

The Palliative Care Illusion on Acute Wards An Ethnographic Study of the Introduction of a Palliative Care Consultation Team

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Abstract

Acute care and palliative care are described as different incompatible organisational care cultures, with contrasts and contradictions. Few studies have observed the actual meeting between these two cultures.

Purpose: To study the meeting and interaction of two different organisational care cultures, palliative care and curative acute wards, when a palliative care consultation team introduces consulting services to acute wards regarding end-of-life palliative care.

Methods: An ethnographic study design was used, including observations, interviews and diary entries. A palliative care consultation team visited surgical and internal medicine wards during one year. An integrative bedside education approach was used, where physicians and nurses experienced in PC tried to embed PC principles and interventions into daily practice. The analysis was inspired by Spradley's ethnography.

Results: Three themes were found in the study: 1) Values, illusions, and wording in the acute care culture; 2) Didactic challenges and strategies, and 3) The palliative illusion becomes a fusion. On the acute wards, fast "turn over" was the goal of care: to treat patients quickly and send them home. Primary health care team members believed that they gave dying patients good care, a conclusion not supported by the palliative care team, who identified values problems and a knowledge shortage among all primary team members. Because the primary team did not have time for reflection regarding patients' whole situation, and wanted to do as much as possible before "giving up", their patients could be one hour from death before the primary team provided palliative care. After one year, primary team members wanted the palliative care consultation team to continue, since they felt they could not handle dying patients on their own.

Conclusion: Palliative care consultation team make changes about end- of- life care when working with primary health care team members on acute wards. The didactic challenges are many and require efforts.

Introduction

In health care, different care cultures are described. One is the organisational culture that is defined as: "the values, behaviours, goals, traditions, attitudes, practices and beliefs shared across an entire organisation¹ which are deeply ingrained in the everyday life of the organization and its members²". Another culture is the workplace culture: "a specific type of subculture involving an identifiable grouping within an organisation. In healthcare, such a 'workplace' may be a unit, ward, department, or a professional group, e.g., medicine or nursing"¹.

Sometimes, acute care and palliative care (PC) are described as different incompatible cultures, with contrasts and contradictions³. The biomedical, acute culture involves "adding or continuing all life-sustaining therapies"⁴. On acute wards⁵, the logic of care is motivated by limited resources and the

demanding medical unit create a context of constant activity. Hierarchies and priorities influence roles, routines and interactions, as well as how primary care team members approach different patient groups. The vast workload results in priorities, and assumes the importance of curative care over PC. Team members prioritise life-prolonging activities, and are less attentive to care of dying patients. Important outcomes for acute wards are mortality rates, failure to rescue, readmission rates and adverse events/medication errors¹.

In contrast, PC has its origins in philosophy and is an interdisciplinary approach with importance given to all members of the multi-professional team. The patient and his/her family, rather than the patient alone, are the essential unit of care. Care should be holistic where physical, psychological, social, spiritual, and existential needs are in focus⁶. It is of value to have conversations about end of life, as death is not a failure. Important outcomes in PC are the patient-reported outcome measures regarding physical symptoms, emotional, psychological and spiritual needs, provision of information, and support of quality of life^{7 8}.

A question exists whether there any benefits to introducing palliative care consultation team (PCCT) on acute wards. When introducing PCCT on acute wards, patient satisfaction has improved⁹ as well as perceptions of well-being^{9 10}. Different studies have shown improvement in symptom distress^{11-15 16}, as well as no difference/improvements in symptom scores¹⁷. They also assists in that fewer patients less admitted to, or die in intensive care units, patients received less invasive procedures, and costs was thereby reduced^{18 19}. PCCT also influences the reduction of potentially inappropriate medications²⁰. There are also qualitative data regarding implementation of PCCT in acute wards. Studies have focused on primary team members' knowledge of and attitudes towards PC and PCCT²¹, including expectations^{22 23}, collaboration, and partnership^{24 25}.

However, patients' die despite health care organisation or culture. Therefore, it is important that all health care personnel have basic skills in PC to care for these patients. Previously, unmet PC needs among patients dying in hospital were identified²⁵⁻²⁸. It is also known that team members in settings other than specialised PC may not prioritise, do not recognise, or are uninterested in PC competencies^{25 29} and have deeply rooted beliefs in their self-sufficiency³⁰. It is therefore a delicate didactic question whether it is possible for PC competencies to influence the acute care culture about PC in the end of life.

The current study reports qualitative results from a larger study³¹, where the focus has been to implement PCCT on internal medicine and surgical wards. Although there is evidence about the benefits and effectiveness of PCCT, this study will focus on the process when participants in these two cultures meet on acute wards.

The aim was to study the meeting and interaction of two different organisational care cultures, PC and curative and acute wards, when a PCCT introduces consulting services to acute wards regarding end-of-life PC.

Methods

Design

We used ethnography in this study as it documents the culture, perspectives and practices, of people in different settings³². The central aim of ethnography is to provide holistic insights into groups of humans' views and actions, as well as the nature (sights, sounds) of the location they inhabit, through the collection of detailed observations and interviews. In this study, the cultures are PCCT and acute hospital wards with their team members.

The intervention

This intervention was inspired by the pedagogical ideas of Dewey^{33 34}, where experience and knowledge are intertwined and developed together. Knowledge creates in social processes together with others and changes without the appearance of chaos. When integrating new knowledge and comparing it with reality and its consequences, people reconstruct their picture of reality. Participants are introduced to the problem, discuss it, argue, negotiate and agree on a solution. Another important aspect in this pedagogical thinking is evaluation.

The intervention continued through one year, and was designed to support the primary team members to make changes in their clinical practice regarding the PC provided in acute wards. An integrative bedside education approach used, where two physicians and two nurses specialised in, and experienced in PC tried to embed PC principles and interventions into daily practice. PCCT were available for 1–8 daytime hours/week for one year (m = 6.5 hours/week), visiting the wards and taking part in reports, rounds, and communications. Specific aims were to identify and emphasise and relieve physical, psychological, social, spiritual, and existential needs in dying patients and their family members on the local wards⁶ by educating primary team members in these areas. They also identified patients at risk for poor outcomes, who may benefit from a PC consultation. PCCT supported primary health care team members for example when communicating with patients. The primary teams could also ask for specific education for all team members on the wards. For more detailed information regarding the study and the quantitative part, see Friedrichsen et al³¹.

Data collection

The study took place in a local hospital in the south of Sweden with 2 400 employees. Three different wards, one internal medicine ward and two surgical wards were field sites, as these wards should start to involve a PCCT in the daily care. Twenty- eight patients were cared for on each in-patient wards.

The data collection was based on participatory observations (passive level), interviews and diary entries written by PCCT during one year (Table 1). The first author, with long experience in different qualitative methods (female associate professor in palliative nursing), collected the data. The observations focused on almost all situations where the PCCT were involved: in the daily routines of the primary team

members, actions and roles during rounds, staff meetings, and evaluations and interdisciplinary conferences, but not when working with patients or family members. All field notes were written down in a notebook concerned what was said, how and where. Depending on the situation on the ward, interviews were prepared and audio-recorded, or spontaneous interviews were recorded in the notebook. Questions were posed regarding a specific situation and participant's experience. Prepared interviews focused on evaluation of the PCCT intervention from the different cultures. The interviews lasted between three minutes to one and a half hours. A total sample of 136 team members participated actively or passively (Table 2).

Table 1
Data collection during one year.

Data collection	H/n
Observations	143
Interviews	35
Notice from diaries	57

Table 2
Socio-demographic data of all participants.

	Total sample n = 136
Gender	
Males (%)	14 (10)
Females (%)	122 (90)
Age in years (m)	41
Years of experience working in health care	17.0
Occupation	
Physicians (%)	21 (15)
Nurses (%)	73 (54)
Assistant nurses (%)	39 (29)
Others (%)	3 (2)

Data analysis

Analysis of data involves explicit interpretation of the meanings and functions of human actions and takes the form of verbal descriptions and explanations. Domains identified by reading through interviews and, coding words, quotes, situations and reflections from the data material³⁵. Similar data constituted one domain. Further, the analysis systemised and identified relationships between the domains. Similarities and differences were compared. The taxonomic analysis included terms and cover terms from the domain analysis in order to identify the relationship between them and to get a better understanding of the meaning in the domains. The established domains were condensed into cultural meaning categories and finally a presentation of the cultural themes discovered in the componential analysis was made. All data material was reread; themes, domains, situations and quotes deemed, relevant for the analysis³⁶ was identified, and this process continued until no further information emerged. The first author was the main analyser and the other authors questioned the analysis. Finally, the results were presented to, and discussed with the primary nurses and assistant nurses at a workplace meeting (no physicians participated). Participants recognised the results and further discussions focused on practicalities regarding PC.

Ethical considerations

The study was conducted according to the Declaration of Helsinki. This project was assessed as a quality improvement project and ethical approval given by the head of the clinics. Patients were part of the intervention, but did not participate in the study, as the study focused on PCCT and primary team members. All team members were informed verbally and in writing of the purpose of the study, their voluntariness and their right to refrain without explanation, and assured of confidentiality in analysis and publications. The wards and hospital were anonymised. No one declined to participate.

Results

Hospital wards – the setting

Upon starting the project, a hectic ward environment was immediately noticed. Food carts, medication carts, hospital beds, wheel chairs moved quickly back and forth creating noise. Team members hurried between different rooms and patients, often avoiding eye contact with visitors, as if they had no time, or did not wish to be disturbed in their duties. All staff were hurried and busy. A curative culture was in focus, where a fast “turn over” was the goal of care. Treat patients fast and effectively and then send them back home. Physicians were the decision-makers, with the power to judge a patient’s treatment needs and period on the ward. Younger physicians were often silent at the rounds, and listened to the senior consultants, who had knowledge and experience in the field. Nurses and assistant nurses were the deliverers of important information, but were not in position to make decisions although they could influence a physician’s decision. A hierarchy was visible during coffee breaks, where nurses and assistant nurses sat together, and physicians kept to themselves. Different systems regarding rounds were used in the wards. In one ward, patients arrived in a large room to speak with the whole team, while on other wards; the team has a sitting round before going out to patients’ rooms. During rounds, all primary team

members focused on a large screen to see patients' records. The round room was messy, with different occupations coming and going, physicians' pagers beeping, phones ringing, and whispered conversations creating background noise during round discussion.

Values, illusions and wording

Primary team members had different opinions about PCCT. Some wanted to learn more about PC, especially symptom management. Some physicians believed that only nurses and assistant nurses would handle PC, or else specialist PC units, and did not see it as their own responsibility, since they had other important tasks to carry out. Others team members claimed that they already knew how to take care of dying patients, while a few just wanted the PCCT to transfer their patients to the specialized PC unit, so they could focus on the patients that they could "really" help and cure.

Primary consultant SW 1 (F = female): This patient should be transferred to the specialised PC unit (looks at PCCT)!

PCCT, nurse X (F): But that is not our task here.

Primary consultant SW 1(F): Then, why are you here?

PCCT nurse X (F): To implement PC thinking here, in this ward.

Primary consultant SW 1(F): We are already very good at PC (sighs, disappointed). Observation from a round.

Primary team members defined PC as a short time in a patient's life, a few hours before he/she dies. Then the patient is given pain-relief and eventually other drugs to ease symptoms. The primary team members wanted to be clear about ensuring the PCCT that they could not practice specialised PC, i.e., giving the "little extra support" to dying patients, since they did not have time to do so when their focus was on curing patients. Primary nurses and assistant nurses showed an understanding of the PC values. They claimed that the major problems were the physicians' lack of knowledge or skills in PC, and inability to listen to them as nurses, of which, unfortunately, physicians remained unaware. Consequently, patients were not relieved of pain, no decisions about resuscitation were made, and no communication to patients and family members about the transition from curative to PC at end-of life was provided, which in turn lead to patients dying alone. Nurses expected that PCCT should give them support in their thinking about PC, especially in telling physicians how and when to decide about PC. Still, nurses missed seeing their own part in the curative culture, how they influenced the care of the dying patient.

A woman with generalised cancer, over 80, who lost her appetite. The two nurses reported that they should make a cost registration. I asked why. Then it all started! They said of course, we have to make a registration, as we do not know how much she eats. That was a good thought to make things clear, but what will they do with the results? Then the physician became irritated: we cannot starve her to death! He

became fiery. In addition, I commented: but that is what her disease will do with her anyway. However, he replied we could not starve her to death, can we? Diary, PCCT, nurse X (F).

Primary team members also expected severely ill and dying patients to tell them if there were any problems, without actively asking patients. No one used tools/scales to identify symptoms, and instead used their clinical view, i.e., if patients grimaced when being touched or moved.

PCCT, nurse X (F): Have you tried to measure this patient's symptom?

(It becomes silent. The question is unpleasant. Both the nurse and the assistant nurse wince. It becomes obvious that they have not asked the patient)

Primary nurse SW 4(F): No, but he does not have any symptoms... (The answer is hesitant and uncertain. She turns to the assistant nurse for confirmation.)

Primary assistant nurse SW 5(F): Nooo (hesitates)... he has never said anything about that.

(There is a silent agreement between the nurse and assistant nurse that this patient do not have any symptoms. The round continues.) Observation from a round.

After this round, PCCT measures this particular patient's symptom, and he estimates his symptoms to 8–10 on a VAS-scale, pain, nausea, anxiety and so on. Following notice.

PCCT identified a values problem among all primary team members, and felt overwhelmed, especially as regards patient participation, patient autonomy, and the lack of ethical reasoning and interest in patients' and their families' needs. Decisions were taken without patients' presence, and then delivered to them during rounds. The curative values were strong, diagnosing and treatments was the first priority, even when this clearly did not serve the patient. The direction of thinking was on doing as much as possible regarding medical interventions rather than reflecting on the benefits for each patient, giving each patient "a chance". On rounds, discussions and planning focused about scrutinising each patient's record, test results, treatments as well as which patients could be discharged.

I think they are missing a palliative philosophy and values. It is some kind of general attempt to be holistic. Interview with PCCT, consultant B (F).

Previously, there had been discussions and conflicts between primary team members whether to provide PC when a patient was dying. Patients' status deteriorated death neared, and they became unconscious before any discussion about PC arises. Unpleasant decisions were postponed or avoided, sometimes within one hour of the patient's death,, as the team did not have time for reflection around the patient's whole situation and wanted to do as much as possible before "giving up". There was a fear of being criticised by family members, team members, colleagues, and the head of clinic for making the wrong decision. Primary team members were surprised when patients became unconscious. This made planning of the last care phase incomplete, as no one spoke with the patient and his/her family, and

knew nothing about preferences regarding death and dying. Instead of using the term “PC”, they had their own definition of care circumscribed as “*restricted or modest care*”, not as definitely as PC and easily changed if someone should complain that they did not do “*enough*”.

PCCT, consultant B (F): What you say now is very important; how you see, what PC is will influence your decisions.

Primary consultant IMW 10 (M = male): Well, that is the dilemma here.

PCCT, consultant B (F): This man cannot be healthy again, he is incurably ill, but you still have not reach the breaking point.

Primary consultant IMW 10 (M): No (firm).

PCCT, consultant B (F): Still you want to relieve his symptoms and improve quality of life.

Primary consultant IMW 10 (M): Yes, we use restricted, limited care, which is what it is (hesitates).

PCCT consultant B (F): Then it is obvious (annoyed).

Primary consultant IMW 10 (M): Many patients is not in the terminal stage and do not get PC.

PCCT, consultant B (F): But they ought to (determine). Observation from an intense discussion between physicians on a sitting round.

Didactic challenges and strategies

Initially, the PCCT remained cautious and observed how team members work and discuss during the rounds and when meeting with patients. They tried to establish relations by chatting during coffee breaks, and politely asking questions about routines, as well as by showing their own competence and skills. They were smooth, supple, and attentive to what was said by the primary team members.

Soon, PCCT realized that they must confront the problems and values of the unit, because patients suffered severely. They began to ask more questions of both physicians and nurses at the rounds. At the beginning, primary team members were polite, kindly answered questions, and listened to suggestions, but did not follow PCCT advice. This made PCCT change strategy. At the same time as they confronted difficult questions, they tried to understand the primary team members' perspective. By repeating their questions “*What is the goal of this treatment/test and what's in it for the patient?*”, they clearly showed that they wanted to discuss PC. Ethical issues were raised, and they continually lift patient's needs, symptom management and family member's needs. They also used body language, bending their upper body forward to show their interest in the round discussions, repeating, and summarising their advice at the end of each discussion. They started to use the word “*we*” and “*we, together*” and spoke of how “*we can solve*” certain problems, in order to further develop relationships.

The problem today was the young nurse's values. "This patient should not even be in this kind of ward. We do not have time". My reply to that was, yes, but the patient is here and we have to work with her symptoms and help her together. You have dying patients here, don't you? Let's do this together. Diary, PCCT, nurse X (F).

I gave the physician support in clearing out medications in two palliative patients. We discussed pros and cons and that felt good. Otherwise, they would not have done it at all. We really felt like a team. Diary, PCCT, consultant B (F).

PCCT thought it was important to be humble about the lack of time, and to confirm primary team members' fears regarding PC decisions. They claimed it was necessary for many professionals to discuss together so that everyone could feel "safe" in these situations. They walked a fine line, at the same time as they confronted difficult questions; they tried to be diplomatic and flexible in their conversations.

After a couple of weeks, the discussion time for dying patients during the rounds increased. Not all primary team members appreciated this, since it was a barrier to a fast turn over, as well as it resulted in inner conflicts.

Researcher: I wonder what you thought about the round today?

Primary nurse IMW 5 (F): What I was thinking about was that I had so many other things to do as well as a meeting for care planning... It takes too much time ... at the same time, there are questions that should be discussed... but at the same time, you are torn since you want to listen, but you do not have time. Interview with primary nurse after the round.

Gradually, primary physicians and nurses started actively asking PCCT for advice. This gave PCCT a feeling of success, and they became more confident and forward.

PCCT, nurse X (F): Why should we take these tests? If the tests are bad, what will we do about it?

(It becomes silent. No one seems to find an explanation.)

Primary consultant SW 8 (M), (appealing to PCCT nurse): It will not cost that much...

The primary nurse (SW9) feels that she has to save the situation and say: I do not think you get a good answer to that question (turns to PCCT), but I definitely think that we have to start thinking about it. Observation from a round.

PCCT taught primary team members a new vocabulary, with words like break point, breakpoint dialogue, terminal care, the real meaning of PC and structured symptom management as an active care since they felt they lacked basic knowledge about this. They carefully built up trust in relationships by using confirmation and compliments when primary teams performed good PC, while not wanting to step on

anyone's toes. PCCT had patience, and considered it important not to find faults or judge, as this could harm relationships.

I want to be careful that they do not feel that we observe them, or judge them... I try to be a little diplomatic. So that they do not feel like, "they are out to get me, watch what I'm doing wrong, and say what I should do better". I do not think that it should be that way. Reflection among PCCT, consultant A (F).

At certain times, PCCT could not visit the wards. They discovered that nothing happened regarding PC when they were not there themselves, and everything went back to the way it was. This made PCCT feel disappointed and sometimes hopeless, as they saw that patients suffered, and that it was hard to influence team members' own motivation and interest in this area. Primary team members did not have the strength to do it themselves, *"they forgot it"*, since it was easier to continue with the old routines.

Today was a day of hopelessness! Last week we solved many of a patient's symptom, but now after the weekend many new symptoms appeared. In addition, no one understands why these appeared and did not manage it! Symptom management does not work by itself, I feel discouraged... Diary, PCCT, nurse X (F).

The nurses appreciated PCCT, but they felt caught between PCCT and their own physicians. Now they felt that they had to fight for their patients to get the best care, which took a lot of the nurses' energy. They also had other things to do than these discussions, but did not always take these discussions with PCCT.

In the morning, PCCT arrives to the ward. The head nurse meets them immediately.

Head nurse SW 22 (F) (in hurry): You have to know that the nurses are not able to talk about PC issues when our physicians start to question their ideas, as the nurses do not have enough knowledge. It is different when you (PCCT) start these discussions, then the doctors listen. Observation from a ward.

Some physicians question PCCT's right to be on their ward, the increased time for rounds, their real medical competence and their right to get involved in *"their patients"* tests, treatment, and diagnosis. *"There is too much of the palliative stuff here. The curative values do not have enough space anymore."* Some physicians complained about having to take medical advice from a PCCT- nurse.

PCCT tries to influence the prevailing culture to get critical primary team members "on board", and they therefore actively confront their critics. Through discussion and argumentation, but without complaining, they succeeded in getting some critics to "their side", or at least neutralising their opinions about PCCT. In some cases, they also needed to engage the head nurse or head of clinic, in order to remind the team members that they are there to help. Sometimes, team members did not give PCCT access to their patients, as they thought they were not in need of PC. They also had to fight for some patients' rights to die, as primary team members wanted to help patients as much as possible.

“There was a dying woman on the round whom they decided to give blood. Although they had been visiting her, and seen her, they still prescribed this. She was in the terminal phase her breathing was irregular. Therefore, I asked if they realised that she was dying, and the goal of the treatment. The goal was “to make her a little more alert”. I talked about the dying process, the thinking around it, and her needs right now! Diary, PCCT, nurse X (F).

The palliative illusion becomes a fusion

One year after the intervention, primary team members in the acute wards felt that the new PC skills had come to stay, and were partly integrated. They realised that their dying patients did not receive as good PC as they previously believed. Formerly, they were living in an illusion, and believed that they provided good PC so long as the patient got opiates in the last hour of life. This was a kind of self-delusion necessary to survive in the fast acute care culture.

One of the nurses told me that she felt ashamed yesterday, when I came out from a patient room and showed her how much pain the patient really had and she was not even aware of it. I tried to give her support and told her how many patients she had. I told her that this was my job, to be a support regarding symptom management. Diary, PCCT, nurse X (F).

Primary team members appreciated the competence provided by the PCCT, and thought that they had learned a lot about symptom control, break point dialogues, and planning end-of-life care for patients and families. They felt they had better and more useful tools and vocabulary, and now realized they needed even more knowledge.

It is so good that PCCT are here. They remind you. Otherwise, I think we forget it. Every patient should leave our ward “healthy” (laughing). Interview with primary nurse SW33 (F).

Most primary team members were satisfied with the intervention, and the quality of PC among their patients had increased, but they did not believe that it was possible to handle the PC issues by themselves. They felt that they still needed support, as they did not have the knowledge, energy or interest themselves. Some nurses described ethical distress after the intervention, as they knew that patients suffered if they were not more active themselves. The planning for both patients and families was difficult, as they could not be certain that the patient really was dying.

It is important to get another set of eyes, with another specialist competence than one’s own. There are so many other things here, so you have to think a bit longer. No one has a total picture of the patient, and sometimes we do things that are not of help. Interview with primary nurse SW27 (F).

Assistant nurses felt that the intervention had focused only on physicians and nurses, and wanted more knowledge to provide better care, but confirmed that patients and family members got enhanced care. Physicians valued the bedside education and the thinking and reasoning behind each decision as well as tools to manage a break point dialogue. They felt strengthened in communication, PC reasoning and symptom management.

Before the round, the primary consultant IMW2 tell the others (PCCT consultant, one primary nurse, and two junior physicians) about a break point dialogue with a critical husband. "He looked at me, said: is it cancer? I confirmed that it was cancer in her abdomen. He started to tremble, what are we going to do? I said that we absolutely would treat her pain. He understood that she was deteriorating".

PCCT, consultant A (F): What did he say about not having any treatment?

Primary consultant IMW2 (M): He understood.

PCCT, consultant A (F): How did you feel? Are you still a good doctor?

Primary consultant IMW2 (M): Well, yes. She (the patient) will not have a good life with treatment (chemotherapy). It feels okay. We cannot examine and treat her just because we should have good statistics. Observation from a round, discussion between consultants.

Head of ward, nurse IMW 27(F): Doctor G (consultant) noticed a big (positive) difference when we started to use ESAS (symptom score). However, the staff were so upset when they realised how many symptoms they missed, that patients felt very ill without them noticing it. Observation from a meeting between PCCT, management of the clinic and the ward.

Discussion

This study contributes detailed insight regarding when team members in two different care cultures meet. The main finding of this study is the possibility to influence primary care team members on acute wards to start broadly thinking about PC before the final hours of life. After one year, primary team members realised that they had lived in an illusion about PC, but now saw the true nature of care on the wards for dying patients. This may have been an expensive professional lesson, but it will help all primary team members' growth in terms of PC knowledge and skills, and will contribute to the quality of future patients' end-of-life care.

The didactic challenges for implementation were many, including attitudes and lack of time and interest, but they were possible to overcome. One often mentioned challenge was the lack of time. That has also been reported in other studies^{4 5 37-39}. Even though the curative culture is intense and active, the primary team members still have no time to reflect on each patient's holistic wellbeing or lack thereof, which may lead to care that is not entirely secure. This is also a question of priorities. Acute wards have dying patients, and according to Swedish law⁴⁰, care must be given with respect to the equal value of all human beings and for the dignity of the individual human being. The care must meet patient needs for security, continuity, and safety, especially regarding symptom management. Therefore, PCCT was needed, since care should be adapted to the needs of all inpatients, not only those who will recover. Moreover, it is not possible to have specialised wards for every diagnosis or condition.. Being medically active for a patient at the end of their life can diminish quality of life and hinder the opportunity to end his/her life with dignity, as well as leading to consequences for the family's grieving. It may also result in unnecessary

costs for examinations^{19 41}. To build relationships was a vital task in the current study. This is in line with Dewey's^{33 34} thoughts about social processes to advance knowledge. Dewey means that humans can recreate their image of reality, and this partly showed in the current study, where primary team members' illusion about PC became a fusion, to discuss pros and cons, argue, negotiate, and find a shared or individual solution.

Interestingly, some primary team members had their own name for PC, so-called restricted or limited care, a kind of "*PC light*", and restricted the term PC to care in the last hour of life. The latter has also been reported in another study⁴² where physicians, even after training, continued to associate PC with the terminal or dying stage. This shows how difficult (but not impossible) it can be to change the everyday thinking and routines of a culture. In the current study, primary team members received bedside training in their own ward regarding PC terminology, as well as how to talk to patients and families regarding death and dying, which may have been important. However, their usual work place may also hinder primary team members' new PC thinking and development, since it is associated with "old" routines. According to the "organizational learning theory in hospital"⁴³ there are a number of contextual factors necessary for learning. Team members must share the same purpose for improving their organisation, feel motivated to improve, feel psychologically safe relationships, have sufficient time, space, technology, resources, and processes necessary, and finally, have the skills needed to improve performance within their organisation. Some of these factors were not found in the acute care organization and can explain why they could not manage PC by themselves.

In the current study, primary care nurses were more interested in PC than physicians were assuming it did not interfere with their own practice. A review study focusing on nurses in acute care hospitals showed that nurses felt a commitment to help dying patients to a good death, and to share the end-of-life experience with patients/families. The challenge was managing the different needs of curative and PC patients in a biomedical culture of care. Nurses' ideals of good PC care were not recognized and supported by the organisation³⁸, which is important. However, nurses in the current study initially also lacked knowledge about their own PC practice, for example regarding nutrition and symptom management.

Primary team members in acute wards continually receive training in resuscitation, as this is a main and prioritised part of a curative culture. Still, they usually do not receive PC training, although many patients die in their wards. This mirrors the perspective and thinking of the culture. In the future, there will probably be a need for a PCCT to integrate PC as a natural part of care, and for at minimum annual PC training on acute wards. A large organisation, like health care, cannot only view individuals with specific interest in one diagnosis or area. Health care should be secure and safe for all consumers, e.g., patients and family members. As long as acute care wards treat dying patients, they have a responsibility to provide the best care for them, too. This may also be a question of experience, as one study showed that nurses with postgraduate training perceived significantly fewer barriers towards end-of-life care than those inexperienced in caring for dying patients⁴⁴. Another study showed that primary team members thought

that PC can be perceived as a last resort, and do not want to believe themselves or suggest to their patients that future treatment is futile³⁰.

There are a number of methodological limitations to our study. Is it possible to make an ethnographic study of different cultures such as internal medicine wards and surgical wards? They may not have the same culture, even though there are studies that show that it is the organisational culture, and its attitudes, that colours the ward's atmosphere^{45 46}, with even impacts on patient pain management outcomes.

One can question Dewey's ideas regarding knowledge increases in social processes, and changes without the appearance of chaos. This statement was not fully confirmed by this study regarding the chaos reasoning, since there were found both conflicts and ethical distress during the intervention. When different organisational cultures meet, this is almost inevitable, as seen in other studies^{21 37}. Thus, transferability of our findings to other health care systems or different organized institutions is possible as there are other studies despite of country origin that partly has found comparable results^{1 5 47}. Strength is the large volume of data collection and the different data collections that provided the study with rich material. The first author has her research area in PC, and the analysis might be influenced by that.

To conclude, this study shows the challenges when two different care cultures meet and attempt to work together. Primary team members in acute care settings may provide good end-of-life care, but this study did not confirm that. However, a fusion is possible, but requires efforts from all involved. Cultural routines and thinking are challenged, but can overcome.

Based on the current study's results, we suggest that success with a PCCT on acute wards requires building relationships and create a team feeling among members of the different cultures, for example by using words like "we". It is useful to validate new knowledge and skills with confirmation and compliments. Nevertheless, it is also important to confront, question, and discuss attitudes and malpractices, in order for all team members to understand the reasoning around PC practices, and advance the care of dying patients and their families. Finally, repetition of the message, and humility regarding other cultures, are needed and most important.

Declarations

Acknowledgement:

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Author contributions:

Design and data collection: MF.

Analysis of the data: MF, YH, MJ, KB and AM.

Writing and approval of the final manuscript: MF, YH, MJ, KB and AM.

Ethics approval and consent to participate:

The head of the clinics at Vrinnevi Hospital ethically approved this study. All participants received verbal and written information about the project prior to the study. In the hospital wards, it is not possible to obtain written consent of all professionals who work there. Therefore, ethnographic studies can use the negotiation and renegotiation of unwritten consent during the study time. A relationship, based on trust should be developed between the observer and the observed. In this study, consent to the observation work was ensured by notifying participants that today the researcher was observing. If any participants did not want to be part of the study or had any concern about it, they had the possibility to contact the researcher or the head nurse. No one declined to participate.

Consent for publication:

Not applicable.

Availability of data and materials:

The data are not publicly available due to them containing information that could compromise research participant privacy/consent. If you have any questions or comments with regard to the availability of the data and materials, please contact the corresponding author (MF).

Competing interests:

The authors declare that they have no competing interests

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References

1. Braithwaite J, Herkes J, Ludlow K, et al. Association between organisational and workplace cultures, and patient outcomes: systematic review. . *BMJ Open* 2017;7:e017708. doi: 10.1136/ bmjopen-2017-017708
2. Nelson W, Taylor E, Walsh T. Building an Ethical Organizational Culture. *Health Care Manager* 2020;39(4):168-74.
3. Johansson K, Lindahl B. Moving between rooms - moving between life and death: nurses' experiences of caring for terminally ill patients in hospitals. . *J Clin Nurs* 2012;21 2034-43.
4. Suwanabol P, Reichstein A, Suzer-Gurtekin Z, et al. Surgeons' Perceived Barriers to Palliative and End-of-Life Care: A Mixed Methods Study of a Surgical Society. *Journal of palliative medicine* 2018;

- 21(6):780-88.
5. Chan L, Macdonald M, Carnevale F, et al. 'I'm only dealing with the acute issues': How medical ward 'busyness' constrains care of the dying. *Health* 2018;22(5):451-68.
 6. World Health Organization. WHO Definition of Palliative Care 2015 [Available from: <http://www.who.int/cancer/palliative/definition/en/> accessed 13-08 2015.
 7. Bausewein C, Daveson B, Currow D, et al. EAPC White Paper on outcome measurement in palliative care: Improving practice, attaining outcomes and delivering quality services - Recommendations from the European Association for Palliative Care (EAPC) Task Force on Outcome Measurement. . *Palliat Med* 2016;30(1):6-22. doi: 10.1177/0269216315589898.
 8. de Wolf-Linder S, Dawkins M, Wicks F, et al. Which outcome domains are important in palliative care and when? An international expert consensus workshop, using the nominal group technique. *Palliat Med* 2019 33(8):1058-68. doi: 10.1177/0269216319854154
 9. de Santiago A, Portela M, Ramos L, et al. A new palliative care consultation team at the oncology department of a university hospital: an assessment of initial efficiency and effectiveness. *Support Care Cancer* 2012;20:2199-203. [published Online First: Epub 2012 May 3.]
 10. Laguna J, Goldstein R, Allen J, et al. Inpatient palliative care and patient pain: pre- and post-outcomes. *J Pain Symptom Manage* 2012;43 doi: 1051-9. doi: 10.1016/j.jpainsymman.2011.06.023.
 11. Brinkman-Stoppelenburg A, Polinder S, Meerum-Terwogt J, et al. The COMPASS study: A descriptive study on the characteristics of palliative care team consultation for cancer patients in hospitals. *European Journal of Cancer Care* 2020;29(1)
 12. Naaktgeboren M, Magdelijns F, Janssen D. Added Value of Early Consultation of an Inpatient Palliative Care Team in Hospitalized Older Patients With High Symptom Burden: A Prospective Comparative Study. *Am J Hosp Palliat Care* 2020:1049909120982606.
 13. Silva M, Diniz M, Carvalho R, et al. Palliative care consultation team: symptom relief in first 48 hours of hospitalization. *Rev Bras Enferm* 2020;73(6):e20190391. doi: 10.1590/0034-7167-2019-0391
 14. Brinkman-Stoppelenburg A, Vergouwe Y, Booms M. The Impact of Palliative Care Team Consultation on Quality of Life of Patients with Advanced Cancer in Dutch Hospitals: An Observational Study. *Oncology research and treatment* 2020;43(9):405-13. doi: 10.1159/000508312
 15. Engel P, Thavayogarajah T, Görlich D, et al. Establishment of a Palliative Care Consultation Service (PCCS) in an Acute Hospital Setting. . *Int J Environ Res Public Health* 2020 17(14):4977. doi: 10.3390/ijerph17144977.
 16. Schoenherr L, Bischoff K, Marks A, et al. Trends in Hospital-Based Specialty Palliative Care in the United States From 2013 to 2017. *JAMA Network Open* 2019;2(12):e1917043. . doi: 10.1001/jamanetworkopen.2019.17043
 17. Sasahara T, Miyashita M, Umeda M, et al. Multiple evaluation of a hospital-based palliative care consultation team in a university hospital: activities, patient outcome, and referring staff's view. *Palliat Support Care* 2010 8:49-57. [published Online First: Epub 2010 Feb 18.]

18. Morrison R, Dietrich J, Ladwig Sea. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Aff (Millwood)* 2011 30:454-63.
19. May P, Garrido M, Cassel J, et al. Prospective Cohort Study of Hospital Palliative Care Teams for Inpatients With Advanced Cancer: Earlier Consultation Is Associated With Larger Cost-Saving Effect. *Sep J Clin Oncol* 2015 1;33(25):2745-52. . doi: 10.1200/JCO.2014.60.2334.
20. Marin H, Mayo P, Thai V, et al. The impact of palliative care consults on deprescribing in palliative cancer patients. . *Support Care Cancer* 2020;28(9):4107-13. doi: 10.1007/s00520-019-05234-w.
21. McDarby M, Carpenter B. Barriers and Facilitators to Effective Inpatient Palliative Care Consultations: A Qualitative Analysis of Interviews With Palliative Care and Nonpalliative Care Providers. *The American journal of hospice & palliative care* 2019 36:191-99.
22. Pantilat S, O'Riordan D, Dibble S, et al. Hospital-based palliative medicine consultation: a randomized controlled trial. *Arch Intern Med* 2010;170:2038-40.
23. Kamal A, Swetz K, Carey E, et al. Palliative care consultations in patients with cancer: a mayo clinic 5-year review. *J Oncol Pract* 2011;7:48-53.
24. 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 *Palliative Medicine* 2016 30(3):240-56. doi: 10.1177/0269216315615483.
25. Gardiner C, Gott M, Ingleton C. Factors supporting good partnership working between generalist and specialist palliative care services: a systematic review. *Br J Gen Pract* 2012 62(598):e353-62. doi: 10.3399/bjgp12X641474.
26. Le BHC, Watt J. Care of the Dying in Australia's Busiest Hospital: Benefits of Palliative Care Consultation and Methods To Enhance Access. . *J Palliat Med* 2010;13:855-60.
27. Eriksson H, Milberg A, Hjelm K, et al. End of Life Care for Patients Dying of Stroke : A Comparative Registry Study of Stroke and Cancer. *PLoS ONE* 2016;11(2):e0147694. doi: 10.1371/journal.pone.0147694
28. Hatano Y, Shikata Y, Izumi H, et al. Discrepancies between Reasons of Palliative Care Team Consultation and Palliative Care Team Activities. *J Pall Med* 2018;21(9):1278-83. doi: 10.1089/jpm.2018.0086
29. Rodriguez K, Barnato A, Arnold R. Perceptions and Utilization of Palliative Care Services in Acute Care Hospitals. . *J Palliat Med* 2007;10:99-110. .
30. McDarby M, Carpenter B. Barriers and Facilitators to Effective Inpatient Palliative Care Consultations: A Qualitative Analysis of Interviews With Palliative Care and Nonpalliative Care Providers. . *Am J Hosp Palliat Care* 2019 36(3):191-99. . doi: 10.1177/1049909118793635.
31. Friedrichsen M, Hajradinovic Y, Jakobsson M, et al. Palliative care consultation team on acute wards- an intervention study with pre-post comparisons. *Supportive Care in Cancer* 2017;25(2):371-80. doi: 10.1007/s00520-016-3406-9
32. Hammersley M, Atkinson P. *Ethnography Principles in Practice*. 4th Edition ed: Routledge 2019.

33. Dewey J. Experience & Education. New York: Kappa Delta Pi 1938.
34. Dewey J. Democracy and Education Mac Millan Company 1916.
35. Spradley J. Participant Observation. 1980.
36. Spradley J. The Ethnographic Interview: Long Grove Waveland Press 2016.
37. Coym A, Oechsle K, Kanitz A, et al. Impact, challenges and limits of inpatient palliative care consultations - perspectives of requesting and conducting physicians. . *BMC Health Serv Res* 2020 20(1):86. doi: 10.1186/s12913-020-4936-x.
38. Gagnon J, Duggleby W. The provision of end-of-life care by medical-surgical nurses working in acute care: a literature review. *Palliative & supportive care* 2014 12(5):393-408.
39. Bosshardt M, Coyne P, Marsden J, et al. Palliative Care Consultation Policy Change and Its Effect on Nurses' Moral Distress in an Academic Medical Center August - Volume - Issue - p doi: . *Journal of Hospice & Palliative Nursing* 2018;20 (4):325-29. doi: 10.1097/NJH.0000000000000456
40. Riksdag) TS. Health care law (2017:30)(in swedish Hälso och sjukvårdslag). https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso-och-sjukvardslag-201730_sfs-2017-30, 2017.
41. Penrod J, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med* 2010;13:973-9.
42. Flierman I, van Rijn M, de Meij M, et al. Feasibility of the PalliSupport care pathway: results from a mixed-method study in acutely hospitalized older patients at the end of life. . *Pilot Feasibility Stud* 2020;6(129) doi: 10.1186/s40814-020-00676-0. eCollection 2020.
43. Lyman B, Jacobs J, Hammond E, et al. Organizational learning in hospitals: A realist review. . *Journal of Advanced Nursing* 2019;75(11):2352-77. doi: doi:10.1111/jan.14091
44. Chan C, Chow M, Chan S, et al. Nurses' perceptions of and barriers to the optimal end-of-life care in hospitals: A cross-sectional study. *J Clin Nurs* 2020 29 (7-8):1209-19. doi: 10.1111/jocn.15160.
45. Lipshitz R, Popper M. Organizational learning in a hospital. *Journal of Applied Behavioral Science* 2000;36(3):345-61. doi: 10.1177/0021886300363005
46. Avallin T, Athlin Å, Sørensen E, et al. Person-centred pain management for the patient with acute abdominal pain: An ethnography informed by the Fundamentals of Care framework. *Journal of Advanced Nursing* 2018;74(11):2596-609. doi: 10.1111/jan.13739
47. Bergenholtz H, Jarlbaek L, Hølge-Hazelton B. The culture of general palliative nursing care in medical departments: an ethnographic study. *International Journal of Palliative Nursing* 2015;21(4):193-201. . doi: 10.12968/ijpn.2015.21.4.193