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Barriers and Facilitators to Effective Inpatient Palliative Care Consultations: A Qualitative Analysis of Interviews With Palliative Care and Nonpalliative Care Providers

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Abstract

Objective: To identify factors that hinder or facilitate the palliative care consultation team's (PCCT) successful collaboration with other providers from the perspectives of both PCCT and nonpalliative specialists.

Methods: Qualitative study, including semistructured interviews with PCCT and nonpalliative care providers from various specialties at 4 Midwestern hospitals. Interviews were audio-recorded and transcribed into written text documents for thematic analysis. Palliative care consultation team (n = 19) and nonpalliative care providers (n = 29) were interviewed at their respective hospital sites or via telephone. Palliative care consultation team providers included physicians, nurse practitioners, registered nurses, social workers, and one chaplain. Specialists included critical care physicians, surgeons, hospitalists, nephrologists, oncologists, and cardiologists.

Results: Six themes emerged reflecting barriers to and facilitators of successful collaboration between the PCCT and other providers. Primary barriers included attitudes about palliative care, lack of knowledge about the role of the PCCT, and patient and family resistance. Facilitators included marketing of the palliative care service and education about the expertise of the PCCT.

Conclusion: In order to engage in more effective collaboration with other specialty providers, the PCCT may consider strategies including structured educational interventions, increased visibility in the hospital, and active marketing of the utility of palliative care across disciplines.

Keywords

palliative care; interprofessional relations; referral and consultation; inpatients; qualitative research

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Introduction

Inpatient palliative care consultation teams (PCCTs) enhance patient and family satisfaction and decrease health-care spending.¹⁻⁴ However, successful PCCTs require effective collaboration with other inpatient providers. Various factors, including open communication, knowledge of and respect for interprofessional competencies, and shared responsibility for success, may influence the quality of collaboration with PCCTs.⁵

Previous research has identified barriers that affect providers' openness to professional collaboration by examining their willingness to seek out consultations from the PCCT. For example, patients with cancer cite lack of physician referral as a barrier,⁶ and physicians' attitudes toward and knowledge about palliative care may influence their willingness to collaborate with PCCT providers.⁷⁻¹⁰ As a result, the extent to which specialty providers understand the expertise of the inpatient PCCT may affect their desire to seek out a consultation.^{11,12}

Previous work has also provided direct evidence about what specialists believe affects consultation interactions with the PCCT.^{9,13} For example, specialist providers report that their level of trust in the care provided by the PCCT, the PCCT's level of expertise, and the degree to which care is integrated all influence their collaboration with the PCCT.¹³ Additionally, provider beliefs about the roles of different health-care professionals in the consultation process may affect expectations about how the process should unfold.¹⁴

A recent set of important studies by Firn and colleagues identified and qualitatively synthesized¹³ barriers to collaboration between palliative care and other providers, highlighting specialists' perspectives on factors that diminish the quality of the consultation process. To our knowledge, however, no studies have examined PCCT and specialist provider perspectives within the same hospital settings concurrently or considered the extent to which professional interactions influence specific aspects of the consultation process (eg, requesting a consultation, working together on patient care, and implementing recommendations). Furthermore, much of the previous qualitative work in this area is limited to small, homogeneous samples and is thus limited in its generalizability. Additional, contemporary research in this area could help PCCT providers optimize professional interactions across the consultation process.

Consequently, the goals of the current study were to (1) investigate PCCT providers' and nonpalliative specialist providers' perceptions of the palliative care consultation process, including barriers to the maximal utilization of the PCCT, and (2) describe the nature of professional interactions between the PCCT and specialists in order to gain better insight into factors that may influence successful team collaboration.

Method

Participants and Procedure

Approval to conduct this study was granted by the Washington University's institutional review board in June 2017. Participants were provided with a study information sheet prior to the start of the interview.

We interviewed PCCT and non-PCCT providers at four Midwestern hospitals between July 2017 and July 2018 (Tables 1 and 2). Of 22 PCCT providers contacted, 19 (86.3%) agreed to participate (Table 2). Each PCCT team developed a list of non-PCCT providers to contact, including providers who either (1) regularly consulted the PCCT, (2) occasionally consulted the PCCT, or (3) did not regularly consult the PCCT, but could, based on their typical patients. Specialty providers were contacted by e-mail to solicit participation: Of 117 providers contacted, 29 (24.8%) agreed to participate (Table 2). The majority of non-PCCT providers who agreed to participate were those who the PCCT had described as "regular" or "moderate" consultation requestors.

Interviews were conducted individually, in a private space in each hospital, or via telephone when an in-person interview could not be arranged ($n = 3$). A graduate student (M.M.) conducted 43 interviews, and a medical fellow trained in the interview procedure conducted 5 interviews. All providers responded to a brief, anonymous demographic survey before the interview. Semistructured interview questions were developed based on a review of research in this area, along with observations during a previous quantitative study.^{15,16} Questions were designed to elicit information about team interactions, the qualities of "successful" and "unsuccessful" palliative care consults, reasons providers might consult the PCCT, responsibilities performed by a PCCT, and types of recommendations requested from and made by the PCCT. Questions contained slightly different content based on the interviewee's role (PCCT or non-PCCT provider). On average, interviews lasted 24:25 minutes (standard deviation = 9:03, range = 8:41–53:59).

Data Analysis

Interviews were audio-recorded and transcribed into text documents. We followed an iterative coding procedure for a thematic analysis of the interview data,¹⁷ which allowed us to specify themes in advance based on previous literature and to identify themes inductively as they emerged during coding.¹⁸

Following standards for conducting and reporting qualitative research,¹⁹ we operationally defined deductive codes, then both coders (M.M. and B.D.C.) independently read the first 5 interviews, applying codes and also coding inductively to address emergent concepts. The coders met to discuss and compare the utility of predefined codes and the emergence of new codes. We collapsed codes and redefined others to address discrepancies, then we independently reviewed the first 5 interviews again to resolve discrepancies and apply the updated coding scheme. We applied the same iterative coding procedure until we had both coded 12 interviews with PCCT providers, at which point we had resolved all coding discrepancies. Based on the coding consistency we had achieved, M.M. independently coded the 7 remaining PCCT interviews. The same coding procedure was used for interviews with

non-PCCT providers. Interview responses from non-PCCT providers fit into the preexisting codes created for the PCCT interviews, so the 2 coders only read 5 non-PCCT interviews together to substantiate agreement. M.M. coded the remaining 24 interviews independently, and B.D.C. was consulted when questions surfaced. We utilized QSR International's NVivo 10 Software to support data analysis.

Results

Across 6 themes (see Table 3), provider responses indicated factors that inhibit the consultation process, as well as mechanisms by which these barriers could be reduced. These themes reflect the perspectives of palliative and nonpalliative providers about the collaborative consultation process (Table 4).

Theme 1: Interactions Between Providers

Potential barriers.—Participants reported interactions between PCCT and non-PCCT providers that were inconsistent and superficial, limiting opportunities for deeper collaboration. Despite having some formal interactions, like interdisciplinary meetings, hospital lectures, and grand rounds, these interactions were described as irregular and not conducive to direct conversations among providers. In contrast, the majority of the interactions between PCCT and non-PCCT providers were described as more informal, brief, and patient focused. Providers stated that they rarely have conversations about personal topics or engage in personal activities together.

Strategies to facilitate.—Both PCCT and non-PCCT providers discussed the key role of visibility of the PCCT team, in both facilitating new consultations and maintaining positive relationships between providers. One provider described her colleague's strategy of "chart[ing] in the area where she was more visible" to reinforce the PCCT's presence (Table 4). Providers also discussed unintentional visibility (eg, passing each other in the hallway) as unplanned, but equally important.

Theme 2: Patient and Family Perceptions About Palliative Care

Potential barriers.—Providers described patient and family confusion about palliative care as an impediment to successful collaboration, both in terms of requesting an initial consultation and during collaboration. A family's active resistance to the PCCT's involvement in care could prevent providers from seeking out a consultation altogether or affect involvement of the PCCT after a consultation is requested.

Strategies to facilitate.—Providers discussed ways to increase education about palliative care among patients and families, as well as in the community. For example, some providers suggested that positive outpatient experiences might soften a patient's interest in palliative care down the line.

Theme 3: Provider Attitudes Toward Palliative Care

Potential barriers.—Both palliative and nonpalliative staff described or endorsed several negative attitudes and beliefs about palliative care among non-PCCT providers. Some of

these attitudes were rooted in misinformation and lack of knowledge about the true scope of palliative care, yet others reflected differences in philosophy about medicine and practice.

Similarly, several participants pointed out that palliative care can be perceived as a last resort and that providers do not want to believe themselves or suggest to their patients that the chosen course for future care reflects futility. Other providers alluded to deeply rooted beliefs in self-sufficiency among non-PCCT providers that might prevent them from seeking palliative care consults.

Strategies to facilitate.—Providers discussed the importance of marketing the utility of the PCCT. Although participants reported that their respective PCCTs had presented at events within each hospital, they also stated that even more of these events could underscore the utility of palliative care. Palliative care consultation teams providers also described the value of demonstrating their relevance across specialties: They tend to receive consults from providers who understand how palliative care can support their patients' needs. They stated that cultivating positive views about the service and its utility for different specialties via exposure could facilitate the consultation process. Lastly, providers discussed the utility of the longstanding, trusted relationships that they had developed with certain providers over time and the direct effect of these relationships on their collaboration.

Theme 4: Education and Training About Palliative Care

Potential barriers.—Providers described systemic deficits in education about palliative care, as well as the pervasive confusion between palliative care and hospice. Participant responses implied that the general misunderstanding of palliative care as synonymous with hospice care stems from a broader misrepresentation of palliative care in the education and training of medical providers. Furthermore, providers underscored that this misunderstanding is still widespread, despite attempts to improve education about key differences between the two.

Strategies to facilitate.—Similar to the mechanisms suggested to address negative provider beliefs about the PCCT, providers pointed to education about palliative care and its utility for different specialties as the best way to correct misconceptions about the role of the PCCT and misinformation about differences between palliative and hospice care.

Theme 5: The Role of the PCCT

Potential barriers.—Both PCCT and non-PCCT providers' descriptions of the roles and responsibilities of the PCCT highlighted discrepancies in perspective that may not only obstruct providers from seeking the input of the PCCT but could also reduce meaningful collaboration once the consultation process is underway. For example, almost all PCCT and non-PCCT providers agreed that facilitating communication is a key role of the inpatient PCCT. However, there was a divergence in responses between providers in terms of what communication with families should entail, as well as ambiguity about requesting providers' true reasons for consulting and the PCCT's perceived reality about the services they can and should provide.

Furthermore, providers generally agreed that pain and symptom management are key roles of the PCCT. However, some non-PCCT providers added caveats to the utility of the PCCT's expertise in these domains, such as their ability to manage strong pain medications in the outpatient setting after discharge.

Strategies to facilitate.—In addition to providing more education surrounding the goals of palliative care, providers also described strategies to market the intended roles of the PCCT. Other non-PCCT providers described explicit tactics that could be used to correct misperceptions about the PCCT's scope of practice.

Theme 6: PCCT Recommendation Implementation

Potential barriers.—Non-PCCT providers stated that they generally follow PCCT recommendations, but responses were mixed regarding pain and symptom recommendations. For example, participants occasionally described reluctance to implement certain pain medication recommendations (eg, opioids) when other providers do not feel informed or comfortable about using it.

Strategies to facilitate.—Palliative care consultation team providers described situations when their recommendations were typically followed, including when they are for a certain team (ie, "Gynecology always takes our recommendations."), they address a particular symptom (ie, "I think probably mine related to constipation."), or they apply to a specific location (ie, "Out on the floor ... upwards of 85%–90% of the time [they] listen to my recommendations ... less in the ICU.").

However, PCCT providers also described specific strategies to convey their recommendations when they are writing notes in a patient's chart, like writing out the explicit drug, route, dose, and timing, or "giving rationale for why I'm recommending what I am." (PCCT nurse practitioner) Palliative care consultation team providers also discussed follow-up strategies to maximize the likelihood of implementation, such as following up "with a phone call, or face to face." (PCCT physician)

Discussion

Insights from the current study suggest that inpatient PCCTs still face challenges in their work with other providers but that there may be methods to enhance the collaborative consultation process, especially through targeted educational and training interventions to increase knowledge about the utility of palliative care. Our study extends previous work that addresses similar issues^{9,13} by evaluating barriers to interprofessional collaboration between PCCTs and other hospital providers from the perspectives of both groups simultaneously and illuminating areas where these perspectives converge and diverge.

What Are the Barriers to Collaboration and How Can the PCCT Address Them?

Our findings underscore that barriers, some unique, and others reported in the literature as many as 10 years ago, continue to inhibit successful collaboration between PCCT and other providers.¹³ Some of these challenges stifle opportunities for collaboration with other providers altogether, and others interfere with collaboration once the consultation process is

underway. The most intransigent challenge to getting palliative care consultations is misunderstanding about the role of the PCCT. For example, many non-PCCT providers in this study associated palliative care with hospice care and described it as a “last resort.” These provider beliefs exist across specialty practices and seem to reinforce the perception of palliative care as solely end-of-life care, a misunderstanding palliative care has been battling since its inception.²⁰

However, providers described methods to combat the barriers posed by lack of education and provider misconceptions, including providing formal workshops, seminars, and educational opportunities. The need for greater education about palliative care among medical students and medical professionals has also been underscored in previous literature,²¹ yet few studies supply a framework for targeted educational interventions about palliative care as a specialty practice or evaluate such interventions rigorously, despite the fact that those tested have produced promising results.^{22,23} Increased opportunities for structured education, especially for currently practicing providers, may highlight the utility of the PCCT as a complementary care partner.

Participants in this study also described a sense of self-sufficiency among non-PCCT providers, who felt they already provided something equivalent to palliative care independently. This assumption by non-PCCT providers is important to understand and evaluate. It may be the case that some non-PCCT providers are quite skilled, but it is unclear whether that is true, in which case the specialized competencies of the PCCT may go underutilized.^{24,25} There is a consensus that training is required in order to prepare nonpalliative care specialists,²⁶ and training in primary palliative care will be essential, given the limited availability of palliative care specialists.²⁷ Education about basic palliative care approaches may help non-PCCT providers recognize complex care situations when a referral to palliative care would be beneficial and simultaneously empower them to deliver high-quality, palliative informed care for less complex cases.²⁸

Participants in this study described other strategies that could facilitate the receipt of new consultations and the consultation process, including strategic visibility, which has also been identified by providers in previous research.¹³ Palliative care providers might consider using this technique more intentionally in order to maximize contact with other providers and maintain a presence throughout the hospital.

Participants also suggested that collaboration is enhanced when providers have a clear understanding of the utility of palliative care. Beyond targeted educational interventions, providers cited the value of “marketing and promoting,” via case presentations and in-services, so that colleagues better understand how the PCCT could complement their specialty practice. However, it is likely that the content highlighted by the palliative care team during educational and marketing events may directly affect providers’ perceptions of the PCCT, so it is essential for PCCT providers to strategize how best to portray their service to other providers. For example, PCCTs may choose to highlight different aspects of their service based on the discipline of the audience, the previous professional and educational experiences of their colleagues, and the PCCT’s understanding of what usual services they can offer to that provider’s clientele.

Lastly, providers suggested that longstanding, trusted relationships among providers facilitate collaboration. Some relationships are the result of working together for long periods of time and are therefore not amenable to brief interventions, but there may be ways to enhance working relationships that would require minimal investment by PCCTs. For instance, research in other contexts has demonstrated the value of nurturing familiarity and friendships in work contexts.^{29,30} Although limited research evidence exists about the role of personal relationships among health-care providers,³¹ findings from this study support the idea that facilitating more meaningful, personal connections between PCCT and non-PCCT providers may enhance collaboration by promoting trust and shared values.

Limitations and Future Directions

This study provides insights into the workings of several diverse PCCTs and the providers who interact with them, although the study was limited in several ways. First, because the disciplines of our non-PCCT providers were heterogeneous, patterns in perceptions of the PCCT by type of provider could have been obscured. Additionally, it is possible that providers who chose not to participate in the study could have different insights not represented in the current data.

Future research might explore the value of educational interventions aimed at resolving discrepancies in the perceived function of the PCCT. These interventions could include structured educational opportunities organized by members of the PCCT (eg, presentations for individual practices and subspecialties), as well as informal social opportunities to encourage the exchange of personal and professional information between PCCT and non-PCCT providers and promote the development of trusted provider relationships. More evidence would be needed to evaluate the effectiveness of these interventions and their impact on collaborative palliative care consultations.

Conclusion

This study highlights barriers to collaboration between PCCT and non-PCCT providers, including lack of knowledge about the specialty, varying perceptions about the PCCT's role, and a general belief among providers that PCCT expertise, while clearly present, is not always necessary. However, providers also pointed to strategies that facilitate collaboration, including educational and marketing interventions, that might remedy some of the most daunting factors inhibiting effective collaboration. Meaningful interprofessional teamwork and collaboration is essential, relying on the contributions of all providers involved.

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References

1. Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Aff.* 2011;30(3):454–463.
2. Casarett D, Johnson M, Smith D, Richardson D. The optimal delivery of palliative care: a national comparison of the outcomes of consultation teams vs inpatient units. *Arch Intern Med.* 2011; 171(7):649–655. [PubMed: 21482838]
3. Morrison RS, Penrod JD, Cassel B, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med.* 2008;168(16):1783–1790. [PubMed: 18779466]
4. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med.* 2010;363:733–742. [PubMed: 20818875]
5. O'Daniel M, Rosenstein AH. Professional communication and team collaboration In: Hughes RG, ed. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* Rockville, MD: Agency for Healthcare Research and Quality; 2008.
6. Kumar P, Casarett D, Corcoran A, et al. Utilization of supportive and palliative care services among oncology outpatients at one academic medical cancer center: determinants of use and barriers to access. *J Palliat Med.* 2012;15(8):923–930. [PubMed: 22731514]
7. Ahmed N, Bestall JC, Ahmedzai SH, Payne SA, Clark D, Noble B. Systematic review of the problems and issues of accessing specialist palliative care by patients, carers, and health and social care professionals. *Palliat Med.* 2004;18(6):525–542. [PubMed: 15453624]
8. Buckley de Meritens A, Margolis B, Blinderman C, et al. Practice patterns, attitudes, and barriers to palliative care consultation by gynecologic oncologists. *J Oncol Pract.* 2017;13(9):e703–e711. [PubMed: 28783424]
9. Firn J, Preston N, Walshe C. What are the views of hospital-based generalist palliative care professionals on what facilitates or hinders collaboration with in-patient specialist palliative care teams? A systematically constructed narrative synthesis. *Palliat Med.* 2016;30(3):240–256. [PubMed: 26873984]
10. Smith TJ, Coyne PJ, Cassel JB. Practical guidelines for developing new palliative care services: resource management. *Ann Oncol.* 2012;23(3):ii70–ii75.
11. Salerno SM, Hurst FP, Halvorson S, Mercado DL. Principles of effective consultation: an update for the 21st century consultant. *Arch Intern Med.* 2007;167(3):271–275. [PubMed: 17296883]
12. Sibert L, Lachkar A, Grise P, et al. Communication between consultants and referring physicians: a qualitative study to define learning and assessment objectives in a specialty residency program. *Teach Learn Med.* 2002;14(1):15–19. [PubMed: 11865743]
13. Firn J, Preston N, Walshe C. Ward social workers' views of what facilitates or hinders collaboration with specialist palliative care team social workers: a grounded theory. *BMC Palliat Care.* 2018; 17(1):1.
14. Oishi A, Murtagh FEM. The challenges of uncertainty and inter-professional collaboration in palliative care for non-cancer patients in the community: a systematic review of views from patients, carers, and health-care professionals. *Palliat Med.* 2014;28(9):1081–1098. [PubMed: 24821710]
15. Kozlov E, Carpenter BD, Thorsten M, Heiland M, Agarwal A. Timing of palliative care consultations and recommendations: understanding the variability. *Am J Hosp Palliat Med.* 2015; 32(7):772–775.
16. Kovlov E, Carpenter BD, Thorsten M, Heiland M, Agarwal A. Palliative care consultation trajectories. *Am J Hosp Palliat Med.* 2014;31(4):459–463.
17. Miles MB, Huberman AM, Saldaña J. *Quantitative Data Analysis: A Methods Sourcebook.* 3rd ed. Thousand Oaks, CA: SAGE; 2014.
18. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qualitative Meth.* 2006;5(1):80–92.

19. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245–1251. [PubMed: 24979285]
20. LeBlanc TW, O'Donnell JD, Crowley-Matoka M, et al. Perceptions of palliative care among hematologic malignancy specialists: a mixed-methods study. *J Oncol Pract*. 2015;11(2): e230–e238. [PubMed: 25784580]
21. Horowitz R, Gramling R, Quill T. Palliative care education in US medical schools. *Med Educ*. 2014;48(1):59–66. [PubMed: 24330118]
22. Head BA, Schapmire TJ, Earnshaw L, et al. Improving medical graduates' training in palliative care: advancing education and practice. *Adv Med Educ Pract*. 2006;7:99–113.
23. Aldridge MD, Hasselaar J, Garraida E, et al. Education, implementation, and policy barriers to greater integration of palliative care: a literature review. *Palliat Med* 2015;30(3):224–239. [PubMed: 26405109]
24. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. 2013 https://www.nationalcoalitionhpc.org/wp-content/uploads/2017/04/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf. Accessed 28 March 2018.
25. Schaefer KG, Chittenden EH, Sullivan AM, et al. Raising the bar for the care of seriously ill patients: results of a national survey to define essential palliative care competencies for medical students and residents. *Acad Med*. 2014;89(7):1024–1031. [PubMed: 24979171]
26. Quill TE, Abernethy AP. Generalist plus specialist palliative care—creating a more sustainable model. *N Engl J Med*. 2013; 368:1173–1175. [PubMed: 23465068]
27. Weissman DE, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the center to advance palliative care. *J Palliat Med*. 2011; 14(1):17–23. [PubMed: 21133809]
28. Lupa D Estimate of current hospice and palliative medicine workforce shortage. *J Pain Symptom Manage*. 2010;40(6): 899–911. [PubMed: 21145468]
29. Riordan C, Griffeth RV. The opportunity for friendship in the workplace: an underexplored construct. *J Business Psychology*. 1995;10(1):141–154.
30. Berman EM, West JP, Richter MN Jr. Workplace relations: friendship, patterns, and consequences (according to managers). *Public Administration Review*. 2002;62(2):217–230.
31. Yang LS, Yang HH, Chen HT, et al. A study of nurses' job satisfaction: the relationship to professional commitment and friendship networks. *Health*. 2012;4(11):1098–1105.

Table 1.

Characteristics of PCCTs at Study Sites.

Site	Hospital A	Hospital B		Hospital C		Hospital D	
	University medical center	Community hospital		Community hospital		Community hospital	
Setting	Urban	Suburban		Suburban		Suburban	
Providers (total)	7	3		9		3	
Chaplains	1	0		0		1	
Nurses	0	3		0		0	
Nurse practitioners	2	0		5		0	
Physicians	2	0		3		1	
Social workers	2	0		1		1	
Year team initiated	2005	2003		2004		2012	

Abbreviation: PCCT, palliative care consultation team.

Table 2.

Characteristics of PCCT and Non-PCCT Provider Participants.

Variable	PCCT Members (n = 19)		Non-PCCT Providers (n = 29)	
	n/M	%/SD	n/M	%/SD
Age	53.1	10.9	47.6	9.4
Gender (% male)	3	15.8	21	72.4
Race				
Asian	1	5.2	8	27.6
Black	2	10.5	1	3.4
Hispanic/Latino	0	0	1	3.4
Other race	1	5.2	1	3.4
White	15	78.9	18	62.1
Type of provider				
Chaplain	1	5.2	0	0
Nurse	3	15.8	0	0
Nurse practitioner	7	36.8	1	3.4
Physician	5	26.4	28	96.6
Social worker	3	15.8	0	0
Length of employment as provider				
2–5 years	2	10.5	5	17.2
6–10 years	5	26.3	4	13.8
11–15 years	2	10.5	6	20.7
16–20 years	3	15.8	2	6.9
20+ years	7	36.8	12	41.4

Abbreviations: PCCT, palliative care consultation teams; SD, standard deviation.

Table 3.
Themes From Semistructured Interviews with PCCT and Non-PCCT Providers.

Theme	Potential Barriers	Strategies to Facilitate
Interactions between providers	- Formal interactions (grand rounds, lectures, and presentations) are infrequent and provide little opportunity for conversation - Informal interactions are largely focused on patient care - Providers tend to have exclusively professional relationships with one another	- Strategic visibility (rounding and spending time on patient floors, attending hospital-wide events with consistency) - Unintentional visibility (being present around the hospital) - Nurturing casual relationships
Patient and family perceptions about palliative care	- Patients and families resist the involvement of the PCCT in care - Patients and families are often confused about why the PCCT is involved once a consultation has been placed	- Increase opportunities to educate in the inpatient setting (eg, informational videos) - Educate the community - Bolster support via positive outpatient experiences
Provider attitudes toward palliative care	- Self-sufficient, can provide palliative care independently - Consulting the PCCT implies failure or is a last resort	- Demonstrate the utility of palliative care for different patient populations via exposure - Cultivate trusted relationships with providers who may consult
Education and training about palliative care	- Curricula and other practical training for health-care providers do not adequately address palliative care - Confusion between palliative care and hospice	- Provide education to providers earlier in training sequence - Demonstrate the utility of palliative care across disciplines
The role of the PCCT	- Pain/symptom management is key role, but providers are hesitant about some medications - Communication is another key expertise, but expectations about content may diverge	- Expand outpatient services to ensure management after discharge - Market role of PCCT as intended - Provide education about scope of competencies
PCCT recommendation implementation	Providers sometimes hesitate to prescribe strong pain medications	- Provide clear, explicit rationale and empirical support for suggested recommendation - Use verbs like “recommend” instead of “suggest” to convey recommendations - Follow-up with direct contact to explain recommendations and urge implementation

Abbreviation: PCCT, palliative care consultation team

Table 4.

Sample Direct Quotes From PCCT and Non-PCCT Providers.

Theme	Potential Barriers	Strategies to Facilitate
Interactions between providers	"Most of the people who consult us are in the internal medicine department, and in that case, we have shared conferences. Most of them are large, so they're not the sort of conferences that we go to and have a discussion at." (PCCT physician) "My interactions with them are typically one-on-one with the head of the palliative care team, in the hospital or on the phone in the hospital, so either at the nursing unit or on the phone where I've consulted them or asked for the team's help." (Cardiothoracic surgeon)	"She would sit out and chart in the area where she was more visible, because... if we're walking by and somebody sees us, it prompts [them]. When you're in front of them, on the floor, we're more apt to pick up another one." (PCCT registered nurse) "Because obviously if you see Dr X [PCCT physician] up there talking about palliative care, it keeps it in your mind which one of your patients might benefit, more in real time." (Colorectal surgeon)
Patient and family perceptions about palliative care	"We walked in the door into the room and her sister was there ... And she says, 'So you're here to pull the plug?' We said, 'No, we're here to provide support and just assure those goals and so forth that your sister has and your family, if they can be reached, we can try to provide support.' 'You're here to pull the plug, aren't you?' We said, 'Not really.' So that's about it, and she threw us out." (PCCT physician) "It may seem appropriate to us but they [some patients and families] haven't quite mentally gotten there, and I think that's where sometimes we have some difficult things." (Critical care physician)	"We're doing a video in the ICU [that]... has a couple minute blurb on palliative care and why we can be involved." (PCCT nurse practitioner) "We've had a couple of cardiologist patients as outpatients that I think we had some positive effects on, and I'm hoping that means that when they go back to see their cardiologist they understand that we do offer some value that's different than what they do and that's helpful in their work." (PCCT physician)
Provider attitudes toward palliative care	"[They believe that] any PC involvement will signal to the patient and family that death is imminent and [that] our agenda is to stop whatever active treatment they are doing and prepare for hospice." (PCCT physician) "Like, 'We're going to give up, so we'll consult palliative care.' And I don't believe that's really what it really is, so I think that we would consult more if we didn't have this kind of bias about that and feeling like that was synonymous with giving up." (General surgeon)	"... building relationships with not only the physician providers but the NPs out there, the nurses, like the nurses in the ICUs, the nurses on the TCU, the ground level people, if you will. I think just developing those relationships and reminding them because they can advocate for a consult sometimes, I think that makes a big difference." (PCCT social worker) "I think the biggest thing for palliative care is making a relationship with that patient or that family, because for some there is a trust issue, so if they don't trust you, they will not listen to you. Same with the doctors, but if they don't trust you and you don't have a relationship with them, they're not going to listen to you at all." (Internist)
Education and training about palliative care	"I think some of it is misconceptions. Palliative care is a relatively new specialty, really, in the last 15–20 years it's kind of really taken off, so there's a lot of providers who were not trained in a time that it existed, and I do think that there is a generational impact, providers who only see it as hospice and end of life and who have not been able to make the shift to recognize that we offer more than that." (PCCT social worker) "People don't consult me because they think we are a rebranding of hospice. I think that people don't always understand the scope of what we do, that we can help with advance care planning, goals of care discussion, symptom management, I think they don't quite understand, I think they just see us as the pre-hospice crew or the death squad. 'Well, I'm not going to call you because my person's not dying yet, I don't need palliative care because they're still warm, and therefore they don't need you.' So they don't understand, so I think there's some lack of education." (PCCT physician)	"It's kind of a nebulous field, makes it more difficult. People have a hard time understanding what we do... and I think we need to do a better job presenting what we actually do and what value we add." (PCCT physician) "When it comes to the residents, we do formal teaching with them... I think that has helped in disseminating the word about what PC can do at different levels." (PCCT physician)
The role of the PCCT	"I think they have evolved into this communication type service, and they're trying to do more than just focus on death and dying." (Critical care physician) "I think we get consulted a lot when somebody is getting really sick, and they're not going to get better. And the family wants to continue with aggressive care and the medical team doesn't think that's a good idea, and it's kind of a secret, 'Please change my code status,' consult... and you know, sometimes we are able to do that, and sometimes we aren't." (PCCT social worker) "Sometimes if it's a complex pain issue, and I'm looking for more novel ideas about how to manage it, sometimes they can come up with things that I don't, because it's their expertise. So when I feel like I'm pushed to my limits, I always wanna acknowledge, 'It seems I don't know,' and there's a reason that there's a specialty/expertise in this." (Hospitalist)	"We go to nursing orientation every other week for the new hires, and we talk about palliative care, how do you consult us, if you see a patient who needs palliative care, this is how you talk to the doctor about getting a palliative care consultation. I've also worked with our hospital marketing people, and so we have screen savers on all of the computers throughout the hospital... one for 'Is palliative care right for your patient?' and listed some general criteria. And said, 'The palliative care team is here to help.'" (PCCT physician) "I think just trying to communicate to whichever department they're concerned isn't utilizing them very well. You know, specifically what their role is and what they can help... I think if other physicians were aware of,

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Theme	Potential Barriers	Strategies to Facilitate
PCCT recommendation implementation	"It's not so much that the PCCT recommendations are not going to be followed, it's that in the effort to maximize our goals, like limit pain, we have to also manage the side effects, so I can think of a few instances that as we got really on top of somebody's pain, we also made them really constipated ... so we had to go back and forth."¹⁰ (Critical care physician) "Well, a lot of times they're really afraid to give anything that... sometimes the pain medicine is hard because they don't want... they're really watching their patients and they don't want you to make them any sicker, so it depends on what their goals are."¹¹ (PCCT nurse practitioner)	"This is what we do, and this is what we don't do," clarifying like, "If your patient wants to go to hospice, then don't call us. Call hospice."¹² (Hospitalist) "If I make a symptom recommendation that involves drugs, I write out very explicitly what I would want them to implement: the drug, the route, the dose, the timing, the schedule as needed. And lots of time I give rationale for why I'm recommending what I am."¹³ (PCCT nurse practitioner) "I'll use words like recommend or consider. Recommend is more definitive, consider is more 'let's think about it.' Bolding, underlining."¹⁴ (PCCT physician)

Abbreviations: ICU, intensive care unit; NP, nurse practitioner; PC, palliative care; PCCT, palliative care unit.