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Journal of Clinical Research and Reports
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Open Access

Research Article

Consultants Views on Barriers to Palliative Care in Two District General Hospitals in England, United Kingdom

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Received date: August 11, 2025; Accepted date: August 25, 2025; Published date: September 19, 2025

Citation: Shaheen Sardar, Nicholas Herodotou, (2025), Consultants Views on Barriers to Palliative Care in Two District General Hospitals in England, United Kingdom, *J Clinical Research and Reports,* 21(1); **DOI:**10.31579/2690-1919/568

Abstract

Background: Earlier Palliative Care referrals could improve health-related quality of life. Decisions regarding Palliative Care referrals can be made by consultant doctors in some trusts within the United Kingdom and can be explored to gain more of an understanding of barriers to Palliative Care referrals.

Aims: 1. Understand consultants' views on barriers to palliative care referrals and measure their subjective confidence levels in having discussions regarding End of life (EoL)/palliation. 2. To understand consultants' views on cultural perceptions and the potential influence it may have on decisions regarding EoL/palliation. 3. Identify where consultants want more support from the Palliative Care Team across the two hospitals.

Materials and Method: An anonymised survey was distributed via email to all consultants across two hospitals within a trust in England, United Kingdom over October 2024 to January 2025. In December 2024, the wording of some questions was adjusted, and a question was added.

Results: In total, 27 consultants responded to the survey, and key themes were analysed by assessing recurrent topics and comparing them to the available literature. 48% of consultants indicated that they felt 'very confident' having discussions regarding EoL/palliative care with patients, and their next of kin. Preventative factors to Palliative Care referrals based on the survey included: challenges with collaboration, diagnostic/prognostic uncertainty, and resource availability. Common topics that respondents would like further teaching on are explored. Respondents indicated that they wanted support with symptom management (7/18 respondents, 39%, with one consultant also commenting they would like support with all 3 options), followed by support with management decisions (28%), and support with communication (17%). Three respondents selected 'other' and indicated that they wanted support with all 3 options.

Conclusion: This study explored consultants' views on barriers to Palliative and EoL care, including challenges with communication, resource availability, and potential knowledge gaps. This area would benefit from further quantitative study.

Keywords: palliative care; medical education; teaching; culture

Introduction

Palliative care aims to provide support to patients and their families with an aim to help patients live as actively as they can until death. Palliative care hopes to provide relief from distressing symptoms. It also aims to combine both the psychological and spiritual components of patient care (Koffman 2014) to help provide a comprehensive and holistic manner of care.

Earlier Palliative Care intervention has been shown to improve 1-year survival rates (Bakitas, Tosteson et al. 2015). A controlled trial randomly assigned outpatients with chronic health conditions (including heart failure, chronic obstructive pulmonary disorder, and cancer) with a life expectancy of 1-5 years to one of either two groups, usual care or usual care with the involvement of a comprehensive palliative care team. The physicians involved with the intervention group had multiple consultations with the palliative care team, and patients received advanced care planning, training for family caregiving, and advanced care planning. The patients in the intervention group were noted to have less dyspnoea, anxiety, and improved sleep quality and spiritual well-being. It was also noted that patients had a reduced number of primary care and urgent care visits. However, it should be noted that there was no change in patients' pain, depression or quality of life in this study (Michael W. Rabow, Suzanne L. Dibble et al. 2004).

However, another randomised clinical trial assessed patients with lung or non-colorectal gastrointestinal cancer, where they were assigned to either usual oncological care (with consultations with a palliative care clinician if they wished) or integrated palliative and oncology care. The patients on the intervention arm reported larger improvements in quality of life at week 24 from baseline compared to the control arm. They also reported lower depression (when baseline scores were controlled for). Patients who were on the intervention arm were noted to be more likely to say that they had discussed their wishes surrounding end of life care compared to patients in the control arm (Temel, Greer et al. 2017).

One non-blinded randomised control study looking at the impact of earlier palliative care on caregivers of patients with lung or gastrointestinal cancer, demonstrated that caregivers of patients who were assigned to receive earlier palliative care reported lower depression symptoms and anxiety in the months approaching the patient's death, in comparison to caregivers of patients who were assigned to receive usual oncology care (El-Jawahri, Greer et al. 2017).

Within our trust, many decisions regarding Palliative Care referrals are made by our consultant doctors. We wished to explore their perspectives regarding their own experiences on what may stop them from referring to the Palliative Care team, as well as explore wider socio-cultural factors that may contribute towards their decision-making (and their views on whether and how much patients are influenced by this). This could open avenues to exploring interventions that could remove these barriers and improve health outcomes moving forward.

The aim of our survey was to 1. Understand consultants' views on barriers to palliative care referrals and measure their subjective confidence levels in having discussions regarding End of life (EoL)/palliation. 2. To understand consultants' views on cultural perceptions and the potential influence it may have on decisions regarding EoL/palliation. 3. Identify where consultants want more support from the Palliative Care Team across the two hospitals.

Materials and Methods:

An anonymised survey was emailed out to all consultants (in both adult and paediatric departments) in Luton and Dunstable Hospital and Bedford Hospital, two district general hospitals in England, United Kingdom, from October 2024 to January 2025. We constructed the questions aiming to improve access to Palliative Care services within the hospitals by understanding what barriers existed preventing consultants and healthcare teams from referring. Questions were constructed aiming to understand biopsychosocial factors, internal and external influences that may influence decision-making. Questions 1-6 were partially inspired by a review by Love and Liversage (2014). The survey (Table 1), when sent out in October/November, consisted of 7 questions. Adjustments to 3 questions were made to the survey in December based on feedback received which resulted in an extra question being added (question 8) pertaining to what specific support respondents wanted from the palliative care team, and a change to the wording of questions 1, 2, and 3 to improve clarity (where we changed the phrasing to include 'Care of the Dying Plan'). In total, 27 consultants from the 2 hospitals responded to the survey, with all consultants' responses being considered. Key themes were analysed by assessing recurrent topics mentioned in the survey responses and comparing them to the available literature.

Question 1: What clinical features in a patient indicate to you that a patient may need a Care of the Dying Plan? Do you use a performance score indicator tool to help you (ECOG, Karnovsky)?
Question 2: What factors do you consider before commencing a Care of the Dying Care Plan for a patient?
Question 3: How much does family or friends' views and input influence your decision to commence/not commence a Care of the Dying Plan for a patient?
Question 4: How confident do you feel having discussions regarding End of life/palliative care with patients and their families/friends? (0 being not confident at all, 5 being very confident)
Question 5: Have there been cases where you felt you could have commenced End of life or palliative care management for a patient but didn't? If so, what stopped you from doing this?
Question 6: Do you think more palliative care training and teaching is needed for resident doctors and consultants? If so, what topics do you think doctors would benefit from?
Question 7: Do you think that cultural perceptions (of both doctors and patients) of dying and stopping treatment influences decisions regarding End of life/palliative care?
Question 8: What kind of help would you most value from the Palliative Care Team?

Table 1: Questions within the survey sent out to consultant doctors in 2 District General Hospitals within England, United Kingdom.

Results:

Question 1: What clinical features in a patient indicate to you that a patient may need a Care of the Dying Plan? Do you use a performance score indicator tool to help you (ECOG, Karnovsky)?

This question was edited for clarity in December 2024 after it had been distributed to consultants at Luton and Dunstable Hospital once. The original question was: 'What clinical features in a patient indicate to you that a patient may require End of life care? Do you use a performance score indicator tool to help you (ECOG, Karnovsky)?'. The answers to the originally phrased question have also been included.

Clinical features that were mentioned included comorbidities, advanced dementia, terminal disease, disease burden, change in consciousness level, change in oral intake, change in breathing, rapid deterioration with little hope of recovery, worsening observations and response to treatment. Two consultants also mentioned the importance of discussing the patient with the nursing staff/the multidisciplinary team (MDT).

Thirteen consultants who answered this question (both before and after editing the question) overtly mentioned that they do not use a clinical performance score (few mentioned they utilised Clinical Frailty Scoring), and that their decisions were centred around clinical judgement, with some consultants also making use of biochemical markers such as lactate, and discussion with next of kin (NOK) in helping make their decision. Three consultants responded that they use performance score tools to help indicate that a patient may require a Care of the Dying Plan.

Question 2: What factors do you consider before commencing a Care of the Dying Care Plan for a patient?

This question was originally phrased: 'What factors do you consider before commencing End of Life care for a patient?'. All answers to this question before and after editing were considered during the thematic analysis.

Eleven respondents mentioned considering the patient or next of kin's wishes prior to commencing a Care of the Dying Care Plan. Patient directives were also mentioned by 1 consultant, and advanced care plans by another consultant.

Other factors that were mentioned included: patient fitness for any intervention, and the likelihood of this succeeding (1 consultant), patients' stage of disease/underlying condition (4 consultants), quality of life (2 consultants), rate of deterioration, consideration of the ethical pillars/principles (2 consultants), response to treatment (2 consultants), treatment options, which location the patient should be cared for (4 consultants), number of admissions, comorbidities, MDT discussion (2 consultants), and religious needs.

Three consultants emphasised they would consider the factors they mentioned in Question 1.

Question 3: How much does family or friends' views and input influence your decision to commence/not commence a Care of the Dying Plan for a patient?

This question was originally phrased: How much does family or friends' views and input influence your decision to commence/not commence End of life care for a patient?' Again, answers collated before and after the editing of the question have been considered.

Seven of the respondents expressed that considering the views and opinions of patients' next of kin was important, however emphasising that decisions surrounding palliative or EoL care were a medical one. Some of these respondents emphasised the importance of ensuring explanations on the reasoning surrounding this is communicated, as demonstrated in a response by one of the consultants below:

'Family and friends often have a differing viewpoint and feel a great weight of responsibility if they feel they are being asked to make decisions about End of life care. It is our duty to ensure they are informed but not that they feel guilty or responsible for steps taken. There should be a[n] empathic approach to End of life care from medical professionals. But there also needs to be realistic expectation as to what is possible within realms of medical care'

Three consultants mentioned the importance of prioritising the views and best interests of patients over that of the NOK, with one consultant responding:

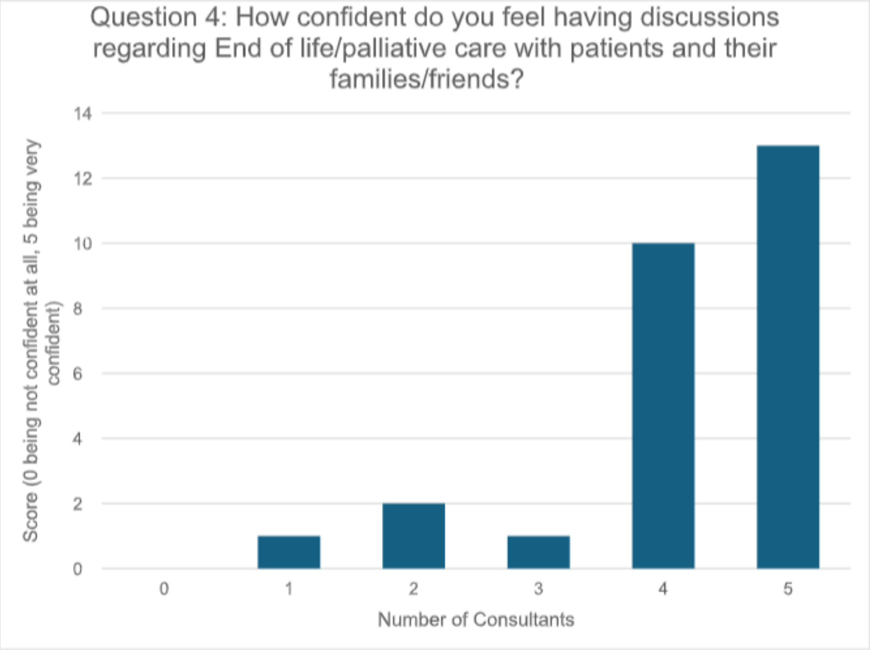
'Family and friends' views and input are highly valued and considered carefully but are not the sole determinant in the decision to commence or not commence a Care of the Dying Care Plan. Their insights often provide crucial context about the patient's wishes, values, and baseline functional status, especially when the patient lacks capacity to participate in [decision making]. However, the decision is ultimately guided by the patient's best interests, clinical evidence, and multidisciplinary consensus, ensuring that care remains patient-centered and ethically sound'

Two consultants mentioned that views of NOK influence their decisions '*a lot*'. One consultant explained that if NOK are not in agreement with the decision, it makes the decision-making '*more challenging*'. One consultant mentioned it can influence decision making to an extent in scenarios where NOK express strong views which at times may conflict with the MDT's advice.

Two consultants' responses mentioned that ideally, they hope that suitable communication would have taken place prior to their arrival at hospital (i.e. presumably with their parent team if they have one).

Question 4: How confident do you feel having discussions regarding End of life/palliative care with patients and their families/friends? (0 being not confident at all, 5 being very confident)

This question asked respondents to rank on a scale and had an optional section where comments could also be made (Graph 1).



Graph 1: Bar chart showing results from Question 4.

On a scale out of 5, 13 out of the 27 (48%) consultants self-scored 5/5 indicating that they felt 'very confident' having discussions regarding EoL/palliative care with patients, and their friends/family. Ten consultants (37%) scored themselves 4/5, 1 consultant (4%) scored 3/5, 2 consultants (7%) scored 2/5, and 1 consultant (4%) scored 1/5 (not feeling confident at all).

Eleven consultants provided written comments, in addition to ranking. Amongst these comments, two consultants indicated that they felt very confident, but may need a second opinion on occasion, with one of the consultants specifying that they feel more supported when the Palliative Care team are involved in the patient's care (to support the consultant's decision, as well as to further support NOK). One consultant mentioned they felt confident in having conversations regarding resuscitation, however, found discussions surrounding palliative care challenging as they felt they were unable to access Palliative Care support. One respondent felt they can find conversations surrounding Palliative/End of Life Care challenging especially if there is any disagreement and if there has not been a significant amount of time to develop rapport with the patient.

Another of the written responses to this question indicated that a consultant felt being unsure regarding the prognosis of conditions such as cancers, would lead to their feeling it was inappropriate for them to have conversations regarding EoL/palliation as they were unfamiliar with the statistics regarding the condition.

One consultant explained having challenges with facilities, mentioning a lack of private spaces on the wards to have conversations regarding EoL/Palliation.

Question 5: Have there been cases where you felt you could have commenced End of life or palliative care management for a patient but didn't? If so, what stopped you from doing this?

This question allowed respondents to select 'yes' or 'no' and had an option to provide comments. When asked whether there have been scenarios in which the respondents felt they could have initiated palliative care management but did not, 21 out of the 27 respondents indicated 'Yes'.

Eight consultants (from 22) consultants who commented here mentioned that disagreement with the next of kin impacted the commencement of EoL/Palliative care.

Other reasons provided included:

- Patients wishing to be actively treated (3 responses),
- Being unsure if palliation/initiating EoL care was the right decision (3 responses).
- A high workload (2 responses), meaning some discussions are held on a weekend or out-of-hours consequently, or not given as much time as the consultants wished.
- Opposing views from different medical teams (2 responses)
- Respondents not being able to access palliative care services out of hours and at weekends (potentially due to being unaware of out-of-hour contact details).
- Delays in accessing palliative care services.
- Not being able to contact the NOK before the patient passed away.
- One consultant indicated that they did not have a comprehensive awareness of what the Palliative Care team could support with.

Question 6: Do you think more palliative care training and teaching is needed for resident doctors and consultants? If so, what topics do you think doctors would benefit from?

Twenty-seven consultants responded to this question, and all except 2 indicated that they felt more palliative care training and teaching is needed.

Six consultants felt more training and teaching was needed on communication skills, particularly having sensitive conversations, with one consultant specifying on how to have conversations regarding prognosis, EoL planning and care goals.

One consultant mentioned that, as well as training/teaching, ongoing availability of palliative care nurses is needed both in the community and in hospital (again potentially reflecting that there may not be aware of contact details of the Palliative Care team out of hours).

Responses to this question have been summarised in the table below (Table 2), describing desired teaching areas respondents believed would be beneficial.

Desired Teaching Areas
Developing communication techniques for having sensitive conversations surrounding patient prognosis, the aims of care and EoL planning, as well learning how to have challenging conversations with practice scenarios.
Teaching on ethics and legal aspects of Palliative Care, including on capacity, consent, withdrawal of treatments or limitations of this.
How to make decisions regarding Do Not Attempt Resuscitation (DNAR/DNACPR) if patient lacks capacity, as well as the legal positions of doctors, patients and next of kin. They also wanted to learn more regarding who to seek a second opinion from on legal matters specifically with DNACPR
Differentiating palliative care and EoL care
How to recognise patients may be entering their last months and importance of initiating palliative care sooner.
When to take the decision to palliate a patient, including teaching on how to recognise key indicators (including clinical features and tools) in patient care that signals when the best time to have these conversations to initiate Care of the Dying plan would be
When to refer patients to the Palliative Care team
When to start anticipatory medication
How to manage more complex symptoms such as pain, agitation, shortness of breath and other common symptoms
Teaching on how cultural and religious beliefs influence thoughts, beliefs and decisions regarding End of life.

Table 2: Summary of responses on what areas of teaching/training consultants feel are needed in response to Question 6: Do you think more palliative care training and teaching is needed for resident doctors and consultants? If so, what topics do you think doctors would benefit from?

Question 7: Do you think that cultural perceptions (of both doctors and patients) of dying and stopping treatment influences decisions regarding End of life/palliative care?

Twenty-seven consultants responded to the poll. Twenty-two of these consultants (81%) felt that cultural perceptions do have an impact on decisions, with 5 responding it does not. Amongst the written comments, cultural perceptions were perceived both pertaining to one's own culture, with one consultant explicitly disagreeing, mentioning that they believe it is the culture within the workplace that influences these decisions rather than individual culture.

Two consultants mentioned that some cultures may find it less acceptable to stop treatment with one of the consultants' mentioning patients and next of kin may need more time and discussion to consider a Palliative/EoL route.

A respondent mentioned that for healthcare providers, their cultural background may subconsciously influence their advice and style of communication. A consultant mentioned that many doctors may struggle to take part in decisions surrounding EoL care as they may feel it is conflicting with their religious beliefs. Four consultants mentioned the importance of navigating cultural differences through clear communication.

With regards to workplace culture, one consultant mentioned that time constraints and two mentioned challenges with care continuity also impact on these discussions, which may mean consultants are left to leave their colleagues to have these conversations. One also mentioned that staff's fear of complaints may influence decision making.

Question 8: What kind of help would you most value from the Palliative Care Team?

As this question was added to the survey after it had been distributed, answers to this question are lower in number compared to previous questions. This question provided options that could be selected: 'Help with communication', 'symptom management', 'management decisions', and 'other' with respondents being able to expand on the latter in the comment section.

Eighteen consultants responded to this question, which also had an extra optional section to add comments. Three (17%) consultants from the 18 indicated that they would like more support with communication, 7 (39%) wanted more support with symptom management, 5 (28%) wanted more support with management decisions, and 3 selected 'other' indicating in their comments that they wanted support with all 3 options. One consultant chose symptom management among the options and then commented that they would like support again with all 3 areas (discussed below).

With regards to comments, one consultant mentioned:

'I would tick all of these at some point! Some patients require quite expert symptom control. Some situations require input from the palliative care team about a change to their perception of the treatment trajectory patients can fear moving from an active to a palliative pathway (and also doctors can be reluctant to do this) and input from palliative care and follow-up can be extremely helpful. In addition, training the doctors at all levels on recognition of the deteriorating patient approaching End of life and how to have conversations regarding the patient's wishes, in advance of the patient becoming moribund'

Another responded:

'I don't think it is the palliative care teams job to tell patients that they are dying… We need enhanced community primary and palliative care (and practical social support to families) to prevent patients spending

their last days and weeks in acute hospitals. There ought to be better resource for analgesia in the community some patients struggle to get prescribed anticipatory medicines for example.'

Both comments highlighted the importance of the Palliative Care team in helping support healthcare teams, as well as the patient in transitioning from active to palliative care.

One consultant mentioned one of the important reasons to involve the Palliative Care team in patient care is that the team has access to referral pathways, hospices, placement, and care in the community, which allows patients to pass away in environments most appropriate for them.

Three consultants mentioned in the comments mentioned that they wanted support with all 3 options, with one of the consultants expanding on this, mentioning they wanted help in:

'Symptom Management: Expertise in managing complex or refractory symptoms such as pain, agitation, or breathlessness, which are sometimes challenging in acute care settings. Help with Communication: Support in navigating particularly difficult conversations with patients and families about prognosis, treatment limitations, and transitioning to End of life care. Additionally, timely advice or input for decision making in ambiguous cases and support in developing clear protocols for identifying and managing end of life care needs would be highly beneficial.'

One consultant highlighted the need for access and prompt responsiveness from the Palliative Care team.

Discussion:

Preventative factors:

From the surveys, it seems, based on the consultant's views, that barriers to local palliative care services are multifactorial, and have the potential to influence decision-making. We have summarised the more common factors below:

a) Challenges with collaboration: which may occur between medical teams and NOK, or between different medical teams.
b) Diagnostic and prognostic uncertainty: some respondents mentioned they were unsure if initiating a Care of the Dying plan was the correct decision due to the possibility that patients may improve.
c) Resource availability: some respondents mentioned that there were limited opportunity and time to engage in comprehensive discussions, and unavailability of private spaces within the clinical environment. Some mentioned they felt there were delays in accessing palliative care input or support to guide decision making.

Theme 1: Teamwork and Communication

Communication was a prominent topic that was mentioned in many of the survey responses. Indeed, it has been noted in the literature that patients (specifically those with cancer) are more likely to receive EoL care in line with their preferences when wishes surrounding EoL care have been discussed with a doctor (Mack, Weeks et al. 2010).

Communication in the context of teamwork was also touched on in the survey responses. The importance of decisions being made as part of a multi-disciplinary team (MDT) was highlighted, as well as having early conversations with patients, to set expectations and allow for patients, families and the MDT to plan ahead.

Another area identified was communication between different medical teams. One respondent mentioned challenges in communications between medical teams and that in some cases, one team may build up patients' expectations for active treatment. One consultant in question 5 also mentioned that a plan (presumably regarding palliation) may not have been discussed with patients by the parent team. This was also reflected within the literature, with studies examining the communication between palliative care teams and oncologists. One systematic review by Bennardi et al (2020) noted part of the reason behind challenges in communication could be due to poor exchange of information between the teams (Ansari, Rassouli et al. 2018, Mcilfatrick 2007, Norton, Wittink et al. 2019) and the insufficiency of effective communication (Llamas, Llamas et al. 2001, Mcdarby, Carpenter 2019). This was thought to be secondary to not having enough opportunities between the specialities to have discussions regarding this (Mcdarby, Carpenter 2019, Bennardi, Diviani et al. 2020).

Theme 2: Cultural Perceptions

One of our aims within this survey was to assess whether and how much impact one's culture (both doctors and patients) may have on discussions surrounding EoL/Palliative Care and in what way. Culture is a broad concept, with many definitions. We had considered culture to mean the shared and learned beliefs and values held by a group of people (Albarran, Rosser et al. 2011). It is important to note that cultural meanings also derive from social locations, and are influenced by social, historical and political factors, affecting how patients view the world, and this awareness could help facilitate individualised patient care (Cain, Surbone et al. 2018). It is important to note that whilst our survey did not specifically explore religion and patients/doctor's religious views within this article, culture and religion, are many times interlinked with one another (Speck 2016).

It is mentioned within the literature that culture can play an influential role within palliative care in various ways, including patients' preference for care, communication styles, providing meaning to suffering and the process of making decisions (Cain, Surbone et al. 2018).

We noted that most respondents seemed to have answered question 7 with answers in keeping with this definition, however, some interpreted the question as also referring to workplace culture.

In our survey responses, one consultant responded that culture has an impact when it comes to the time taken to have conversations surrounding EoL/Palliative Care:

'For patients and families, cultural and religious beliefs often shape their views on the acceptability of stopping treatment, preferences for life-prolonging measures, and approaches to death and dying. Similarly, healthcare providers' own cultural backgrounds and personal experiences can subconsciously affect their recommendations and communication style.'

The reasons surrounding the acceptability of palliative care to patients from a cultural perspective are numerous. We explore some of the reasons behind this below:

Further understanding of the consultants' responses can be provided by appreciating some patients' cultural contexts, where there may be a preference for pursuing curative options trying to maintain hope

(Schuster-Wallace, Nouvet et al. 2022). This could conflict with healthcare professionals' views regarding the next stages of the patient's journey.

It is also important to note that within contexts where some populations may have faced marginalisation, some patients and their family's trust in authority and the healthcare system may have deteriorated (Koffman 2014).

Cain et al (2018) recommend multiple methods of improving palliative care for patients from diverse cultural backgrounds. One method is for doctors to be prepared and have the skill set to have challenging conversations regarding not only death, but also cultural histories of distrust, the role of religion and spirituality (Cain, Surbone et al. 2018, Morrison, Wallenstein et al. 2000, Crawley 2000). Cain et al (2018) emphasise the importance of departing from 'cultural competency' (Cain, Surbone et al. 2018, p. 1414) concepts and moving towards an approach that is open and humble.

Another method that is recommended is to work with communities to help healthcare professionals learn more about patients and their families' cultural views regarding this area, which could also help with adapting responses within a clinical environment (Cain, Surbone et al. 2018).

In line with this, our respondents also emphasised the importance of clear communication, accurate assessment, training and creating supportive environments to ensure culturally attuned decisions surrounding EoL/Palliative care are made.

Another consultant mentioned they believed general workplace culture influenced decisions regarding Palliative Care management/EoL care, including a lack of awareness (regarding Palliative Care) and passing on discussions regarding palliative care.

In our survey, some respondents mentioned that some doctors may find discussions surrounding palliation and EoL care difficult and may pass it on to other doctors or to the Palliative Care team. One study by Udo et al, demonstrated that physicians may respond to conversations regarding palliation reactively, in response to the sudden deterioration of a patient, rather than proactively. This could mean that patients may not receive all the information regarding their condition as desired (Udo, Lövgren et al. 2018). This study, which utilised focus group interviews, highlights the benefit of ongoing discussion, with gradual proactive communication, allowing patients to communicate their fears, and symptoms when relatively well from a disease perspective. The study mentions that barriers to what they termed "breakpoint communication" (Udo, Lövgren et al. 2018, p. 2) (communication when patients transition from early to later palliative care) included uncertainty regarding prognostication, and apprehension in approaching break point communication. This study confirms responses in our survey where diagnostic uncertainty was a factor that some consultants had indicated as influencing their delaying initiating patients on palliative or EoL care. It also may provide some insight as to reasons behind why some doctors may feel apprehensive about having conversations regarding EoL care and may pass on discussions surrounding this to other professionals.

Lack of knowledge regarding Palliative Care was also considered a barrier in other studies (Grudzen, Richardson et al. 2013, Enguidanos, Cardenas et al. 2021, Brooks, Manias et al. 2017, Kawaguchi, Mirza et al. 2017). One study (Kawaguchi, Mirza et al. 2017) noted that many doctors felt unsure with regards to integrating active management with comfort care, finding overlapping both challenging, with doctors feeling they needed to select between the two. This could also explain why delays are made in discussing palliation. Our respondents suggested further training and teaching within Palliative Care would help to support improving this.

Another consultant mentioned that fear of complaints would prevent staff from initiating Palliative/EoL care. One study from the United States, performed in an Emergency Department where semi-structured interviews were conducted mentioned some staff may fear medicolegal repercussions when making decisions regarding palliation. They suggested that clear guidelines would benefit and help with these concerns, on avoiding intensive treatment for patients for whom this may not benefit (Grudzen, Richardson et al. 2013).

Theme 3: Availability of Resources

One practical challenge one respondent mentioned was how they felt they did not have the facilities to have conversations surrounding EoL/palliative care as they were unable to find private spaces on the ward. This has also been seen elsewhere in the literature, where noise and a lack of privacy were considered a barrier to sensitive conversations (Brooks, Manias et al. 2017).

Another challenge was time constraints in which to have discussions regarding Palliation and EoL care, which has also been reflected in other studies (Grudzen, Richardson et al. 2013), where staff may have competing demands which may prevent them from having these sensitive conversations.

Limitations:

As mentioned, the survey required adjustment in the wording of some of the questions for the sake of clarity, which means that some consultants may have misunderstood initial questions, however, considering the responses given, which were felt to be relevant to the questions, this seems unlikely. Another limitation is the addition of the last question after sending the survey to the consultants. This meant the final question of the survey had a lower number of responses compared to the other questions.

Methodological limitations included the risk of subjective bias influencing interpretations of the responses from the survey. In the future, this area would benefit from further quantitative study to help decrease subjective bias, with a larger sample size to allow for the generalisability of the findings.

This survey was sent to consultants from two District General Hospitals within the United Kingdom. It would be helpful to see responses from consultants from other hospitals as well as General Practitioners to gain a more comprehensive understanding of barriers to Palliative Care services.

Another limitation is that due to the anonymised nature of the survey, it was not possible to ascertain the specialties and departments respondents work in (unless explicitly mentioned by the respondents), which would have allowed for further detailed analysis of what support/teaching a given specialty desired.

Conclusion:

This study aimed to explore consultants' views on barriers to palliative care referrals on a local level. It seems the most common challenges faced are challenging conversations with patients and their next of kin, resource availability, and diagnostic/prognostic uncertainty. Most consultants who responded to the survey seemed confident in having conversations regarding EoL/Palliative Care with patients, however, some wanted more support and teaching on this. With regards to cultural perceptions, it was felt by consultants that cultural beliefs may influence both their and patient's decisions regarding EoL/palliative care. Workplace culture was also touched on, where challenges in continuity of care could result in other doctors are left to have conversations regarding EoL/palliation rather than the original consultant.

This area would benefit from further quantitative study, as well as quality improvement projects to address barriers explored in this article. This survey explored the views of consultants, and future studies focussing on patients' and families' perspectives would be beneficial to provide a holistic understanding of barriers to services.

Acknowledgements:

Thank you to Janine Hall for proof-reading this article, and to Dr Penny McNamara for her feedback on the survey questions.

Competing Interests:

There are no competing interests for any author

Ethics Statement:

This article involved exploring consultant doctors' views on barriers to Palliative Care services via an anonymised electronic survey. No patients were involved in this study.

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DOI:10.31579/2690-1919/568