Palliative Psychiatry for Patients with Severe and Persistent Mental Illness: A Survey on the Attitudes of Psychiatrists in India compared to Psychiatrists in Switzerland

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Abstract

Background

Palliative psychiatry is a new approach for the care of patients with severe and persistent mental illness (SPMI). To assess the attitudes of psychiatrists in India towards palliative psychiatry for patients with SPMI and to compare these to the attitudes of psychiatrists in Switzerland.

Methods

In an online survey, data from 206 psychiatrists in India were collected and compared with data from a previous survey among 457 psychiatrists in Switzerland.

Results

Psychiatrists in India generally considered it very important to prevent suicide in SPMI patients (97.6%). At the same time, they considered it very important to reduce suffering (98.1%) and to ensure functionality in everyday life (95.6%). They agreed that palliative psychiatry is important for providing optimal care to SPMI patients without life-limiting illness (79.6%) and considered palliative psychiatry as indicated for patients with SPMI (78.2%). By contrast, curing the illness was considered very important by only 39.8 % of respondents. Relative to psychiatrists in Switzerland, psychiatrists in India were significantly more concerned about preventing suicide and less willing to accept a reduction in life expectancy, even at the expense of quality of life in patients with severe and persistent schizophrenia and recurrent major depressive disorder. At the same time, they were significantly more likely to advocate palliative psychiatry.

Conclusion

Most of the participating psychiatrists in India agreed that palliative psychiatry can be indicated for patients with SPMI. The comparison with psychiatrists in Switzerland highlights the need to take account of cultural differences in future studies of this kind.

Key Message

While psychiatrists in India as in Switzerland believe palliative care approaches can be indicated for patients with severe and persistent mental illness, important cultural differences were found and need to be considered.

Background

The emerging field of palliative psychiatry (or palliative care approaches in psychiatry) is increasingly attracting interest (1–9). Palliative psychiatry is based on accepting that some psychiatric symptoms are irremediable and offer a valuable means of improving the quality of life of patients with severe persistent mental illness (SPMI) (8–10, see also (11) for an in-depth discussion of the concept of SPMI).

When should psychiatrists use palliative psychiatry? At what point should psychiatrists focus on palliative psychiatry in addition to curative psychiatry or on its own? In countries with relatively scarce health care resources, additional ethical difficulties may arise, and multiple factors must be considered when deciding whether to forego further treatment, including duration and severity of illness, response to previous treatment and whether it is appropriate to focus on palliative psychiatry before all other possible options have been exhausted (e.g., due to a lack of financial resources) (12). In low- and middle-income countries, where only a small fraction of mentally ill patients receive adequate psychiatric treatment (13–15), the appropriateness of palliative psychiatry is an open question.

Since the 1980s, India's Kerala region has shown how requisite palliative care can be provided free of charge, using local resources (16–21). In their descriptive study, Philip et al. (21) reported that in recent years in Kerala, patients with SPMI were commonly included in these programs. However, having a SPMI was also an important factor in early program drop out, and here as elsewhere, patients with mental illness receive insufficient health care.

However, it would be counterproductive and ethically questionable to misuse palliative psychiatry as a low-cost option for cost- and time-intensive psychiatric service users. As McGorry et al. noted (6), an under-resourced mental health system may consign patients to persisting and unremitting illness, and we concur that no group of patients should be neglected in this way. Rather, palliative psychiatry is about abandoning harmful or ineffective treatment to focus on quality of life and reduction of suffering when further curative treatment is considered futile (6, 10, 22).

Attitudes of healthcare professionals towards palliative psychiatry for patients with SPMI might be influenced by cultural aspects and economic factors of the respective healthcare system. Therefore, in this study, the question is addressed how palliative psychiatry is understood and lived in psychiatric practice in different cultures. This survey of psychiatrists in India and its comparison with a previously published survey from Switzerland (9, 23, 24) sought to assess attitudes among psychiatrists on palliative psychiatry, especially for patients with SPMI. The comparison is especially interesting because, as discussed above, differing resource levels as well as cultural differences may promote different views of palliative psychiatry and treatment of psychiatric patients with SPMI.

Methods

The online survey investigated attitudes among psychiatrists in India to palliative psychiatry, physician-assisted dying, and compulsory interventions for patients with SPMI. The data were then compared with findings from an earlier survey of Swiss psychiatrists using the same questionnaire (9, 23, 24). The methods used in India are described below.

Sampling and data collection in India

Between April and June 2020, 3,056 members of the Indian Psychiatric Society were sent an email containing information in standard text and a survey link, followed at intervals by four reminders. In total, 562 of the recipients clicked on the link; 285 commenced the process, and 206 of these completed the questionnaire using the SoSci Survey tool. Recipients were informed that, by clicking on the supplied link, they were giving their informed consent. For reasons of data security, no record was kept of whether the questionnaire had already been processed (i.e., no IP address was saved). Only fully completed questionnaires were included in the data analysis.

Survey and case vignettes

The survey and case vignettes from the corresponding previous studies were translated from the original German version to English and adapted for the use in India (9, 23–26). Like the original questionnaire, the adapted version comprised 23 items, along with three additional questions on age, gender, and year of graduation from medical school (as proxy marker for career duration). Five items related to the general treatment of patients with SPMI, and eight related more specifically to palliative psychiatry and SPMI. Additionally, each of the two case vignettes was accompanied by five items (see Tables 1 and 2). In each instance, participants responded on a 7-point Likert scale ranging from 1 (*not important/strongly disagree*) to 7 (*very important/strongly agree*), with a midpoint at 4 (*moderately important/neutral*).

Statistical analysis

Arithmetic means were calculated for the age and work experience items. Percentages were calculated for gender data, and for items related to treatment of patients with SPMI, palliative psychiatry in SPMI, and the two case vignettes. For better readability and to facilitate interpretation, 7-point Likert scale data were combined into three categories: *disagree/unimportant* (1, 2, 3), *neutral* (4), and *agree/important* (5, 6, 7).

To compare the samples from India and Switzerland, data from the respective samples were first tested for normal distribution. As the Shapiro-Wilks test indicated that all items deviated significantly from the normal distribution ($p < .05$), these differences were evaluated using the nonparametric Mann-Whitney U test, equivalent to Wilcoxon's rank-sum test. Mean and median values were calculated for each item, as the median is more useful for interpreting non-normally distributed data (27). In addition, the effect size r was determined to further refine interpretation of the data (27, 28). For increased readability, we report only significant comparisons with at least medium effect size ($r \geq .3$) in the text. IBM SPSS Statistics Version 25 was used to perform the statistical analysis.

Results

The fully completed questionnaires ($n = 206$) represented a response rate of 6.7%. Of these, 33% were women and 67% were men, with a mean age of 43.1 years ($SD = 12.9$, range = 25–78 years) and mean career duration of 19.0 years since graduation ($SD = 12.9$, range = 2–56 years).

General views on treatment of patients with SPMI

Most participants (42.7%) felt it was moderately important to *cure* patients with SPMI; 39.8% regarded this as (very) important while 17.5% considered it less important to cure the illness (see Fig. 1). Overwhelming majorities considered it (very) important to *reduce suffering* in patients with SPMI (98.1%), to help them *function in daily life* (95.6%), and to *impede suicide* (97.6%).

General views on palliative care and its applicability to different forms of SPMI

48.1% of respondents disagreed that the term *palliative* relates directly to end of life while 25.7% agreed and 26.2% were neutral. Regarding the proposition that *palliative care is indicated for some patients with SPMI*, 78.2% agreed while 16.5% remained neutral and only 5.3% disagreed. Regarding the proposition that *palliative care models are an important means of providing optimal care for patients with non-terminal illnesses*, 79.6% agreed while 13.1% remained neutral and 7.3% disagreed. Regarding the proposition that SPMI can be a terminal illness, 35.0% disagreed while 34.5% remained neutral and 30.6% agreed; a further 26.7% strongly disagreed, and 19.9% strongly agreed.

Most participants (81.6%) agreed that in severe, chronic, and therapy-refractory schizophrenia a palliative approach would be suitable with just 4.9 % disagreeing (see Fig. 2). The view that a palliative approach would be appropriate in cases of severe, chronic, and therapy-refractory bipolar disorder was shared by 68.9%, by 66.0% in cases of severe, chronic, and therapy-refractory depression, and by 54.4% in cases of severe, chronic, and therapy-refractory substance disorder with 11.7 %, 13.1%, and 19.9 % disagreeing, respectively.

Responses to the case vignettes

Schizophrenia

Overall, 42.7% of respondents agreed that *further curative intervention would probably be futile in this case of schizophrenia* while 29.1% disagreed and 28.2% remained neutral (see Fig. 3). 40.8% indicated that they would not be comfortable with *a reduction in life expectancy to increase or maintain the patient's quality of life* while 32.0% indicated they would be comfortable with this and 27.2% remained neutral. When asked whether they would be *surprised if the patient died within the next 6 months*, 41.7% agreed while 41.3% remained neutral and only 17.0% disagreed.

Recurrent Major Depressive Disorder

Most respondents (45.1%) disagreed that *further intervention to cure the patient's depression would probably be futile* while 32.0% remained neutral and 22.8% agreed (see Fig. 3). While 40.3% would not be comfortable with *a reduction of life expectancy to increase or maintain the quality of life of this patient*, 31.1% said they would be, and 28.2% remained neutral. Finally, 38.3% of respondents said they would not

be surprised if the patient died within the next 6 months while 35.9% remained neutral and 25.7% said they would be surprised.

Comparison of psychiatrists' views in India and Switzerland

Psychiatrists in India agreed significantly less than psychiatrists in Switzerland that *SPMI can be a terminal illness* ($U = 16244.0, p < .001, r = -.55$; see Table 4), and considered it significantly more important to *impede suicide* when treating SPMI ($U = 21310.0, p < .001, r = .48$; see Table 3). However, psychiatrists in India agreed significantly more than psychiatrists in Switzerland that *a palliative approach would be appropriate for patients with severe, chronic, and therapy-refractory schizophrenia* ($U = 28897.5, p < .001, r = .32$).

Regarding the case vignette of a patient with severe and persistent schizophrenia, psychiatrists in India were significantly less comfortable than psychiatrists in Switzerland with a *reduction in life expectancy to increase or maintain quality of life* ($U = 28752.0, p < .001, r = -.31$; see Table 5). The same was true in the case of the patient with recurrent major depressive disorder ($U = 28731.5, p < .001, r = -.31$). In this case, psychiatrists in India also reported to a significantly greater extent that they would be surprised *if the patient died within the next 6 months* ($U = 27121.5, p < .001, r = .34$).

Discussion

For a vast majority of psychiatrists in India, suicide prevention in patients with severe and persistent mental illness (SPMI) was very important. Psychiatrists in India also tended not to view SPMI as a terminal illness with 26.7% even strongly disagreeing with this notion. However, curing the illness was not very important for the majority, and some psychiatrists in India even regarded further curative treatment as futile in specific cases. Almost all psychiatrists emphasized the importance of reducing suffering and of functionality of SPMI patients in everyday life, both of which are central concepts in palliative psychiatry (8, 10). Consecutively, a majority believed that palliative psychiatry is indicated for some patients with SPMI (especially schizophrenia), even in the absence of a life-limiting somatic disease. However, when confronted with vignettes of specific patients with severe, chronic, and therapy-refractory schizophrenia and depression, most psychiatrists in India indicated that they would not be comfortable with improving quality of life at the expense of life expectancy.

At first glance, this strong emphasis on both duration and quality of life of SPMI patients may be difficult to reconcile. However, palliative psychiatry can be accommodated alongside a curative approach, and as the disorder does not need to be terminal for the application of palliative psychiatry (8), it does not necessarily mean discontinuing curative treatment (6). In line with this interpretation, only a minority of surveyed psychiatrists in India found that the term *palliative* directly relates to end of life.

Comparison of psychiatrists' attitudes in India and Switzerland

The participating psychiatrists in India tended to support both curative and palliative approaches for patients with SPMI more strongly than psychiatrists in Switzerland. Regarding curative approaches, psychiatrists in India considered it more important to impede suicide and to cure patients with SPMI than psychiatrists in Switzerland. In line with these attitudes, psychiatrists in India were less likely to believe that SPMI can become a terminal illness. The same trend is apparent in both case vignettes; psychiatrists in India would be more surprised if the patient with severe and persistent schizophrenia or recurrent major depressive disorder would die within the next 6 months. They were less likely to consider further intervention futile in both cases than psychiatrists in Switzerland, and they would not be comfortable with a reduction of life expectancy in either case, even at the expense of quality of life.

How might we explain the stronger support for curative approaches and suicide prevention in SPMI of psychiatrists in India? First, as referred to in the introduction, it is considered important not to classify patients as chronic or therapy-refractory because of insufficient treatment and resources; on that basis, a curative approach should not be abandoned (6). As psychiatrists in India are likely very aware of this issue, they may therefore tend to favor a curative approach even for patients classified as suffering from chronic, severe, and therapy-refractory mental disorders.

Second, although suicide rates in India are generally comparable to Switzerland (30), in persons aged between 15 and 49, suicide rates in India are almost twice as high as in Switzerland (31). Vijayakumar (29) reported that more than 70% of suicides in India involve persons younger than 44, which is the age range in the case vignettes. In a comparative study of attitudes to suicide among medical students in India and Austria, overall attitudes were more negative in India, and suicide was associated with mental illness, cowardice, and even illegality (32). In India, attempted suicide was only recently decriminalized in the Mental Health Care Act of 2017 (33). Indian medical students also exhibit a strong aversion to physician-assisted suicide (32). In contrast, physician-assisted suicide has been legal for decades in Switzerland, and the psychiatrists surveyed in Switzerland supported the idea for patients with SPMI to some extent (23).

Third, while it might seem interesting to explore whether these differences in pro-life attitude relate to religious beliefs, Etzersdorfer and colleagues found no evidence that religion played a role in the differing attitudes to suicidal behavior of medical students from India and Austria (32). Referring primarily to the Hindu religion, they found no greater aversion to suicide than in the Christian religion and further noted that there is some evidence of institutionalized suicide in India. In a more recent questionnaire study, Thimmaiah and colleagues (34) reported that negative attitudes to suicidality are less common among Hindus than Muslims, and these cultural differences invite further research.

Besides the greater support for curation and suicide prevention, psychiatrists in India also assigned greater importance to the reduction of suffering and functionality in daily life than their counterparts in Switzerland. They agreed more strongly that palliative approaches might be indicated in patients with SPMI, even in the absence of life-limiting disease.

By implication, the participating psychiatrists in India tended to support both curative and palliative approaches for patients with SPMI. This suggests that, for psychiatrists in India, curative approaches and palliative psychiatry are not mutually exclusive but can complement each other to alleviate suffering and increase functionality in daily life in parallel to curative treatments (8). Such a notion of compatibility of palliative psychiatry and curative approaches may be facilitated by regarding the term *palliative* as not directly related to the end of life, which psychiatrists in India were significantly more likely to do than psychiatrists in Switzerland.

Strengths and limitations of the study

One limitation of the study is the low response rate of 6.7% in the Indian sample. Basing the calculation on the population who clicked on the link yields a response rate of 36.7%. The generalizability of the data may therefore be limited as the participants are likely to have an existing interest in SPMI and palliative care. However, there is evidence that nonresponse bias may be of less concern in physician surveys than in surveys of other populations (35). Also, response rates are known to be lower in online surveys (36) and in surveys of physicians (35), especially psychiatrists (37).

As only psychiatrists were surveyed, the generalizability of the response patterns to other professions is limited.

The observed differences between the two samples might relate to differences in age and career duration. It is also important to note that response behavior can vary across countries and cultures (38), which may be compounded by the fact that the questionnaires were presented in different languages (German and English). For example, the psychiatrists in India (up to 30%) chose the middle category more often than those in Switzerland. To limit and identify any interpretive bias associated with dichotomous significance testing, effect sizes were also calculated.

Other general limitations of this type of survey have already been mentioned in previous studies based on the same questionnaire (9, 23, 24) but can be briefly summarized as follows. First, a Likert scale can only reflect the opinions of individuals to a limited extent and cannot fully capture the complexity of the topic. Importantly, we did not assess how the individual participants conceptualize palliative psychiatry. Second, the case vignettes represent highly specific cases and are not representative of the respective disorders in general.

Implications for clinical practice and future research

The reluctance to integrate palliative psychiatry in existing mental healthcare structures may reflect the fact that it is too often associated with end of life, giving up, and hopelessness (2, 3, 7). The present findings, and especially the views of psychiatrists in India, suggest that first, palliative psychiatry is considered valuable across cultures as a means of improving patients' quality of life, without necessarily accepting a reduction in life expectancy, and second, rather than asking "palliative *or* curative?", we should discuss the possibility of palliative *and* curative, combining both approaches to offer optimal treatment to patients with SPMI. As Strand and colleagues (7) have argued, "[...] the type of interventions

referred to as palliative are by no means ‘novel’ and ‘cutting-edge’—quite the contrary, we interpret palliative care as an approach defined by its goals and not by the use of specific treatments” (p. 6). It seems important, then, that researchers and clinicians focus on developing a framework for clinical practice that optimally combines curative and palliative approaches for the individual patient and situation.

List Of Abbreviations

SPMI

severe and persistent mental illness

Declarations

Ethics approval and consent to participate

The study was approved by the ethics committee of the Government Medical College, Thiruvananthapuram (HEC.No.01/06/2020/MCT, dated February 2nd, 2020). The authors confirm that all methods were performed in accordance with the relevant guidelines and regulations. All participants were informed that, by clicking on the supplied link, they were giving their informed consent for the participation in the study.

Consent for publication

Not applicable.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare no conflicts of interest, including financial or other relationships that might be perceived as influencing the research methods or content.

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Authors' Contributions

AM, CV, AP, and MT conceived the study and were involved in adapting the questionnaire for data collection in India. AM, CV, JS, MT were involved in data collection. JS and MT evaluated the data and drafted the article. All authors were involved in critical revision of the draft manuscript, and all approved the final version submitted for publication.

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References

1. Berk M, Singh A, Kapczinski F. When illness does not get better: do we need a palliative psychiatry? *Acta Neuropsychiatr*. 2008;20:165–166.
2. Berk M, Berk L, Udina M, et al. Palliative models of care for later stages of mental disorder: maximizing recovery, maintaining hope, and building morale. *Aust N Z J Psychiatry*. 2012;46(2):92–99.
3. Etgen T. Case series of introducing palliative care consultation in psychiatry. *J Palliat Med*. 2020;34(5):680–683.
4. Lindblad A, Helgesson G, Sjöstrand M. Towards a palliative care approach in psychiatry: do we need a new definition? *J Med Ethics*. 2019;45:26–30.
5. Lopez A, Yager J, Feinstein RE. Medical futility and psychiatry: Palliative care and hospice care as a last resort in the treatment of refractory anorexia nervosa. *Int J Eat Disorder*. 2010;43(4):372–377.
6. McGorry PD, Berk M, Berk L, Goldstone S. Commentary on “Palliative models of care for later stages of mental disorder: Maximising recovery, maintaining hope and building morale.” *Aust N Z J Psychiatry*. 2012;46(3):276–278.
7. Strand M, Sjöstrand M, Lindblad A. A palliative care approach in psychiatry: clinical implications. *BMC Med Ethics*. 2020;21(29):1–8.
8. Trachsel M, Irwin SA, Biller-Andorno N, Hoff P, Riese F. Palliative psychiatry for severe persistent mental illness as a new approach to psychiatry? Definition, scope, benefits, and risks. *BMC Psychiatry*. 2016;16(260):1–6.

9. Trachsel M, Hodel MA, Irwin SA, et al. Acceptability of palliative care approaches for patients with severe and persistent mental illness: a survey of psychiatrists in Switzerland. *BMC Psychiatry*. 2019;19(111):1–9.
10. Westermair AL, Buchman DZ, Levitt S, Trachsel M. Palliative psychiatry for severe and enduring anorexia nervosa includes but goes beyond harm reduction. *Am J Bioeth*. 2021;21:60–62.
11. Zumstein N, Riese F. Defining severe and persistent mental illness—a pragmatic utility concept analysis. *Front Psychiatry*. 2020;11:648.
12. McKinney C. Is resistance (n)ever futile? A response to “Futility in chronic anorexia nervosa: A concept whose time has not yet come” by Cynthia Geppert. *Am J Bioeth*. 2015;15(7):53–54.
13. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. *Bull World Health Organ*. 2004;82(11):858–866.
14. Patel V. The future of psychiatry in low- and middle-income countries. *Psychol Med*. 2009;39:1759–1762.
15. Wang PS, Aguilar-Gaxiola S, Alonso J, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet*. 2007;370:841–850.
16. Bollini P, Venkateswaran C, Sureshkumar K. Palliative care in Kerala, India: A model for resource-poor settings. *Oncol Res Treat*. 2004;27:138–142.
17. Kumar S. Learning from low income countries: what are the lessons?: Palliative care can be delivered through neighbourhood networks. *BMJ*. 2004;329(7475):1184.
18. Paleri A, Numpeli M. The evolution of palliative care programmes in North Kerala. *Indian J Palliat Care*. 2005;11(1):15–18.
19. Shanmugasundaram S, Chapman Y, O’Conor M. Development of palliative care in India: An overview. *Int J Nurs Pract*. 2006;12:241–246.
20. Kumar S. Models of delivering palliative and end-of-life care in India. *Curr Opin Support Palliat Care*. 2013;7(2):216–222.
21. Philip RR, Philip S, Tripathy JP, Manima A, Venables E. Twenty years of home-based palliative care in Malappuram, Kerala, India: a descriptive study of patients and their care-givers. *BMC Palliat Care*. 2018;17(1):1–9.
22. Hodel MA, Trachsel M. Euthanasia or assisted suicide in patients with psychiatric illness. *JAMA*. 2016;316(20):2153–2154.
23. Hodel MA, Hoff P, Irwin SA, et al. Attitudes toward assisted suicide requests in the context of severe and persistent mental illness: a survey of psychiatrists in Switzerland. *Palliat Support Care*. 2019:1–7.
24. Stoll J, Hodel MA, Riese F, Irwin SA, Hoff P, Biller-Andorno N, Trachsel M. Compulsory interventions in severe and persistent mental illness: a survey on attitudes among psychiatrists in Switzerland. *Front Psychiatry*. 2021; 12:537379.

25. Brenner HD, Dencker SJ, Goldstein MJ, et al. Defining treatment refractoriness in schizophrenia. *Schizophr Bull.* 1990;16(4):551–561.
26. Baweja R, Singareddy R. Concomitant use of maintenance ECT and vagus nerve stimulation for more than 10 years in treatment-resistant depression. *Am J Psychiatry.* 2013;170(9):1059–1061.
27. Field A. *Discovering statistics using IBM SPSS Statistics*, 3rd ed. London, UK: Sage, 2012.
28. Fritz CO, Morris PE, Richler JJ. Effect size estimates: Current use, calculations, and interpretation. *J Exp Psychol.* 2012;141(1):2–18.
29. Vijayakumar L. Indian research on suicide. *Indian J Psychiatry.* 2010;52:S291-S296.
30. World Health Organization. Suicide rate estimates, crude. Estimates by country. Last update: 2019. Available from: <https://apps.who.int/gho/data/node.main.MHSUICIDE?lang=en>. Accessed July 23, 2021.
31. World Health Organization. Suicide rate estimates, crude, 15–29 and 30–49 years. Estimates by country. Last update: 2019. Available from: <https://apps.who.int/gho/data/node.main.MHSUICIDEAGEGROUPS15293049?lang=en>. Accessed July 23, 2021.
32. Etzersdorfer E, Vijayakumar L, Schöny W, Grausgruber A, Sonneck G. Attitudes towards suicide among medical students: comparison between Madras (India) and Vienna (Austria). *Soc Psychiatry Psychiatr Epidemiol.* 1998;33:104–110.
33. Mishra A, Galhotra A. Mental Healthcare Act 2017: need to wait and watch. *Int J Appl Basic Med Res.* 2018;8(2):67–70.
34. Thimmaiah R, Poreddi V, Ramu R, Selvi S, Math SB. Influence of religion on attitude towards suicide: an Indian perspective. *J Relig Health.* 2016;55(6):2039–2052.
35. Kellerman SE, Herold J. Physician response to surveys: A review of the literature. *Am J Prev Med.* 2001;20(1):61–67.
36. Fan W, Yan Z. Factors affecting response rates of the web survey: A systematic review. *Comput Hum Behav.* 2010;26(2):132–139.
37. Cunningham, CT, Quan, H, Hemmelgarn, B, et al. Exploring physician specialist response rates to web-based surveys. *BMC Med Res Methodol.* 2015;15(1):1–8.
38. Harzing A-W. Response styles in cross-national survey research: A 26-country study. *Int J Cross Cult Manag.* 2006;6(2):243–266.

Tables

Table 1 *Survey items*

I: Questions regarding the treatment of patients with severe and persistent mental illness (SPMI)
In the treatment of patients with SPMI, how important are the following:
a) curing the illness
b) reduction of suffering
c) patient's ability to function in daily life
d) patient retaining decision making autonomy
e) impeding suicide
According to the World Health Organization, palliative care "is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness 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."
How strongly do you agree or disagree with the following statements?
f) For me, the term "palliative" relates directly to end-of-life.
g) For some SPMI, palliative care is indicated.
h) In psychiatry, it is important to apply a palliative care model to provide optimal support for certain patients with no life-limiting medical illness.
i) SPMI can be terminal.
j) In severe, chronic, and therapy-refractory <i>schizophrenia</i> , a palliative approach would be appropriate.
k) In severe, chronic, and therapy-refractory <i>depression</i> , a palliative approach would be appropriate.
l) In severe, chronic, and therapy-refractory <i>bipolar disorder</i> , a palliative approach would be appropriate.
m) In severe, chronic and therapy-refractory <i>substance disorder</i> , a palliative approach would be appropriate.
II: Case vignettes: Please provide an evaluation of the case vignettes.

a) In this case, I would not proceed against the patient's wishes.
b) For this patient, any further intervention to cure their schizophrenia/depression would most likely prove futile.
c) In this case, I would be comfortable with a reduction of life expectancy in order to increase or maintain the patient's quality of life (if consistent with their goals).
d) In this case, I would accept a temporary decrease in quality of life as a consequence of coercive measures.
e) I would not be surprised if this patient died within the next 6 months.

Note. The Table has been designed in the style of and adapted after Trachsel et al., Hodel et al., and Stoll et al. (9, 23, 24).

Table 2 *Case vignettes*

<p>Patient 1:</p> <ul style="list-style-type: none"> • 33-year-old male • Schizophrenia with onset at age 17; no significant comorbidities • Positive symptoms: auditory and visual hallucinations, persecutory delusions • Negative symptoms: apathy, social withdrawal, poverty of speech (all rated severe)
<p>Despite long-lasting high-dose pharmacological treatment (several atypical neuroleptics, haloperidol, clozapine, and their combinations), as well as electroconvulsive therapy, the patient has never been free from positive or negative symptoms. Multiple psychotherapies employing various approaches have also failed to stabilize the patient or to improve his quality of life. He does not wish to continue treatment because he feels it is too intrusive. While the positive symptoms predominated in the years immediately following his initial diagnosis, he developed severe negative symptoms, as well as aggression and self-injurious behavior, including burning himself with cigarettes. The negative symptoms and his strong functional deficits are exacerbated by chronic unemployment and an inability to live independently. Additionally, the patient has no family system, and his persisting illness has left him completely isolated, with no social contacts and no hobbies or interests. Two experts have declared that he possesses decision-making capacity regarding his illness and its treatment.</p>
<p>Patient 2:</p> <ul style="list-style-type: none"> • 40-year-old male • Recurrent Major Depressive Disorder; no significant comorbidities • Somatic symptoms: energy loss, insomnia, and fatigue • Persistent suicidal ideation over the past 20 years; current acute and concrete suicidal intent
<p>The patient underwent different forms of intensive, long-term, evidence-based psychotherapy, including specialized approaches such as cognitive behavioral analysis system of psychotherapy (CBASP) and interpersonal psychotherapy (IPT). Both psychotherapy alone and in combination with adequate treatment trials of antidepressants (selective serotonin reuptake inhibitors, tricyclic antidepressants, venlafaxine, augmentation with lithium and antipsychotic medications (quetiapine and aripiprazole)) failed to improve his depression, and the patient experienced significant adverse effects from several of the medications. Exhausted, he has decided to undergo electroconvulsive therapy as a last resort. However, maintenance electroconvulsive therapy again proved insufficient to prevent the reappearance of suicidal ideation; indeed, his symptoms worsened. Experiencing severe hopelessness, the patient states that his quality of life is very poor, that he doesn't want to deal with his illness anymore, and that he plans to commit suicide in the near future. Two experts have declared that he possesses decision-making capacity regarding his illness and its treatment.</p>

Note. Case vignettes modified from Brenner et al. and Baweja et al. (23, 24) and adapted in the style of Trachsel et al., Hodel et al., and Stoll et al. (9, 23, 24).

Table 3 *General treatment of patients with SPMI: Comparison of India and Switzerland*

Item	Group	<i>n</i>	<i>M</i>	<i>Mdn</i>	<i>U</i>	<i>Z</i>	<i>p</i>	<i>r</i>
la: curing the illness	India	206	4.73	4				
	Switzerland	447	3.73	4				
	Total	653			32431.0	-6.27	<.001***	-0.25
lb: reduction of suffering	India	206	6.87	7				
	Switzerland	456	6.66	7				
	Total	662			38091.5	-5.64	<.001***	-0.22
lc: function in daily life	India	206	6.74	7				
	Switzerland	456	6.55	7				
	Total	662			39209.0	-4.42	<.001***	-0.17
le: impeding suicide	India	206	6.84	7				
	Switzerland	454	5.80	6				
	Total	660			21310.0	-12.38	<.001***	-0.48

Notes. Only abbreviated questionnaire items are shown (see Table 1 for complete items). *r*. effect size (for calculation see citations 27, 28). Significant *p* values ($p < .05$) in **bold**: *** $p < 0.001$, ** $p < .01$, * $p < .05$.

Table 4 *Palliative care for patients with differing forms of SPMI: Comparison of India and Switzerland*

Item	Group	<i>n</i>	<i>M</i>	<i>Mdn</i>	<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
If: term “palliative”	India	206	3.29	4.00				
	Switzerland	452	4.24	4.00				
	Total	658			34116.0	-5.58	<.001***	-0.22
Ig: SPMI and palliative care	India	206	6.00	7.00				
	Switzerland	444	5.39	6.00				
	Total	650			31241.5	-6.75	<.001***	0.26
Ih: Palliative Care support (not life-limiting)	India	206	5.96	7.00				
	Switzerland	449	5.43	6.00				
	Total	655			32133.5	-6.53	<.001***	0.26
Ii: SPMI can be terminal	India	206	3.83	4.00				
	Switzerland	453	6.36	7.00				
	Total	659			16244.0	-14.22	<.001***	-0.55
Ij: schizophrenia (palliative approach)	India	206	6.12	7.00				
	Switzerland	452	5.24	6.00				
	Total	658			28897.5	-8.10	<.001***	0.32
Ik: depression (palliative approach)	India	206	5.40	6.00				
	Switzerland	452	5.00	6.00				
	Total	658			37811.0	-3.96	<.001***	0.15
Il: bipolar disorder (palliative approach)	India	206	5.52	6.00				
	Switzerland	452	4.94	6.00				
	Total	658			35209.0	-5.14	<.001***	0.20
Im: substance disorder (palliative approach)	India	206	4.86	5.00				
	Switzerland	452	5.26	6.00				
	Total	658			43921.5	-1.19	.233	-0.05

Notes. Only abbreviated questionnaire items are shown (see Table 1 for complete items). *r*: effect size (for calculation see citations 27, 28). Significant *p* values ($p<.05$) in **bold**: *** $p<0.001$, ** $p<.01$, * $p<.05$.

Table 5 Case vignettes: Comparison of India and Switzerland

(1) Schizophrenia								
Item	Group	<i>n</i>	<i>M</i>	<i>Mdn</i>	<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
IIb: futility of further intervention	India	206	4.27	4				
	Switzerland	448	4.82	5				
	Total	654			40541.5	-2.53	.011*	-0.10
IIc: quality of life vs. reduction of life expectancy	India	206	3.65	4				
	Switzerland	448	5.15	5				
	Total	654			28752.0	-7.88	<.001***	-0.31
Ile: dying within the next 6 months (surprise question)	India	206	3.34	4				
	Switzerland	450	4.39	4				
	Total	656			31333.5	-6.80	<.001***	-0.27
(2) Depression								
IIb: futility of further intervention	India	206	3.38	4				
	Switzerland	450	4.41	5				
	Total	656			32672.0	-6.14	<.001***	-0.24
IIc: quality of life vs. reduction of life expectancy	India	205	3.63	4				
	Switzerland	450	5.05	5				
	Total	655			28731.5	-7.87	<.001***	-0.31
Ile: dying within the next 6 months (surprise question)	India	206	4.23	4				
	Switzerland	450	5.71	6				
	Total	656			27121.5	-8.76	<.001***	-0.34

Notes. Only abbreviated questionnaire items are shown (see Table 1 for complete items). *r*. effect size (for calculation see citations 25, 26). Significant *p* values ($p < .05$) in **bold**: *** $p < 0.001$, ** $p < .01$, * $p < .05$.

Figures

How important, in the treatment of patients with severe persistent mental illness (SPMI), is...

Figure 1

Indian psychiatrists' attitudes on general treatment of patients with SPMI

Figure 2

Indian psychiatrists' attitudes on palliative psychiatry and its use in patients with different SPMI

For this patient, further interventions to cure the disease will most likely be futile.

In this case, I would be comfortable with a reduction of life expectancy in order to increase or maintain quality of life if consistent with the patient's goals.

I would not be surprised if this patient died within the next 6 months.

Figure 3

Indian psychiatrists' attitudes on the case vignettes