There is a growing interest in palliative care for patients with advanced COPD as part of end-of-life care. Despite these promising results in patients with advanced COPD, chronic obstructive pulmonary disease (COPD) is a major cause of disability, impaired quality of life, and premature mortality in old age. Patients with advanced COPD are most likely to experience symptoms of excessive dyspnea with minimal exertion, generalized pain, elevated psychological distress and fatigue, and increased comorbidities. These, cumulatively or individually, may increase disability, acute exacerbations, the use of emergency care, and admissions to the hospital and intensive care facilities. There is a growing interest and awareness of the value of integrated palliative care alongside usual care, as shown by recent national and international COPD guidelines that recommend palliative care (PC) and advance care planning (ACP) as part of a holistic, patient-centered, and disease-directed care for patients with advanced COPD. However, there are limited data available on the use of PC and access to a PC specialist for patients with advanced COPD as part of end-of-life (EOL) care in the years or months prior to death as compared with cancer patients. This is in part due to the lack of access to PC services (for nonmalignant diseases), lack of adequate training, prognostic uncertainty as to when to provide PC for patients with advanced COPD by clinicians, including other subtle barriers as shown in Table 1. In contrast, a recent systematic review and meta-analysis in patients with advanced cancer showed that PC was related with reduced symptom burden and improved quality of life in patients as well as increased caregiver satisfaction and reduced health care utilization. Despite these promising results in patients with advanced cancer, the unmet needs of PC for patients with advanced COPD often remain unaddressed.

In this issue of the *Polish Archives of Internal Medicine (Pol Arch Intern Med)*, Brożek et al. report their findings from data collected in an online survey among Polish pulmonologists. They conducted a timely online survey among pulmonologists who were members of the Polish Respiratory Society to inquire about EOL, including their attitude, symptomatic treatment, and communication between physicians and patients with advanced COPD or lung cancer. A list of the participants was obtained from the Polish Respiratory Society, who were contacted by email. A self-administered survey questionnaire was adopted from a previous study by Gasper et al. among Portuguese pulmonologists. The questions were prepared specifically to explore the following themes: palliation of symptoms, frequency and topics of EOL communication, timing and initiators of EOL communication, and obstacles to EOL communication. A total of 139 responses (27.2%) were obtained from 639 physicians who were predominately pulmonologists (90%) (including allergology and palliative medicine specialists). The average age was 49 years, over 40% (n = 102) of the participants were women. About 28% of the participants reported that they used opioids to relieve pain symptoms in advanced COPD always or often, compared with 87% in patients with lung cancer. Similarly, about a third of the participants reported the use of opioids to relieve distressing symptoms of dyspnea in advanced COPD compared with 79% in patients with lung cancer. Moreover, 79% of the participants believed that discussion about EOL care in advanced COPD was essential, but 1 in 5 respondents initiated these conversations often or always. Furthermore, about 82% of the respondents reported that they always or often referred patients with lung cancer for PC or to a PC specialist for consultation, compared with less than 1 in 5 in the case of patients with advanced COPD. About half of the participants (often or always) discussed EOL care issues only with the caregivers or family of patients and excluded patients from the discussion. The most commonly reported and perceived barriers as shown in Table 1 were lack of adequate training, prognostic uncertainty as to when to provide PC for patients with advanced COPD, compared with 79% in patients with lung cancer. Moreover, 79% of the participants believed that discussion about EOL care in advanced COPD was essential, but 1 in 5 respondents initiated these conversations often or always. Furthermore, about 82% of the respondents reported that they always or often referred patients with lung cancer for PC or to a PC specialist for consultation, compared with less than 1 in 5 in the case of patients with advanced COPD. About half of the participants (often or always) discussed EOL care issues only with the caregivers or family of patients and excluded patients from the discussion. The most commonly reported and perceived
TABLE 1  Barriers to palliative care and end-of-life care for patients with advanced chronic obstructive pulmonary disease

| Barriers                                                                                     |
|---------------------------------------------------------------------------------------------|
| Poor communication between doctors and patients                                             |
| Negative attitude of health care professionals about PC                                     |
| Lack of knowledge about PC                                                                   |
| Limited resources availability to provide PC                                                 |
| Fear of taking away patients’ hope                                                          |
| Lack of confidence                                                                           |
| Lack of time                                                                                 |
| Patients unwillingness to discuss EOL care issues                                            |
| Absence of culturally sensitive integrated protocols about PC                                |
| Uncertainty about the information to provide about the prognosis of advanced COPD           |

Abbreviations: COPD, chronic obstructive pulmonary disease; EOL, end of life; PC, palliative care

Barriers by the participants included belief that a patient was not ready for such discussion, fear of destroying patients’ hope, lack of resources to provide PC, and inadequacies in training.

Surprisingly, about 9% of the participants always or often made the decisions regarding the EOL for COPD patients with other health care professionals without including patients or caregivers. Unsolicited comments from the participants about dignity of care for patients with advanced COPD include the importance of better access to PC, involvement of patients and their caregivers in the discussion and decision-making process about EOL care, and better access to psychological services.

What are the possible implications of the findings to Polish pulmonologists and multidisciplinary care teams in terms of providing PC for patients with advanced COPD in the future? First, Brozek et al. should be praised for their diligent work in conducting this survey and highlighting the deficiency of PC for patients with advanced COPD in Poland. The findings underscore the importance of EOL care and limited availability of PC in Poland. However, PC is usually provided by a multidisciplinary care team (ie, nurse, psychologist, social worker, physician, and pulmonologist) that meets on a regular basis to evaluate the patient’s condition and modify the care plan accordingly. Having said that, the pulmonologist and primary care physician play significant roles for the provision of PC to succeed. There is a great need for health care providers to establish culturally sensitive and integrated PC teams in Poland. For example, a recent Australian study showed that integrated PC for patients with advanced COPD was related with better prescription rates of opioids (morphine) to relieve dyspnea and pain. Notably, most provision of integrated PC was related with over 50% reduction in the mean emergency care utilization and over 85% of the participants discussed or completed an advanced care plan with patients with advanced COPD. A retrospective study by Smallwood et al. with 2.5 to 8 years of follow-up examined whether labeling patients with advanced COPD with do-not-resuscitate (DNR) order may impact their survival. Findings indicate that DNR orders were significantly associated with an increased number of death during hospitalization. These observations highlight the fact that early EOL care and advance care planning for patients with advanced COPD may help reduce these adverse events. Thus, there is a great need for robust integrated PC teams that would evaluate DNR or advance care planning orders in a timely manner during hospitalization, or periodically review these where appropriate, for example, in routine care.

Second, the study highlights that there are many potential barriers in the provision of PC in Poland, including the limited availability of resources, lack of training and misconceptions in patients and their caregivers about PC and the use of opioids to relieve dyspnea and pain symptoms in patients with advanced COPD. However, these issues were identified by other researchers from different countries and thus require joint effort of clinicians and professional societies around the world. Therefore, professional societies both in Poland and in other countries not only should provide guidelines about PC but make it a priority to lobby the health care providers to increase PC provision for patients with nonmalignant diseases including those with advanced COPD. In addition, they need to play an active role to make sure that medical schools and universities provide adequate training for doctors and allied health care professionals about PC and EOL communication in their training programs. Furthermore, this needs to be complemented by continuous education training for pulmonologists and allied health care professionals, periodically highlighting the need to include patients and their caregivers in the EOL discussion and the decision-making process to improve the quality of care and satisfaction in patients with advanced COPD. These discussions need to be done in a sensitive manner with a focus on addressing the unmet needs of the patient and caregivers. Finally, there is no one single silver bullet to address all these complex issues of PC provision for patients with advanced COPD, either in Poland or in other countries. Creating culturally sensitive and integrated PC requires a great deal of effort to enhance effective communication with patients and their family caregivers. In the current climate of health care provision, the health care providers are always keen to see evidence value for money, such as reduced health care utilization, improved quality of care, as well as high patient and caregiver satisfaction with the service. Therefore, the challenge for the researchers and clinicians alike is to conduct a prospective randomized controlled trial to show the benefits of integrated PC for patients with advanced COPD. Providing PC alongside the routine care to alleviate patients’ distressing symptoms, improve quality of life, and reduce health care utilization is a worthy pursuit.

The strengths of the study include a representative sample of pulmonologists who were engaged
or showed interest in the provision of PC for patients with advanced COPD and lung cancer in Poland. However, the findings should be cautiously interpreted in the light of some study limitations, as already recognized by the researchers. The small sample size (and a small percentage of respondents to survey) was comparable with survey studies that were conducted to explore the provision of PC by pulmonologists and junior doctors who deal with patients with advanced COPD in other countries. Furthermore, the self-reported information may not reflect what pulmonologists actually do in their practice. It would be useful if the survey included a vignette describing a patient’s main problems with advanced COPD to quantify and highlight the importance of EOL communication and PC provision objectively, for example, by using a video.

With the growing interest and studies demonstrating the benefits of PC for nonmalignant diseases, there is a need to train both pulmonologists and other health care professionals to deliver integrated PC in hospital and home settings with the roles of multidisciplinary team including pharmacist, local priest, physical therapist, PC specialist, PC nurse and psychologist, psychiatrist, social worker, and community-based caregiver volunteers. We join forces and applaud the Polish Pulmonary Society for developing the guideline for PC in patients with advanced COPD. The next step is to address the challenges identified by Brożek et al to develop practical strategies and address educational training needs for clinicians. Thus, it is paramount to employ effective EOL communication to develop trust between patients and physicians, which is a step forward in the right direction to achieve palliative care goals. The time has come to develop an integrated PC provision that would be widely available for patients with advanced COPD in Poland.

ARTICLE INFORMATION

CONFLICT OF INTEREST None declared.

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