individually answering queries about the effects of certain medications. About 40.5% could discuss different environmental options available for patients but would even score higher if they would accomplish under an expert's closed supervision.

A small proportion of physicians were confident to react and cope with situations like terminal pain, terminal delirium, terminal dyspnea, nausea/vomiting, bladder incontinence/constipation and decision-making/mental capacity. In these scenarios, many doctors found it difficult to deal with how to let the patient cope with these symptoms and expected to handle in a better way if they were provided with certain guidance, support, and supervision by other palliative care staff.

A total of 40.50% participants opined that control of pain and depression were needed to be dealt with utmost priority. A similar percentage of physicians considered issues like patient's emotional need (38.10%); legal concerns (40.50%); ability to meet spiritual needs (40.50%); better communication with family (40.50%), other palliative care staff (38.10%) and doctor (33.33%) were also of importance and should not be neglected. (Table 4)

## DISCUSSION

The present study was conducted to assess to assess palliative care practises among physicians providing palliative care.

In this study, about 90.5% had previous experience/s in dealing with terminally ill patients and 64.3% of the physicians have had an experience of dealing with terminal illness of their family members/loved ones.

Most of the physicians involved in care giving to the terminally ill were specialist care providers (67%) and only 16.7% of the physicians had received training or have undergone some course in palliative care. Patel A et al in their study among medical professionals showed that 56% had not received any basic training in palliative care.<sup>15</sup> It was seen that the physician who had either had training in palliative care or had a personal loss of near and dear one through the state of terminal illness showed much compassionate care giving attitude. Overall it was seen that as high as 83% of the physicians had a positive care giving attitude towards their patients and about 70% to 90% of the physicians showed a positive perception that terminal stage clinical symptoms should be promptly managed.

**Table 3: Practice of palliative care in terms of patient/family interaction and clinical management**

Assessment of Patient/family interactions and clinical management	Response Category			
	1 (%)	2 (%)	3 (%)	4 (%)
"Answering patient's questions about the dying process"	11 (26.20)	09 (21.40)	07 (16.70)	15 (35.70)
"Supporting the patient or family when they become upset"	09 (21.40)	13 (31.00)	12 (28.60)	08 (19.00)
"Informing people of the support services available"	11 (26.20)	11 (26.20)	11 (26.20)	09 (21.40)
"Discussing different environmental options"	07 (16.70)	17 (40.50)	14 (33.33)	04 (9.50)
"Discussing patient's wishes for after their death"	11 (26.20)	09 (21.40)	07 (16.70)	15 (35.70)
"Answering queries about the effects of certain medications"	16 (31.80)	16 (31.80)	05 (11.90)	05 (11.90)
"Reacting to reports of pain from the patient"	09 (21.40)	13 (31.00)	13 (31.00)	07 (16.70)
"Reacting to and coping with terminal delirium"	13 (31.00)	13 (31.00)	12 (28.60)	04 (9.50)
"Reacting to and coping with terminal dyspnea"	10 (23.80)	14 (33.33)	11 (26.20)	07 (16.70)
"Reacting to and coping with nausea / vomiting"	09 (21.40)	14 (33.33)	12 (28.60)	07 (16.70)
"Reacting to and coping with reports of constipation"	11 (26.20)	13 (31.00)	11 (26.20)	07 (16.70)
"Reacting to and coping with limited patient decision-making capacity"	09 (21.40)	13 (31.00)	11 (26.20)	09 (21.40)

[1 = "Need further basic information", 2 = "Confident to perform with close supervision", 3 = "Confident to perform with minimal consultation", 4 = "Confident to perform independently"]

**Table 4: Perception of physicians on specific issues of terminally ill cancer patients**

Statement	Very important	Important	Unsure	Less important	Not important
Control of pain	17 (40.50)	12 (28.60)	07 (16.70)	03 (7.10)	03 (7.10)
Managing depression	17 (40.50)	06 (38.10)	03 (7.10)	03 (7.10)	03 (7.10)
Legal concerns	17 (40.50)	17 (40.50)	01 (2.40)	04 (9.50)	03 (7.10)
Ability to meet spiritual needs	17 (40.50)	17 (40.50)	04 (9.50)	02 (4.80)	02 (4.80)
The patient's emotional needs	16 (38.10)	16 (38.10)	05 (11.90)	03 (7.10)	02 (4.80)
Communication with family	17 (40.50)	15 (35.70)	04 (9.50)	02 (4.80)	04 (9.50)
Communication with another staff	16 (38.10)	18 (42.90)	03 (7.10)	03 (7.10)	02 (4.80)
Communication with another doctor	14 (33.33)	19 (45.20)	03 (7.10)	03 (7.10)	03 (7.10)
Uncertainty about what is best care	17 (40.50)	17 (40.50)	03 (7.10)	02 (4.80)	03 (7.10)

Figure in the parenthesis indicate percentage.

Improvements in bringing the knowledge and tools that are necessary to accomplish lacunas in care providing are needed.<sup>16</sup> This will require persistent effort and increased and sustained training. End-of-life issues can be difficult from the perspective of the physician.<sup>17</sup> "The *Society of Critical Care Medicine* and the *American Thoracic Society* emphasized the need for physicians working in the critical care environment to intimately understand problems and impediments to physician communication to patients and families, as well as physician performance in the arena of end-of-life."<sup>16</sup> Control of pain, management of depression should be taken care of primarily as opined by 40.5% of physicians in our study. Symptoms like terminal delirium, dyspnoea, constipation and depression should very promptly manage as stated by almost 60% of them.

While dealing with a dying patient, besides planning for alleviation of symptoms and treatment, a physician must understand decision making and advanced directives, be effective in interaction with families, understand the influence of religion and spirituality, acknowledge diversity, be facile with palliation and transition to comfort care, communicate well with the primary care team, and enlighten medical students and residents regarding end-of-life issues.<sup>16,18</sup> Other concerns like legal and spiritual (40.5%) are also needed to be addressed or at least help should be arranged for the terminally ill either by self-directing or asking the family members to take prompt action. No such arrangements were seen for

taking care of other aspects apart from just clinical manifestations.

## CONCLUSION

Providing the best care and support is the very instinct of a physician but certain aspects could be better if they are trained in milieu of palliative care. Family and physician interactions need to be improved so as to facilitate better care for the terminally ill patients. There should be arrangement of home visits by physicians to minimize shuttling of terminally ill patients. There should be regular training and workshops organised for physicians along with other health care providers dealing with terminal ill patients so that they can keep themselves abreast with the best palliative care practices around the globe.

## LIMITATION

Doctor's attitude and perception in relation to care for terminally ill patients could be explored in a better way by qualitative research. A limitation of this study is that it was carried out in only one centre.

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