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The Perceived Facilitators and Challenges of Translating a Lung Cancer Palliative Care Intervention into Community-Based Settings

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Abstract

Despite significant progress in implementing palliative care interventions for cancer patients, few intervention studies seek healthcare clinicians' input prior to implementation of these into the community. The purpose of this study was to explore palliative care and oncology clinicians' perspectives on the perceived facilitators and challenges in meeting the quality of life needs of lung cancer patients and family caregivers in community-based settings. The RE-AIM model for implementation research was used as a framework. This was a multi-site qualitative study using focus group and key informant interviews. Nineteen clinicians addressed useful practices and challenges in the following areas: (a) early palliative care; (b) interdisciplinary care planning; (c) symptom management; (d) addressing psychological and social needs; and (e) providing culturally respectful care, including spiritual care. In preparation for the intervention, specific education needs and organizational challenges were revealed. Challenges included timing and staffing constraints, the need for clinician education on palliative care services to increase organizational buy-in, and education in providing spiritual support for patients and family caregivers. This research allowed investigators to understand perceptions of clinicians as they prepared to integrate palliative care in their settings. Hospice and palliative care nurses can be instrumental in implementing palliative care into community practice.

Keywords

Lung Cancer; Clinicians; Intervention; qualitative research

BACKGROUND

Lung cancer patients and family caregivers (FCGs) often struggle with unmet quality of life (QOL) needs related to physical, psychological, social, and spiritual well-being.¹ QOL is a

multidimensional concept that addresses the impact of traumatic events such as cancer on aspects related to physical, psychological, social, and spiritual well-being.² The aim of palliative care (PC) is then to maintain the highest possible level of QOL for patients and their families throughout the illness experience. The very core of PC is to improve QOL through palliative care interventions (PCIs), which assess and meet the diverse needs of patients with life-threatening illnesses.³

Nurse-led PCIs, which include the integration of PC early alongside standard oncology treatment,⁴ attention to QOL needs, interdisciplinary team planning, and education for both the patient and FCG have shown to improve (QOL) outcomes.^{5–9} Even so, these interventions have had limited translation into community settings.⁴ In order to integrate structured PCIs, which affect the involvement and workflow of specialized clinicians in community settings, it is of value to assess the perceived facilitators and challenges in meeting patient and FCG QOL needs as well as clinicians' perceived needs for successful integration of the PCI into their clinical practice.

PC clinicians' perspectives were explored on the approach to early PC for patients with advanced cancer in outpatient settings. Roles in providing early PC was perceived as having three distinct tasks: (1) managing symptoms to improve functional status and as a bridge to other discussions such as emotional issues; (2) engaging patients in emotional work to facilitate coping, accepting, and planning; and (3) ensuring that the oncologist and patient each understand and are able to discuss prognosis and treatment.¹⁰ In this way, the aims of early PC assist in the communication between patient and oncologist. This study explored clinicians' perspectives in an outpatient community setting, however was limited by its single-site location and small number of PC clinicians. Perspectives from oncology and primary physicians are vital in understanding the challenges and useful practices to PCI implementation and the collaborative referral process. These perspectives were emphasized by researchers who reported on implementation challenges during phases of the Education, Nurture, Advise Before Life Ends (ENABLE) project study design, including sampling, clinician cooperation in referrals, and recruitment.¹¹ Two issues reported were trying to "win over" or achieve buy-in from oncologists to prevent gate-keeping, and possible clinician bias about who is referred to PC programs and intervention studies compared to the inclusion criteria.¹¹ Challenges in PC referrals deemed it essential to then explore oncology clinician perspectives on the concurrent oncology/palliative care model.

Following the completion of the ENABLE II project on the concurrent oncology PC model, a qualitative study was conducted to explore oncology clinicians' perspectives on the care of advanced cancer patients.¹² Oncology clinicians believed that integrating PC at the time of an advanced cancer diagnosis enhanced patient care and complemented their practice. Referral challenges involved referring to "palliative care," a label that could easily be misunderstood to being equated with hospice or impending death. To avoid this misperception, clinicians in this study introduced the notion of palliative care early on as a standard of care thus normalizing the concept. Challenges were associated with the patient not being ready, lacking preparation for referral, and the prevalent misconceptions of PC. Clinicians perceived the identification of a new advanced cancer diagnosis as a prompt for PC referral; however, knowing when to refer patients remained a barrier for some.¹²

Practical suggestions from interdisciplinary clinicians include providing education on the benefits of early PC, and recommendations related to the prime time of introducing it.¹³

There is a gap in the current evidence-base on incorporating the perspectives of interdisciplinary teams to enhance components of PCIs prior to implementation in community settings. Feedback and buy-in from front-line clinicians involved in the care of lung cancer patients and FCGs may assist in the implementation and maintenance of structured PCIs.

Conceptual Framework

In an effort to improve the care of patients with lung cancer and support their FCGs, innovative practices as PCIs must be adapted to community settings and re-evaluated to determine if it is effective and maintainable. The theoretical framework used for this study was the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) model,¹⁴ a conceptual framework used to evaluate the effectiveness of translating intervention research into practice. To contribute to the successful implementation and dissemination of the PCI, the third dimension of RE-AIM, Adoption, was used to guide this study. Adoption is further defined, as how feasible it is for the program to be adopted in the real-world settings and whether it can be adopted by low resource settings. Assessing the success and failure factors at organizations before implementation can help gauge needs and ensure buy-in.¹⁵

OBJECTIVES

This study explored PC and oncology clinicians' perspectives on the perceived facilitators and challenges to implementing a nurse-led Lung Cancer PCI. The three specific aims of this study were to (a) identify clinicians' perspectives on how to best address QOL dimensions (physical, psychological, social, and spiritual needs) of lung cancer patients and family caregivers through palliative care services; (b) identify clinicians' perspectives on challenges in addressing patient and family caregiver QOL dimensions (physical, psychological, social, and spiritual needs) through palliative care services; and (c) Identify needs of palliative care clinicians in order to support patients and FCGs across QOL dimensions.

METHODS

Study Design

This multi-site descriptive, qualitative study used focus group and key-informant interviews with oncology and PC clinicians at three outpatient sites in the Southwestern United States. This study contributed to an ongoing two-phased intervention study conducted to test the dissemination of a PCI for Non-Small Cell Lung Cancer (NSCLC) patients and their primary FCGs in community based settings. In the healthcare system where this study was conducted, outpatient PC services had organically developed and were in operation for nearly 10 years at a few sites and were only beginning to be dispersed to the remaining sites in the past few years. Since adoption of PC services is subject to variance across the sites, this variability in implementation provided an opportunity for the PCI model to be adopted, and if successful would be disseminated to the remaining sites within the healthcare system.

¹⁸ This healthcare system was chosen for its substantial commitment of bridging outpatient services to the community and to include diverse populations. This PCI was previously developed and tested at a National Cancer Institute (NCI)-designated comprehensive cancer center. The intervention was delivered concurrently with oncology and disease-focused therapies and improved outcomes, particularly with regard to QOL.^{1, 16–17} The three components of the intervention included: (a) attention to the comprehensive patient and FCG QOL dimensions (physical, psychological, social, and spiritual needs); (b) support for interdisciplinary team input in the plan of care; and (c) patient and family caregiver education.¹⁶ The study protocol and lessons learned were previously discussed, which included the facilitators and barrier to implementation.¹⁸ This study describes the perspectives of PC and oncology clinicians as they prepared to implement this structured nurse-led PCI for NSCLC patients and their primary FCGs in community based settings.

Participants and Setting

Purposive sampling was used to represent a range of disciplines including nurses, physicians, social workers, chaplains, and nurse administrators to capture the varied experiences of the team members. The population for this study included clinicians working at three selected outpatient settings. Eligibility criteria were: (a) employment at one of the three selected facilities, (b) licensing in the profession, and (c) having provided care to a lung cancer patient/s. Ethical approval was obtained from the institutional review board from the three selected facilities and deferred approval was obtained from Loma Linda University.

Data Collection and Procedures

Permission to access and communicate with clinicians was obtained from research administrators at the selected facilities. As an alternative to written consent, an information sheet was distributed to participants involved in focus group and key-informant interviews. Content included on this sheet was the purpose and procedures of the study, and information regarding confidentiality. Participation in this study was explained as voluntary. Information sheets were reviewed with participants prior to beginning the focus groups and key-informant interviews.

One focus group interview was conducted at each of the three research sites. Group sessions were held in a private, comfortable room at each designated facility and lasted approximately 1 hour. Each focus group was conducted by a team consisting of 1 moderator who lead the discussion using open-ended questions and prompts, a nurse researcher as co-moderator to keep participants engaged in discussion, and a note-taker who kept track of identifying information, notable quotes, and observations during the focus group interviews. The principal investigators (PI) involved in the PCI study were present at each group session. Prior to beginning the focus group discussion, each participant was given a diagram of the four QOL quadrants and asked to fill in each quadrant, listing “three things that you feel your palliative care team does particularly well in improving patients and FCGs needs addressing their physical, psychological, social, and spiritual well-being” and “three things you find particularly difficult in improving patients’ and family caregivers’ needs.” This method allowed participants to reflect on each dimension and develop individual perspectives prior to discussion. Individual contributions triggered group discussions which

identified both areas of agreement and differences. Participant interaction was also stimulated by open-ended interview questions, which probed different aspects of the topic (Table 1). Key informant interviews were used as an alternative option for those who were unable to attend one of the three available focus groups. These interviews were conducted by one researcher in the form of phone interviews. The same QOL diagram and open-ended questions were used to guide the key-informant and focus group interviews. All focus group and key-informant interviews were audio recorded and transcribed verbatim.

Analysis

Focus group and key-informant data were professionally transcribed and analyzed in the same manner. Initial analysis of transcripts was conducted manually and organized using MAXQDA,¹⁹ a computer-based qualitative data management program. The process of analyzing qualitative data was conducted through conventional content analysis in order to systematically examine and discover key concepts.²⁰

First, data were transcribed and read verbatim by the researcher. Participants in focus groups were identified by profession and labeled for analysis purposes. Notes taken during each focus group were used during the review of transcripts. During the initial review, certain key phrases from the transcription were highlighted that seemed particularly significant. Notes were taken of first impressions and thoughts. Second, transcripts were re-read to derive codes centered on the responses of participants. Labels for codes were initiated from ideas that emerged and were reflective of more than one key thought. Codes centered on QOL dimensions for patients and family caregivers were an example of initial emerging codes, with overlapping concepts (physical, psychological, social, and spiritual needs). Overlapping codes with related concepts were collapsed into one code or renamed to meet the description of the text. Codes were then placed into categories which specifically addressed the success and challenges in meeting patient and FCG quality of life needs and the needs of clinicians in adopting a new PCI. Codes were then sorted into categories based on their relationship and further broken down into subcategories which enlightened the identified category. Each category and subcategory was then acknowledged and organized to reflect the three aims of this study, and exemplar texts were formed for each category and subcategory. Definitions for categories and subcategories were formed to reflect key content described in the text. Codes, categories, sub-categories, and text exemplars were examined for feedback and validation with two additional researchers (principal investigators of PCI study) during preliminary and final stages of the analysis to improve accuracy and enhance rigor, credibility, and internal validity of the findings. Revisions were made during this process and reported frequently to the PCI research team.

FINDINGS

Description of Sample

Three focus groups and five individual phone interviews were conducted. A total of 19 PC and oncology clinicians were involved in this study (i.e., physicians, nurse coordinators, nurse administrators, social workers, and chaplains). Participation included 14 clinicians from three interdisciplinary PC teams (one team per site). Clinicians who were unable to

attend focus groups were invited to participate in individual phone interviews to elicit additional perspectives. Five clinicians were then added to this study. This included one oncology physician, a thoracic surgeon, two oncology nurses, and one chaplain. Table 2 presents demographic characteristics of the interview participants, which was composed mostly of Caucasian non-Hispanics (47.4%), followed by Asian Pacific Islanders (26.3%). Categories emerged that addressed useful practices and challenges in the following areas: (a) early palliative care; (b) interdisciplinary care planning; (c) symptom management; (d) addressing psychological needs, (e) addressing social needs; and (e) providing culturally respectful care, to include spiritual care. Two major categories identified the needs of palliative care clinicians in the adoption of a PCI: (1) clinician education needs and (2) organizational challenges (Table 3).

Useful Practices in Meeting Patient and FCG QOL Needs

Buy-in and support from the PC team and referring clinicians was a significant element in referring lung cancer patients early in the trajectory of illness. Clear communication about the plan of care between the oncology and PC groups was seen as important to successful care. Interdisciplinary team planning which incorporated care planning was also viewed as a vital component to meeting the QOL needs of patients and caregivers. This was well illustrated by a response during one of the focus group sessions:

Giving them that support and using the interdisciplinary model ... If there is a psychosocial issue, we have a social worker there to sort of jump in and see if we can pick that apart, and the team allows that ... I will use the term 'dance'. If there is a spiritual thing that comes up, I am there. The doctor and the nursing team are great at assessing the physical part.

Addressing each dimension of QOL—physical, psychological, social, and spiritual—was discussed. Anticipating needs and keeping patients and family informed were considered vital in symptom management: “Maybe they don’t have any symptoms today but we know what it potentially will look like, so getting them kind of prepped for that.” Relationship building in which clinicians offer social support by “being there” and getting to know the patient is vital in building trust and communication with the patient and family. This was stressed as a key factor. Attention to spiritual needs was seen as important in helping patients and family cope and find meaning in illness. Specifically, assessing patients’ spiritual needs by asking questions concerning their spirituality was seen as necessary in providing culturally respectful spiritual care without imposing personal beliefs on the patient. Clinicians often explained addressing spirituality as taking the support role, as well as consulting with members of the interdisciplinary team such as a chaplain or social worker.

Challenges in Meeting Lung Cancer Patient and FCG QOL Needs

Introducing PC, planning interdisciplinary care, addressing social needs, and providing culturally respectful care were perceived as direct challenges in meeting lung cancer patient and FCG QOL needs through PC services. The stigma associated with PC was seen as a major challenge in introducing PC. Clinicians felt that an understanding of PC and the types of services offered was vital for the patient, FCG, and oncology clinician.

“A lot of the doctors are holding off on referring the patients to us because, sometimes the patients will think, “well if you refer me to palliative care, does that mean you’re giving up on me?” So, because of that stigma, the doctors, I think, are holding off.”

Communication with the interdisciplinary teams or other teams involved in the patients’ care was also a challenge, especially when discussing the goals of care: “I feel like sometimes there’s a disconnect, for me personally, between the palliative care, what the plan is, and what’s going on with the patient.” PC specialists felt a working relationship with the oncology team was vital in the communication and understanding of the patients’ care goals.

Addressing psychological and social needs was often a challenge due to the availability of resources, such as the lack of support groups for patients and FCGs. “We don’t, at this point, have any support groups, that’s something we’re hoping to start ... it’s just a hard thing for patients to find and they’re looking for them.” Both PC and oncology clinicians felt addressing patient and FCG spiritual needs in an open, helpful manner was difficult, as well as advocating for the patient while honoring the cultural needs and dynamics of the family.

Clinicians’ Perceived Supportive Needs in Adopting the PCI

Clinicians were asked about their needs regarding PC issues to better meet the needs of patients and their FCGs. Researchers asked clinicians about their needs and concerns in adopting the new structure PCI into their current practice. The educational needs of non-PC clinicians to enhance buy-in and increase early PC referrals, and in addressing the spiritual needs of patient and FCGs were discussed. Organizational challenges were identified, with similarities and differences noted between each site. Staffing constraints and workload, time constraints, and the work environment were considerations discussed within the organization.

LIMITATIONS

This study has limitations. Although it was convenient for this study to be embedded in a funded research project, recruitment and involvement of clinicians may not be easily transferable to other outpatient settings without this advantage. Though the presence of the PCI researchers enhanced the implementation process of the PCI, it cannot be ruled out that their presence influenced how clinicians responded to questions during the focus group interviews.

DISCUSSION

Clinicians have acknowledged that meeting the physical needs of patients includes symptom management. In fact, symptom management, encompassing pain control, was discussed across all interviews as a core component of PC for lung cancer patients. These findings were comparable to a study by Back and colleagues,¹⁰ which explored the perceptions of experienced PC teams on their roles in providing early PC in outpatient settings. Managing symptoms was seen as leading to patients’ improved functioning and as a bridge to other discussions such as emotional issues. Clinicians in this study reported that first addressing

symptom management helped build rapport and made it easier for patients to share their emotional and spiritual concerns, increasing trust between the provider, the patient, and their family. Clinicians then viewed their role as supporting the social needs of the patient and family caregiver.

The practice of addressing the social needs of patients and family caregivers by connecting them to financial resources and emotional support was described as care coordination by the clinicians interviewed for this study and in the current literature.²¹ Clinicians participating in this study further defined the practice as “relationship building,” in which they offered social support by “being there,” getting to know the patient and building trust and communication. While some felt that providing social support was part of the social workers’ role, especially when professional intervention was needed, all clinicians discussed the importance of providing emotional support for their patients. A challenge of addressing patient and FCG social needs was related to the resources available at each site; one example was the lack of support groups. While the notion of peer support is well referenced,²¹ the barrier ‘lack of support groups’ as mentioned by one of the three sites was not reported in the literature.

Addressing psychological needs was defined by clinicians in this study as addressing patient and family mental well-being or any related distress associated with illness. Perspectives of clinicians were that both patients and FCG experience psychological distress. They further described their experiences with patients and family members who exhibited forms of grief, uncertainty, anger, resentment, isolation, and anxiety. Likewise, depression and anxiety are common types of psychological needs experienced by lung cancer patients.²² A number of researchers referenced the importance of recognizing when a patient was exhibiting these symptoms, providing education on symptoms, and anticipating future needs for psychological support. These practices were useful in facilitating coping and decreasing the anxiety of not knowing what to expect. Likewise, Le, Mileskin, Doan and colleagues,¹³ described the roles of PC clinicians in helping facilitate patient’s emotional coping, acceptance, and planning. Meeting the psychological needs of patients and FCGs was aided by resetting goals and expectations for treatment as the patient’s prognosis changed. These changes were described in the literature as “transitions”.²⁴ During times of transition the need to provide both psychological and spiritual support for patients is especially high. Transitions occur most often during four critical points: diagnosis, completion of treatment, disease progression, and terminal care.²⁴ Clinicians framed the challenge to follow-up with patients throughout their treatment as an organizational challenge of inadequate social work staffing. The lack of psychological follow-up and targeted psychological interventions have often been pointed out in clinical practice.²⁵ Clinicians’ challenges in providing culturally respectful spiritual care were in assessing spiritual needs, not having enough time, and feeling uncomfortable discussing spiritual issues. Similarly, it was reported that conducting a spiritual history with a patient, or communicating about spiritual needs is most difficult, especially at the end of life.²⁶

IMPLICATIONS FOR NURSING

There is a lack of clarity on palliative care services among clinicians who are not a member of a specialized palliative care team. Implications for nursing education lie in clearly

defining PC to decrease stigma and to promote the early integration of PC into standard oncology care.⁴ This study elicited the perspectives of highly trained and experienced interdisciplinary clinicians on the subject of palliative care in community-based settings. Training in the general concepts should include an assessment of QOL needs of cancer patients, with attention to symptom management, and psychological, social support, and spiritual needs. This general assessment should be done prior to consulting specialized PC services, leaving a more in-depth comprehensive assessment of the patient in need of PC services.⁴ It may be useful to identify signs to help nurses and clinicians know when to consult PC teams.

CONCLUSION

This study provides insight into the way experienced clinicians approach the quality of life needs of lung cancer patients and their family caregivers. This was a multi-site study involving several disciplines (e.g. nurse, physician, social work, and chaplain) involved in the care of lung cancer patients and FCGs. This study is unique because it translates the perspectives of clinicians involved in an ongoing PCI study into community-based settings and describes the “real-world” challenges of integrating palliative care into patient treatment. The perspectives on the useful practices and challenges of early integration of PC into standard oncology care lends insight on the significance of educating patients, FCGs, and clinicians on what is unknown, about PC services. Future studies in the translation of PCIs into clinical practice must include the perspectives of palliative care nurses, who are influential in implementing palliative care into community practice.

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Table 1**Questions Guiding Focus Group and Key-Informant Interviews**

Topics and Introduction	Focus Group Guiding Questions	Prompts to be used as needed
Strengths of Palliative Care First, we want to learn from you about your positive experiences of addressing patient and family needs. This includes their physical, psychological, social, and spiritual needs.	Take this piece of paper and write down three things that you feel your palliative care team does particularly well in improving patients' and family caregivers' needs-please address their physical, psychological, social and spiritual well-being.	A number of you said X was a strength. Talk more about that. Discuss two or three items as time allows.
Challenges/Barriers to Palliative Care Now let's talk about what needs improvement. Let's use the same process	Using the same piece of paper, write down three things you find particularly difficult in improving patients' and family caregivers' needs-again, please address their physical, psychological, social and spiritual well-being.	What strategies have you used to overcome these barriers? - How successful were you in overcoming these barriers? - What did you learn?
Minority/Cultural Needs. We are also interested in tailoring a palliative care intervention to meet your patient population. We are interested to explore the cultural barriers and needs of your patients and families.	Think of an encounter that you found particularly difficult or unique in providing culturally sensitive palliative care to patients with lung cancer. Please tell us about this encounter and what you found to be difficult or unique Are there any cultural barriers that you see in the population that you serve?	Are there any noticeable trends seen in the populations that you serve? - Describe your response to their needs. - How confident were you in your ability to meet their needs?
Clinicians Needs We are interested in your needs as clinicians and how the palliative care intervention should be structured to best serve you as you care for patients and families with lung cancer.	What are your concerns regarding implementation of the palliative care intervention?	How might this structured palliative care intervention change your current workflow? - Discuss areas of training that may help prepare you to be more effective in providing palliative care. - In what areas and how can communication be improved amongst your interdisciplinary team? - What have you learned from Phase I with patient and caregiver recruitment that might be helpful to inform Phase II?

Table 2

Characteristics of health care clinicians who participated in focus groups and interviews

Study Sample (<i>N</i> = 19)		
Variable	<i>n</i>	%
Focus groups or Phone Interview		
Focus group	14	73.7
*Phone interviews	5	26.3
Sex		
Male	7	38.8
Female	12	63.2
Racial/Ethnic Identity		
African-American	1	5.3
Asian/Pacific Islander	5	26.3
Caucasian (non-Hispanic)	9	47.4
Latino or Hispanic	4	21
Discipline		
Physician/Oncology	1	5.3
Physician/Thoracic Surgeon	1	5.3
Physician/Palliative Care	3	15.8
Nurse/Oncology-Coordinator	2	10.5
Nurse/Palliative Care-Clinician	6	31.6
Nurse/Palliative Care-Administrator	2	10.5
Chaplain/Palliative Care	2	10.5
Social Work/Palliative Care	2	10.5
	<i>M</i>	<i>SD</i>
Mean Age by Discipline		
Nurse	47.5	23.6
Physician	50	24.9
Social Work	52	25.9
Chaplain	51.5	25.6
Mean Years of Experience in Discipline		
Nurse	15.2	24.7
Physician	19.8	32.2
Social Work	18	29.3
Chaplain	8.5	13.8

* Individual phone interviews were conducted with one oncology physician, one thoracic surgeon, three oncology nurses, and one chaplain.

-All nurses in study were registered nurses (RN).

Table 3**Key Findings**

Clinicians' Perceived Needs in Order to Support Patient and FCGs across QOL Dimensions and Needs in Adopting the PCI.

Categories and Description	Sub-category and Text Exemplar
Education Needs Training and education needs of clinicians in meeting patient and family caregiver QOL needs and adopting the PCI.	Support in providing spiritual support for patients and family caregivers: "I would welcome help in that area. If we can recognize it I guess is the problem." (Nurse) "We need proper training to address it." (Nurse) Non-Palliative Care Clinician education on Palliative Care Services to increase organizational buy-in and palliative care referrals "On the education side, we're still a black box I think. We're getting out there to educate with internal medicine with all the sub-specialties. I would say, organizationally, even getting buy-in to educate staff (Nurse).
Organizational Challenges Challenges in meeting patient and family caregiver QOL and adopting the PCI related to constraints or workflow of the organization.	Staffing constraints and workload: "Our challenge with us on the social medicine piece is that we don't have enough bandwidth.... we've just added another social worker to assist with that battle. We're addressing social needs right then and there. But then, follow up is lacking. " (Nurse). "It would be great to have, maybe a chaplain available because I think most of us share privately we feel we're limited because we don't have the proper training to maybe address it." (Nurse) Time constraints: "The biggest is time constraints... the teaching sessions will take time and preparation and creating a plan for each patient, so I know it's going to take time, and we are quite stretched as we are." (Nurse) Environment: "When I say environment, I mean there's less opportunity to talk about spirituality. It's just the way inpatient is set up. There just so much going on and so many people. " (Nurse).
Outcome of Focus Group towards Adoption of a new PCI for lung cancer patients and family caregivers	Buy-in from clinicians " "The way I would say it is that the palliative care intervention is excellent. It should be done." (Physician) Opportunity for Interdisciplinary Team Collaboration: "It's good to take a minute to just, see where we're at, you know... and what's working and what isn't, It's a helpful dialogue." (Chaplain)