Improving palliative care for patients with COPD

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The need for palliative care in COPD is under-recognised and unaddressed at hospital discharge
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High quality palliative care for patients with chronic obstructive pulmonary disease (COPD) remains a major challenge in our modern healthcare systems throughout the world. The World Health Organization (WHO) defines palliative care as “the active total care of patients whose disease is not responsive to curative treatment” [1], a definition that certainly describes the care for patients with COPD. The WHO goes on to say that this care should include “an approach that improves the quality of life of patients and their families ... through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” [2]. Relief of suffering should also include effective patient- and family-centred communication, identification of the patients’ goals of care, shared decision-making, and advance care planning.

Patients with COPD have an incurable disease and have a significant burden of diverse symptoms, including dyspnoea and cough, and also pain, anxiety, depression, fatigue and many others [3, 4]. In fact, studies comparing symptom burden and quality of life among patients with COPD to patients with cancer or those with other diseases often show that patients with COPD have an equal, or even higher, burden of symptoms [3–6]. However, studies have shown that patients with COPD are less likely to receive palliative care services or hospice care than patients with cancer [7]. Patients with COPD are also less likely to receive opiates and benzodiazepines than patients with cancer and, despite similar preferences for intensity of care at the end of life, are more likely to die in an intensive care unit and on a ventilator [8, 9]. Physician communication for patients with COPD about advance care planning or end of life care is often absent or poor quality and, according to one study, may be worse in Europe than in the USA [10, 11]. There is also evidence that this communication does not improve as the illness progresses [12]. Importantly, patients with COPD can live with, and suffer from, this condition for years, providing us ample opportunity to address these issues.

In this context, an important study is published in this issue of *European Respiratory Journal* by Meffert *et al.* [13] that was designed to identify the proportion of hospitalised patients with COPD who, at discharge, were identified by the discharging physician as having palliative care needs. The investigators identified 39 849 patients discharged from a single centre, of whom 1455 were identified as having COPD. Nearly 100% of the discharging physicians completed a required electronic discharge form that asked the question “does or did this patient have palliative care needs?” Physicians also completed a 90-min mandatory training defining palliative care and standardising the identification of palliative care needs. The investigators found that 9.1% of patients with COPD (132 of 1455) were identified by the discharging physician as having palliative care needs. Among 267 patients for whom COPD was identified as the principal diagnosis for the

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hospitalisation, 11.6% were identified as having palliative care needs. Importantly, a little more than half of the patients with COPD identified as having palliative care needs also had malignant neoplasms (51.5%).

An important feature of this study is that the palliative care needs were identified by physicians, not by the patients or their family members. Patients' symptoms and distress are often under-recognised by physicians [14, 15]. This is obviously an important limitation if the goal is to identify the actual palliative care needs of patients and their family members. However, identification of palliative care needs by physicians is likely to be an important driver of the implementation of palliative care. This would include both "primary palliative care" by all physicians who care for patients with serious illness, as well as "specialty palliative care" provided by clinicians with specialty training in palliative care [16]. Therefore, it is interesting that only about one-tenth of patients hospitalised for COPD, *i.e.* a life-limiting illness with a high symptom burden and a dramatic impact on quality of life, were identified as having palliative care needs. This may speak to the under-recognition of palliative care needs in this population. It is also interesting that over 50% of the patients with COPD who were recognised as having palliative care needs also had malignancy. Since cancer was a major independent predictor of the identification of palliative care needs in multivariate analyses, this finding suggests that it may be cancer that is often causing physicians to recognise palliative care needs, rather than COPD.

How can we improve palliative care for hospitalised patients with COPD? First, we must be able to recognise palliative care needs in this patient population. The study by MEFFERT *et al.* [13] documents that we are not doing that well and suggests that, even after requiring that physicians document palliative care needs at hospital discharge, these physicians are likely to under-diagnose these needs. Secondly, once we identify palliative care needs, we must have a way to meet these needs. This study suggests that only 2% of patients with identified palliative care needs received palliative care treatment, implying a high degree of unaddressed needs. Improved palliative care for these patients could be accomplished either through systematic approaches to enhance primary palliative care or through improved access to specialty palliative care. In fact, the approach that is likely to be the most effective is an integrated approach that involves both enhanced primary palliative care and, when palliative care needs are particularly difficult or persist, referral to palliative care specialists. At the time this study was done, however, the study hospital had no access to palliative care specialists and this is a common problem in many parts of the world.

There has been a dramatic increase in the emphasis on, and implementation of, palliative care in the past decade. Innovative models of integrating primary and specialty palliative care for patients with COPD are being developed and evaluated [17, 18]. However, recent studies, like the one by MEFFERT *et al.* [13], highlight the work yet to be done. We need additional research and quality improvement efforts designed to identify the most effective and cost-effective ways to implement high quality palliative care for all patients with serious illness and their families. There are likely to be features of these approaches that are universal across diseases, countries and clinical settings. There are also likely to be features of these approaches that will need to be tailored to patients with COPD, to patients with multimorbidity that includes COPD, and to specific healthcare systems and settings.

Patients with COPD have a serious, life-limiting illness that is not curable and that causes a high burden of symptoms and a dramatic reduction in quality of life. By definition, most of these patients have palliative care needs. Our challenge is to ensure that we are routinely identifying those needs and that we have a systematic way to address the needs of all our patients. Our healthcare systems have developed under an ethos of curing and prolonging life. These are important goals of medicine. However, since reducing symptoms, maximising quality of life, and minimising the suffering and stress associated with serious illness are also important goals of medicine, we have our work cut out for us.

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