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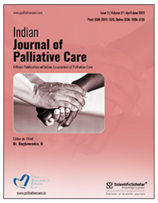

Original Article

Attitudes and Practices of Healthcare Professionals in Palliative Care for Heart Failure

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ABSTRACT

Objectives: This study explores the attitudes and practices of healthcare professionals on palliative care of patients with heart failure (HF), uncovers potential barriers and identifies possible interventions to meet the palliative care needs.

Materials and Methods: We conducted semi-structured interviews with 12 cardiovascular and palliative care professionals from six hospitals in Beijing, China. Purposive sampling ensured diversity in roles and clinical settings, and we used directed content analysis to analyse the data.

Results: Healthcare professionals discussed their views and experiences on the timing of palliative referral for patients with HF. They stated that patient and family perceptions of illness and palliative care could influence palliative care referral and other barriers to palliative care. They also suggested that quality communication was a key to palliative care implementation.

Conclusion: Hospitals should increase the building of palliative care professional teams and improve the communication skills of healthcare professionals. Palliative care related publicity and education should be carried out for patients, their families and the public to improve their cognition of palliative care. Healthcare professionals should fully assess the needs and disease progression of patients with HF and their families to better integrate palliative care at an earlier stage of disease development to improve patients' quality of life.

Keywords: Healthcare professionals, Heart failure, Palliative care, Qualitative study

INTRODUCTION

Heart failure (HF) is a chronic, progressive and life-limiting disease that affects more than 64 million people worldwide.[1] In China, the prevalence of HF amongst adults aged ≥35 years was 1.3% or an estimated 8.9 million individuals with HF.[2] Patients with HF often suffer from high physical and psychosocial burdens, such as dyspnoea, fatigue, anxiety and depression, that dramatically impair their performance status and quality of life.[3,4] Palliative care is the active, holistic care of individuals across all ages with profound health-related suffering due to severe illness, especially those near the end of life.[5] It could be initiated at any point in the disease trajectory and combined with curative or life-extending treatments. In this study, we considered palliative care as the service provided by a multidisciplinary team that focuses on quality of life and a good death through early identification, impeccable assessment and management of physical, psychological, spiritual distress and social needs. Many professional and policy organisations have provided recommendations for palliative care in patients with HF.[6,7] In 2020, the European Association for Palliative Care issued an expert position statement highlighting palliative care's role and integration in treating HF patients.[8] In 2025, a policy statement published by the HF Society of America emphasised that palliative care should be integrated into all patients with advanced cardiovascular disease.[9]

Palliative care has been shown to reduce hospitalisations substantially and improve quality of life and documentation of preferences.[10,11] However, only 6.4% of hospitalised patients with HF were referred to palliative care, which is significantly lower than referral rates in cancer populations.[12] A retrospective study of data from the UK Primary Health Care database showed that only 7% of patients with HF were enrolled in palliative care, with 29% of patients starting

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palliative care within 1 week of death.[13] Mandawa tracked patients with HF amongst veterans, conducted a 7-year cohort study and found that only 7.6% of patients with severe HF received palliative care at the beginning, and although this proportion increased year by year, the increase was slow.[14]

The attitudes and practices of healthcare professionals may contribute to underuse.[15] Most healthcare professionals are not trained in palliative care and have poor communication skills. For example, in one study, more than half of cardiologists surveyed would not discuss palliative care with elderly advanced HF patients.[16] Other obstructive factors in the referral of palliative care for patients with HF include the unpredictable trajectory of HF disease and patient and caregiver confusion regarding palliative care. Influenced by traditional culture, most patients and their caregivers believe that only dying patients need palliative care, which is difficult to accept emotionally.[17] What remains unclear are Chinese healthcare personnel's attitudes and practical experience towards palliative care for patients with HF. To increase the field evidence and assess the situation of China's healthcare environment, we conducted a qualitative study to explore the attitudes and practices of healthcare professionals on palliative care of patients with HF.

MATERIALS AND METHODS

Study design

This qualitative study employed a descriptive phenomenological approach to explore healthcare professionals' attitudes and clinical practices regarding palliative care for patients with HF. The study received ethical approval from the Institutional Human Ethics Committee (No.2022-1708) and adhered to the Consolidated Criteria for Reporting Qualitative Research guidelines to ensure methodological rigour and transparency.[18] A semi-structured, in-depth, personal interview method was utilised to gather data.[19] Participants signed an informed consent form before the interview, and all documents were kept confidential. All recorded audio or video was reviewed solely by the transcriber and the principal investigator. Each participant was assigned a specific code (e.g. N1, N2, N3) that did not reveal private information such as name and affiliation.

Setting/participants

Purposive sampling was used to select interview participants from 6 hospitals in Beijing, China. Participants were purposively sampled from specialised clinical fields (e.g. cardiology, critical care and palliative care) across multiple healthcare settings, ensuring representation of diverse professional roles (physicians, nurses). There was no pre-established relationship between the researchers and the participants to minimise the influence of the researchers on the participants' involvement. Inclusion criteria were as follows: (1) Cardiologists and nurses, and palliative care doctors, and nurses with experience in caring for patients with HF; (2) more than 5 years of clinical work experience; and (3) informed consent and voluntary participation in the interview. Exclusion criteria: Interviewees who quit during the interview. The interview was concluded when no new themes emerged from the participants' experiences. One participant declined to participate in the study due to time constraints.

Data collection

The first author, Haojie Yang, conducted semi-structured one-on-one interviews with health professionals through remote video. The interviewer was a male nurse with a master's degree and had undergone training in qualitative research. No other individuals were present during the interviews, and no repeat interviews were conducted. Before the interview, the primary researcher introduced the basic information of the interview to the potential participants in detail, such as the purpose and significance of the study, collected general demographic data and signed the informed consent form. With the interviewees' consent, video or audio recordings were made during the process. Interviews followed a semi-structured format guided by an interview outline developed through literature review and expert consultation [Table 1]. The questioning strategy included open-ended prompts (e.g. 'Can you describe your experiences with palliative care for HF patients?') followed by probing questions to clarify responses. Techniques such as active listening, paraphrasing and summarising were used to enhance data accuracy. Moreover, notes were taken during the interview to provide background information about the interview for future reference. Interviews were audiotaped and later transcribed verbatim. The interviews lasted about 43 minutes each (M = 42.41, standard deviation = 13.57).

Table 1: Interviews' guide for healthcare professionals.

No.	Question
1.	What are your attitudes towards palliative care for patients with heart failure?
2.	Could you please talk about your experience referring a patient with heart failure to palliative care service?
3.	In the clinical practice of palliative care for patients with heart failure, what are the main difficulties, obstacles and coping strategies?
4.	What are the main factors you consider for referring a patient with heart failure to palliative care?
5.	In your opinion, at what stage do you think patients with heart failure should receive palliative care?
6.	What else would you like to share about palliative care for patients with heart failure?

Data analysis

The content analysis method was employed to examine the interview data. Recordings were transcribed into text within 48 h following the conclusion of each interview, and the transcribed data were then imported into NVivo 11.0 software. Codes were grouped into genera and subgenera based on their correlation and degree of association, and the genera were organised and conceptualised to form themes. Initial codes, such as 'prognostic uncertainty' and 'communication training', were derived from literature on palliative care barriers. Emerging codes, including 'family-centric decision-making', were integrated iteratively. Themes were developed through constant comparison and consensus amongst researchers. Through continuous comparative analysis, codes were clustered into categories and subsequently synthesised into overarching themes, ensuring theoretical saturation through iterative sampling. All participants received a copy of their interview transcripts for review and confirmation, and two provided a small amount of additional commentary.

Table 2: Sociodemographic characteristics of healthcare professionals.

Variable	*n*	Percentage
Gender		
Male	2	16.67
Female	10	83.33
Age		
30–39 years	4	33.33
40–49 years	8	66.67
Time in clinical practice		
10–15 years	6	50.00
16–20 years	5	41.67
21–25 years	1	8.33
Profession		
Palliative care	6	50.00
Cardiologist	2	16.67
Cardiovascular nurse	4	33.33

RESULTS

Sociodemographic characteristics

According to the saturation standard of sample size, 12 medical workers were interviewed, including 2 males and 10 females, 4 doctors and 8 nurses, aged 32 ~ 45 (39.50 ± 3.26) years, and engaged in cardiovascular medical care or palliative care for 8 ~ 22 (14.92 ± 4.14) years. The total interview duration was 396 min, with each interview duration ranging from 39 to 107 (33.00 ± 6.27) min. The characteristics of the participants are shown in Table 2.

Qualitative findings

Theme 1: Timing of referral to palliative care for HF patients

Medical staff have different opinions on the referral time of palliative care. Most respondents agreed that discussion of palliative care-related topics should begin at the time of HF diagnosis, and a few participants reported that palliative care referral is not considered until patients with HF begin to deteriorate rapidly or when no further medical management measures are available. '*I think the premise of palliative care is that there is no effective way to continue the patient's life after diagnosis of heart failure.' N1 'It is recommended to start thinking about palliative care admissions early in the disease, as 5-year mortality is high for heart failure patients, so that patients and families can plan and be prepared.' N2 'I think patients with heart failure, admitted to palliative care at least until the end of the disease, there is no treatment, if there is a possibility of cure, may still need to further guide them to actively do treatment.' N3 'Once you have a diagnosis of something as life-threatening as heart failure, you need to consider palliative care access. If the patient's distress symptoms are obvious, the admission time for palliative care can be appropriately advanced.' N6.*

Referral to palliative care should be guided by the needs and preferences of patients and their families. The concept of palliative care is centred on the patient and family, and the patient's life is their own. The palliative care team should respect the wishes of the patient and their family and decide whether to enter palliative care based on the wishes of the patient and their family. It should be done step by step rather than overnight. '*Patients and their families should have a family meeting to discuss their treatment goals and take their wishes into consideration. Palliative care teams should also guide the families to listen to the patients themselves.' N3 'The life expectancy of patients is not strictly limited, so that more patients with symptomatic needs can receive timely help of palliative care, which is equivalent to advocating the clinical prepositioning of palliative care based on symptomatic needs.' N4 'If someone doesn't know about palliative care before, it can be difficult for them to receive it when they suddenly become ill. But if he gets comfortable with palliative care slowly, he may end up accepting it more.' N11.*

Theme 2: Patients' and families' perceptions of HF disease and palliative care

Respondents indicated that patients usually have a poor understanding of HF disease and have limited experience with prognosis. They believe that HF could be cured and is a non-fatal disease, leading to a low admission rate of palliative care. '*The psychological state of patients with HF is completely different from that of patients with cancer. Unlike patients with cancer, who often perceive themselves as nearing death, most HF patients retain hope for recovery or prolonged survival.' N1 'Patients with HF may think that they could be cured and that* *their symptoms will be relieved when they take a pill, so they may have more expectations.' N3.*

Some patients and their families do not understand or misunderstand palliative care. Palliative care can coexist with healing goals at the same time. Patients or family members may think of palliative care as a service for cancer patients or dying people, often equated with palliative care. '*Patients or their families may think that palliative care means waiting to die. They may feel that there is no hope if they are admitted to palliative care. If they do not understand palliative care, they may feel that they have given up treatment.' N3 'Patients may think that because they are admitted to palliative care, they are afraid that they will not be able to go out. In fact, they can be admitted and allowed to go out. When the patient is better, he can still be discharged.' N4.*

The treatment programmes, nursing intentions, patients' preferences for independent choice and other issues involved in palliative admission may be related to cultural background, family values and age. '*When it comes to palliative care, older people are relatively well received. Some younger people, especially in their 30s and 40s, may be more resistant.' N2 'Family members are afraid to communicate with the patient and hide the patient's illness, which may also be related to our traditional culture, filial piety.' N12.*

Theme 3: Barriers to referral to palliative care for patients with HF

The trajectory of the disease is difficult to predict, and the condition repeats. Respondents reported barriers to palliative care in HF patients due partly to significant individual differences, variable disease progression and difficulty determining prognosis. '*Heart failure is very persistent, and every attack is very painful, but when the disease is managed, the quality of life is probably very good.' N1 'Patients with heart failure may have a plateau, they may fluctuate, they may get better with treatment, they may bounce back and get worse over time, making it difficult to make palliative care decisions.' N6.*

There is a shortage of professionals in palliative care. Due to the limited human resources of the palliative care speciality, it is far from meeting the needs of patients. Therefore, it is necessary to strengthen the construction of multidisciplinary teams and increase the investment in palliative care resources. '*The quality of people specialising in palliative care in clinical practice is uneven, and there is no special discipline to train them. They are all transferred from different specialities. Subsequent medical colleges did not train relevant talents, resulting in a shortage of clinical talents.' N4 'How to expand the capacity of the palliative care team is not something that can be handled by nurses. It requires a multidisciplinary team and the implementation of the professional knowledge and skills training of the relevant staff.' N8.*

Healthcare workers lack training in palliative care. Few cardiovascular medical professionals have received palliative care training, and the concept of palliative care may need to be understood. '*Now it's probably highly recognised by oncologists, and we cardiovascular doctors may not know much about palliative care. Many doctors only say the patient is hopeless and then transfer to palliative, which is too late, and the patient will benefit little.' N10.*

It is difficult for Chinese people to talk about the concept of palliative care, which affects the application of palliative care in patients with HF. Both patients and medical staff should change their ideas and break through the traditional view of life and death. '*In addition to the traditional breakthrough in the common people's view of life and death, more importantly, medical students must be taught to recognise that it is a glorious mission of medicine to help patients die peacefully when necessary.' N4.*

Theme 4: Quality communication is the key to palliative care

Respondents indicated that medical staff might have limited time or lack communication skills, leaving them with no time or confidence to communicate with patients. '*If the patient is judged to have a poor clinical treatment effect and there is no active treatment, it is difficult to communicate with them and discuss palliative care, and the medical staff are usually not confident.' N1 'Most patients with heart failure have many comorbidities and complex conditions. 'Doctors spend more time discussing care goals and treatment needs with patients, but there is not enough time to do this in the clinic.' N4 'Many health care professionals shy away from the topic of death because they don't have the confidence and conversation skills to communicate with patients to jointly establish and implement a care plan.' N9.*

Communication training should be carried out to improve communication skills. Good communication is essential to promote harmonious doctor–patient relationships and for patients to reach a consensus on treatment goals. There are established modes of palliative care communication, and relevant training and simulated immersive exercises should be carried out for medical staff. '*For palliative care communication, the medical staff should first understand the patient's awareness of the disease, the current state of the patient and what the patient's thoughts are, rather than us medical staff informing the patient unilaterally.' N3 'They have to have the experience to learn how to communicate, how to convince the patient that they are going to be able to relieve their pain. They have to have the communication skills.' N8.*

The medical staff should carry out a pre-emptive medical care plan. Nearly all respondents agreed that pre-emergent care programmes are critical for early access to palliative care for patients with HF to inform patients and families of the HF trajectory and treatment possibilities and limitations, to educate patients better and provide more comprehensive care. '*We should discuss treatment goals with patients and their families, but we should not do this in a single visit. Let the patient get used to it and try to personalise it with the patient.' N5 'I feel that the medical staff is inexperienced in pre-emptive care planning and should intervene earlier to facilitate the setting and implementation of end-stage care goals for patients.' N7.*

DISCUSSION

This study explored the attitudes and experiences of healthcare professionals in providing palliative care to patients with HF in China. The findings show that healthcare professionals all agree that there are many benefits to referral to palliative care for patients with HF. However, there has been no consensus on the appropriate referral time to palliative care for patients with HF. Most respondents agreed that patients should be referred early in the HF disease trajectory, which is consistent with the guidelines published by the European Association for Palliative Care.[9] However, many countries have the problem of late referral to palliative care for patients with HF, and most respondents tend to refer to palliative care at the end stage of HF. Khurigachi surveyed 544 medical institutions in Japan, and 98% of them believed that palliative care was necessary for patients with HF, but only 7% of physicians discuss the option of palliative care with patients and families at the beginning of a diagnosis. In most institutions, physicians recommend palliative admission when patients are nearing the end of their lives.[20] This may be related to HF's unpredictable disease trajectory. In addition, some healthcare professionals lack confidence in their communication skills and are concerned about lowering the level of hope for patients, resulting in low palliative referral rates.[17] Ament suggested that referral to palliative care for HF patients should fully consider patient needs and disease progression with the help of palliative care needs assessment tools.[21] For example, Janssen *et al*. used the Needs Assessment Tool: Progressive Disease-HF, (NAT: PD-HF) to assess patients' needs for palliative care and provide a reference for symptom management and decision-making in palliative care.[22]

Patients' and families' perceptions of HF disease and palliative care can influence their referral to palliative care. Patients with HF often have little information about their condition and its outcome, and few patients can discuss their future care goals, treatment modalities and preferred place of death with clinicians and nurses. Chinese people generally fear and avoid the topic of death and psychologically and emotionally reject palliative care.[23] Patients and their families tend to pay more attention to treatment techniques and outcomes and have negative perceptions of palliative care. Equating palliative care with euthanasia and giving up treatment are common misconceptions about palliative care services, which may be related to people's cultural beliefs, socioeconomic status and age.[24] Zheng *et al*. surveyed 1200 members to understand their cognition of palliative care. The results showed that the public's awareness of palliative care was low, and their comprehension was generally insufficient.[25] To promote the implementation of palliative care, it is necessary to further strengthen relevant publicity through news media, public service advertisements and other forms, to deepen the understanding of patients, their families and the public on the disease and reduce the misunderstanding of palliative care. Miller-Lewis *et al*. developed death education course resources on the network platform to improve the public's acceptance of palliative care and promote the development of palliative care for patients with HF.[26]

Healthcare professionals are the vehicle through which palliative care services are delivered. A high-level team is beneficial to the development of palliative care. Due to the late development of palliative care in China, there need to be more professionals engaged in palliative care. A study shows that only four tertiary hospitals out of 9 medical institutions in a district of Beijing offer outpatient, consultation and inpatient palliative care services. The number of palliative care doctors and nurses in 4 hospitals was 35 and 40, respectively. There were 267 inpatients in palliative care, indicating that palliative care service work was still in its infancy, and the construction of professional personnel and related supporting policies could not meet the needs of the palliative care service. In addition, the professional training in palliative care for medical staff needs to be further improved. Palliative care involves many professional fields, such as symptom control, comfort care, death education, psychological support and disease communication.[27] Medical staff also need to improve their professional competence level continuously. The training and education related to palliative care in China have yet to form standardised formal training content. There are a few types of research on training methods and training effect evaluation. Healthcare professionals should base on the actual situation of palliative care training, learn from the advanced experience of foreign countries and build a palliative care training system suitable for Chinese cultural backgrounds. In addition, medical colleges should increase the investment in palliative care education, integrate palliative care courses into medical courses and add palliative care courses to fill the gaps in palliative care education in recent years. In the future, the linkage at the primary level should be strengthened by national policies, hospital management, medical colleges and universities to improve the medical personnel's ability to practice and promote the development and application of palliative care.

Communication between healthcare professionals, patients and families is vital in palliative care. Effective doctor–patient communication can guide patients and their families to establish a correct view of medical treatment, reduce excessive medical treatment and improve patients' quality of life.[28] This study shows that lack of time, inexperience and ineffective and even conflicting communication amongst healthcare personnel can make it more difficult for patients and families to cope with the impact of the disease. This is consistent with the conclusions of Siouta's study. Interviewees indicated that medical staff should be comprehensive, honest and objective in their information; accurately perceive the needs of patients and their families, can empathise and make appropriate changes according to the communication process and consider their acceptance degree and cultural background.[29] Moreover, advance care planning (ACP) is an essential component of palliative care, helping patients with HF to receive medical care services consistent with their wishes at the end of their life and reducing decision-making conflicts.[30] ACP is sensitive to Chinese patients due to the taboo of talking about life and death in traditional culture. The medical staff discussed that ACP should start with patients with optimistic personalities and respect the Chinese patriarchal decision-making model. In addition, family-centred ACP communication should be implemented to allow family members to participate in ACP discussions and decision-making.[31]

There are two limitations to our study. Interviews were conducted with 12 physicians and nurses specialising in palliative care and cardiology who play a leading role in a multidisciplinary palliative care team for HF patients. Other team members, such as psychotherapists, social workers and volunteers, were omitted and may have different attitudes and experiences with palliative access for patients with HF. This qualitative study is limited to the medical environment in China. Palliative care practices in other countries may differ, and the findings cannot be generalised to a broader range of countries and regions.

CONCLUSION

This study explored the attitudes and experiences of healthcare professionals towards palliative care for patients with HF. The results show that the referral time of palliative care for patients with HF is challenging to judge. The needs and disease progression of patients and their families should be fully considered to integrate palliative care better early in the disease trajectory. The perception of patients with HF and their families about the disease and palliative care, the shortage and insufficient capacity of medical staff and Chinese traditional culture may influence referral to palliative care. High-quality communication is the key to palliative care referral, which can improve palliative care decision-making and patients' quality of life with HF.

Ethical approval: The research/study was approved by the Institutional Review Board at Fuwai Hospital, Chinese Academy of Medical Sciences, approval number No.2022-1708, dated 8th December 2022.

Declaration of patient consent: The author's certify that they have obtained all appropriate patient consent.

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