**Barriers to the Effective Utilization of Palliative Care Services in the Acute Care Setting – with Emphasis on Terminal Non-Cancer Diseases**

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Introduction

Although palliative care and the involvement of a specialty team has shown short term and long term benefits to the patient, the provider and to the institution, studies has proven the specialty’s underutilization. This study assessed the views of nurses, resident doctors and attending physicians of the use of a readily available pain and palliative care specialty at their institution while assessing their ability to recognize terminal non-cancer illnesses.

Methodology

In community hospital consisting of an on-site pain and palliative specialty service of two specialist physicians and a specialized nurse, attending physicians, residents and nurses participate in a survey highlighting the following: parameters for referral/ consultation, definition of non-cancer related terminal illnesses, role of pain and palliative care in acute care, consult/ referral delay, barriers to effective referral, recognition and withdrawal of futile care and opioid prescription. Patterns of responses by each professional group were compared and contrasted. Primary themes addressed palliative care, while secondary themes addressed opioid prescription in chronic pain and dyspnoea.

Results

The most common accepted reasons for referral were that of hospice care, terminal cancer and uncontrolled pain, while reasons related to terminal non-cancer illnesses were less accepted. A majority of approved physical and social parameters to define terminal non-cancer illnesses was not universally accepted among the groups – especially among attendings and residents. While most participants agreed that the best time to refer to palliative care specialty was at the point of diagnosis of a terminal illness, more than 25% of participants from each group felt that referrals should be done later in the course of the illness. The most highlighted reasons expressed by attendings and residents for delay in consult were either that of excessive withdrawal of modalities of care or interference with ongoing management that may benefit the patient. Most residents and nurses agreed that attendings’ reluctance to consult is a major barrier to its utilization. Patient and medical professional views of the meaning of palliative care were also accepted barriers. While most of the doctors prescribed opioids, many of them showed some level of discomfort. The role of a pain and palliative care specialty in managing chronic pain was not universally accepted among residents and attendings. Palliative care as a subspecialty was not universally recognized and its role in acute care not widely accepted.

Conclusion

Barriers to effective utilization are multifactorial, mostly relating to perceptions of the specialty as well as ineffective communication within specialties. With respect to non-cancer related illnesses, major barriers exist regarding consideration for specialty referral and defining terminal non-cancer illnesses. There needs to be a greater emphasis on medical professional education, physician-physician communication, and policy implementation to improve its utilization and service.