

Comparing Kerala, India and Cambridge, the UK: a study of doctors' and nurses' attitudes towards palliative care

Dear Editor,

We have recently undertaken a study comparing doctors' and nurses' attitudes towards palliative care in Kerala, India and Cambridge, UK.

The two countries have very different social and medical cultures, with differing health services and access to palliative care education that may influence clinicians' attitudes towards end of life care. Palliative medicine is a young discipline in India: it was only approved as a postgraduate specialty in 2011 and there is no nationwide palliative care policy at present. By contrast, palliative medicine is a well-established specialty in the UK and a standard part of medical and nursing student training.

The study sought to compare the attitudes towards palliative care, prioritisation of resources and end-of-life decision-making among doctors and nurses in Kerala, India and Cambridge, UK,

and explore the potential for further improvement in services in both localities.

A questionnaire using attitudinal statements and four-point Likert scales was developed from previous instruments,^{1 2} and administered to doctors and nurses working in specialist palliative care and generalist settings in India and the UK (Arthur Rank House Hospice and Addenbrooke's Hospital in the UK and the Institute of Palliative Medicine and Little Flower Hospital in India). Sampling was opportunistic. A translation for non-English speaking nurses from Kerala. Of the 99 respondents 48 were from the UK (33 generalist, 15 specialist) and 51 from India (33 generalist, 18 specialist). Senior staff in all participating institutions gave permission for the study. Non-parametric analysis was undertaken in SPSS, with statistical significance taken at $p < 0.05$.

Both Indian and UK clinicians had broadly similar attitudes towards most aspects of palliative care, except that Indian clinicians were more likely to agree that religion or spirituality were important in helping them care for patients (table 1).

Clinicians in India reported having fewer resources than in the UK, and ranked nursing care as the most important resource to support patients. When asked to rank six factors in order of priority when influencing decisions about whether to give life-extending treatments to patients, both Indian and UK clinicians ranked 'quality of life as deemed by the patient' as the most important factor. Indian clinicians ranked their 'own views' second, whereas UK clinicians ranked this fourth, behind 'prognosis' and 'quality of life as deemed by the family' (data available from the corresponding author).

To our knowledge, this is the first study to compare attitudes towards palliative care among Indian and UK clinicians. It is striking how alike the responses were in the UK and Indian sites: most of the attitudes were

Table 1 UK and Indian clinicians' attitudes towards palliative care

Question	UK respondents (n=48)					India respondents (n=51)				
	1	2	3	4	Mean response (UK)	1	2	3	4	Mean response (India)
Doctors and nurses have a responsibility to help patients at the end of life prepare for death	1	0	9	38	3.75	0	0	12	39	3.76
Doctors and nurses have a responsibility to provide bereavement care to the patient's family members after a death	1	1	25	21	3.38	5	7	14	25	3.16
It is possible to tell patients the truth about a terminal prognosis and still maintain hope	2	7	26	13	3.02	5	17	18	11	2.69
I find it easier to care for palliative patients because of my religion/spirituality	14	14	16	4	2.21*	12	6	13	20	2.80*
I dread having to deal with the emotional distress of family members of a patient at the end of life	14	25	9	0	1.89	21	14	13	3	1.96
I think I may feel guilty after the death of a patient I am caring for	14	28	6	0	1.83	22	11	14	4	2.00
My medical colleagues view patient deaths as a failure	20	22	6	0	1.71	32	10	9	0	1.55
My medical colleagues encourage me to talk about my feelings about patient deaths	2	22	18	6	2.58	6	17	19	9	2.61
My medical colleagues think that physicians should be emotionally uninvolved with their patients	5	25	18	0	2.27	20	9	12	10	2.24

*statistically significant result (Mann-Whitney U test: $z=2.62$, $p=0.009$).

similar among both groups, except that most Indian clinicians reported that their religion and spirituality enabled their caregiving, whereas most UK clinicians disagreed that this was the case. This may reflect the wider religious context of each country: the majority of Indian respondents reported they were religious, a minority in the UK. Religion and spirituality might be usefully explored further in future cross-cultural research, being closely related but not synonymous constructs.

Perhaps predictably, Indian clinicians had access to fewer resources than their UK counterparts; they ranked nursing care and counselling as more important than palliative drugs and specialist doctors. This was in marked contrast to UK clinicians who felt that access to essential drugs and specialist doctors was of the highest importance. This reflects the different models of caregiving in each locality: Kerala's decentralised palliative care network relies on training volunteers and home visits, compared to greater emphasis on doctor-led interventions and inpatient care in the UK. In addition, access to palliative drugs is limited in India: Kerala has strict laws

governing opioid prescribing,³ including licensing requirements for clinicians prescribing and dispensing opioids.

The higher importance that Indian clinicians gave to their 'own views' in their end-of-life care decision-making may reflect a more paternalistic medical culture. MW and AK observed that respect for autonomy, confidentiality and consent was not always evident in Kerala; an observation with some support from the literature.⁴ Alternatively, Indian clinicians might be more willing to express their own views compared to their UK counterparts because they practise in a less 'medico-legal' environment: between 2008 and 2012 the Medical Council of India did not permanently strike off a single doctor. In contrast, 73 doctors were permanently struck off in the UK in 2010 alone.⁵

The study had some limitations. The questionnaire comprised a composite set of questions; some from validated questionnaires and others developed for this study by the authors. Sampling was opportunistic and the sample size was too small to permit subanalysis of doctors/nurses or hospital/hospice: data from doctors and nurses from palliative

and non-palliative backgrounds were analysed together. Some questions were less relevant to some participants (eg, nurses are generally less involved in decisions concerning life-extending treatment), and the equivalent registration status of the Indian nurses is unknown.

In conclusion, clinicians' attitudes were broadly similar in Kerala, India and Cambridge, UK, although Indian clinicians were more religious and felt psychosocial interventions were more important than biomedical. The vision of delivering holistic palliative care has been implemented in very different ways in two very different cultural settings. The challenge remains to ensure it is implemented in all settings worldwide.

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Acknowledgements MW and AK undertook this study during their elective as final year medical students at the University of Cambridge. Their main source of funding for this project was a grant from the Royal Society for Asian Affairs. SB is funded by the University of Cambridge School of Clinical Medicine and the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) East of England at Cambridgeshire and Peterborough NHS Foundation Trust. The views expressed are those of the authors and not necessarily those of the NHS, the University of Cambridge, the NIHR or the Department of Health.

Contributors AK and MW planned the study, aided by SB's guidance. AK and MW jointly conducted the survey. AK and MW wrote drafts of the short report which were reviewed and improved by SB. AK submitted the study. Please note that the first two named authors (AK and MW) contributed equally to the paper

and if possible would like to receive equal credit/'joint' first authorship.

Funding Royal Society for Asian Affairs.

Competing interests None declared.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement All unpublished data is available to anyone who should ask, please contact the authors at arjunkingdon@gmail.com or mkswillmott@gmail.com.



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To cite Willmott M, Kingdon A, Barclay S. *BMJ Supportive & Palliative Care* 2015;**5**:468–470.

Received 10 July 2014

Accepted 23 June 2015

Published Online First 10 July 2015

BMJ Supportive & Palliative Care 2015;**5**:468–470.
doi:10.1136/bmjspcare-2014-000762

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BMJ Support Palliat Care 2015 5: 468-470 originally published online July 10, 2015

doi: 10.1136/bmjspcare-2014-000762

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