

**Hospital-based generalist social workers' views of what facilitates or hinders collaboration with specialist palliative care social workers:
A grounded theory**

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This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy. The candidate has already achieved 180 credits for assessment of taught modules within the blended learning PhD programme.

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere

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To my husband, Dallas Burkholder: This thesis is for you. Your encouragement to pursue my dreams and follow my passion is invaluable. You hold my heart.

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Abstract

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Background: In the United States inpatient generalist social workers in discharge planning roles work alongside specialist palliative care social workers to care for patients. As a result two social workers may concurrently be involved in the same patient's care. Previous studies identifying components of effective collaboration, which impacts patient outcomes, care efficiency, professional job satisfaction, and healthcare costs, were conducted with nurses and physicians. The components of effective collaboration for generalist social workers' interactions with specialist palliative care social workers are unknown.

Aim: To explore inpatient generalist social workers' views of what facilitates or hinders collaboration with specialist palliative care social workers.

Methods: Using a grounded theory approach, qualitative interviews with inpatient generalist social workers (n=14) were systematically analysed to develop a theoretical model of generalist social workers' collaboration with specialist palliative care social workers.

Results: The emerging theoretical model of collaboration consists of: 1) trust, which is comprised of a) *ability*, b) *benevolence*, and c) *integrity*, 2) information sharing, and 3) role negotiation. Effective collaboration occurs when all pieces of the model are present. Collaboration is facilitated when generalists' perceptions of trust are high, pertinent information is communicated in a time-sensitive manner, and a flexible approach to roles is taken.

Conclusion: Trust is increased when generalist social workers' perceive the specialist palliative care social worker has the necessary skills to identify and address patient needs, manage interactions with the multidisciplinary healthcare team, support the generalists' roles, and adheres to social work professional values. Opportunities for formal and informal communication boost collaboration, along with regular access to the specialist palliative care social worker. At the organisational level effective collaboration is hindered by a lack of clarity regarding roles. Research about specialist palliative care social workers' perceptions of what facilitates or hinders collaboration with generalist social workers is needed.

Key Words [mesh headings]

Palliative care; Patient care teams; Cooperative behaviour; Communication; Social work; Referral and consultation

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Chapter 1: Introduction to thesis, multiprofessional collaboration, specialist palliative care, and social work

1.1 Introduction

Multiprofessional inpatient teams comprised of physicians, nurses, social workers, chaplains, therapists, and technicians work together to care for hospitalised patients. Collectively, team members address patient needs and concerns, order and interpret test results, coordinate with sub-specialists and other disciplines to create a treatment plan and move the patient through the hospital from admission to discharge, and manage medical issues and respond to emergencies (Ledford et al., 2015). This emphasis on professional collaboration amongst health and social care providers is crucial as it is a vital part of achieving better patient outcomes, improving patient satisfaction, reducing length of stay, lowering costs, and contributing to fewer and shorter delays in the provision of care (Barker et al., 1985, Knaus et al., 1986, Baggs et al., 1999, Sexton et al., 2000, Firth-Cozens, 2001, Institute of Medicine, 2001, Rafferty et al., 2001, Tam et al., 2011). Additionally, collaboration contributes to increased job satisfaction and retention, improved work efficiency, and lowered stress for staff (Rubenstein et al., 1984, Barker et al., 1985, Knaus et al., 1986, Baggs and Ryan, 1990, Baggs et al., 1999, Sexton et al., 2000, Firth-Cozens, 2001, Rafferty et al., 2001, Tam et al., 2011). For these reasons effective professional collaboration is of interest to healthcare organisations, government agencies, health and social care providers, and patients world-wide (Baggs et al., 1999, D'amour et al., 2005, Tamiya et al., 2010, Davis et al., 2014, Menefee, 2014).

Professional collaboration is central to the philosophy and provision of specialist palliative care, which includes combining multiple health and social care professionals' expertise to meet the needs of patients and families (Weissman, 1997, American Academy of Hospice and Palliative Medicine, 2014). Multiprofessional specialist palliative care teams are also of interest to healthcare agencies and patients and families for their ability to positively impact healthcare quality and

improve patient outcomes (Weissman, 2001, O'mahony et al., 2005, Auerbach et al., 2007, Twaddle et al., 2007, Waller, 2011). The World Health Organization (WHO) is interested in the provision of palliative care for hospitalised adult patients as many experience inadequately treated symptoms, fragmented care, and poor communication with their doctors at the end of life (Hall et al., 2010, World Health Organization, 2011, World Health Organization, 2014). WHO have called for further exploration of the collaboration of specialist palliative care teams with other health and social care professionals (Morrison et al., 2005, Meier, 2006, Goldsmith et al., 2008, World Health Organization, 2011, World Health Organization, 2014). Further exploration of generalists' collaboration with specialist palliative care is the aim of this thesis.

1.2 Key Terms

Within the specialist palliative care literature terminology is used interchangeably leading to a conflation of terms (Ledford et al., 2015). To avoid confusion the key terms used in this thesis are defined in Table 1.

Table 1: Key terms

<ul style="list-style-type: none"> • An <u>acute care hospital</u> is a 'short-term hospital where medical staff and all necessary personnel provide diagnosis, care and treatment of a wide range of acute conditions (Connecticut Department of Health, 2001).' Patients admitted to an acute care hospital are considered 'inpatient' when they spend at least one night in the hospital (Centers for Medicare and Medicaid Services, 2014). • <u>Professional collaboration</u> in healthcare can be defined as health and social care providers (physicians, nurses, social workers, etc.) taking on complementary roles to cooperatively work together through sharing problem-solving responsibilities and making decisions to formulate and carry out plans for patient care (Baggs and Schmitt, 1988, Fagin, 1992). • <u>Multiprofessional teams</u> are defined as a group of professionals from a variety of health and social care disciplines, i.e. specialised nurses and a specialist physician in palliative care, psychologist, physiotherapist, and/or spiritual counselor and social worker, who collaborate to provide patient care (Vissers et al., 2013).
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- Inter-disciplinary also refers to the team composition and the collaboration among health and social care providers with specialised knowledge from multiple disciplines (Goldsmith et al., 2010). The terms multiprofessional and interdisciplinary are often used interchangeably in the literature.
- Intra-disciplinary teams are composed of professionals within a single discipline or profession who may have different scopes of practice or training, i.e. social workers collaborating with social workers, or nurses with nurses (Jelley et al., 2013).
- Hospital-based specialist palliative care teams do not assume full responsibility for or take over the care of the patient; rather they liaise with the ward team to provide care to patients by meeting with the patient and making recommendations based on patient needs and goals which the ward team then operationalises.
- "Generalist" is defined as 'the acquisition and application of a broad spectrum of knowledge and skills (Trevithick, 2012, p. 141)' that can be used to address the range of different situations regularly encountered caring for patients in the hospital. Here, generalist is used to refer to health and social care providers who are not part of the specialist palliative care team, such as oncologists, neurologists, and the ward social worker.
- 'Specialist' in this context refers to the specialist palliative care team members, including the specialist palliative care social worker, who have 'superior knowledge and skill acquired through extensive practice experience and/or additional training (Trevithick, 2012, p. 142)' in palliative care.
- Social work roles can differ between and within countries. For an overview of social work in the United States see Appendix A.

1.3 Need for Research on Hospital-Based Specialist Palliative Care

Specialist palliative care is provided in a number of settings to patients of all ages throughout the disease trajectory (Center to Advance Palliative Care, 2012). For adult patients within the hospital setting, specialist palliative care teams often collaborate with generalist medical and allied health personnel in a consultative role (Pan et al., 2001, Morrison et al., 2005, Goldsmith et al., 2008, Kendall et al., 2009). In this role multiprofessional specialist palliative care teams offer advisory and advocacy services to patients, families, and staff (Kendall et al., 2009). They complement the services provided by the ward team and deliver personalised care, symptom control, complex psychosocial care, liaise with other palliative care services, and provide end-

of-life care for hospitalised adults with advanced disease (World Health Organization, 2011).

Despite the specific interest in hospital-based generalist-specialist palliative care team collaboration, in a recent systematic review by Gardiner et al. (2012) exploring the factors supporting a good partnership when generalists work with specialist palliative care providers the authors did not differentiate between inpatient and community services when reporting their findings. Of the 22 articles included in the review only one article, by Ewing et al. (2009) was conducted in an inpatient hospital setting (Gardiner et al., 2012). The remaining 21 studies were in the community setting (Gardiner et al., 2012).

Another systematic review conducted by Ahmed et al. (2004) identified the problems and issues of accessing specialist palliative care by patient, carers, and health and social care professionals. This review, whilst including the perception of professional providers, did not differentiate between inpatient, outpatient, or community settings, nor did it differentiate between models of specialist palliative care (Ahmed et al., 2004). Of the 40 studies in the review only one by Dharmasena and Forbes (2001) directly addressed collaboration with the palliative care team in the inpatient hospital setting (Ahmed et al., 2004). This focus on community care over hospital care may be because the bulk of care is provided in the community, and for most patients the preferred location for care is at home, however, many patients still receive end of life care in hospital (Radbruch and Payne, 2009, Clark et al., 2014). The remaining 39 studies describing patient and carer experiences did not directly address collaboration with the inpatient specialist palliative care team or were conducted in the community setting (Ahmed et al., 2004). Although there may be overlap between generalists experiences of collaborating with specialist palliative care team in the inpatient and community settings, failing to separate them limits the

applicability of the review findings to both settings. This gap in the literature needs to be addressed.

1.4 Generalist-Specialist Palliative Care Collaboration

Whilst supported by the World Health Organization as a way to meet the needs of hospitalised adults, the move to specialisation in palliative care is a much debated one (Leighninger, 1980, Hudson, 2002, Jack et al., 2002a, Mytton and Adams, 2003, Clausen et al., 2005, Ferrer et al., 2005, Blacker and Deveau, 2010, Trevithick, 2012). Hospital-based specialist palliative care teams are often, but not always, comprised of physicians, nurses, and social workers (Meier and Beresford, 2008a, Radbruch and Payne, 2010). The generalist ward team membership may mirror that of specialist palliative care teams, also including physicians, nurses, and social workers (Doherty and Crowley, 2013). Patients with a low symptom burden may be managed by generalists with basic knowledge of palliative care (Von Gunten, 2002). A smaller number of patients with challenging symptoms, physical or psychological, may benefit from specialised palliative care services provided by specialist teams (Von Gunten, 2002, Payne and Radbruch, 2009, Palliative Care Australia, 2013). Consequently, there are a number of combinations for *inter*-professional interactions between generalists and specialist palliative care teams. For example, generalist physicians may work with specialist palliative care nurses, or, specialist palliative care nurses may work with generalist social workers. There are also opportunities for *intra*-professional interactions between the two teams. For example, specialist palliative care nurses may work with generalist nurses, or, generalist social workers may coordinate care with specialist palliative care social workers. The interaction between generalist and specialist palliative care social workers is the focus of this study.

1.5 Generalist-Specialist Social Work Collaboration

The recognition of palliative care as a medical specialty in the United States, United Kingdom, and elsewhere has led to specialisation amongst various medical

professions including social work (Monroe, 1994, Seymour et al., 2002, Centeno et al., 2007, Meier et al., 2008). As professions develop they seek to differentiate themselves from other professions, arriving at their own professional identity (Leighninger, 1980, Davidson, 1990, Payne, 2006). Hospital-based social workers have worked hard to develop their role on the multiprofessional healthcare team and have a strong sense of ownership regarding their work with patients (Payne, 2009, Blacker and Deveau, 2010). Prior to the development and growth of palliative care, hospital-based 'generalist' social workers provided the full range of end of life services (Meier et al., 2008). Today, for hospitals which employ both 'generalist' and 'specialist palliative care' social workers, more than one social worker may be involved in providing care to the same patient. In these situations there is concern that social workers' similar education and skill set could lead to role confusion and challenges in care delivery, although these issues have not been studied in the acute hospital setting (Gardiner et al., 2012). Whilst some discussion about the various aspects of consultation etiquette has been ongoing in the medical field over many years, and in nursing for some time as well, social work is late to the conversation (Weissman, 1997, Weissman and Von Gunten, 2012, Von Gunten and Weissman, 2013). As specialist palliative care social work continues to grow this *intra*-professional tension needs to be better understood.

Previous research has shown that the quality of generalist-specialist palliative care partnership is impacted by communication between providers; opportunities for joint education; clear definition of roles and responsibilities; issues of timing of referral; and continuous support for all team members (Rizzo et al., 1970, Abramson and Mizrahi, 1996, Gardiner et al., 2012). With the inclusion of a specialist palliative care social work role on the hospital specialist palliative care team the generalist-specialist struggle has come to the forefront for clinical social work (Leighninger, 1980, Hudson, 2002, Jack et al., 2002a, Mytton and Adams, 2003, Ferrer et al., 2005,

Blacker and Deveau, 2010, Trevithick, 2012). Social work as a profession places a strong emphasis on teamwork and collaboration but little is known about intra-disciplinary collaboration in social work (Weinstein et al., 2003). To identify the facilitators of collaboration the generalist-specialist interface in social work needs to be explored. It is hoped that a collaborative approach will heighten team members' awareness of one another's professional knowledge and skills, resulting in ongoing improvement in decision-making and better outcomes for patients and families (Christensen and Larson, 1993, Gardiner et al., 2012). However, it has also been argued that specialisation could result in the fragmentation of care, duplication of services, role-ambiguity, and decreased job satisfaction for generalist providers, as well as lead to competition or 'turf-wars' between generalist and specialist providers (Rizzo et al., 1970, Leighninger, 1980, Siefert et al., 1991, Kadushin and Kulys, 1995, Holliman et al., 2003, Woodhouse, 2009). To date, studies have not explored hospital-based generalists' interactions with specialist palliative care social workers.

Prior studies of collaboration in healthcare have shown that the most substantial impact on patient care occurs when physicians, nurses, and social workers were satisfied with their professional relationships with other team members (Sommers et al., 2000). However, the literature indicates that each health or social care profession views collaboration from a different perspective (Krogstad et al., 2004). As a result, what one profession identifies as the factors most strongly contributing to collaboration may vary from those of another profession (Krogstad et al., 2004). Studies in the broader literature have also indicated that the *perception* of collaboration appears to be strongly correlated with achieving better patient care outcomes (Butterill et al., 1992, Abramson and Mizrahi, 1996, Barr, 1997, Sommers et al., 2000). Therefore, for optimal patient care outcomes to be achieved it is critical that the perceptions of each profession be well understood. No data exist currently for

the generalist-specialist palliative care social work interactions in the hospital. For collaboration to be successful there is a need for research in this area.

1.6 Summary

There is a dearth of knowledge specifically addressing generalist social workers' collaboration with specialist palliative care social workers in the hospital setting. Increased knowledge of the underlying factors contributing to generalist social workers' perceptions of collaboration could explain the conditions under which collaboration is facilitated or hindered. In turn, this information could assist with the development of professional practice, which could then positively impact healthcare quality and patient outcomes. Therefore, generalist social workers' perceptions, attitudes and experiences collaborating with the specialist palliative care team social worker in the hospital are explored in this thesis. Before initiating the study a systematic literature review of generalist providers' experiences of collaborating with specialist palliative care teams will be conducted to ascertain existing empirical knowledge. The review is described in chapter two.

Chapter 2: Systematic review of the literature on hospital-based generalists' perceptions of what facilitates or hinders collaboration with specialist palliative care teams

2.1 Introduction

A systematic review of the literature was conducted to understand generalists' (physicians, nurses, and other health and social care providers) perceptions of collaboration with specialist palliative care in the hospital. Previous systematic reviews looking at generalists' collaboration with specialist palliative care providers have focused on the community setting (Ahmed et al., 2004, Walshe et al., 2009, Gardiner et al., 2012, Oishi and Murtagh, 2014). Results from these earlier reviews may not apply to hospital-based care. The inpatient hospital setting differs substantially from that of the community: patient acuity is higher, immediacy of patient needs and response time from providers is more pressing, and providers episodically care for patients rather than follow patients for the entirety of their disease process. Specialist palliative care professionals have proposed several strategies for effective collaboration with generalist providers in the hospital related to communication, being accessible and responsive, and respecting the authority of the referring providers (Meier and Beresford, 2007, Von Gunten and Weissman, 2013). Evidence about generalists' perceptions of these efforts towards collaboration have been highlighted in the literature but not systematically assessed.

Traditionally, grounded theorists, concerned that the literature would have undue influence on theory development, deferred the literature review until after the research was completed and theoretical development had occurred (Glaser and Strauss, 1967, Charmaz, 2006, Dunne, 2011). As grounded theory methodology has continued to develop it has become acceptable to conduct the literature review before initiating a study (McGhee et al., 2007, Hallberg, 2010, Dunne, 2011). The realization that many researchers are close to their area of study and are often already theoretically sensitized or aware of the literature on the research topic, in addition to

the demands of funding agencies and ethics boards, has led to the acceptability of completing a literature review prior to starting the research process (McGhee et al., 2007, Hallberg, 2010). With reflexivity, use of the constant comparative method, and careful attention to how this preexisting information could have influence, use of the literature, or any other prior knowledge for that matter, should not prevent a grounded theory from emerging (McGhee et al., 2007, Hallberg, 2010, Dunne, 2011, Giles et al., 2013). Completing a literature review prior to initiating a study, therefore, can improve rigour, heighten theoretical sensitivity, and facilitate new insight (Dunne, 2011, Giles et al., 2013).

The literature review outlined in this chapter was conducted to meet the above goals using reflexivity and constant comparison to safeguard against bias and allow a theory that closely fits the data to emerge (Glaser and Strauss, 1967, Charmaz, 2006, Giles et al., 2013). In addition, situating the literature review prior to initiating the study provided confirmation that similar studies have not been published, as well as ensured that the research was focused and addressed an identifiable gap in the literature (Mccallin, 2003, Hallberg, 2010). Conducting a thorough, systematically constructed review allowed for the identification of a gap in the literature related to social work. Without a full systematic review it would not have been possible to establish this gap as data related to generalist social workers' perceptions of collaboration in the literature is buried within the results of broader studies looking at physicians and nurses. Consequently, this systematically constructed review and synthesis of the literature heightens understanding of generalists' perceptions of collaborating with specialist palliative care teams, and the conditions under which collaboration is facilitated or hindered. In addition, as little is known about generalist social workers' perceptions of collaboration with specialist palliative care the review gives attention to the identification of their experiences. The review was accepted for

publication in *Palliative Medicine* (see Appendix N). The review process and results are outlined in the sections below.

2.2 Methods

2.2.1 Aim

To identify and assess the current evidence to determine what is known about hospital-based generalist providers' perceptions of what facilitates or hinders collaboration with inpatient multiprofessional specialist palliative care teams, additionally taking note of any responses specific to social work.

2.2.2 Review Design

In synthesis, as in research, the question being asked should inform the choice of which method is utilised. Whilst reality exists independently of our experiences and interpretations, knowledge about reality is influenced by individual perceptions and beliefs, thus a collective, shared understanding of reality is possible (critical realism) (Barnett-Page and Thomas, 2009). In addition, numerous sources may legitimately influence the formation of knowledge, thus source heterogeneity is both necessary and desirable. As the existing evidence on integrated hospital-based palliative care is diverse an approach that facilitates the synthesis of heterogeneous literature is needed. The synthesis method, therefore, must support the epistemological assumptions about reality, describe experiences, beliefs, barriers, and facilitators of the phenomenon being studied, and manage studies of a heterogeneous nature. Therefore, a narrative synthesis approach was chosen over other methods, such as meta-analysis or content analysis. Narrative synthesis is an appropriate choice because of the descriptive nature of the synthesis question and the ability of the method to combine heterogeneous information (Mays et al., 2005, Dixon-Woods et al., 2007). Other types of synthesis reduce data into quantitative information, which would decrease the usefulness of the synthesis in relation to the application of findings to clinical practice.

The review follows the Guidance for Narrative Synthesis (Popay et al. 2006). The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) (Moher et al., 2009) guidelines are followed in the reporting of the review.

2.3 Search Process

2.3.1 Database Searches

The databases of PsycINFO, PubMed, Web of Science, CINAHL, and ProQuest Social Services Abstracts were searched for articles published from 1 January 1990 to 31 May 2014. Data about integrated palliative care produced before 1990 is scarce and may no longer be relevant as the palliative care field has evolved, therefore, was not included. The major palliative care journals were also hand searched: The American Journal of Hospice and Palliative Medicine; European Journal of Palliative Care; Journal of Hospice and Palliative Nursing; Journal of Pain and Symptom Management; BMC Palliative Care; Palliative Medicine; Journal of Palliative Medicine; and Journal of Social Work in End-of-Life and Palliative Care (Center to Advance Palliative Care, 2014a). Lastly, citation tracking was completed using Web of Science and the included studies' reference lists were reviewed for relevant articles. The searches were conducted in April/May 2014 and updated in December 2014, and November 2015.

2.3.2 Database Search Terms

For those databases which use MeSH headings or a thesaurus, these were employed to initiate the search. Included search terms and the Boolean operators used are in Table 2. Where the same terms did not exist, the closest substitutive terms were chosen to maintain as much consistency as possible throughout the search process. The search strategies for each database can be found in (Appendix B).

Table 2: Terms used in search strategy

1)	<u>Identification of palliative care</u> : Terminally ill patients OR Palliative care OR Terminal care OR Hospice OR End of life OR Dying OR Death
2)	<u>Professional personnel</u> : Social work OR Doctor OR Physician OR Nurse OR Medical staff OR Medical personnel OR Team OR Patient care team OR Health team OR Consultants OR Hospital medical staff OR Hospital nursing staff OR Allied health personnel OR Specialist palliative care OR Generalist palliative care OR Multidisciplinary OR Interdisciplinary OR Interprofessional
3)	<u>Attitude</u> : Attitude OR Perception OR Attitude of health personnel OR Experience OR View
4)	<u>Action</u> : Professional consultation OR Interdisciplinary treatment approach OR Communication OR Collaboration OR Decision making OR Cooperation OR Cooperative behaviour OR Interdisciplinary communication OR Interprofessional relations OR Joint practice OR Referral and consultation OR Shared care
5)	<u>Location</u> : Inpatient OR Hospitalised patients OR Acute care OR Hospital-based

2.4 Selection Criteria

2.4.1 Inclusion criteria

- English language research studies reporting empirical data published in peer-reviewed journals.
- Studies describing the interaction, perceptions, attitudes, and experiences of hospital based generalist care providers with at least one member of the hospital specialist palliative care team when simultaneously caring for a patient, even if the inpatient setting is not the only focus of the study.
- Studies describing generalists' perceptions of the factors that facilitate or are barriers to collaboration with the hospital based specialist palliative care team.
- Studies focusing on generalists and specialists providing care to adult patients within the acute hospital setting.
- Studies with a quality score of 19 or above on the scoring tool created by Hawker et al 2002.

2.4.2 Exclusion criteria

- Grey literature, newspaper articles, editorials, non-peer-reviewed articles, theoretical papers, and publications consisting of subject matter expert opinions.
- Studies with pediatric palliative care providers or occurring in pediatric hospitals, taking place in the outpatient ambulatory care, community based palliative care, or free-standing hospice settings, and studies of obstetrics and maternity wards.
- Studies exploring *intra*-team interactions between specialist palliative care team members, or the interactions between specialist palliative care providers and patients and carers, or interactions between generalist palliative care providers and patients and carers, or describing only generalist palliative care.

2.5 Data Extraction and Analysis

The search strategy was applied to identify papers. Once identified the papers were assessed for whether they met inclusion criteria. The narrative synthesis guidelines by Popay et al. (2006) were applied, which include (1) preliminary analysis, (2) exploration of relationships, and (3) assessment of the robustness of the synthesis. Preliminary analysis entailed extracting the descriptive characteristics of the studies in a table and generating a textual summary of the results. Data were placed into a table and thematic analysis was then used to extract the main themes. Analysis explored various relationships within and between each study. These relationships included: between and within countries, specialist palliative care team membership, patterns associated with the length of time the specialist palliative care team was active in the institution at the time of the study, differences and similarities between respondents (i.e. nursing vs. medicine), differences and similarities between areas of medicine (i.e. neurology vs. cardiology), differences within disciplines (i.e. neurology vs. neurology, or, nursing vs. nursing), and the impact of the size, number of beds, or type of hospital (i.e. community vs. academic medical centre). During analysis attention was also given to the identification of areas related to social work.

The five themes developed in the results section represent the main areas of knowledge available about hospital-based generalists' collaboration with specialist palliative care providers. Although the studies range over a span of 14 years, these themes remain fairly consistent, even when taking into account the length of time a specific specialist palliative care team may have been active at a given hospital, the membership of the specialist palliative care team, country, diagnosis, professional discipline, or research design.

2.6 Results

A total of 24 articles met the inclusion criteria and were included in the synthesis (Figure 1).

2.7 Assessment of Quality

Hawker et al.'s scale was used to assess the quality of the 24 studies (Hawker et al., 2002). The scale was created to assess heterogeneous studies allowing greater use of qualitative studies in systematic reviews, a particularly desirable trait for synthesis in palliative care as much of the existing evidence on perception and collaboration is qualitative (Hawker et al., 2002). The appropriateness of a quality tool is based on the understanding of the phenomena under study, rather than the procedures and instruments used in the evaluation, and is relative to the purposes and circumstances of the assessment and how well the tool fits those purposes (Maxwell, 1992, Boaz, 2003, Hannes et al., 2010). Whilst there remains disagreement regarding what criteria should be used to distinguish high-quality qualitative studies from others, as a quality assessment measure for specialist palliative care literature on a little-studied topic Hawker et al.'s (2002) tool is adequate for the task (Hannes et al., 2010).

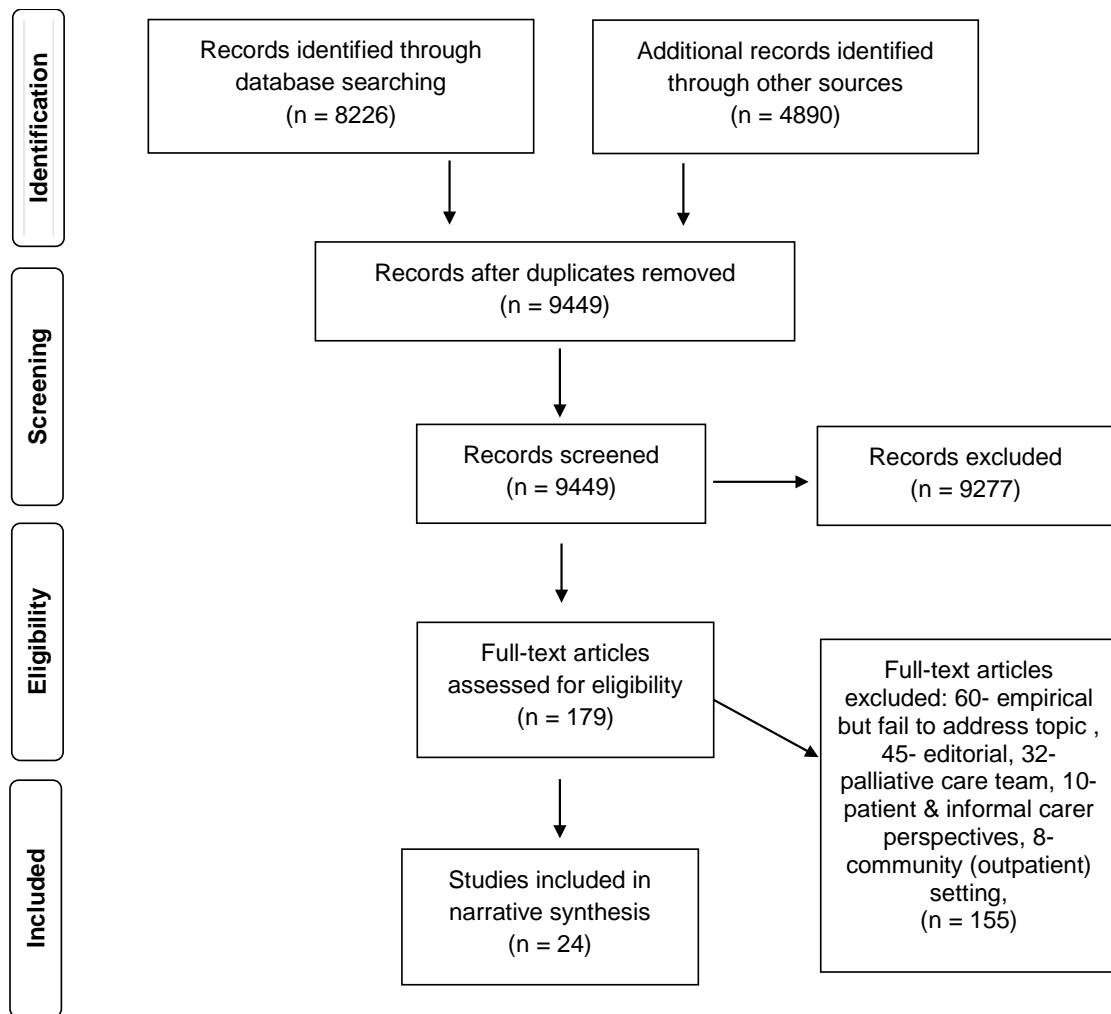


Figure 1: PRISMA flow diagram study selection

In addition, the tool was shown to have good inter-rater reliability. This characteristic may be helpful for comparing the results of this review with those of related palliative care systematic reviews which also utilised the scale (Hawker et al., 2002, Ahmed et al., 2004, Claessens et al., 2008, Oishi and Murtagh, 2014).

The tool produces an overall score for each study, ranging from as low as nine to as high as 36. Hawker et al. (2002) do not provide guidance regarding how low a score is too low to be acceptable for inclusion, leaving the determination up to the reviewer. A score of 19 was chosen as the lowest acceptable score for inclusion as studies with “poor” or “very poor” ratings lack the desired quality level for inclusion. Previous applications of the scoring tool have also utilised a score of 19 as an inclusion cut-off (Flemming and McInnes, 2011). All of the studies were included in

the synthesis as they met the inclusion criteria of a score of 19 or higher. Scores of the 24 identified studies ranged from 25 to 36, with a median score of 31.

2.8 Overview of Studies

The publication dates of the studies ranged from 2001 to 2015 and were heterogeneous, with 13 being qualitative (Jack et al., 2002a, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Enguidanos et al., 2009, Ewing et al., 2009, Le and Watt, 2010, Norton et al., 2011, Burton and Payne, 2012, Gott et al., 2012, Lane et al., 2014, Morikawa et al., 2015), six quantitative (Dharmasena and Forbes, 2001, Salomon et al., 2001, Cherny et al., 2003, Turner-Stokes et al., 2007, Johnson et al., 2012, Armstrong et al., 2013), and five mixed methods (Carter et al., 2002, Dowell, 2002, Snow et al., 2009, Ward et al., 2009).

Of the 24 studies, ten were from the UK (Dharmasena and Forbes, 2001, Dowell, 2002, Jack et al., 2002a, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Turner-Stokes et al., 2007, Ewing et al., 2009, Burton and Payne, 2012, Johnson et al., 2012), five from the USA (Rodriguez et al., 2007, Enguidanos et al., 2009, Snow et al., 2009, Norton et al., 2011, Armstrong et al., 2013), and three from Australia (Ward et al., 2009, Le and Watt, 2010, Lane et al., 2014). New Zealand (Carter et al., 2002), and France (Salomon et al., 2001) had one study each, and two studies were from Japan (Sasahara et al., 2010, Morikawa et al., 2015). There were two multi-country studies, one which included respondents from Australia, USA, Asia, Africa, and Europe (Cherny et al., 2003), the specific Asian, African, and European countries were not identified, and one which included respondents from both England and New Zealand (Gott et al., 2012). Study hospitals ranged in type from small secondary care centres to large tertiary teaching hospitals. Two specialist cancer centres (Ewing et al., 2009, Morikawa et al., 2015) and one acute stroke centre (Burton and Payne, 2012) were also included. The smallest hospital had 240 beds (Armstrong et al., 2013) and largest had 1300 beds (Jack et al., 2003). Hospitals

were located in urban, inner city, and rural settings. Nine studies focused only on physicians (Hibbert et al., 2003, Turner-Stokes et al., 2007, Snow et al., 2009, Ward et al., 2009, Gott et al., 2012, Armstrong et al., 2013, Dharmasena and Forbes, 2001, Cherny et al., 2003), three on nursing staff alone (Mytton and Adams, 2003, Sasahara et al., 2010, Johnson et al., 2012), six included both physicians and nurses (Salomon et al., 2001, Jack et al., 2002, Jack et al., 2003, Enguidanos et al., 2009, Ewing et al., 2009, Lane et al., 2014), five studies included physicians, nursing and allied health (speech and language pathology, occupational therapy, physical therapy, chaplains) (Dowell, 2002, Carter et al., 2002, Rodriguez et al., 2007, Le and Watt, 2010, Norton et al., 2011), and five studies specifically mentioned social work (Carter et al., 2002, Dowell, 2002, Rodriguez et al., 2007, Le and Watt, 2010, Norton et al., 2011). Specialist palliative care team membership varied considerably (Table 3). Half of the studies did not identify the professional membership of the specialist palliative care team. Specialist palliative care teams had been active for as little as one year (Enguidanos et al., 2009) to as much as 11 years (Ewing et al., 2009, Sasahara et al., 2010). The referral models ranged from hospitals where any member of the ward team could make a referral to specialist palliative care (Carter et al., 2002), to hospitals where referrals could only be made with the approval of the attending (head) physician (Snow et al., 2009). No consistency existed in the titles or terms used to refer to the hospital-based specialist palliative care teams.

2.9 Themes

Analysis produced the following five themes: Model of Care (Integrated vs. Linear); Professional Onus; Expertise and Trust, Skill-Building vs. Deskillling, and Specialist Palliative Care Operations. Each study contributed to different number of themes, with some studies having multiple themes and some only two or three (Table 3). The five themes identified through the analysis process are discussed below.

Table 3: Data extraction and study quality ordered by year of publication

Author (Year) Cntry, Score	Research Aim	Participants	Method	Pall Care Team	Themes	Key Findings
Dharmasena and Forbes (2001) Wales, 25	Will doctors refer non-cancer patients to palliative care?	78 consultants	Postal survey, 8 items. Analysis not described.	Not described	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskilling	Integrated care preferred. Cardiology concerned palliative care may not have the disease-specific expertise needed. All doctors should be skilled in palliative care. Concern for deskilling and patient abandonment.
Salomon et al. (2001) France, 30	To describe the current management of terminally ill patients from care providers' viewpoint.	31 physicians 16 nurses	Structured self-administered 33 item survey. SPSS used for analysis.	Physician, nurse, psychologist.	Model of Care; Skill Building vs. Deskilling; Specialist Palliative Care Operations	Integrated care provided for skill-building opportunities. Ward team desired expertise of specialist palliative care. Availability of specialist palliative care important.
Carter et al. (2002) New Zealand, 29	To determine health professionals' perception of the service's impact on patients, families, and staff, and areas that need improvement.	127 doctors 242 nurses 11 social workers	Postal survey, 5 point Likert scale & Yes/No questions. EPI6 used for analysis.	Full time nurse, part-time physician.	Model of Care; Skill Building vs. Deskilling; Specialist Palliative Care Operations	Integrated care desired. Skill-building, communication, availability of services, and ease of access important aspects of involving specialist palliative care.
Dowell (2002) England, 27	To establish a baseline of palliative care knowledge, attitudes, and practices of multidisciplinary hospital staff.	Focus group: 2 nurses, 1 doctor, 1 pharmacist, 3 chaplains, 1 social worker, 1 OT, 1 PT. Questionnaire 30 people.	Focus groups, 16 item survey. Analysis not described.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskilling; Specialist Palliative Care Operations	Integrated care desired by some but experienced as challenging by others. Role differentiation unclear. Ward and specialist palliative care team expertise sometimes at odds or of concern. Trust impacted by lack of inclusion of or communication with ward team in planning for patient care.
Jack et al. (2002a) England, 29	To explore generalists' perception of de-skilling.	19 nurses - managers and ward staff, 4 consultants, 4 doctors, 4 CNS SPC.	Open-ended interviews. Analysed using case/cross-case analysis.	4 CNSs, a consultant and specialist registrar.	Professional Onus; Expertise & Trust	Concern for deskilling. Junior staff less concerned than senior staff. Desire from ward team to maintain generalist palliative care skills.
Cherny et al. (2003) Europe, USA, Asia, Australia, Africa, 35	To describe Oncologists involvement and attitudes toward palliative care of patients with advanced cancer	895 physicians	Postal survey. Multivariate analysis.	Not described.	Model of Care; Professional Onus; Expertise vs. Trust	Integrated care highly valued and sought by most. Want to share responsibility of care. Role conflict and confusion about who is best at managing oncology patients' palliative care needs. Issues of expertise and trust, unsure palliative care can manage their patients.

(Table 3 Continued)

Author (Year) Cntry, Score	Research Aim	Participants	Method	Pall Care Team	Themes	Key Findings
Hibbert et al. (2003) England, 30	Explore doctors' views of developing palliative care for patients with heart failure	7 focus groups of physicians	Open-ended interviews. Thematic analysis.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskilling, Specialist Palliative Care Operations	Linear care more the norm. Referral to palliative care means failure for cardiologist. Two-way learning process between palliative medicine and other specialties is positive experience. Concern that cardiology will not address palliative needs, trust and expertise are issues.
Jack et al. (2003) England, 32	Explore the impact of hospital-based palliative care clinical nurse specialists on doctors and nurses	23 nurses 8 physicians	Open-ended interviews. Case/cross-case analysis.	4 clinical nurse specialists, consultant and registrar available for advice via phone.	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskilling	Integrated care seen as a positive. Skill-building and deskilling concerns voiced by staff. Appreciation of palliative care expertise cited.
Mytton and Adams (2003) England, 35	Examine how specialist and generalist nurses work together in the care of terminally ill patients.	8 generalist nurses 2 nurses from SPC	Open-ended interviews, case vignette. Thematic analysis.	5 clinical nurse specialists.	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskilling; Specialist Palliative Care Operations	Integrated care helpful, however, concern for abdication of responsibility, deskilling, and role confusion led to more linear approach to care. Appreciation for specialist expertise.
Rodriguez et al. (2007) USA, 36	Explore how physicians and other health care providers in acute care hospital perceive and utilise palliative care services.	129 participants: administrators and ward staff	Semi-structured interviews, ethnographic observation. Thematic analysis.	Not described.	Model of Care; Professional Onus, Expertise & Trust; Specialist Palliative Care Operations	Linear care preferred. Role confusion and view that involving palliative care means failure and abandonment. Generalists view symptom management as their responsibility. More referrals to specialist care made when specialists were seen as being experts and respecting referring teams' expertise and role.
Turner-Stokes et al. (2007) UK, 28	To explore the interaction between SPC, neurology, and rehabilitation services.	82 neurologist, 149 SPC, 53 Rehab physicians	Postal Survey. Analysed w/ SPSS, chi-squared stats, expected frequency >5.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations.	Linear care common. Role confusion, belief that it is generalist's responsibility to manage symptoms. Easy access and appreciation of skill needed for specialist palliative care enabled referrals.
Enguidanos et al. (2009) USA, 34	To explore Physician and nurse perceptions of an inpatient palliative care team consultation service after 1 yr. of operation	33 participants 16 physician, 17 nursing	Focus groups. Analysed using grounded theory.	2 quarter time physicians, one nurse, and one social worker.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations	Integration seen as valuable. Responsiveness of specialist team increased utilisation. Expertise desired, collaboration enhanced through good communication. Trust increased by collaboration, inclusion, and skill-building, decreased by exclusion.

(Table 3 Continued)

Author (Year) Cntry, Score	Research Aim	Participants	Method	Pall Care Team	Themes	Key Findings
Ewing et al. (2009) England, 33	Referrers and providers views of multidisciplinary SPC in the acute hospital setting.	5 Junior doctors, 13 Consultants, 6 Clinical Nurse Specialists	In person interviews, observation. Analysed thematically using framework analysis.	2 consultants, Associate Specialist in palliative medicine, 2 Specialist Registrars, 5 CNS, 2 staff.	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskillling; Specialist Palliative Care Operations	Integrated care desired. Oncologists view their role as first line for symptom management; collaborate with specialist services if unable to control symptoms themselves. Want to maintain ownership of and relationship with patient. Some concern for deskillling. Ease of access important.
Snow et al. (2009) USA, 32	To better understand the utilisation of palliative care consultative services and to identify specific factors that might influence physicians referral practice.	74 physicians. 50 who had referred to SPC, 24 who had not referred.	Interviews & 11- item, Likert scale survey, Univariate statistics, interviews analysed using a standard method.	Physician, nurse practitioner, social worker.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations	Integrated care viewed positively. Majority want to maintain relationship and role with patient. Some want to turn over care to specialists at end of life. Specialists seen as experts for advanced disease symptom management.
Ward et al. (2009) Australia, 33	To investigate the attitudes of oncologists and trainees toward SPC and collaboration with SPC services	115 total, 78 oncologists, 37 trainees.	Web survey, Likert & open- ended questions, Descriptive statistics, thematic analysis.	Not described.	Model of Care; Expertise & Trust; Skill Building vs. Deskillling; Specialist Palliative Care Operations	Frequent integration of specialist services, although frequency could increase. Some role confusion. Good communication helps to mitigate role confusion. Desire for even more integration. Greater disease specific expertise desired for specialists.
Le and Watt (2010) Australia, 31	To assess the care provided to patients dying within the hospital and understand senior clinicians decision making around referral to SPC.	27 clinicians: 10 Nurses, 11 physicians, 2 social workers, 2 pastoral care, 1 speech pathologist, 1 OT	Retrospective chart review, semi-structured interviews, thematic analysis.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations	Integrated care viewed as valuable but not accessed as frequently as it could be. Timing of involvement unclear. Expertise of specialists appreciated. Some role confusion can occur, desire to retain involvement in patient's care, maintain skills.
Sasahara et al. (2010) Japan, 31	To clarify the activities, patient outcome, and referring staff's view of an established SPC Consultation Team in Japan	68 nurses	Survey, Likert scale, yes/no & open-ended questions, Descriptive statistics, thematic analysis.	Physician, certified nurse specialists and psychiatrist.	Expertise & Trust; Skill Building vs. Deskillling; Specialist Palliative Care Operations	Expertise, inclusion of ward staff, and responsiveness of specialists facilitate integration.

(Table 3 Continued)

Author (Year) Cntry, Score	Research Aim	Participants	Method	Pall Care Team	Themes	Key Findings
Norton et al. (2011) USA, 31	To describe the multiple perspectives of administrators and clinicians about the tensions between a SPC and the larger hospital setting.	79 participants total, 21 hospital leadership, 33 clinicians who used SPC, and 25 from SPC team	Ethnographic study, in-depth interviews, and "cultural artifacts". Analysis not described.	Physicians, nurse practitioners, social worker, chaplain, psychologist, ethicist, massage therapist, bereave. coordinator, and a harpist.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations	Mix of integrated and linear care. Greater utilisation of specialist services led to even higher rates of integration. Desire for mutual respect of expertise. Easy access to specialist services facilitated integration. Concerns about role confusion and meaning of referral on professional identify cited as barriers to integrating care.
Burton and Payne (2012) England, 32	To produce explanatory practice model to help clinicians meet the palliative and end of life care needs of patients and families through the integration of palliative care within acute stroke services.	29 total: 1 psychologist, 1 physician, 1 health care assist, 2 OT, 2 PT, 5 specialist stroke nurses, 1 speech language pathology, 7 stroke unit nursing, 1 family advocacy, 8 not identified.	Semi-structured interviews. Thematic analysis.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations	Linear care common. Involvement of specialist services seen as failure. Involvement of specialist occurring only when ward team has done all they can think of to treat. Concern specialists do not have enough expertise to manage stroke patients.
Gott et al. (2012) England and New Zealand, 33	To explore understandings of, and perceived roles in relation to, palliative care provision amongst generalist and specialist health providers in England and New Zealand	England – 58, 5 of who worked in acute hospital NZ – 80, 10 of who worked in acute hospital. Mix of professions.	Focus groups. Analysed with grounded theory.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Skill Building vs. Deskilling; Specialist Palliative Care Operations	Linear care. Integration hampered by role confusion. Specialisation of services seen as fragmenting care and taking responsibility and skills from generalists. All generalists should be able to provide palliative care.
Johnson et al. (2012) England, 28	To survey Heart Failure Specialists about their attitudes regarding general PC provision for HF and access to SPC.	152 nurses in 2005. 174 nurses in 2010.	Web-based and paper surveys. Analysis not discussed.	Not described.	Model of Care; Expertise & Trust; Specialist Palliative Care Operations	Integrated care valued but not actualised. Ease of access important for facilitating integration. Concern that specialists might lack expertise to manage heart failure.

(Table 3 Continued)

Author (Year) Cntry, Score	Research Aim	Participants	Method	Pall Care Team	Themes	Key Findings
Armstrong et al. (2013) USA, 29	To measure the impact of SPC Consultation on clinical, customer, operational, and financial domains.	18/19 participants responded. Physicians and other providers	Survey, 9 item Likert scale. Descriptive statistics.	Not described.	Model of Care; Specialist Palliative Care Operations	Integration is desired and positive experience. Communication and ease of access make integration possible.
(Lane et al., 2014), Australia, 30	To explore health care professionals' views and experiences of interdisciplinary interactions when caring for patients with advanced cancer who present to the emergency room.	83 professionals in focus groups, 11 one-on-one interviews.	Focus groups, Semi structured phone interviews. Analysed using thematic analysis.	Not described.	Model of Care; Professional Onus; Expertise & Trust; Specialist Palliative Care Operations	Integrated care desired but not actualised. Communication and access would improve integration. Lack of trust in other's expertise a barrier to integration.
(Morikawa et al., 2015), Japan, 31	To explore haematologist & SPC perceptions of SPC role & barriers to collaboration	11 hematologists, 10 SPC physicians	Semi-structured interviews. Analysed using content analysis	Physicians, otherwise not described.	Model of Care; Expertise & Trust; Specialist Palliative Care Operations	Linear but integration desired by some. Communication would improve integration. Concern that SPC may lack expertise needed to care for haematology patients' needs.

SPC = Specialist Palliative Care, PC=Palliative Care, CNS = Clinical Nurse Specialist, OT = Occupational Therapist, PT = Physiotherapist, HF = Heart Failure.

2.9.1 Model of Care: Integrated vs. Linear

Two models of care emerged from the literature review; an 'integrated' model and a 'linear' model. Whilst formal definitions of integrated and linear care exist, the descriptions of each model used here have risen from the studies themselves and are not formal definitions. Here 'integrated care' is concurrent care with generalist and specialist palliative care providers. It consists of a multiprofessional approach to patient care, combining various health and social care specialties, services, and professionals to meet the need of the patient at different points in time throughout the course of an illness. Studies reporting a more integrated approach to care noted higher utilisation of multiprofessional specialist palliative care services, viewed palliative care as applicable throughout the disease process, and deemed it appropriate for use in a variety of life-limiting illnesses (i.e. not just cancer) (Dharmasena and Forbes, 2001, Salomon et al., 2001, Carter et al., 2002, Mytton and Adams, 2003, Enguidanos et al., 2009, Ewing et al., 2009, Ward et al., 2009, Le and Watt, 2010, Norton et al., 2011). 'Linear care' here views transitions to different specialties as a passing of the 'care baton.' In linear care, one type of care ends before another begins.

An integrated care approach was preferred and implemented in 12 studies (Dharmasena and Forbes, 2001, Dowell, 2002, Cherny et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Enguidanos et al., 2009, Ewing et al., 2009, Snow et al., 2009, Ward et al., 2009, Johnson et al., 2012, Lane et al., 2014). Four studies consisting of Cardiology (Dharmasena and Forbes, 2001, Hibbert et al., 2003) and Neurology (Turner-Stokes et al., 2007, Burton and Payne, 2012) professionals found these providers preferred and took a more linear approach to palliative care involvement. Of the seven remaining studies, three did not provide enough information to determine model of care (Jack et al., 2002a, Mytton and Adams, 2003, Sasahara et al., 2010), three reported that integrated care is desired

but not actualised into patient care (Le and Watt, 2010, Johnson et al., 2012, Lane et al., 2014), and two reported a mixed response about which model of care was preferred (Gott et al., 2012, Morikawa et al., 2015).

Of the studies which reported generalists' as viewing an integrated care model positively, integrated care was a means to address patient and family needs whilst still fulfilling the professional's obligation to remain involved in the patient's care (Dharmasena and Forbes, 2001, Cherny et al., 2003, Enguidanos et al., 2009, Ewing et al., 2009, Snow et al., 2009, Ward et al., 2009, Le and Watt, 2010, Norton et al., 2011). In the majority of studies integrated care model providers maintain the right to their autonomy in medical decision making (Dharmasena and Forbes, 2001, Cherny et al., 2003, Enguidanos et al., 2009, Ewing et al., 2009, Snow et al., 2009, Ward et al., 2009, Le and Watt, 2010, Norton et al., 2011). Integrated care model providers preferred an 'unequal' partnership with specialist palliative care, one where the referring team claims the leadership role, and the specialist palliative care team defers to the leader. These findings were consistent across the studies regardless of provider type (nursing, physician, etc.), country, and hospital size.

Three studies reported that several providers preferred a linear model where they are able to 'hand over' their patients' care to specialist palliative care teams after they had delivered all the interventions at their disposal (Hibbert et al., 2003, Turner-Stokes et al., 2007, Burton and Payne, 2012). The 'linear model' was more often associated with providers whose skills and options for patient care included a broad range of interventions, those that were most frequently mentioned were Cardiology, Neurology, Oncology, General Surgery, and Vascular Surgery (Cherny et al., 2003, Hibbert et al., 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Burton and Payne, 2012, Johnson et al., 2012, Lane et al., 2014). In the studies these providers were more likely to express that their area of responsibility was being invaded when specialist palliative care became involved earlier in the illness trajectory (Dowell,

2002, Mytton and Adams, 2003, Rodriguez et al., 2007, Ewing et al., 2009, Snow et al., 2009, Norton et al., 2011, Gott et al., 2012).

The Oncology related studies spanned a variety of settings and countries, whilst those studies reporting responses from Cardiology, Neurology, General Surgery, and Vascular Surgery were conducted in the UK, USA, and Australia only and included only one specialist centre (stroke). Findings related to generalist Oncology views may be more broadly applicable as a result. Additionally, whilst there are bound to be variations amongst groups of providers, of the five groups listed above Oncology was found to be the most polarised in their preferences for integrated versus linear care, half favouring linear and the other half favouring integrated care (Cherny et al., 2003, Hibbert et al., 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Ewing et al., 2009, Ward et al., 2009, Burton and Payne, 2012, Lane et al., 2014, Morikawa et al., 2015). Polarisation in Oncology was persistent across countries, regardless of specialist palliative care team membership or hospital setting (i.e. specialist cancer centre vs. secondary hospital).

2.9.2 Professional Onus

Professional onus denotes the provider's professional responsibility towards the patient and the duration of that responsibility. Studies reported a range of results between and within individual studies. Several studies found that some generalist providers were concerned that involvement of the specialist palliative care team was an abdication of responsibility or a sign that they have either 'given up on' or 'failed' the patient (Dharmasena and Forbes, 2001, Salomon et al., 2001, Cherny et al., 2003, Hibbert et al., 2003, Mytton and Adams, 2003, Turner-Stokes et al., 2007, Ewing et al., 2009, Snow et al., 2009, Le and Watt, 2010, Burton and Payne, 2012, Gott et al., 2012). A number of studies also reported the opposite finding, with many generalist providers' viewing specialist palliative care involvement as an extension of their responsibility and a way to increase the care given to the patient (Dharmasena

and Forbes, 2001, Cherny et al., 2003, Hibbert et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Ewing et al., 2009, Snow et al., 2009, Ward et al., 2009, Le and Watt, 2010, Burton and Payne, 2012, Gott et al., 2012). In studies where specialist palliative care involvement was perceived as an extension of their role, providers struggled less with the timing of the referral; involving specialist palliative care earlier in the disease course (Salomon et al., 2001, Carter et al., 2002, Cherny et al., 2003, Enguidanos et al., 2009, Ewing et al., 2009, Snow et al., 2009, Le and Watt, 2010, Armstrong et al., 2013). Providers who perceived specialist palliative care involvement as the end of their role in patients' care had more difficulty determining when to involve specialist palliative care, sometimes waiting until days to hours before death (Dharmasena and Forbes, 2001, Dowell, 2002, Cherny et al., 2003, Hibbert et al., 2003, Rodriguez et al., 2007, Snow et al., 2009, Le and Watt, 2010, Burton and Payne, 2012, Gott et al., 2012).

Also included in professional onus are the concepts of 'abdication of responsibility' and 'professional laziness'. With the integration of specialist palliative care, studies indicated generalist providers were concerned with becoming 'disinclined' to provide the patient with care which would normally be within their purview (Dowell, 2002, Jack et al., 2003, Gott et al., 2012). Generalists' worried that providers would 'take a back seat' to specialist palliative care teams, remaining on paper the patient's provider but in reality being absent (Mytton and Adams, 2003, Gott et al., 2012). Furthermore, there was a strong sense that every generalist provider should know and be competent providing 'basic' palliative care services to all of their patients (Dharmasena and Forbes, 2001, Dowell, 2002, Cherny et al., 2003, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Ewing et al., 2009, Le and Watt, 2010, Norton et al., 2011, Burton and Payne, 2012, Gott et al., 2012, Johnson et al., 2012). These findings were consistent regardless of country, hospital size, specialist palliative care

team membership, or study design. Overall, although generalists were reported to have concerns for abdication of responsibility, these fears were not realised. Generalist providers were able to maintain their role and responsibilities towards their patients if they desired to do so.

2.9.3 Expertise and Trust

The themes of expertise and trust appeared in many of the studies (Dharmasena and Forbes, 2001, Dowell, 2002, Jack et al., 2002a, Cherny et al., 2003, Hibbert et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Enguidanos et al., 2009, Ewing et al., 2009, Snow et al., 2009, Ward et al., 2009, Norton et al., 2011, Burton and Payne, 2012, Gott et al., 2012, Johnson et al., 2012, Lane et al., 2014, Morikawa et al., 2015). Expertise and trust were often coupled together, at times used interchangeably, making it difficult to definitively distinguish and report each as separate themes. Whilst formal definitions exist, the meanings of expertise and trust used here are derived from the studies themselves. Definitions here are limited by the conflation of terms within the original studies. Trust relates to the referring team's ability to rely on the specialist palliative care team to act as desired. Desired behaviours consist of respecting the hierarchy of decision making, particularly as it relates to treatment planning, recommended clinical direction, and goals of care, as well as communicating frequently with the all the ward staff involved in the patient's care (Carter et al., 2002, Mytton and Adams, 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Enguidanos et al., 2009, Ward et al., 2009, Le and Watt, 2010, Norton et al., 2011, Burton and Payne, 2012, Armstrong et al., 2013, Morikawa et al., 2015). Expertise refers to the specialist palliative care team having a strong working understanding of specific disease trajectories and available active treatment options for each disease process in order to counsel patients about choices for continuing care (Hibbert et al., 2003, Turner-Stokes et al., 2007, Snow et al., 2009, Ward et al., 2009, Johnson et al., 2012, Morikawa et al., 2015). Expertise also

consists of having the necessary medical, psychosocial, and spiritual skills to adequately address the needs of the patient (Carter et al., 2002, Dowell, 2002, Hibbert et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Enguidanos et al., 2009, Ward et al., 2009, Armstrong et al., 2013, Morikawa et al., 2015). Irrespective of hospital size, disease type, country, and specialist palliative care team membership, trust was increased when the specialist palliative care team was able to consistently demonstrate their expertise and referring teams became convinced of their capabilities.

Many studies reported generalists' as having a high level of respect for the specialist palliative care skillset, viewing the services specialist palliative care provided as requiring extra training and experience to execute (Cherny et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Ewing et al., 2009, Le and Watt, 2010). Generalists' perceptions of the level of skill involved in specialist care services directly impacted their willingness to refer and the types of issues they requested be addressed (Carter et al., 2002, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Morikawa et al., 2015). In particular, Cardiology, Neurology, Physical Rehabilitation, and Oncology providers' perceptions of specialist palliative care's disease specific expertise, or lack thereof, influenced how much they trusted specialist palliative care and directly impacted the teams' willingness to integrate care (Dharmasena and Forbes, 2001, Cherny et al., 2003, Hibbert et al., 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Norton et al., 2011, Burton and Payne, 2012, Johnson et al., 2012, Lane et al., 2014, Morikawa et al., 2015). When generalists' viewed specialist palliative care as lacking skill it was difficult for generalists to trust their ability to adequately discuss goals of care or make appropriate treatment related recommendations (Hibbert, 1998, Dharmasena and Forbes, 2001, Cherny et al., 2003, Turner-Stokes et al., 2007, Burton and Payne, 2012, Johnson et al., 2012). Conversely, several studies reported

generalists' perception that specialist palliative care was at times dismissive of the ward team's expertise and role in patients' care, as exhibited by failing to include them in the plan of care, discuss recommendations, or update them on what was discussed during family meetings (Carter et al., 2002, Dowell, 2002, Jack et al., 2002a, Mytton and Adams, 2003, Enguidanos et al., 2009, Sasahara et al., 2010). This lack of respect for generalists' expertise damaged collaboration.

Areas where generalist teams were able to acknowledge their own discomfort and lack of expertise mirrored the areas for which they were more likely to integrate specialist palliative care services unrelated to country, disease type, hospital size, or specialist palliative care team membership. Trust and utilisation were fostered when both the referring team and the specialist palliative care team were able to express mutual respect and appreciation for each other's roles, expertise, and contributions to patient care outcomes, and when communication was high (Carter et al., 2002, Dowell, 2002, Enguidanos et al., 2009, Ewing et al., 2009, Ward et al., 2009, Sasahara et al., 2010, Norton et al., 2011).

2.9.4 Skill-Building vs. Deskillling

The concern of skill-building vs. deskillling was shared by all provider types (nurse, physician, social worker, administrators, etc.), and persisted regardless of specialist palliative care team membership, country, or hospital size. Skill-building, or the gaining palliative care skills, was viewed as desirable by the generalists and was identified in the studies as being one of the positive products of integrated specialist palliative care (Salomon et al., 2001, Dowell, 2002, Jack et al., 2002a, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Ward et al., 2009, Sasahara et al., 2010). Whereas, 'deskillling' refers to the fear that the integration of specialist palliative care could prevent ward staff from learning skills to provide comprehensive end of life care themselves, or that skills once acquired could be lost from lack of regular practice (Dharmasena and Forbes, 2001, Jack et al., 2002a, Jack et al., 2003,

Mytton and Adams, 2003, Ewing et al., 2009, Norton et al., 2011, Gott et al., 2012). Skill-building was especially important for generalists without formal training in palliative care (Salomon et al., 2001, Jack et al., 2002a, Jack et al., 2003).

Studies reported that generalists found integrated specialist palliative care contributed to their education (formally and informally), with skill-building occurring chiefly through observation of the specialist palliative care team at work (Salomon et al., 2001, Carter et al., 2002, Dowell, 2002, Jack et al., 2002a, Jack et al., 2003, Mytton and Adams, 2003). Learning and the acquisition of skills by generalists was demonstrated by an increased understanding of the role of the specialist palliative care team, more appropriate referrals to specialist palliative care, and ward staff's increased capacity to provide generalist palliative care services (Carter et al., 2002, Dowell, 2002, Ward et al., 2009). In regards to deskilling, senior level, more experienced staff reported being more concerned about it than junior level, less experienced staff (Jack et al., 2002a, Jack et al., 2003, Ewing et al., 2009). Study results revealed that deskilling was actually mitigated by specialist palliative care integration, with generalists who partnered with specialist palliative care citing higher levels of comfort with and involvement in the holistic management of symptoms than infrequent or non-referrers (Dharmasena and Forbes, 2001, Carter et al., 2002, Cherny et al., 2003, Enguidanos et al., 2009, Ewing et al., 2009, Snow et al., 2009, Ward et al., 2009, Sasahara et al., 2010). Generalists were more able to provide front-line, generalist palliative care to their patients as a result of integrating specialist palliative care regardless of disease type, country, hospital size, or specialist palliative care team membership.

2.9.5 Specialist Palliative Care Operations

Studies listed several operational items which generalist providers perceived as facilitating collaboration with specialist palliative care teams. These items included visibility, ease of engagement, access, communication, and ability to provide

continuity of care. Regarding visibility, ward teams desire specialist palliative care teams to be highly evident throughout the hospital, frequently being seen on the wards, and being available to round or meet with the ward teams (Carter et al., 2002, Enguidanos et al., 2009, Ewing et al., 2009, Norton et al., 2011). Studies indicated that ward teams want easy access to the specialist palliative care team, which includes having specialist palliative care be timely and responsive when a request is made, preferably seeing the patient and posting a note the day of the request (Carter et al., 2002, Turner-Stokes et al., 2007, Enguidanos et al., 2009, Ewing et al., 2009, Norton et al., 2011, Johnson et al., 2012, Armstrong et al., 2013). Several studies reported staff's desire to have specialist palliative care services available off hours and on weekends (Carter et al., 2002, Enguidanos et al., 2009, Ward et al., 2009, Sasahara et al., 2010, Lane et al., 2014). Frequent communication was cited in most of the studies as fostering collaboration with specialist palliative care, allowing the swift implementation of recommendations, and producing a workable plan of care for the patient (Carter et al., 2002, Dowell, 2002, Mytton and Adams, 2003, Rodriguez et al., 2007, Enguidanos et al., 2009, Ewing et al., 2009, Ward et al., 2009, Norton et al., 2011, Armstrong et al., 2013, Lane et al., 2014, Morikawa et al., 2015). Communication consisted of in-person conversations at the initiation of the request, throughout the care of the patient, and at the completion of the referral; formal referrals made via phone, through the electronic medical record, or in person; informal referrals via phone or by stopping the specialist palliative care professional in the hallway for an 'off the record' conversation to obtain recommendations for patient care; specialist palliative care team participation in multidisciplinary patient care rounds; and brief, timely (same-day) notes with recommendations for care in the patient's medical record (Carter et al., 2002, Dowell, 2002, Enguidanos et al., 2009, Ewing et al., 2009, Norton et al., 2011, Lane et al., 2014). Lastly, involving specialist palliative care was viewed as a means for facilitating continuity of care for patients, as specialist palliative care teams were able to follow patients from one ward to another,

and bridge inpatient, outpatient, and community settings (Carter et al., 2002, Mytton and Adams, 2003, Turner-Stokes et al., 2007, Enguidanos et al., 2009, Snow et al., 2009, Le and Watt, 2010, Norton et al., 2011, Lane et al., 2014). The above factors amplified the generalists' perception of specialist palliative care as helpful and increased their willingness to integrate specialist services into patient care.

Studies cited the desirability of multiprofessional specialist palliative care teams (Dowell, 2002, Enguidanos et al., 2009, Snow et al., 2009, Ward et al., 2009, Johnson et al., 2012, Lane et al., 2014). Generalist teams utilised multidisciplinary specialist palliative care teams, when present, as a means to quickly and efficiently involve multiple disciplines to simultaneously give input on a case and impact patient outcomes. Specialist palliative care teams with more than one discipline (i.e. physicians and nurses) seemed to be preferred over homogeneous (i.e. only nurses) teams (Dowell, 2002, Enguidanos et al., 2009, Snow et al., 2009, Ward et al., 2009, Lane et al., 2014). This preference is difficult to explore further or relate to country, disease type, generalist provider type or hospital size, as half of the studies did not describe specialist palliative care team membership. Regardless of multiprofessional membership, specialist palliative care teams were recognised for their skills in the management of complicated physical symptoms and complex psychosocial and family situations, as well as their ability to assist generalist teams, patients and families with difficult medical decisions (Salomon et al., 2001, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Rodriguez et al., 2007, Turner-Stokes et al., 2007, Ewing et al., 2009, Le and Watt, 2010, Norton et al., 2011, Burton and Payne, 2012, Johnson et al., 2012, Armstrong et al., 2013, Morikawa et al., 2015).

Role confusion, however, could also result when a number of disciplines were involved. Several studies indicated ward teams were confused about their own roles versus the role of the specialist palliative care team when two people of the same discipline were involved in a patient's care (i.e. ward nurse vs. specialist palliative

care nurse) (Dowell, 2002, Hibbert et al., 2003, Jack et al., 2003, Mytton and Adams, 2003, Turner-Stokes et al., 2007, Ward et al., 2009). Confusion about roles also stemmed from many teams struggling with the basic definition and understanding of specialist palliative care in these studies, which also contributed to confusion about when and how to integrate specialist services and when to transition from generalist palliative care to specialist palliative care (Dowell, 2002, Hibbert et al., 2003, Rodriguez et al., 2007, Snow et al., 2009, Ward et al., 2009, Le and Watt, 2010, Burton and Payne, 2012, Gott et al., 2012, Morikawa et al., 2015). The confusion in the definition of and timing for integration of specialist palliative care persisted even for hospitals with well-established specialist palliative care teams.

2.10 Discussion

Generalists experienced collaboration with hospital-based specialist palliative care teams as beneficial yet challenging at times. As with studies exploring specialist palliative care collaboration in the outpatient and community settings, the issues of model of care, perception of expertise, and professional autonomy, as well as the challenges of determining the necessity and timing of specialist palliative care involvement, were identified (Hanratty et al., 2002, Shipman et al., 2002, Ahmed et al., 2004, Goldschmidt et al., 2005, Pavlish and Ceronsky, 2007, Shipman et al., 2008, Walshe et al., 2008a, Gardiner et al., 2012, Oishi and Murtagh, 2014). Consistent with studies conducted outside of the hospital, communication and clarification of roles amongst generalists and the specialist palliative care team were important for reducing power struggles between providers, minimizing role confusion, and facilitating multidisciplinary collaboration (Hanratty et al., 2002, Shipman et al., 2002, Ahmed et al., 2004, Goldschmidt et al., 2005, Hanratty et al., 2006, Pavlish and Ceronsky, 2007, Shipman et al., 2008, Walshe et al., 2008b, Brueckner et al., 2009, Gardiner et al., 2012). Additionally, similar to studies in the outpatient and community settings, education and skill-building were recognised as important aspects of

satisfaction for referring teams and were viewed as one of the largest benefits of integrating the multiprofessional specialist palliative care (Llamas et al., 2001, Schneider et al., 2006, Campion-Smith et al., 2011). Including generalist ward staff to the highest level of their ability through encouraging those who are reluctant about their capacity to effectively contribute and allowing those who are more experienced to exercise their own expertise to the fullest extent appeared to foster referring teams' sense of collaboration with specialist palliative care teams.

Unlike the community setting, the opportunities for role confusion and the need for role clarification may be increased as hospital-based generalist and specialist professionals enter a patient's room in quick succession of one another. Similarly, skill-building occasions may also be increased by the inpatient setting. Different professions are in close physical proximity to and frequently interact with each other, often in the same room at the same time, thus able to observe and learn from one another. Increased attention to communication also becomes more necessary in the inpatient setting as the acute nature of the patient's condition may change rapidly throughout the day. A larger number of professional care providers are usually involved in a patient's care at the same time in the hospital setting, potentially leading to higher chances of mistakes and misunderstandings if teams are not communicating well with each other. The busyness of hospital setting also carries an increased opportunity for interruptions and a high amount of competing demands for ward staff who often care for several patients at the same time, making frequent communication additionally essential.

In the community setting generalists have reported the importance of the responsiveness of the specialist palliative care team (Gardiner et al., 2012). In the hospital setting, potentially even more so than in the community setting, responsiveness, visibility, and availability of the specialist palliative care team were vital for the successful integration of specialist palliative care. Hospital-based

generalists, like community generalists, want easy access to specialist palliative care teams but they often need a much more rapid response to their requests. Patients are admitted to the hospital for acute problems which cannot be managed in another setting. Acute problems require swift reactions. Both the generalist providers and specialist palliative care team are located on site. The urgency of patient need and the location of the specialist palliative care team increased the value generalists' applied to the responsiveness of the specialist team, making timely responses and communication even more important.

Generalists' perceptions of their own role shaped when and how they utilised specialist palliative care services. Integration of specialist palliative care services occurred earlier in the disease process when involvement was viewed as a continuation of generalists' roles. Historically generalists, such as oncologists, have had established relationships with specialist palliative care, this long term familiarity may make them more comfortable with early integration (Clark, 2007, Lindvall et al., 2014). In the future, as other sub-specialties, such as cardiology, interact and become more familiar with specialist palliative care services they too may become increasingly more comfortable with earlier integration (Kavalieratos et al., 2014, Lindvall et al., 2014). Like previous studies on collaboration amongst interdisciplinary teams, generalists' collaboration with specialist palliative care teams was enhanced when individuals frequently worked together and were able to develop mutual knowledge (Michan and Rodger, 2000, Nancarrow et al., 2013). This level of collaboration and mutual development of knowledge may have been specifically possible in and facilitated by the hospital setting. More so than the outpatient setting, the inpatient setting may have allowed for increased frequency of generalists' contact with specialist palliative care teams. Similar to other studies on teamwork, joint decision making and both formal and informal exchanges further improved generalists' communication with specialist palliative care teams (Headrick et al.,

1998, Nancarrow et al., 2013). In addition, two-way communication channels across team boundaries and with the larger organisation fostered the effectiveness of the teams' functions (Firth-Cozens, 2001, Nancarrow et al., 2013).

2.10.1 Limitations

There are several limitations to this review. The synthesis was conducted by only one reviewer which limits the objectiveness and introduces opportunity for error. Whilst a narrative synthesis approach supports and was designed to manage heterogeneous studies, the heterogeneous nature of the studies adds an element of difficulty to synthesizing the information well. The potential for bias through over representing one study versus another, although carefully scrutinised, also remains a possibility. The variety in the key terms and working definitions in the literature used to refer to specialist palliative care teams made searching for articles and having a discussion about the role and scope of the services they provide challenging. Responses from the different generalist palliative care professionals were often combined or not specifically identified in the studies. Physicians, nurses, social workers, etc. might have dissimilar perceptions of the various themes. These nuances are lost when results are pooled which limits the generalisation of results from this review. Further distinction between trust and expertise is also needed. The use of studies with quantitative methods exploring participants' perceptions could be potentially limiting too, as a quantitative approach is not the best approach to answer such nuanced questions. Inherently a closed-item survey approach may limit the usefulness of the results for exploratory type questions. However, from a feasibility standpoint surveys can be administered on large numbers of participants, allowing for statistically significant results which increase the strength of the findings. The quantitative studies in the review used survey tools which were created for each study and were not standardised measures. Two of the six quantitative studies and one of the mix-methods studies (Carter et al., 2002, Dowell, 2002, Cherny et al., 2003) used pre-

tested surveys, thereby improving the validity of the measure and of the results. The remaining quantitative and mix-methods studies did not describe a process for addressing the validity or reliability of their measures, with the exception of the study by Turner-Stokes et al. (2007) where the surveys were developed by experts in the field, patients, and carers (Turner-Stokes et al., 2007). Even with these concerns the quantitative studies are informative and useful for the purposes of this review, and mirror the findings reported in the qualitative studies.

Whilst a qualitative method may be more suited to answering questions of perception, the qualitative studies included in the review also have limitations. From a participant standpoint, the studies were often limited to a single institution where it would not be possible to reach data saturation before all qualified participants had been included. Several studies were of particular concern and thus were rated lower in quality. The article by Dharmasena and Forbes (2001) is poorly written and is missing much needed description. Focus groups in the Dowell (2002) study included a team member from specialist palliative care, potentially biasing generalists' responses as they may not have felt comfortable sharing negative views of palliative care with a member of the specialist palliative care team present. Dowell (2002) also, along with Mytton and Adams (2003), utilised a complicated study design without describing the research team's experience with or justification for the design. The complexity of their designs did not necessarily yield richer data or more valid findings. On the contrary, Dowell's study has a brief findings section. Likewise, Armstrong et al.'s (2013) study only briefly describes findings, limiting the usability and impact of the results. Lastly, the two studies by Jack (2002 and 2003) were conducted in the same institution within a short time period, had similar research questions, and potentially included some of the same participants. This approach may influence the discreteness of the results from each study and the degree to which each of the studies can be considered as separately and uniquely contributing to the overall

synthesis findings. Nonetheless, given the practicalities involved in qualitative research and the confines of a single institution, it appears that the qualitative studies were able to adequately address the research question and their results are informative for clinical practice.

2.10.2 Strengths

Despite the limitations listed above the included studies and synthesis approach appear to satisfactorily answer the review question. The review was conducted rigorously and is replicable. The synthesis question was well addressed by the narrative synthesis approach. The review findings are useful for practice, albeit they should be applied with a degree of caution. By utilising an identifiable and tested approach to the synthesis the reliability of the synthesis results are further strengthened. The rigour of the literature search resulted in the comprehensive identification of relevant studies. Inclusion of all applicable studies in the synthesis allowed for a broad and full understanding of the phenomenon under review. Whilst the synthesis was conducted by one person, measures were taken to reduce bias by discussing the inclusion of relevant articles with the researcher's supervisors, as well as the identification and interpretation of themes. Even with the heterogeneous nature of the studies the findings appear similar. Moreover, the findings from the quantitative studies mirror those of the qualitative studies and vice versa, adding further strength to the synthesis. The themes identified here occur consistently over time, across different populations, and in different countries. The heterogeneity of the populations and of the settings gives encouragement regarding the rigour of the findings and their applicability to a variety of countries, hospital settings, specialist palliative care team membership, disease types, and healthcare professionals.

2.10.3 Future Research

As a result of this review there are several areas where future research could be conducted. Specialist palliative care activities and the generalists' experiences of

integrating specialist palliative care from countries not included in the review studies could be explored. Additional research is also merited about the perceptions and experiences of providers in other sub-specialty areas of medicine, including further investigation of professionals from the fields identified in the review studies (Cardiology, Neurology, Oncology, Surgery, Vascular Surgery, and Physical Rehabilitation). For example, Kavalieratos et al. (2014) recently found that outpatient Cardiologists wanted to integrate specialist palliative care services and were not concerned that patients might be 'stolen' by the specialist palliative care team. It is possible that hospital-based Neurology, Oncology, Surgery, Vascular Surgery, and Physical Rehabilitation providers' perceptions of specialist palliative care integration may have also evolved since the review studies were published. Additionally, the focus of these studies and the review as a whole is on the providers' perceptions of collaboration. From these studies data are not available to draw specific conclusions about the impact of either the integrated or linear care models on patient care outcomes. There remains a need for research exploring the impact of specialist palliative care integration and collaboration on patient experiences and outcomes (Gardiner et al., 2012).

Lastly, the experiences of allied health and social care personnel (physiotherapy, dietitians, speech and language pathology, social work, etc.) could use further investigation as they were under-represented in these studies. Specifically, one of the objectives of the synthesis was to identify areas of collaboration related to social work. Despite explicitly tracking results related to the generalist social workers' experiences of collaborating with the specialist palliative care team and expressly the specialist palliative care social worker, no references to these interactions were discussed in the reviewed literature. Those studies which did include social work as participants failed to extract their responses from those of other disciplines. Therefore, conclusions about what facilitates or hinders generalist

social workers' collaboration with specialist palliative care social workers cannot be made. Given the lack of social work specific data and the importance of collaboration to achieving desirable patient outcomes, research is needed to explore ward social workers' collaboration with the specialist palliative care social worker.

2.11 Summary

Integration of multidisciplinary hospital-based specialist palliative care teams seems to enhance generalists' ability to collaborate with specialist palliative care teams. Collaboration is fostered when each team recognises and supports the expertise of the other. Facilitators of collaboration include: effective communication between both groups of professional caregivers, determination of complementary roles, and shared problem-solving responsibilities. Data specifically addressing generalist social workers' collaboration with palliative care social workers are not available.

Chapter 3: Philosophical underpinnings of the study and an overview of grounded theory

3.1 Introduction

This study explores hospital-based generalist social workers' views of what facilitates or hinders collaboration with specialist palliative care social workers to address the dearth of social work related knowledge identified in the literature review. The philosophical underpinnings and rationale for the research methodology are described in this chapter. The study design and methods are discussed in chapter four.

3.2 Research Paradigm

The choice of which research paradigm to use to best meet the aims and objectives of a study is an important one. Research paradigms address the form and nature of reality (ontological questions), the relationship between the researcher and the phenomenon studied (epistemological questions), and the methods the researcher can use to discover what can be known (methodological questions) (Guba and Lincoln, 1994). The aim of this study is to explore generalist social workers' experiences of collaborating with specialist palliative care team social workers in the acute hospital setting. The research paradigm, therefore, must facilitate the exploration of context, meaning, and the interpretation of underlying influences. Critical realism addresses these needs and is the research paradigm utilised here.

Critical realism provides an ontological foundation for the exploration of natural settings, the collection of situational, contextual information, and the determination of meaning through the solicitation of participants' viewpoints (Guba and Lincoln, 1994). For critical realists, reality exists independent of perceptions and theories (ontological belief) (Maxwell, 2012). However, critical realists support the idea that perceptions of reality are socially constructed in relatively patterned ways (epistemological belief) (Maxwell, 2012). This construction of knowledge means that

completely value-free inquiry cannot take place (Oliver, 2011). Hence, the discovery of absolute truth, however desirable, is not possible, and all theory is revisable (Trochim and Donnelly, 2007, Oliver, 2011). Even if all observations are fallible and have error, both value-free inquiry and the discovery of absolute truth are ideals towards which to strive (Trochim and Donnelly, 2007, Oliver, 2011).

Whilst the potential of achieving a single, 'correct' conceptualisation of the world is not possible, critical realism maintains there is only one reality with a variety of equally valid perspectives of that one reality (Cruickshank, 2012, Maxwell, 2012). (Cruickshank, 2012, Maxwell, 2012). For critical realists, language is the vehicle used to express perceptions of reality (Maxwell, 2012). Reality is comprised of the natural human world, the human population with individual and collective social features, and the array of cultural ideas which people use to understand and cope with their relationships and environment (Maxwell, 2012). A critical realist approach is advantageous, therefore, for understanding generalists' complex social interactions and perceptions of collaboration with specialist palliative care social workers. In this study the hospital environment, the socialisation of working in the medical field as a whole, and in social work specifically, and the broader culture of the American medical system are the reality in which the generalist social workers practice and in which the study takes place. Language is the window into this reality. Although the structures, forces, and phenomenon being studied here are real, by necessity the study results will be grounded in the individual world views and experiences of both the social work participants and of the researcher (Alvesson and Skoldberg, 2009).

A critical realist approach acknowledges that it is not possible, nor necessary, to separate the researcher from the phenomenon being studied; both are part of the world wanting to be understood (Maxwell, 2012). Advancements towards a clearer understanding of reality are made when researchers are explicit about their own perceptions, assumptions, and biases. Vigilant theorising, awareness of theoretical

assertions and empirical justifications, and continuously revising theories as new information is revealed also further the understanding of reality. In addition, researchers should actively look for facts that are inconsistent with the proposed theory, and not hold too tightly to or give up too quickly on a particular theory as they progress in their understanding of reality (Popper, 2013). When such attention is paid to the process, understanding social workers' perspectives and the underlying mechanisms involved can be more correct (Oliver, 2011).

3.3 Qualitative Rationale

The choice of critical realism also arose from the nature of the research question. The research question requires a methodological approach that facilitates an in-depth exploration of generalist social workers' perceptions of collaboration with specialist palliative care social workers. The research question is exploratory as research on this topic has not previously been undertaken. Because it is exploratory a methodology that allows for the pursuit of meaning rather than quantification is desirable. In addition an approach that facilitates rich descriptions through open-ended questions rather than less descriptive information through close-ended questions is needed. Qualitative methodologies, therefore, are most appropriate as they provide participants with the freedom to express ideas in their own words and to describe complex social interactions, situations, and contexts. From a critical realist perspective, a qualitative approach also helps provide information about the perceptions, beliefs, values, feelings, and the motivations that underlie participants behaviours (Berkwits and Inui, 1998).

3.4 Grounded Theory Methodology

As so little is known regarding the generalist social workers' collaboration with specialist palliative care social workers in the acute hospital setting, a rigorous methodology is needed to investigate the phenomenon. From a critical realist standpoint the methodology must also help identify the causal mechanisms,

structures, and facilitators of collaboration. For critical realists, language is the form for discovering these mechanisms. Language is what makes mental states, attributes, meaning, and intentions part of the real world even if they are not directly observable (Maxwell, 2012). The methodological choice must provide a structure for capturing participants' narratives about their experiences and perceptions of collaboration, and serve to render the subsequent narrative into a theoretical understanding of collaboration. With the requirements and challenges listed above the decision about which methodological approach is most able to capture language, account for social work participants' and the researcher's perspectives, address the 'real', and subsequently develop a theory is an important one.

A number of qualitative methodologies acknowledge the existence of the 'real' world and explore interactions, situations, and context. These methodologies include action research, ethnography, phenomenology, and grounded theory. However, not every qualitative method is equal to the task of meeting the research aims and critical realist requirements. Action research, for example, necessitates the assumption of a specific theory before entering the research process (Brydon-Miller et al., 2003). Generalist-specialist palliative care social work collaboration has never been explored, applying a specific theory to the research from the initiation of the study could hinder the discovery of yet unrecognised processes occurring in the generalists' interactions with specialist palliative care social workers. As such, action research is not an appropriate choice for answering the research question. Phenomenology is also not the most appropriate choice. Phenomenology is intended to describe psychological realities by revealing the essential meaning of lived experience; it will not help to identify the causal mechanisms of generalists' collaboration with specialist palliative care social workers (Baker et al., 1992). Ethnography also does not meet the needs of the research question because it is inherently interpretive in nature. Whilst interpretive and realist frameworks share a strong preference for rich

information and observation, critical realists', however, believe that an authentic understanding of the phenomenon under study is possible (Prasad, 1997). In contrast interpretive approaches are focused on the process of cultural sense-making in a specific situation (Prasad, 1997). To fully understand the mechanisms at work facilitating generalists' collaboration with specialist palliative care social workers a realist rather than an interpretive approach is required.

In comparison, grounded theory provides a process for identifying underlying mechanisms of collaboration and rendering a theoretical understanding. As a theoretical framework grounded theory is particularly useful for capturing rich narrative and explaining new, little-understood processes (Charmaz, 2006, Kempster and Parry, 2011, Oliver, 2011). Grounded theory methodology is also useful for exploratory, descriptive studies such as this one (Charmaz, 2006). With the prerequisite of a realist approach and the exploratory nature of the research question, a methodology that clearly guides inquiry is important for the rigour of the study. The methodological approach must also serve to organise and manoeuvre through the complex data that result from a qualitative approach. Of the qualitative methodologies mentioned above, grounded theory appears to be the most appropriate approach for an in-depth, rigorous exploration of generalists' and specialist palliative care social workers' perceptions of what facilitates or hinders collaboration.

Whilst critical realists' acknowledge there cannot be a one-to-one correspondence to reality, it is possible to produce a theory which will adequately model reality and explain generalist social workers' actions, attitudes and perceptions (Keller, 1992). Such a theory will provide general explanations that go beyond the observation of individual events, and will be logically organised and clearly linked to the observable world in order to help to predict when collaboration with specialist palliative care social workers will occur (Kuhn, 2013). The theory needs to define the phenomenon of interest, specifying conceptual boundaries and the laws of interaction

between units, including the operational definitions for each theoretical term (Kuhn, 2013). Defining causality of these states is therefore central to both explaining the nature of the world and generalist social workers' understanding of it (Maxwell, 2012). Lastly, the resulting theory should be simple, accurate, consistent, and have a broad scope (Kuhn, 2013). Therefore, grounded theory methodology is utilised in this study as the design, strategy, and process to address the research question, analyse the data, and produce a theoretical understanding of collaboration (Crotty, 2003).

3.4.1 Critical Realist Grounded Theory

Glaser and Strauss developed grounded theory with the intent that it be useful for a broad range of theoretical perspectives (Glaser and Strauss, 1992). This study engages in grounded theory through the lens of critical realism. Commonly thought to fit more closely with social constructionist philosophy, modern approaches to grounded theory also fit well with a critical realist approach (Alvesson and Skoldberg, 2009, Kempster and Parry, 2011, Oliver, 2011). An application of critical realism to grounded theory takes into account the event being studied (collaboration), the individual meanings made of it (social workers' perceptions), and the broader social structures (hospital setting, professional training, and historical context) and the generating mechanisms behind the event (Kempster and Parry, 2011, Oliver, 2011).

Critical realist grounded theory approaches data openly. Grounded theory from a critical realist perspective recognises preconceived (a priori) concepts that may impact data analysis and interpretation of meaning. Critical realist grounded theory also embraces the process of conceptualisation and reconceptualisation, accepting that understanding is emerging (i.e. partial, tentative, and temporary) (Kempster and Parry, 2011, Oliver, 2011). Thus, the application of a critical realist lens to grounded theory is both conceptually consistent and achievable, and is useful for addressing the aims and objectives of the research study (Kempster and Parry, 2011, Oliver, 2011).

3.5 Personal Influence of the Researcher

Personal experience also influenced the choice of critical realism and grounded theory. Grounded theorists' backgrounds, professional training, and experiences will impact their choice of research topic and the assumptions made about the data (Charmaz, 2006). From a critical realist standpoint the research is part of the phenomenon being studied and the paradigm allows and accounts for the involvement of the researcher. Although personal experiences and viewpoints inform the initiation of research, it is important that the researcher acknowledge the ways in which these particular vantage points could bias the interpretation of the data. The researcher must strive to evaluate the fit between preconceived ideas whilst remaining open to emerging concepts. What is required is careful reflection and acknowledgement of how the researcher is participating in theoretical development and the role taken in what is being studied. Lastly, because the literature review was conducted prior to initiating the research study, reflexivity is needed to avoid previous knowledge about generalist collaboration with specialist palliative care professionals interfering with the new insights into the data (Mccallin, 2003, Mcghee et al., 2007).

3.5.1 Personal Reflection

For me, both the philosophical approach taken here and the research topic were heavily influenced by my professional experience and training. From a philosophical perspective, social work as a profession is appreciative of the ways in which knowledge is socially constructed, the need to develop ever deeper levels of explanation and understanding, and the importance of language in developing a narrative which communicates people's experiences (Houston, 2001, Oliver, 2011). Critical realism and a grounded theory approach are congruent with a social work world perspective which makes every effort to balance respect for individual meaning-making with the ways that meaning-making corresponds to an external reality (Houston, 2001, Oliver, 2011). For example, my clients' experiences of racism,

marginalisation, or other forms of social injustice exist not merely as part of their personal narrative and beliefs, but are present regardless of my or the clients' acknowledgment (Houston, 2001, Oliver, 2011).

From a professional experience standpoint, as someone with nine years of experience as a generalist and another three years as a specialist palliative care social worker, I am aware of the development of sub-specialisation within social work and the issues that can arise from having two social workers simultaneously involved in the same patient's care. Because of my personal experience, it is important that I am open to the data revealing experiences and themes different from my own. Conversely, my personal experience allows me to connect with other social workers around this topic and provides a strong starting point for investigating the research question. To minimise bias throughout the study I utilised memos, personal reflection, and conversations with my supervisors to identify areas where I might be making assumptions, to challenge the themes I identified, and allow for ongoing reconceptualisation of the theoretical understanding of the reality of collaboration.

3.6 Summary

After exploring the ontological, epistemological, and methodological options, a grounded theory approach was determined to be best for addressing the research question. The study design is discussed in more detail in chapter four.

Chapter 4: Study design

4.1 Introduction

In this study generalist social workers' views of the facilitators or barriers to collaboration with specialist palliative care social workers in the hospital setting are explored. In the field of specialist palliative care the professions of medicine and nursing have started to develop practice guidelines for generalist-specialist collaboration (Meier and Beresford, 2007). The social work profession has yet to adequately address generalist-specialist collaboration (Gardiner et al., 2012). A better understanding of the ways in which generalist social workers collaborate with specialist palliative care social workers may inform clinical practice, could minimise fragmentation of care, and ultimately lead to better patient care outcomes. The study design and methods are outlined in this chapter.

4.2 Research Question

Aim: To explore generalist social workers' views of what facilitates or hinders collaboration with specialist palliative care social workers in the acute hospital setting.

Objectives:

- To identify the ways in which generalist social workers interact with specialist palliative care social workers in the acute hospital setting.
- To explore generalist social workers' perceptions of the issues associated with collaborating with specialist palliative care social workers.
- To develop a theoretical model of generalist social workers' collaboration with specialist palliative care social workers.

4.3 Methods

Qualitative interviews (n=14) were utilised to explore the research question. Interviews were conducted between February 2014 through January 2015.

4.4 Sample

Masters trained social workers working in the inpatient hospital setting who share cases with specialist palliative care team social workers were recruited from hospitals in Southeast Michigan, a state located in the Mid-West region of the United States to participate in the study. In Michigan all social workers providing therapeutic, clinical interventions to patients in the hospital are required to be masters trained and licensed with the state (State of Michigan, 2013).

Theoretical sampling, a necessary step in the development of grounded theory, was utilised (Charmaz, 2006). Theoretical sampling consisted of jointly conducting interviews whilst completing coding and data analysis, allowing the data to direct what information was collected next and select where to look for it (i.e. identify the next hospital or participant to approach) in order to refine the data further and develop theory (Charmaz, 2006). The choice for where to look next to collect data was intentional. To meet the needs of theoretical sampling, diversity was sought in social work experience, disease type, age, location, and number of years post-masters training. Diversity was also sought in hospital type (academic vs. private vs. public), size (number of beds), and location. The intent of seeking this diversity was not to obtain a representative sample or to increase generalisability, rather through theoretical sampling, to fit the emerging theory to the data (Charmaz, 2006).

4.4.1 Inclusion criteria

- Generalist social workers working in the inpatient hospital setting,
- Generalist social workers working with adult patients (patients 18 years old and older),
- Generalist social workers from both for-profit and not-for-profit hospitals,
- Generalist social workers working in hospitals that have palliative care teams which include a specialist palliative care social worker,

- Generalist social workers who spend 100% of their time in the inpatient setting,
- Both part-time and full-time generalist social workers from medical and surgical wards, and intensive care units,
- Generalist social workers who speak English, as the researcher does not speak another language.

4.4.2 Exclusion criteria

- Military hospitals and children's hospitals,
- Hospitals without specialist palliative care social workers
- Social work students,
- Social workers who have not been masters trained (i.e. those with a bachelor of social work degree),
- Specialist palliative care social workers

4.4.3 Setting Rationale

The state of Michigan is 56,804 square miles and is the 22nd largest state in the US (Theus50, 2016a). As of 2013, 9,895,622 lived in Michigan, making it the 8th most populous state in the US, after California, New York, Texas, Florida, Illinois, Pennsylvania and Ohio (Theus50, 2016b). Michigan is comprised of two peninsulas surrounded by Lake Michigan, Lake Superior, Lake Huron, Lake Erie, and Lake St. Clair. It is most densely populated in the lower southeast region of the state, where most of the hospitals with palliative care teams, and the researcher, are located (Center for Shared Solutions and Technology Partnerships, 2011, Get Palliative Care, 2016). The state of Michigan has palliative care characteristics similar to those of the US as a whole in the prevalence of palliative care services by hospital type (nonprofit, for-profit, and public) and hospital size (Michigan 66.7% of hospitals vs. US 66.5% of hospitals provide palliative care services) (Center to Advance Palliative Care and National Palliative Care Research Center, 2015). The close location of the hospitals

to the researcher facilitated the ability to conduct in-person interviews and to develop theoretical sampling over the course of the study.

4.5 Recruitment

Participants were recruited between February 2014 and January 2015. Recruitment consisted of the following process (see Figure 2): The National Palliative Care Registry, a repository for information related to palliative care services in the United States, was accessed to identify hospitals with specialist palliative care teams (Center to Advance Palliative Care, 2014b, Get Palliative Care, 2016). Contact information available via the registry is limited to either a main telephone number or email of the specialist palliative care team or someone on their administrative staff. No all-encompassing e-mail repository containing the necessary contact information for social workers exists. The Registry excludes rehabilitation hospitals; psychiatric hospitals; eye, ear, nose and throat hospitals; sub-acute and chronic-care facilities; military hospitals; children's hospitals; and hospitals that did not respond to the American Hospital Association Annual Survey Database (Center to Advance Palliative Care and National Palliative Care Research Center, 2015). Therefore, these types of facilities are excluded from this study. Excluding these types of care centres resulted in 25 Michigan hospitals which provide inpatient specialist palliative care services (Center to Advance Palliative Care, 2014b). Of these 25 hospitals, 21 are within a one hour radius of the researcher and accessible by car, which allowed for the interviews to be conducted in person. Of these 21 hospitals, eight did not have specialist palliative care social workers. The hospital where the researcher works as a specialist palliative care social worker was excluded from the study, leaving 12 hospitals from which to recruit potential participants.

A phone conversation or email contact was made with these hospitals' specialist palliative care teams. These points of contact then provided the name, phone number, and email of the director of social work (or case management) for

each hospital. The directors were then contacted, the research explained, and their permission and assistance obtained for recruiting participants.

After discussing the aims of the study and receiving permission to recruit from that location, a recruitment e-mail (Appendix E: Recruitment Email) was sent to the director of social work (or case management) with a request to forward the invitation to participate to social workers at the hospital. Initially, recruitment was open; the first few interviews occurring without targeting social workers working in specific locations, with specific disease types, or with specific demographics. Recruitment became more focused over time and was guided by theoretical sampling. Theoretical sampling needs were identified through data analysis (Charmaz, 2006). As conceptual and theoretical development took place, and tentative ideas about the data emerged, specific exploration of the emerging concepts was required to explicate the relationships between concepts and to differentiate amongst them. Theoretical development and exploration of themes consisted of investigating whether and how concepts changed depending on hospital location, social work experience, frequency of contact with palliative care social workers, etc., with the aim of developing robust and definitive concepts (Charmaz, 2006). To facilitate theoretical sampling directors from different types of hospitals in diverse locations (i.e. inner city, urban areas, and academic medical centres) were contacted. Directors were asked to identify social workers with specific characteristics (i.e. working in oncology ward, ICU, newly graduated) for participation. Throughout the recruitment process directors gave permission for research to be conducted at their institution and for social workers to be contacted directly.

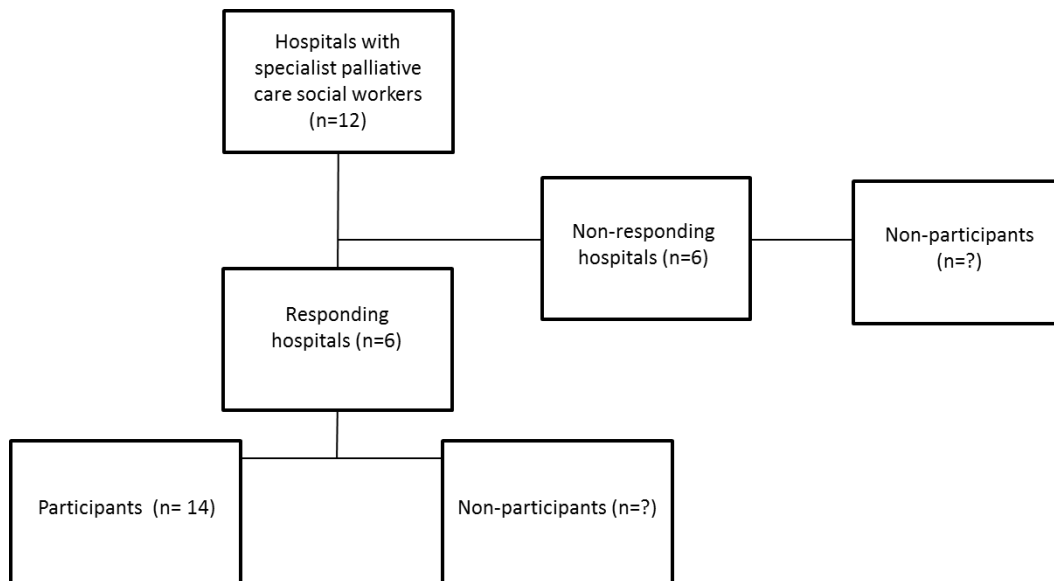


Figure 2: Flow diagram of participants and non-participants

The potential participants identified by the directors were contacted by phone or via email. They were given one week to respond to the invitation. At one week a reminder phone call was made or email was sent. If this second contact did not result in the social worker expressing interest, no further attempts to recruit that individual were made. As social work (or case management) directors had given permission to recruit staff from their hospitals, participating social workers were also asked at the end of their interview to identify specific social workers from their institutions who met theoretical sampling needs. This approach resulted in additional recruitment contacts within each setting which met theoretical sampling requirements. Participation in the study was voluntary.

4.6 Non-Participation

Of the 12 hospitals with specialist palliative care teams six of the hospitals did not respond to the researcher's attempts to contact them (see Figure 2). Non-participating hospitals had similar characteristics to participating hospitals. The number of generalist social workers at each of the six non-responding hospitals and the six participating hospitals are unknown. It was not possible to determine how many social workers declined to participate. For the participating hospitals, as

recruitment went through the social work (or case management) director bias could have been introduced as the director selected which social workers they thought were the most appropriate. For example, directors could have chosen only those who work frequently with specialist palliative care teams or who have more positive perceptions of specialist palliative care, thus biasing the results. Despite these concerns, there seems to be variety in participants' frequency of contact with specialist palliative care social workers, previous work history, experience, and work area (i.e. oncology, cardiology, neurology, general medicine), indicating that responses are sufficiently diverse.

4.7 Data Collection

To explore hospital based generalist social workers' experiences of collaborating with the specialist palliative care social worker intensive qualitative interviews were used (Charmaz, 2006). In grounded theory intensive interviewing allows for in-depth exploration of the research question through the use of open-ended questions, inviting reflection, clarifying details, and adapting the conversation to follow hunches about themes that arise during the interview (Charmaz, 2006). Interviews were done in person, digitally recorded, and were conversational in style; utilising open-ended questions originating from the research question and literature review (Appendix F: Interview Questions). An iterative, reflexive approach was used throughout the interview process, allowing the interview questions to change and develop over time. In grounded theory such flexibility over time facilitates the gathering of specific data and the development of theoretical frameworks (Charmaz, 2006). Each participant was interviewed once, no repeat interviews were done. The interviews lasted from 17 minutes to 53 minutes, with a median interview time of 27 minutes. Transcripts were not returned to participants for correction or comments. Participants requested that the results of the study be shared with them directly when the study is finished.

Participants completed a written informed consent form (Appendix G: Written Informed Consent Form). Prior to the initiation of the interview participants provided demographic information (Appendix F: Interview Questions) including years of experience as a master's trained social worker practicing in health care, type and setting of clinical practice, length of time employed in the current position, training and background experience, medical/surgical services and/or diagnosis served in their primary position, frequency of encountering end of life situations, and the frequency of interactions with the specialist palliative care social worker. Gathering this information provided a context for their responses.

4.8 Analysis

Interview recordings were transcribed by a transcription company and analysed by the researcher for key themes using the grounded theory technique outlined by Charmaz (2006). Charmaz's (2006) underlying philosophical stance is constructivist rather than realist; however she notes that the grounded theory analysis steps outlined in her book are compatible with other philosophical stances. Thus, operationalising the techniques outlined in her book from a critical realist stance is conceivable. Charmaz (2006) supports both an inductive and deductive approach to analysis. Concurrent data collection guided by theoretical sampling and analysis occurred throughout the course of theoretical development (Appendix I: Interview Timetable). An iterative analysis process was applied with interviews being analysed as they were completed, allowing each proceeding interview to be informed by those which preceded it. Theoretical sampling ceased when theoretical saturation occurred. Theoretical saturation was considered to be met when the identified themes were robust and no new codes emerged from the data (Charmaz, 2006). For example, the category of benevolence emerged early in the data collection and analysis process after interviewing a social worker at a smaller institution. The category became more defined over time as it was explored through theoretically sampling social workers

from larger institutions who may have had less frequent encounters with the palliative care social worker, or social workers who had a longer (or shorter) time working with the palliative care social worker, or who may have had more exposure to palliative care type patients (oncology or ICU, vs. general medicine), potentially causing them to feel less need for assistance from the palliative care social worker.

The quality and sufficiency of the data and the level of thematic saturation were assessed from a critical realist lens and by using criteria proposed by Charmaz (2006), which evaluate whether enough background data about persons, processes, and settings is available to allow the researcher to understand and portray the full range of the context of the study (p. 18). Charmaz (2006) considers data to be of quality if it can provide multiple and detailed descriptions of participants' views and actions, reveal changes over time, and what research participants take for granted or do not state, as well as permit the development of analytic categories which in turn facilitates comparisons between the data which then generate and inform theoretical ideas. Additionally, the quality of the data and whether theoretical saturation was reached were assessed from a critical realist standpoint. Enough data need to be available to identify the causal mechanisms and facilitators of collaboration. Quality was further supported by paying attention to actions and processes, as well as words, and the conditions under which those actions or processes were either revealed or repressed (Charmaz, 2006). Finally, participants' assumptions and the meanings they attributed to the process were also noted.

Transcripts were coded line-by-line. NVivo Version 10 (Qsr International Pty Ltd, 2012) was used to organise the data and uphold the rigor by establishing a chain of evidence through tracking data. The initial coding was kept open-ended, with codes emerging from the data (Appendix J: Codes). Over the course of the analysis process the codes continue to change iteratively as new themes emerged. If a code emerged in a later transcript, the previous transcripts were returned to in order to

explore whether the code may have existed in the text and been missed in the initial analysis. Memos were kept throughout the process to document reflective and analytical observations (Appendix K: Memos). Several memos became data for future coding and analysis.

Once the line-by-line coding was completed, the most substantial codes were used to synthesise and explain the data through focused coding. Charmaz (2006) supports focused coding as the second step towards developing larger concepts from the data. Codes were then linked to higher level categories and were compared and contrasted to explore how the categories vary under different conditions and to identify causal mechanisms (Appendix L: Categorical Codes). Throughout the focused coding and the compare/contrast process, as new ideas emerged the original data was returned to and reviewed in light of the additional observations. Coding continued to develop as analysis progressed. As a third and final step, theoretical codes were established to describe the facilitators of and relationships between categories. The data and previous levels of coding strongly influenced the direction and choice of the theoretical coding (Appendix M: Theoretical Modelling).

4.9 Ethics Committee Approval

Ethics approval was jointly obtained from the Lancaster University Research Ethics Committee and the University of Michigan Institutional Review Board (approval number HUM00077521). All participants completed a written informed consent form prior to initiating the interview (see Appendix G: Written Informed Consent Form). There were no direct benefits to the respondents from participating in the study. The indirect benefits of participating in the study could be improved knowledge and identification of what constitutes 'best practices' when specialist palliative care and generalist social workers collaborate. Results from this study may also inform future research endeavours.

Ethical considerations included confidentiality and data storage. Data were collected during interviews. All interviews were conducted in a place of the participant's choosing to protect confidentiality. As participation is voluntary, self-selection could limit the results in several ways. One possible limitation is that social workers who choose to participate may have had positive experiences of collaboration, thereby skewing the data in a positive direction. Conversely, those with the most negative experiences may want to participate to express their opinions, skewing the data in the other direction. As the aim of the study is to identify facilitators and barriers to collaboration, hearing from those social workers who have had either positive or negative collaborative experiences will provide useful information. To minimise potential bias in responses the participants were informed that the researcher is a social worker and a PhD student but were not explicitly informed that the researcher works as a specialist palliative care social worker.

A potential risk for participations is that they might experience some emotional distress as a result of participating in the interview. They may feel some negative emotions associated with reflecting on a difficult or challenging case. Whilst these emotions may occur they are unlikely to exceed those felt by the participant in the course of their daily work, as questions pertain to day-to-day experiences. Participants were permitted to stop the interview at any time and were given the option to restart the interview at a later time or withdraw from the study. If someone withdrew from the study their interview would not be used for analysis, and audio files and demographic information would be destroyed. All participants completed the study; none asked to stop the interview or withdrew.

Interviews were digitally recorded. To mitigate the risk of a breach of confidentiality digital audio recordings of the interviews were transferred from the recording device to a secure, password protected server once the interview was complete. Files were deleted from and not stored on the recording device. Digital files

were directly uploaded to the password protected, encrypted website of the transcription company. As all the necessary information is encrypted, it cannot be intercepted by irrelevant individuals. Transcriptionists signed confidentiality paperwork. Information was used only by selected staff members.

Completed transcripts of the recordings were directly downloaded by only the researcher from the transcription company to a password protected computer and server. Identifying information was removed from the transcripts prior to analysis to further protect participants. Information such as participants' names was stored separately from the recordings in a secure, locked cabinet. The typed narratives and documentation related to the thematic analysis were also stored in a locked cabinet (paper format) or on a secure, password protected server (electronic format). Participants' responses were anonymised. Identifying information was to be retained for 18 months after the completion of the study, at which time it will be destroyed.

4.10 Summary

The study design, including recruitment, participation/non-participation, data collection, analytic approach, and ethical approval were discussed in this chapter. Study results are reported next in chapter five.

Chapter 5: Results and theoretical model of collaboration

5.1 Introduction

Presented in this chapter is an overview of the grounded theory of generalist social workers' collaboration with specialist palliative care social workers. A brief description of participants' characteristics and the context in which these interactions occur are described. A model of the process by which the generalist and specialist social workers interact is included (Figure 3). Then, the grounded theory of collaboration is presented (Figure 4). Each construct of the model is addressed in separate sections. Throughout, quotations are used to illustrate the data. Respondents are identified by the letter "R" and a number (1 through 14). All respondents are represented in the chapter.

5.1.1 Participant Demographics and Hospital Characteristics

A total of 14 inpatient generalist master's trained social workers employed at hospitals in the state of Michigan participated in the study. Participants were all female. As social workers in the United States are predominately female (82%) this uniformity is not surprising (U.S. Department of Labor, 2014). One participant was African American and the remaining 13 were Caucasian. They ranged in age from 25-55 years old, with a median age of 40 years old. The number of years post MSW training ranged from 3-32, with a median of 12.5 years post MSW training. Patient case load ranged from 20-50 patients, with a median of 36 patients per social worker. They represented all areas of the adult inpatient wards. Only one participant had previously worked in hospice. Two participants had sought additional education in palliative care through attending continuing education presentations.

Specialist palliative care teams' membership included physicians, nurse practitioners, and social worker. Frequency of the generalist's contact with the specialist palliative care social worker ranged from less than once a month to daily, with most generalists encountering the specialist palliative care social worker several

times a week. At each hospital the specialist palliative care teams had been in operation for at least 5 years. Hospitals ranged in size from 300 beds to over 1000 beds, with a median of 640 beds, and were located in small community areas, larger urban regions, and the inner-city.

5.2 Workflow for Generalist and Specialist Palliative Care Social Work

The generalist social workers' perception of their patient care workflow, and an overview of generalist versus specialist social worker job responsibilities as perceived by the generalist social workers are detailed in this section. The process as described by the generalist social workers for initiating a referral to specialist palliative care is described in detail. This information is helpful for understanding the context in which the study takes place. Generalists describe the following overarching process by which they and the specialist palliative care social worker are involved in a patient's care during hospital admission (Figure 3).

The patient is admitted to a floor, ward, or intensive care unit and becomes part of the generalist social worker's caseload, although depending on the patient's and family's needs the generalist may not see the patient (Figure 3: A). The patient remains on the generalist's caseload until she either moves to another area (ward, unit) of the hospital or leaves the hospital (Figure 3: G).

"My responsibility as an in-patient social worker is to discharge plan for those patients the minute they walk in the door... At the end of the day, on this unit, it [discharge planning] starts and stops with this office." – R5

At some point in the admission the generalist may advocate for specialist palliative care involvement, or the ward team will determine specialist palliative care is needed,

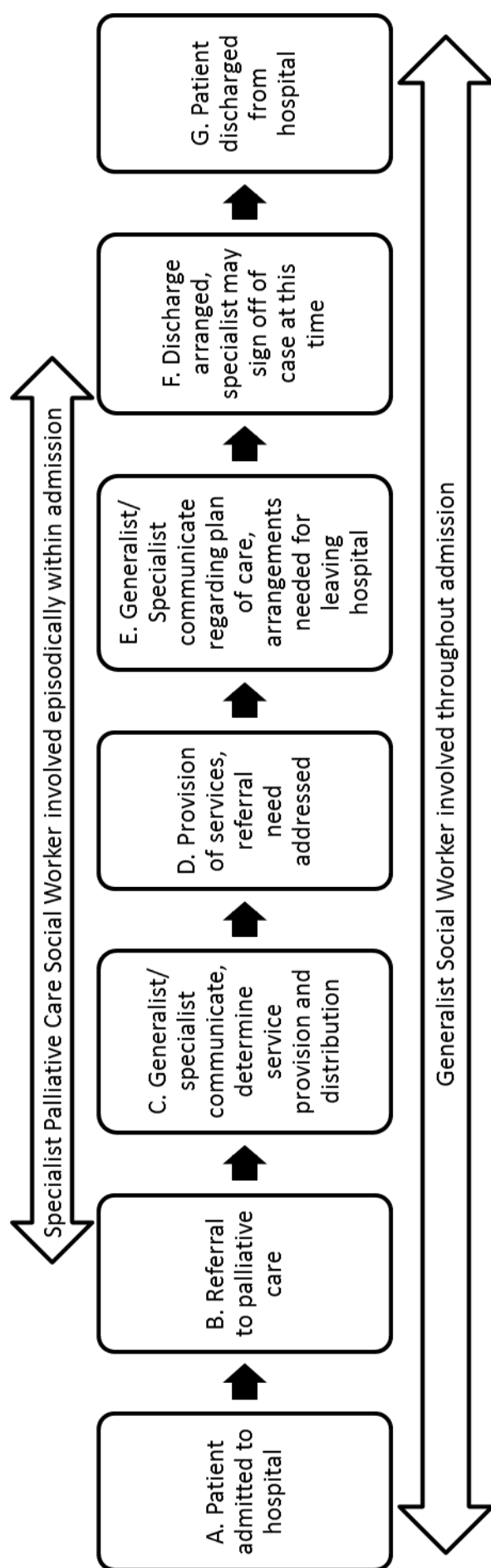


Figure 3: Workflow for generalist and specialist palliative care social workers

and a referral is made to the specialist palliative care team (Figure 3: B). The referral process is described in more detail in the next section.

“I mean, sometimes you keep a patient here for five days and keep deteriorating, you don’t know what’s going on, you suggest a palliative care consult.” – R9

Once the referral has been placed, generalists communicate back and forth with specialist social workers to share information about the case and to determine what services are needed and which social worker will provide them (Figure 3: C and E). Information sharing is iterative and may take place throughout the day and continue over the course of several days, depending on the complexity of patients’ and families’ needs.

Specialist palliative care teams become involved for symptom management (physical, emotional and spiritual) or to meet with the patient and family to discuss the overall plan of care, prognosis, or worst case scenarios (Figure 3: D). When the referral is for physical symptoms alone the specialist palliative care social worker may not see the patient.

“With significant pain and symptom management and not very complicated family issues usually it’s just the nurse practitioner and/or the doctor.” – R7

Once involved, the specialist palliative care social worker remains part of the case until either the specialist palliative care team completes the referral or signs off the case (Figure 3: F), or the patient leaves the hospital (Figure 3: G). The generalist social worker may continue to be involved in the case throughout the admission, but

may defer end of life conversations to the specialist palliative care social worker (Figure 3: A and G).

“Usually I let palliative care take kind of the lead on that because that’s typically an end-of-life.” – R2

This approach does not clearly define the roles of the generalist or the specialist palliative care social worker, leaving opportunity for duplication of work. Additionally, whilst the specialist palliative care social worker is involved the generalist is less visible, becoming more involved again once leaving hospital plans need to be arranged (Figure 3: F).

5.2.1 Referral to Specialist Palliative Care

At all six hospitals the lead physician (the physician primarily responsible for the patient’s care in hospital) makes the final decision to refer to and involve the specialist palliative care team (Figure 3: B). This approach of needing the lead physician’s permission to involve the hospital-based specialist palliative care teams is a common practice in the United States (Center to Advance Palliative Care, 2006). It is not the generalist social worker’s decision to involve specialist palliative care.

“I have to request that the consult go through my doctor.” – R1

The generalist social workers report having the ability to advocate for specialist palliative care involvement, and spoke of doing so frequently, but do not have the permission or authority to make the referral themselves.

"I can't write for it. It's really got to be a doctor's, physician's order but I could ask the nurse to get in touch with the physician." – R13

Once the referral to specialist palliative care has been placed, the decision to include the specialist palliative care social worker in that specific patient's care is up to the discretion of the specialist palliative care team. The generalist social worker does not have control over when and how the specialist palliative care social worker will be involved. The specialist palliative care social worker could be involved whether or not the generalist social worker perceives there is a need for her to be involved.

"They've [specialist palliative care team] been looking at it and saying, "[Palliative care social worker] probably needs to be involved in this case or this isn't so much one that she really needs to be involved in." – R2

This lack of control over the referral process and specialist palliative care social worker involvement could lead to a compulsory interaction with the specialist palliative care social worker, but not necessarily result in collaboration.

"So if they [medical team] say, "we need to ask palliative about this." "Go ahead but I'm telling you, this is what they are going to say." ...just know that we have the same knowledge base. We know what's out there. [Palliative care social worker] might know of a few things maybe." – R5

Such a compulsory interaction is not perceived positively by the generalist and may result in hostile or negative interactions with the specialist palliative care social worker.

5.2.2 Differentiation of Job Duties

In addition to the setting and referral process outlined above, the institutional approach to both social workers' job duties contributes to the environment in which they interact. In principle each social worker has similar education, professional training, and share the same status within the institution; they are peers, at the same level in the organisational hierarchy.

"Right, the training and the skill set are the same." – R8

Generalists from all six hospitals reported that their institutions do not formally differentiate between the social workers' job descriptions.

"No, [she] doesn't have different job description from me it's all about the same." – R12

At each hospital generalists described separate expectations for the generalist versus specialist palliative care social worker's roles, even with no formal differentiation in place. The focus of the workflow for each position is quite different.

"A lot of the support that a social worker gives from palliative care is more of a psycho-spiritual support and we do a lot of the discharge planning." – R7

Broadly speaking, the generalist social worker is expected to manage discharge and leaving hospital services; to move patients through the system in a timely fashion; whilst the specialist palliative care social worker is expected to participate in care conferences, family meetings, and complex medical decision making conversations. As part of the care conference or family meeting the specialist palliative care social worker may help identify and make recommendations for the discharge plan, but without exception they did not execute the plan, leaving the actual arrangement making to the generalist social worker.

5.3 Grounded Theory of Generalist and Specialist Palliative Care Social Work Collaboration

Data analysis of the fourteen interviews resulted in the development of a grounded theory of generalist social workers' collaboration with specialist palliative care social workers. The emerging theory is defined in this section. Generalist social workers collaboration with specialist palliative care social workers consists of three constructs: *Trust*, *Information Sharing*, and *Role Negotiation*. Each piece of the theory is progressive. New pieces build upon prior pieces, similar to building blocks, with *Trust* forming the base and *Information Sharing* and *Role Negotiation* forming a second layer. When all the building blocks are in place and in the correct order *Collaboration* occurs (see Figure 4). Each construct is discussed in a separate sub-section.

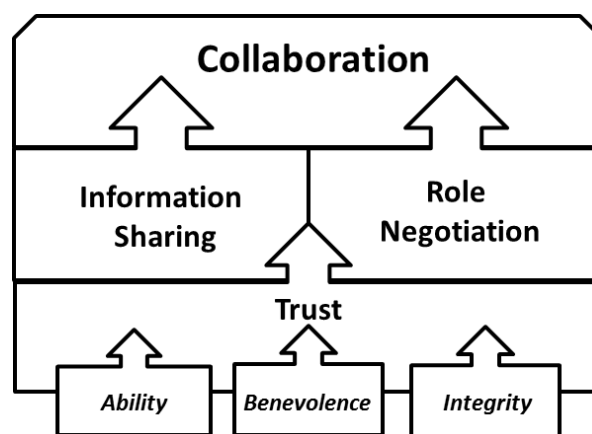


Figure 4: Theoretical model of generalist social workers' collaboration with specialist palliative care social workers

Trust is the base of the model, the foundation on which collaboration is built. Trust has three components: *ability*, *benevolence*, and *integrity*. *Ability*, *benevolence*, and *integrity* all need to be present for Trust to exist. Without the foundation of Trust, the second layer of blocks: Information Sharing and Role Negotiation cannot be placed. If either piece of the second layer is missing, the final block of collaboration has nowhere to rest. Generalist social workers' collaboration with specialist palliative care social workers cannot occur if the interaction lacks either effective information sharing or effective role negotiation even when trust is present. Therefore, just like a brick wall must have all the pieces in their proper place for the wall to remain standing, all the constructs and their components need to be in place for collaboration to occur.

In the following sub-sections an overview of each construct of collaboration is provided. The findings for Trust and the three components which contribute to Trust (*ability*, *benevolence*, and *integrity*) are discussed first. Next, the findings for Information Sharing are discussed. Lastly, the findings for Role Negotiation are discussed.

5.4 Trust

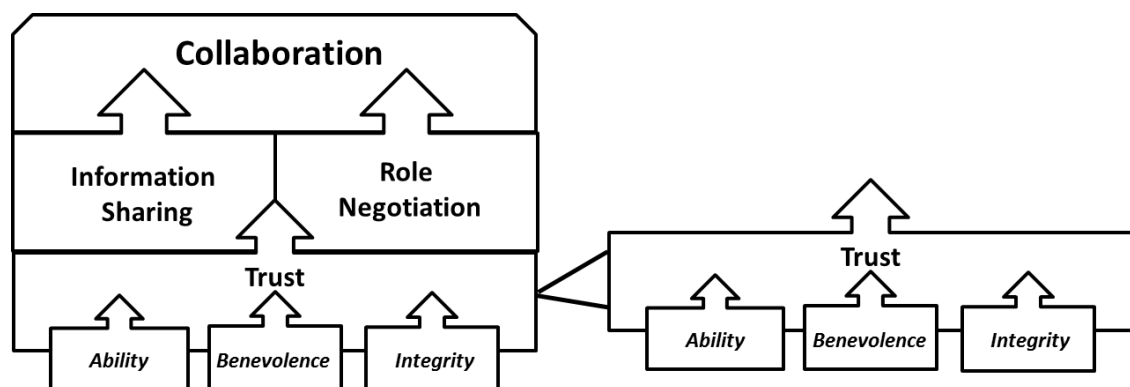


Figure 5: Trust is comprised of *ability*, *benevolence*, and *integrity*

Trust is the foundation of collaboration. It is comprised of three parts: *ability*, *benevolence*, and *integrity* (Figure 5). *Ability* is discussed first, then *benevolence*, and finally *integrity*.

5.4.1 Ability

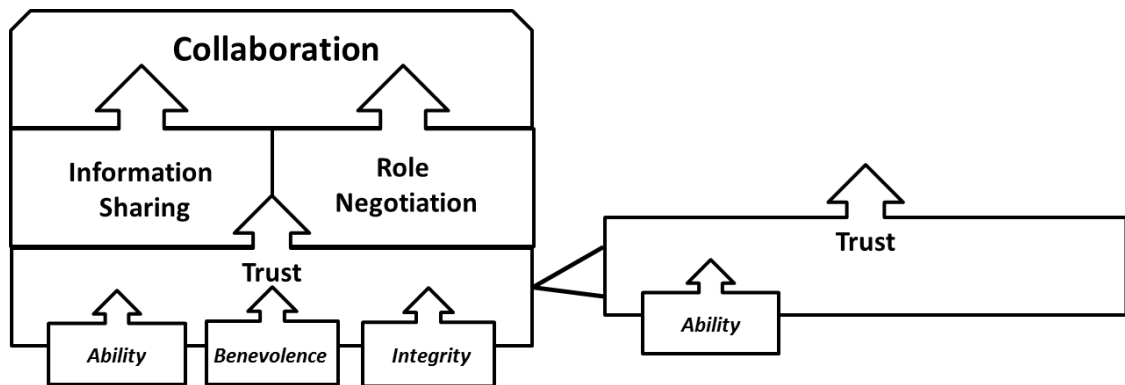


Figure 6: Trust-ability

The first component of Trust: *ability* (Figure 6) is detailed in this section. Ability refers to the generalist social workers' perception of the specific clinical skills, team management competencies, and amount of experience needed to provide specialist palliative care social work services.

"[For collaboration] trust is important about her clinical skills and abilities." -

R1

"She might know of a few things, maybe, [but I don't think she does]." - R5

Trust in the specialist's abilities impacts the generalist's willingness to collaborate with the specialist palliative care social worker. When the generalist thinks the specialist lacks ability, trust is damaged.

5.4.1.1 Ability: Clinical Skill

The first form of *ability* is clinical skill. Generalists perceive that competent specialist palliative care social workers have the necessary skills to provide expert resources and recommendations to meet complex needs of the patient and family. These skills include: facilitate conversations, provide bereavement support, knowledge of

resources and how to access them, develop a plan of care, and help patients and families transition from standard care to palliative care or to hospice.

“A lot of great facilitation skills.” – R7

“A lot of times [her] discussions end up being about quality of life, end of life.” – R14

“It takes a lot of finesse and time and patience and things like that.” – R2

Specialist palliative care social workers are also seen by generalists as needing to have the necessary clinical skills to handle emotionally charged situations, be comfortable around death and dying, and manage uncertainty. Lastly, specialist palliative care social workers need to be able to deal with complicated family dynamics.

“You’re dealing not only with family dynamics that are very intense, and cultural issues ... that come up quite a bit in hospice, you have to have that medical background to explain what’s going. And then, of course, knowing when to call the doctor if they have specific other questions. It takes a little bit of training and experience.” – R7

“Anytime you’re dealing with something as detrimental as death, not every [social worker] is equipped, not only clinically, but emotionally, to deal with

not only that kind of issues, but the various kinds of personalities in the families that you have to encounter.” - R11

Beyond the skills listed above, generalists also think specialist palliative care social workers need a good understanding of medical terminology and disease processes in order to properly guide patients and families in decision making.

5.4.1.2 Ability: Management of Team Dynamics and Needs

The second form of *ability* relates to management of the referring ward team's dynamics and needs. The ward team includes the generalist social worker, as well as the physicians, nurses, and other healthcare personnel primarily responsible for the patient. Generalists perceive specialist palliative care social workers to be capable when they have the skills necessary to address the specific question asked by the ward team.

“At the request of the [ward] team the specialist palliative care [social worker] usually comes in with a specific goal in mind or with a specific task in mind.” – R4

Specialist palliative care social workers become involved in patient care at the request of the ward team and operate in a consultative role. Remaining in the consultative role means not taking over the responsibilities of the ward team (including the generalist social worker), impeding their work, or damaging the relationship they have with the patient, meanwhile still addressing the needs of the patient, family, and ward team.

“I'm just saying that there's a certain onus and accountability that I have that's different from what the [specialist palliative care social worker] is

responsible for... This is the family that has a relationship with me; you are someone who is passing through. You are consulting... Collaborate with the people on your unit. There's a reason why we're all here. These nursing staff, they know these patients better than probably half the [lead physicians] do. Ask the people who are the experts. You are a consultant. Ask the experts." –

R5

In addition to balancing the different interests and roles on the ward team, generalist social workers view specialist palliative care social workers as capable when they are able to skillfully engage each team member within the unique context of that team. These capabilities include navigating relationships with physicians, who may be resistant or hesitant to involve specialist palliative care services.

"You will have doctors that do not want specialist palliative care to get involved with their cases. They have the thought that they can manage it on their own... And then, you have other doctors that will." – R9

It requires skill on behalf of the specialist palliative care social worker to balance the different, and sometimes competing, interests of the generalist social worker and other members of the ward team. When specialist palliative care social workers can successfully manage the ward team's dynamics and needs, trust is facilitated.

5.4.1.3 Ability: Experience

The third form of *ability* is experience. Generalists view the specialist palliative care social work role as something for which a more seasoned social worker may be better suited. They worry that a newer, recently graduated social worker will not have the

practice and frequency of exposure required to comprehensively provide end of life care services to patients and families.

“I would never advise a new social worker to do anything related to end-of-life, because number one, it takes a skill base, and as you know, you build on your skill base with experience, and knowing the different kinds of venues to approach a family, how to assess a family, and knowing what to say, what not to say, how to say it, even your tone of voice and how you speak to them, how you enter their room. All of those things are very important when you’re dealing with families and working with families for end-of-life. So, I would agree with the skill base, I wouldn’t say specifically trained, because only experience trains you for something like that.” – R11

The specialist palliative care social workers’ skills and ability were not viewed by generalists as special per se, rather something that all social workers could aspire to, and could do with additional on the job training and experience. Generalists expressed the belief that all social workers, whether in the generalist or specialist palliative care role, could develop expertise in the specialist palliative care field if given the time, professional maturity, and desire to work in that capacity.

“We’re kind of expected to deal with a wide range of things, and I don’t know if there’s anything specific that she does that we absolutely couldn’t do, but I just think she would maybe be more experienced, more comfortable with it, or more confident.” – R10

“Every social worker should be able to provide palliative care and end of life services. As long as you’re comfortable with death and dying and really sick patients, you should be able to do this for sure.” – R12

Generalists’ thought that it is not possible for one person to provide all the services offered by both the specialist palliative care social workers and generalist social workers within the hospital.

“But part of why we have different teams, different specialties is that I’m not going to know everything. I know how to discharge plan and that’s what I do here and [palliative care social worker] will know how to follow-up on the palliative side.” – R4

What makes specialist palliative care social work “special” is division of labour, allocation of resources, time, practice, and knowledge base.

“You can transfer a lot of your skills to a situation that’s dealing with end of life, but the palliative social worker is going to be a lot more familiar with that, whereas I’m going to be more familiar with something else, like talking to kids about their parents, and ICU. So, that palliative social worker, they could figure that out, you know what I mean? They could do that, but I just might be more readily able to do it.” – R10

Generalists expressed that if they had the desire, and where given the time, practice, and opportunity to develop palliative care related knowledge base they could provide services at a similar level to the specialist palliative care social worker.

5.4.1.4 Ability: Summary

Generalists trust the specialist palliative care social worker's abilities when they perceive her to have a high level of clinical skills, good team management abilities, and to possess the necessary amount of experience.

"I really looked to her when I first started because when I first started she just made it look so classy and eloquent. She gave these patients dignity in times that they don't have much left. It was very nice and it was a huge learning experience for me... Bridging that gap, for me, was a huge thing. I feel so much more comfortable talking about it now. I mean, that is all because of her." – R8

Trust in the specialist palliative care social worker's abilities increases the generalist's desire for collaboration. Conversely, perceptions that the social worker lacks the ability to define her own role, is managed by rather than managing the team dynamics, and is a weak clinician who fails to effectively follow up with patients leads to mistrust.

"She doesn't really have a case load... I would've defined the role a lot different than what she's doing. She's sitting back and getting directions from the nurse practitioners and the physicians in the group as opposed to stepping out and defining her own role. So she doesn't get consults... I think

[she] has the time and opportunity to follow up on cases but [she] doesn't understand what to do in a follow up" - R6

This lack of trust is a barrier to the generalist wanting to work with the specialist palliative care social worker. Trust is impaired and collaboration deterred when generalists perceive that the specialist palliative care social worker lacks either clinical or team management ability.

5.4.2 Benevolence

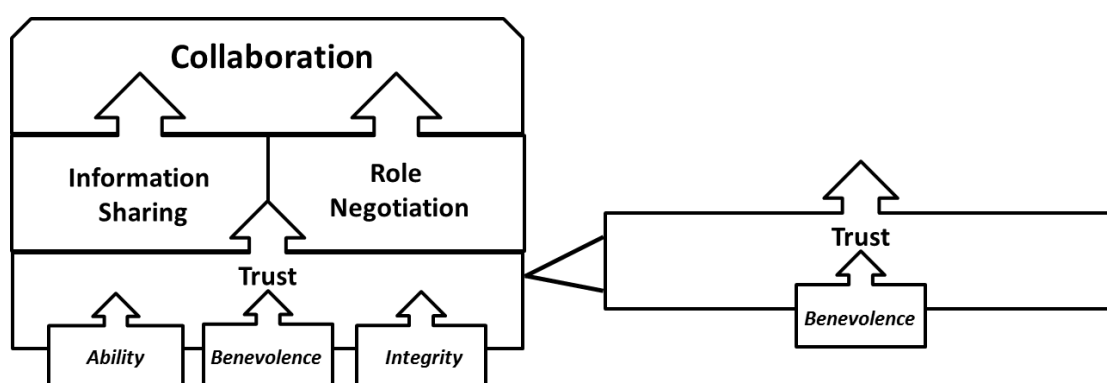


Figure 7: Trust-benevolence

The second component of Trust, *benevolence* (Figure 7), is described in this section. Benevolence relates to generalists' perception that the specialist palliative care social worker has the generalists' best interest at heart. Generalists' identify specialist palliative care social workers as demonstrating benevolence towards them when specialists are helpful, support the generalists' role, and share the burden of caring for the patient and family at end of life. A ready desire to help is demonstrated by the specialist palliative care social worker being available and responsive to the generalist social worker's needs.

"She'll come up that same day and meet with the patient and the family and contact family wherever they are." – R3

“I’ll call her sometimes with a scenario, or if she’s met a family, I’ll run something by her... so she’s been really available in that way, so that’s ideal for me too, as a resource.” – R10

Generalists describe the specialists’ willingness to communicate as another way to demonstrate benevolence. A proactive approach to communication provides clarity about the patients’ care plan, moreover, it makes the generalist’s job easier.

“As long as there’s a proactive [approach] in terms of everybody kind of being on the same page for the care of the patient, yes it’s good for the care of the patient, and continuation of care and yada yada, but it also just makes it easier for everybody.” – R4

Frequent contact and good communication facilitate the generalists’ feeling connected to the specialist palliative care social worker. Having a sense of a good relationship increases perceptions of benevolence. Connection and a positive relationship help to build trust and contribute to the perception of collaboration.

“Getting to know that social worker [having a relationship helps with collaboration]” – R10

“The palliative care social worker is my frontline person since we have the same kind of job ... we’ve created this relationship ... that has given us some mutual understanding of how we work together.” - R2

Limited (or no) interaction with the specialist palliative care social worker prohibits relationship building. The lack of relationship reduces the perception of benevolence, decreasing feelings of trust, which in turn hinders collaboration.

"The social worker, she mainly stays down in the ICU. So I do not see her much." - R3

"Just having more... a little bit more engagement about what her thought process was, I think, that that would've been very helpful, had I gotten more from her." – R14

When the specialist fails to engage with the generalist about patient care decisions it damages their relationship. The generalist perceives the lack of engagement as unhelpful, non-benevolent, and disrespectful of the generalist's role. The perception that benevolence is lacking creates a territorial response on the generalists' part. Instead of working towards collaboration, possessive and defensive behaviours occur.

"I would like a little bit more hands-off approach and understand that I do what you do too. I'm the social worker on this unit. There's a reason why I'm in this position... So, I'm a little bossy. I'm a little assertive... These patients are my babies. All of them are. It starts and stops in this office but it starts and stops with me first." – R5

This territorial response causes a decreased desire for collaboration and a negative view of the specialist palliative care social worker, demonstrated by a diminished desire to work with her.

Showing respect for generalists' abilities, viewing them as skilled clinicians in their own right, is also an important part of demonstrating that specialists have generalists' best interests at heart and facilitating collaboration.

"I respect [her] expertise and [she] respects my expertise on what I get done and what can I do to help the patient and the family." – R3

Remaining in the consultative role and not usurping the generalists' power or role on the ward team also demonstrates best interest. Whilst mentioned above as a dimension of ability for the skill it takes, remaining in the consultative role is also a dimension of benevolence because honouring the generalists' role involves an element of good will.

"Understanding what your role is in the case, understanding what [her] role is in the case and being very clear about that." – R2

The specialist palliative care social worker is perceived to demonstrate a lack of benevolence or respect for the generalist's role when she implies to patients that the generalist will do something for them that cannot happen.

"There's a limited understanding of what the floor social worker does. And so then there are these promises that are made that the floor [ward] social

worker can do x,y,z... And sometimes I can't, based on restrictions or guidelines.” – R4

This lack of understanding on the part of the specialist palliative care social worker places the generalist in an awkward position with patients and the ward team, and may cause her to look unskilled, which undermines trust and collaboration.

5.4.3 Integrity

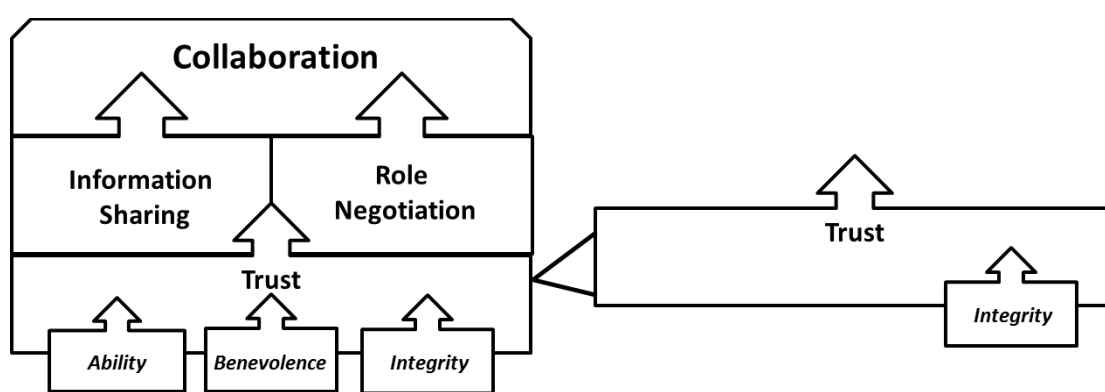


Figure 8: Trust-integrity

Integrity (Figure 8), the third component of Trust, is discussed in this section. Integrity focuses on the patient, rather than the needs of the ward team or the generalist social worker. Integrity is the degree to which the specialist palliative care social worker adheres to the principles of patient-centred care delineated in the professional ethics of social work (Payne and Radbruch, 2009, British Association of Social Workers, 2014, National Association of Social Workers, 2015b). The first principle is a commitment to patient empowerment, ensuring that patients have all the information needed to make the best decisions for their own lives.

"My motto is "You cannot make a good decision unless you're fully informed." I just try to make sure that [patients] know everything - that they know the repercussions that they may be getting into." – R8

The second principle is honouring patient autonomy and self-determination. This principle supports the concept that competent adults are able to make their own decisions about what is in their own best interest, even if the social worker does not agree with the decision.

"Because palliative care in an ideal setting... would be gathering and assessing with the patient what their goals are and then trying to help meet those goals... and that might be continued therapy or it might be go home with a hospice." - R13

The third principle is that each patient be treated individually. This principle flows from social worker's value of viewing the patient as an entire person, mind, body, and soul, within the context of their personal and familial relationships, as well as the their living environment, financial situation, and practical limitations.

"Thinking about what's best for the patient, and the family." – R11

The specialist palliative care social worker is perceived by the generalist to have high integrity when she adheres to these three patient-centred principles of social work. Specialist palliative care social workers are perceived to lack integrity when they are viewed by the generalist to be forcing a patient to do something that is in the best interest of the hospital but not of the best interest of the patient.

“Pushing getting people out of the hospital [before they are ready to go in order to save money].” – R13

“Looking at hospital policy more than patient care... If the specialist palliative care social worker worked with the values that I see that are important, absolutely I would want the specialist palliative care social worker involved in more cases.” - R6

When the specialist is perceived by the generalist to value institutional needs above those of the patient, the specialist is viewed as an agent of the institution rather than an advocate for the patient. The generalist does not want to work with the specialist palliative care social worker who fails to uphold patient-centred values. Lacking integrity, therefore, is a barrier to collaboration.

5.4.4 Summary of Trust Construct

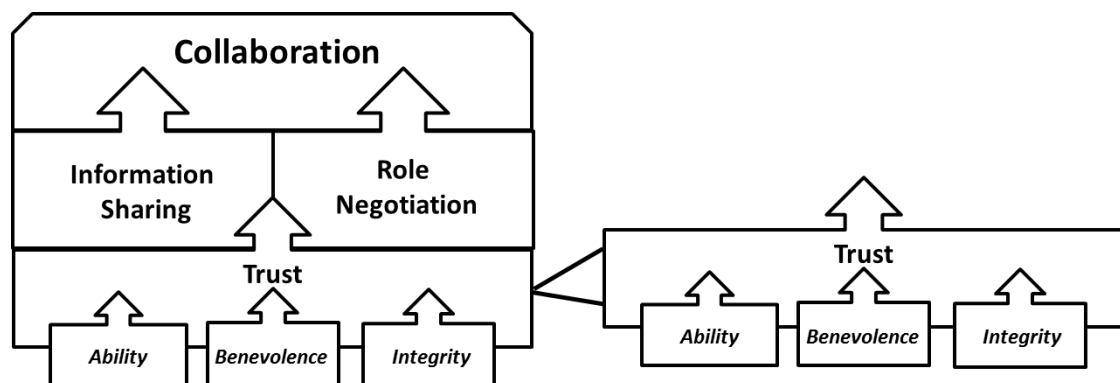


Figure 9: Trust is comprised of *ability*, *benevolence*, and *integrity*

To summarise, when the generalist perceives that the specialist palliative care social worker has high *ability*, *benevolence*, and *integrity* the generalist's belief in her trustworthiness is increased, which facilitates collaboration (Figure 9). Generalists' willingness to collaborate may change based on the level of trust she has for the

specialist palliative care social worker. For example, the generalist may trust the specialist palliative care social worker to provide community resources (*ability*) and be willing to collaborate in that area. Likewise, the generalist may not trust the specialist palliative care social worker to facilitate a family meeting without coercing the patient to make a decision against the patient's best interest (*integrity*), thus impairing collaboration. On the other hand, the generalist may perceive that the specialist has high levels of ability and integrity, yet the specialist palliative care social worker could be disrespectful of the generalist's role and skills demonstrating a lack of good will (*benevolence*), thereby damaging collaboration. The degree to which the generalist views the specialist as embodying *ability*, *benevolence*, and *integrity* is not static and may be situation dependent.

5.5 Information Sharing

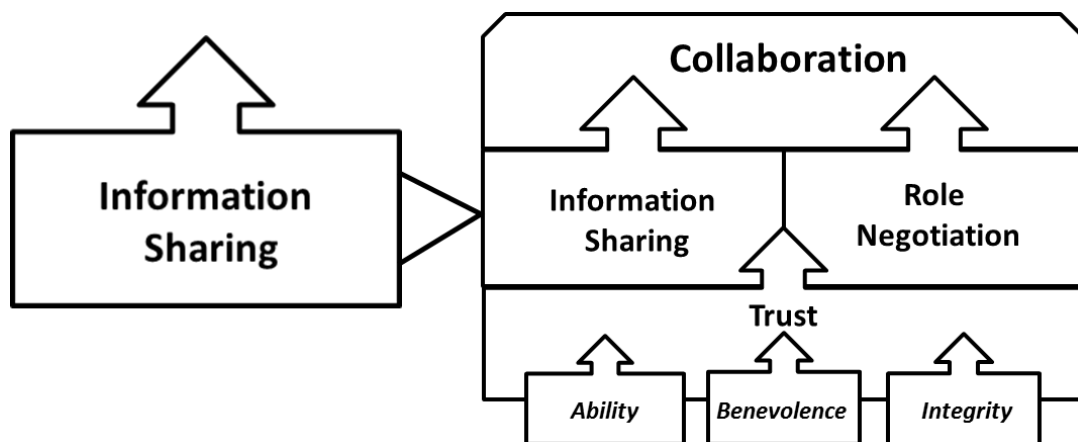


Figure 10: Information sharing

The second construct of collaboration, Information Sharing (Figure 10), is outlined in this section. Several mechanisms for Information Sharing emerged from the data. Generalists and specialist palliative care social workers share information about cases through formal and informal verbal communication, in person or by phone, or direct written communication by email or text-paging, as well as what is documented in the electronic medical record. Generalists often use the word “communicate” to describe how they collaborate with the specialist palliative care social worker.

“Usually, the social worker with palliative, she would just call, leave a message, “This is what’s going on. This is what I did,” kind of the thing. It was helpful.” – R8

“We do a lot of paging back and forth. Sometimes e-mails but mostly phone conversations, “hey! I found out this”” – R2

Generalists’ informational interactions with specialist palliative care social workers include: informing each other of the referral to specialist palliative care and sharing important aspects of the patient’s case related to the referral, reviewing each other’s clinical documentation in the electronic medical record, paging each other through the hospital paging system, and calling one another on the phone. Generalists report that the information shared should consist of family dynamics, coping of the patient and family system, and what the generalist’s or specialist palliative care social worker’s role will be in the case. In addition, good information sharing practices include the specialist palliative care social worker providing a summary of what occurred during the specialist’s interactions with the patient, family, and ward team if the generalist social worker was not present.

“[Give information] on the nature of what the patient is in the hospital for, the complicated medical course, what’s been going on... the key players, and the patient’s decision making, who are the family members, what are the personalities of these family members... you have to know the person that you’re counselling... and also, communicating with the health care team, with the doctors too, because you want to know what the plan is, what’s the

prognosis, what have you been communicating to the family, so that I can help them to better adjust and cope with what you told them.” - R11

Generalists cite having all team members involved in a patient's care in the same room at the same time for face-to-face communication as the preferred way to share information. Whilst this face-to-face communication was viewed as the ideal by generalist social workers, in practice it did not occur as often as they would like. They also spoke of the benefit of both formal and informal opportunities to discuss patient care.

“When we have our [team] conferences... best practice would be to be able to have everyone involved in the case there so that it's coordinated versus feeling somewhat disjointed.” – R1

“We bump into each other a lot, because both of our offices are on the same floor, but we also call each other.” – R7

In-person and by phone communication were viewed as respectful, more personal, and more effective for collaboration than relying solely on documentation in the medical record.

“But the interdisciplinary rounds [face-to-face group meetings] are the best for trying to make sure that everyone's on the same page.” – R7

“Best practice would definitely be more collaboration and notification before [specialist palliative care social worker] is involved... there’s more to it than just what’s in the documentation.” – R5

Generalists support being proactive with communication. Collaboration was served well when the generalist and specialist social workers took responsibility to each own communication. When the generalist knew a referral was going to be made to specialist palliative care she made sure to contact the specialist social worker as soon as possible, rather than viewing it as the specialists’ responsibility to call her. For communication to work well it has to be two-way, timely, and consistent.

“There was a little bit of the lack of communication and most of communication was initiated on my part. So, if there had been a little bit two-way, it would’ve been better.” - R14

When there is a lack of communication, delayed communication, or inconsistent communication collaboration is impeded.

“A little bit more engagement about what her thought process was... sometimes I wouldn’t get the feedback I needed... I knew she was in there but if there was something specific she was working on I wouldn’t always know what that was.” – R14

“Doing the same thing over and over and over again when maybe it was already done.” – R2

Poor communication results in duplication of services or redundant work. It can also place the generalist social worker in an awkward position of looking unprepared for meeting with the patient and family, or not having all the information she needs for the interaction with the patient and family to be as successful as possible.

"[Specialist palliative care social worker] just spent an hour with the family... Communication is a really important aspect of it; I need to know what I might be walking into... If family members are not on the same page, there will be problems. There will be discrepancies." – R9

Poor communication can also over-burden the patient and family by having the generalist asking the same questions just covered by the specialist palliative care social worker or vice versa. If communication works well both social workers can share information with each other outside of the patient's room, limiting the stress placed on the patient. Generalists become protective of their patients and families if they perceive the specialist social worker is an additional burden, and collaboration is impaired.

"You don't want to have two and three different social workers [going in and out of the room asking the same questions] because families get very irritated when they have to constantly repeat themselves... so you want to limit that and limit their stress from anything." – R11

"And the patients are like, 'This is stupid. What's happening? I already told someone this.'" – R8

A lack of communication amongst generalist and specialist social workers may cause confusion on the patient and family's side if they are getting different information from each social worker because the social workers do not share the same understanding. Generalists report that this lack of consistency damages collaboration.

"I think having too many people in there just confuses families; it makes them very overwhelmed because people are telling them different things." – R9

"It is very important that everybody is saying the same things to the patient and family." – R3

Lastly, the more people involved in a patient's care the more important good communication becomes. When communication is absent the negative impact is magnified as the likelihood of differing interpretations or points of view is increased when more people are involved. The lack of communication impairs collaboration in these situations.

"There are just so many involved when the patient's here... I think there's so many people involved that sometimes the communication is not good and so that makes [collaboration] really difficult." – R6

Sharing information and proactive communication are also necessary to the process of Role Negotiation. This final theoretical construct of collaboration will be discussed in the next section.

5.6 Role Negotiation

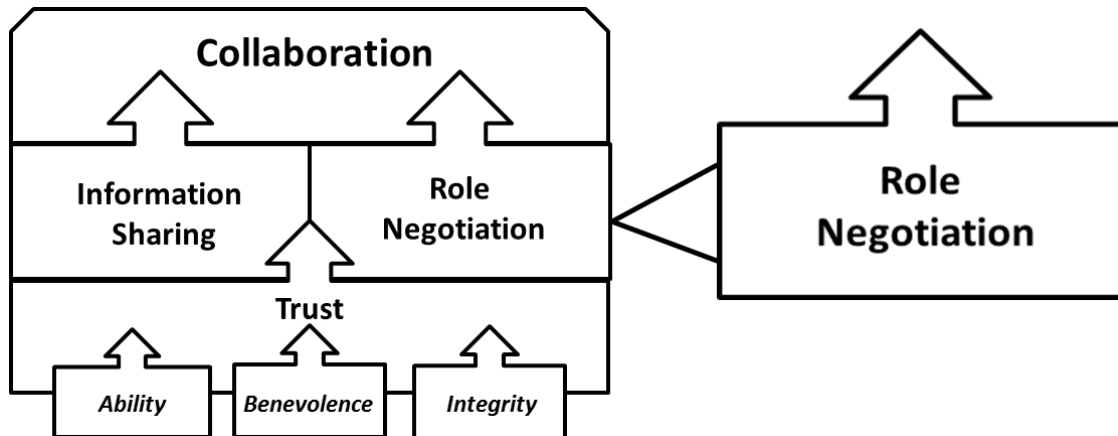


Figure 11: Role negotiation

Role negotiation (Figure 11) is a key feature of collaboration as generalists' report that the hospitals where they worked do not formally differentiate between the generalist and specialist palliative care social work job descriptions. As a result both social workers need to decide how they will be involved in the case. Either they share the case, or the case is turned over to the specialist, or the specialist will not be involved and the generalist will keep the case. Negotiation is involved in all of three decisions. When both social workers remain involved in the case, negotiation is used to determine how they will divide duties and share the care of the patient. The following factors contribute to determining roles: time, individual comfort level, professional humility, patient situation, and willingness to be flexible.

5.6.1 Time and Priority as Determining Factors

All generalists spoke of the limitations of time as a determining factor for dividing up job duties and responsibilities between the two social workers. Generalists primarily manage discharge planning needs, whilst the specialist palliative care social worker is responsible for determining a care plan through involvement in family meetings and patient care conference. Each area of service provision has a different focus. Each

set of tasks takes a different amount of time to complete and entail different scopes of practice.

“I wish I had as much time as they do but really [specialist palliative care social worker] is in there because that’s what they’re there for, that time to sit down, to digest it all with the family.” – R8

Discharge planning takes precedence over other types of clinical work for generalist social workers. Generalists report that it takes a lot of time and effort it takes to fulfil their job duties. They feel busy and stretched thin given their case load and job expectations. They have to prioritise how they spend their time in order to meet their institutional mandate to efficiently discharge patients.

“If we were doing a lot of [counselling] work, we would never get our discharge planning done.” – R13

“Having 40 patients on a unit gets really difficult sometimes... Sharing care with the palliative care social worker I see it as a positive. I mean it helps me out in my role... It saves me time. It saves me energy.” - R9

Time does not allow for the generalist to address both the palliative care and discharge planning needs of the patient. The generalist may have the desire for and required skills to participate in patient related palliative care decisions yet is unable to do so because of time constraints and other priorities.

5.6.2 Comfort Level as Determining Factor

Comfort level and professional humility also contribute to how the generalist negotiates roles and responsibilities with the specialist palliative care social worker. Not surprisingly, generalists range in their individual comfort with and desire to do palliative care and end of life work.

“Some people like just doing discharge planning, some people like myself like to have a variety of things to do during the day.” – R7

“The one area I always wanted desperately to avoid was death and dying.” –

R1

When the generalist is uncomfortable or prefers to avoid end of life topics there are no specific guidelines for how to determine involvement. Generalists stated that they and the specialist palliative care social workers reported to and were managed by the same person. However, the generalist and specialist palliative care social workers were left to their own devices for negotiating how much involvement each will have.

“I don’t know how [we figure out which social worker does what], I think it depends on the social worker, like I know one of us, once palliative gets involved, she prefers [palliative care social worker] take over.” – R10

The default approach, as described by generalists, seems to be higher involvement from and deferral to the specialist palliative care social worker when the generalist is uncomfortable.

5.6.3 Humility as a Determining Factor

A successful negotiation of roles also requires a degree of professional humility. The generalist needs to be willing to set aside their own ego and do what is in the best interest of the patient.

“Every patient that crosses my path, it’s not about me. It’s never about me.

It’s always about the patient... whatever needs to happen happens and its

okay if it’s not me that’s providing it.” – R1

For collaboration to go well generalists report that decisions about what role each social worker takes should be made based on what the patient needs rather than personal desire to look good in their own eyes or the eyes of other team members.

“Why are you doing that family meeting? Why are you doing that? I can do

that.” – R8

When humility is absent collaboration may be impacted. If each social worker is out for their own recognition, they may actively undercut the other’s role, placing roadblocks to efficiency, and acting in counterproductive ways. When the generalist and specialist are in competition with one another, seeking to be important in the eyes of their co-workers, patients, or families, and caring more about their own ego than the good of the patient, role negotiation is unlikely to occur, and if attempted, will fail.

5.6.4 Ongoing Patient Relationship as Determining Factor

Negotiation decisions are also made based on the relationship the generalist had with the patient, and the desire to not duplicate work or confuse the patient and family by involving another social worker at an emotionally intense time.

“If I’ve been working with the family and I have a relationship with them, I’m right on the unit... it’s like a case-by-case of how we go for it... if it’s a family that I had no involvement with, then usually she is the one that follows, if that makes sense. So, it’s really, there’s not really a process, it’s more like with each family, we decide afterwards”. – R10

Generalists’ value the relationships they have with patients and families, and desire for the specialist palliative care social worker to respect these pre-existing relationships, and the generalist, by supporting the continuation of the relationship. When a long-standing relationship is in place the relationship may be the determining factor for which social worker plays what role, rather than the skill set each of them holds.

5.6.5 Flexibility as Determining Factor

With little organisational direction, the challenge of time constraints, and pressures that arise from large patient caseloads, a willingness to be flexible about which social worker does what task when is essential for effective role negotiation. Flexibility is possible with trust. Trust provides an atmosphere where the generalist can be vulnerable and respond with professional humility in role negotiation.

*“Flexibility is important... I’m more than willing to negotiate and back and forth, I want her to *want* to come and work with me and work with my patients versus “oh gosh. Here’s another one that I’m going to have to take over and I don’t have the time to do it.” - R1*

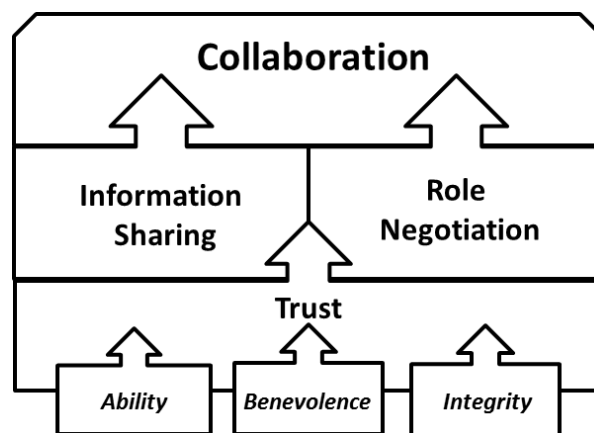
The lack of trust makes flexibility in role negotiation less possible and undermines collaboration. The specialist palliative care social worker may still be involved in the

case but the generalist may actively block or undermine the specialist's role and opportunity to fulfill the specialist's duties.

"We don't negotiate who does what. We don't negotiate because at the end of the day, on this unit, it starts and stops with this office." - R5

When role negotiation does not take place or when it fails, collaboration cannot be achieved. Being unwilling to negotiate impacts the generalist's relationship with the specialist palliative social worker, will impact communication, and will lead to further breakdown of trust, ultimately damaging collaboration further.

5.7 Summary



Repeat of Figure 4: Theoretical model, for reference

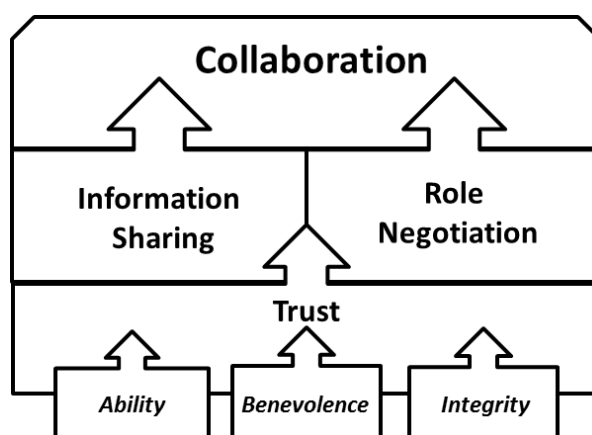
In summary, the key building blocks of collaboration are Trust (comprised of three components *ability*, *benevolence*, and *integrity*), Information Sharing, and Role Negotiation (Figure 12). When Trust, Information Sharing, and Role Negotiation are in place and operating well the generalist experiences interactions with the specialist palliative care social worker as collaborative. When one or more of the building blocks is missing the generalist does not experience interactions with the specialist palliative

care social worker as collaborative. Lastly, although some form of communication and role negotiation happen with or without trust; when trust is absent the quality and timeliness of information sharing are poor and negotiations rigid. Poor communication and inflexible negotiation derail collaboration. The theory of collaboration as it relates to the literature is discussed in the next chapter.

Chapter 6: Discussion of theoretical model of collaboration, and relationship to existing theoretical models and literature

6.1 Introduction

This is the first study to explore hospital-based generalist social workers' perceptions of collaboration with specialist palliative care social workers. In chapter one, an overview of social work and the issues surrounding specialisation in palliative care were provided. The dearth of knowledge related to generalist social workers' collaboration with specialist palliative care social workers was established via a literature review and systematically constructed narrative synthesis in chapter two. The rationales for a grounded theory approach and the study design were described in chapters three and four. Finally, the emergent theory of generalists' collaboration with specialist palliative care social workers was reported in chapter five. In this chapter the theoretical model of collaboration is discussed in relation to existing theoretical models and the literature. Then, the strengths and limitations of the study are outlined. Next, the implications for social work practice and policy are addressed. Finally, areas for future research are identified.



Repeat of Figure 4: Theoretical model, for reference

6.2 Relationship to Literature

Collaboration consists of trust, information sharing, and role negotiation. In this section the results from the study are compared and contrasted to the existing literature, including articles from the literature review as well as those from broader

contexts beyond palliative care. Particular attention is given to the area of trust as these findings further the current understanding of the role of trust in close, peer-to-peer work relationships. For context, prior to discussing trust a general overview of collaboration is given.

6.2.1 Collaboration

Generalist social workers in this study describe the specialist palliative care social worker as a peer. The specialist does not hold a more superior position within the organisational hierarchy, or vice versa. Generalist social workers in this study report that collaboration with specialist palliative care social workers is enhanced when they perceive sharing a common goal, have shared values, share information in a useful manner, and have role flexibility. These *intra*-disciplinary findings are consistent with the existing literature on *inter*-disciplinary team collaboration, indicating that *intra*-disciplinary interactions may share similar elements to interdisciplinary interactions. These interactions, which are relative to an array of healthcare settings, professions, and countries, include cooperating to achieve a common goal, a willingness to share planning and decision making, contributing from their expertise, sharing responsibility, and sharing power based on knowledge and expertise (Hansen et al., 1998, Mcpherson et al., 2001, Clarin, 2007, Nancarrow et al., 2013). As there is overlap between inter- and intra-disciplinary team coordination, the findings here may be applicable to a variety of healthcare settings, professions, and countries where intra-disciplinary teamwork occurs. In the future, the elements of collaboration identified here may also contribute to a more overarching general theory.

Previous studies, as did this study, identified the importance of organisational direction to successful role negotiation, and challenges to collaboration as a result of poor organisational direction. For example, Xyrichis and Lowton (2008) reported that organisational direction was necessary for role clarity and division of labour. Correspondingly, Brown et al. (2014) found that a lack of organisational direction

about these areas of work derails collaboration, leads to territorial responses with team members and decreases efficiency. Inefficiency increases operational costs, slows down hospital throughput, and ultimately negatively impacts patient care outcomes (Institute of Medicine, 2001, Kim et al., 2006). Fewer patients can be seen and there are delays in receiving care (Institute of Medicine, 2001). Without organisational direction social workers may waste time negotiating roles or undermining one another. This ineffective collaboration will negatively impact efficiency, which in turn will hinder patient care.

The findings from this study also further support previous findings on both the importance of professional relationships and their positive impact on perceptions of collaboration (Blackmore and Persaud, 2012, Burroughs and Bartholomew, 2014, Menefee, 2014). In the literature, as in this study, professional relationships include mutual respect for fellow team members and the ability to trust that all team members are working for the common good of the patient, family, and team (Canadian Interprofessional Health Collaborative, 2010, Interprofessional Education Collaborative Expert Panel, 2011, Nancarrow et al., 2013, Giladi et al., 2014). Also, similar to previous studies, relationships and collaboration are enhanced by co-location (Hudson, 2002, Walshe et al., 2008b, Xyrichis and Lowton, 2008).

Trust, the ways the three components, *ability*, *benevolence*, and *integrity* contribute to trust, and the importance of the findings for advancing the theoretical understanding of trust in close peer-to-peer relationships at work are addressed next.

6.2.2 Trust

Trust as a key component of collaboration is well supported in the literature (Mayer et al., 1995, Blackmore and Persaud, 2012). As identified in the literature review, trust is important for generalists' collaboration with specialist palliative care providers as well. However, in the literature review trust and expertise were difficult to distinguish as separate concepts due to the terms being used interchangeably by participants in the

included studies. The results from this study are important because they help to differentiate trust and expertise from one another, and reveal that expertise, in the form of ability, is a part of trust.

The theoretical understanding of trust which emerged from the data most closely reflects the “*Integrated Model of Organizational Trust*” developed by Mayer et al. (1995). In their theory they also posited that trust is comprised of *ability*, *benevolence*, and *integrity*. The Model of Organisational Trust focuses on the role of trust in hierarchal relationships as work, between supervisor and supervisee. When they conceptualised their model of trust Mayer et al. (1995) noted the need for additional empirical research to validate the model and to explore how it operates in different types of work relationships. The results from this study validate and support their theory that *ability*, *benevolence*, and *integrity* are indeed components of trust. What is more, these results add considerably to their model by establishing that *ability*, *benevolence*, and *integrity* are also key components of trust with peers in the workplace. Therefore, the theory of trust developed here fills a gap in the literature. It also addresses the need for further research identified by Mayer et al. (1995) on the relevance of these components to peer-to-peer work relationships. Therefore, the results from this study enhance and expand the theoretical understanding of the role of trust.

6.2.2.1 Trust in Peer Relationships

Generalists report being peers with specialist palliative care social workers within the organisation. Peer relationships, like those of generalists with specialist palliative care social workers, are lateral rather than hierarchical (Burke and Mckeen, 1990). Kram and Isabella (1985) propose two common peer relationships within the workplace. The first and most common type, information peer relationship, is distinguished by the exchange of information about work and the organisation. There are low levels of trust and self-disclosure in this relationship. The second type of peer relationship is

collegial. Here, there is a moderate level of trust and self-disclosure. Both types of peer relationships were described by generalists in this study. Given that these two levels of peer relationships are common in a variety of workplaces, the results from this study may have applications for other professions in a variety of settings. Having broad applicability may, again, allow for the development of a more overarching generalisable theory in the future.

Whilst viewing the specialist palliative care social workers as peers, generalists also view them as having expertise in the area of palliative care. Generalists' perception that the specialist palliative care social worker is more knowledgeable about a specific area introduces the concept of 'expert power'. 'Expert power', a concept developed by French and Raven, is the impression that someone has some superior insight or knowledge about what behaviour or action is best under specific circumstances (French et al., 1959, Raven, 2008). French and Raven (1959) mostly draw on examples of power in supervisor-subordinate relationships. They minimally describe power in peer relationships. The lack of examples makes the application of French's and Raven's theory to peer relationships more challenging. However, they hypothesize that high power in person *A* does not imply low power of person *B* (French et al., 1959). This balance in expert power may be present in generalists' interactions with specialist palliative care social workers. Perceptions of expert power and the equilibrium of that power may impact generalists' willingness to trust. Therefore, the findings here provide an additional example of expert power in peer relationships, further facilitating the application of French's and Raven's (1959) theory to peer relationships. In providing a new example of expert power in peer relationships the results here address a previous hole in the literature. Thus, in addition to confirming and adding to Mayer et al.'s (1995) hypothesis of trust, the results also confirm and add to the current understanding of expert power in peer relationships.

French and Raven (1959) and Mayer et al. (1995) are not alone in their lack of attention to the dynamics of peer relationships at work. With little exception researchers have not explored interpersonal trust in the workplace with peers (Mayer et al., 1995, Ferres et al., 2004, Lau and Liden, 2008, Tan and Lim, 2009, Knoll and Gill, 2011). The dearth of information on peer-to-peer trust in the workplace highlights the importance of this study in ameliorating this knowledge gap. Of the small number of studies examining horizontal interactions with peers, a good portion seek to understand trust of co-workers in relation to the supervisor rather than exploring trust of co-workers as a discrete phenomenon (Lau and Liden, 2008, Knoll and Gill, 2011). This approach to understanding trust amongst peers showed that peers are more likely to trust a co-worker if that co-worker is also trusted by the supervisor (Lau and Cobb, 2010). Failing to account for the influence of the supervisor in the peer-to-peer relationship in these studies potentially impacts the accuracy and applicability of the results.

Exploring trust of peers in relationship to the supervisor poses other limitations as well. In several studies taking this approach resulted in the concepts of integrity and benevolence but not ability appearing to be important components of trust (McCallister, 1995, Tan and Lim, 2009). Conversely, in a study which controlled for the influence of the supervisor, all three components (*ability*, *benevolence*, and *integrity*) were found to be equal predictors of trust in a co-worker (Knoll and Gill, 2011). Isolating peer-to-peer interactions led to findings on trust similar to those which emerged from this study to form the theoretical model of collaboration. Therefore, the model adds to Knoll's and Gill's (2011) findings about trusting co-workers. It also enhances knowledge about how each component (*ability*, *benevolence*, and *integrity*) contributes to trust of peers.

6.2.2.2 Presence of Each Component of Trust

All three components of trust are important and must be present for trust to fully exist when generalist social workers work with specialist palliative care social workers. However, the generalist social worker's trust of the specialist may be circumstantially limited in scope. For example, as described by generalists in this study, the generalist may trust the specialist palliative care social worker to provide community resources and be willing to collaborate in that area but not trust the specialist to manage the complex dynamics of the ward team (*ability*). Alternatively, the generalist may not trust the specialist palliative care social worker to facilitate a complex family meeting without coercing the patient to make a decision not in the patient's best interest, thus impairing collaboration (*integrity*).

The change in the primacy of a specific component as dependent on the level and type of interaction peers have with one another is consistent with the existing literature (Knoll and Gill, 2011, Wasti et al., 2011). The change in the primacy given to each component of trust may also account for some of the disagreement happening in the existing literature about whether all three components need to be present for trust to occur. For example, one study exploring Chinese peers close working relationships, where there is a high degree of interaction with co-workers found that all three components were necessary for trust (Wasti et al., 2011). Additionally, a Canadian study exploring trust of peers who work closely together also found that all three components were important for trust (Knoll and Gill, 2011). Conversely, Turkish co-workers with much less interaction reported only benevolence as needed for trust (Wasti et al., 2011). Thus, this study adds to and strengthens the current understanding of close-working peer relationships. In addition, given the on-site location of hospital-based specialist palliative care social workers and the variety and frequency of generalists' interactions with them, their physical proximity and constant interface makes all three components of trust necessary for successful collaboration.

For hospital-based clinical practice to be successful, then, attention must be given to all three components of trust. These findings on trust may have implications for future research as well as for other professions in peer relationships working in close proximity to one another.

In the sub-sections below each component of trust amongst peers is discussed as it relates to the literature. An overview of *ability* is provided first, then *benevolence*, and finally *integrity*.

6.2.2.3 Ability

Mayer et al. (1995) define *ability* as the “group of skills, competencies, and characteristics that enable a party to have influence within some specific domain.” Other theorists have also identified ability as a key component of trust (Butler, 1991, Sitkin and Roth, 1993, Mishra, 1996). These prior studies, again, focused on trust between superiors and subordinates where there is a clear, organisationally defined power differential between the two parties. In the area of ability, the results here indicate that even when no formally defined power differential exists, for collaboration to occur the generalist social worker must perceive that the specialist palliative care social worker has the knowledge and aptitudes to complete tasks and meet goals (Gabarro, 1978, Interprofessional Education Collaborative Expert Panel, 2011, Blackmore and Persaud, 2012). Therefore, perceptions of ability are highly important with peers just as they are between superiors and subordinates. Additionally, perceptions of skill set are context and situation specific (Mayer et al., 1995). These results are similar to those of studies with generalist and specialist palliative care physicians and nurses (Walshe et al., 2008b). The similarities in professionals’ perceptions of one another’s context specific abilities may mean this theory of collaboration may help in understanding and predicting nurse and physician peer-to-peer collaboration as well. The concepts of specialisation and expertise, integrally tied to the perception of ability, are discussed next.

6.2.2.3.1 Ability: Specialisation

As a profession social work has focused on developing a generic set of skills that are highly transferrable to different settings, client groups, and situations (Leighninger, 1980, Trevithick, 2012). Social workers who are trained to understand and respond to a wide range of individual, family, and community needs are referred to as generalists (Trevithick, 2012). Over time, hospital social workers, like their multidisciplinary counterparts, have increased the degree of internal differentiation of skill amongst roles in order to meet the complex needs of patients and families (Leighninger, 1980). For social work the term specialist can mean a division of labour, or context rich knowledge and experience with a specific client group, method, setting, or problem area (Trevithick, 2012). Broadly speaking, in the United States this division of labour means that the generalist social workers are expected to manage discharge and leaving hospital services to move patients through the system in a timely fashion; whilst the specialist palliative care social worker is expected to participate in care conferences, family meetings, and complex medical decision making conversations (Meier and Beresford, 2008).

Unlike physicians, which use the term specialist to mean 'requires additional training'; social work does not have the similar application of the term specialist. For specialist palliative care physicians in the United States, United Kingdom, and some other countries, palliative medicine is a recognised medical specialty with a specific training program, accreditation, and regulatory requirements (Higginson and Evans, 2010, American Academy of Hospice and Palliative Medicine, 2014, Royal Australasian College of Physicians, 2015). To carry the title and work as a specialist palliative care physician, training, accreditation, and regulatory requirements must be met. Conversely, for nurses, social workers, and chaplains, although a number of certifications or post-graduate programs exist, these are not required for non-physicians to work in the field of specialist palliative care (California State University,

2015, Milford Care Centre, 2015, National Association of Social Workers, 2015a, St. Christopher's Hospice, 2015).

Studies of physician and nurses found these professions were concerned about how the generalist-specialist titles might impact the provision of palliative care (Gott et al., 2012). This concern is valid as prior research has shown that the extent to which professions share a similar status within the hierarchy of the organisation will impact whether and how they work with each other, and collaboration may become more challenging where differences in status are perceived between co-workers (Hudson, 2002). For nurse and physician generalist palliative care providers there is a particular concern that 'specialist' could be interpreted as 'elitist' (Gott et al., 2012). Nursing and physician respondents from several studies have also questioned whether the title 'specialist' implies the need for training and expertise, when in reality the skills may be routine (Mytton and Adams, 2003, Gott et al., 2012). Lastly, previous studies have reported concern that specialisation will deskill generalists, (Jack et al., 2002a, Jack et al., 2002b, Mytton and Adams, 2003, Gott et al., 2012). The generalist social workers in this study do not report sharing these concerns. As the field of specialist palliative care continues to develop, more formal credentialing could be required of social workers. Future assessment to see how generalist social workers' responses to the term 'specialist' may change over time and whether they more closely resemble those of nurses and physicians may be of interest.

6.2.2.3.2 Ability: Need for Specialist Palliative Care Skill Set

Patients with integrated specialist palliative care have better quality of life, maintain quality of life measures over time, and have better symptom control than patients receiving palliative care from generalists alone (Mitchell, 2002, Mitchell et al., 2008, Temel et al., 2010). A study exploring general practitioners' (GP) delivery of palliative care found GPs are uncomfortable with their competence to perform palliative care adequately (Mitchell, 2002). Generalists tend to miss symptoms which are not

treatable by them, or which are less common or unfamiliar to them (Mitchell, 2002). Another study of oncology patients found that home, hospital, and inpatient specialist palliative care significantly improved patient outcomes in pain and other areas of symptom control such as anxiety, and reduced hospital admissions as compared to patients receiving standard oncology care (Higginson and Evans, 2010). Finley et al. (2002) found that for patient outcomes in quality of life and reduced symptom burden there appears to be an advantage of multidisciplinary over uni-disciplinary teams. Lastly, a study of multiple sclerosis patients' perception of the quality of care provided by generalists versus specialists found that the benefit of specialist involvement was a clearly identified action plan for how to continue care, which contributed to patients overall psychological well-being by giving them a sense of control over their illness (Schwartz et al., 1998).

In addition to the expertise of a specialist palliative care nurse or physician, there is reason to believe that the inclusion of a specialist palliative care social worker also improves patient outcomes, assists with the development of a comprehensive action plan, and potentially addresses previously unidentified needs (Monroe, 1994, Sheldon, 2000, Meier et al., 2008). Although generalists and specialist palliative care social workers have similar training, the differentiation of roles within the acute care setting makes further development of certain skills less likely. Being in the role of the specialist palliative care social worker allows for advancement of skills in therapeutic intervention and development of dialectal skills around delivery of difficult news and emotionally charged conversations. In contrast, the generalists' role primarily allows for skill development in case management, resource identification, and leaving hospital processes. The more complex and challenging the clinical situation the larger the need for expertise in the social worker (Skovholt et al., 1997). It is important, then, to understand the qualities which contribute to expertise in general and in social

work specifically. These qualities, whilst discussed below in the context of social work, may also be applicable to other professions.

6.2.2.3.3 Ability: Expertise

An expert is someone who consistently performs a task well in a specific field of human activity (Tan, 1997). Expertise is context specific (Glaser, 1988). For social workers expertise and the use of the specialist title are not necessarily synonymous. A 'specialist' is not automatically an expert. Generalists' perceptions that motivation, hard work, perseverance, effort, and desire are necessary to develop expertise are supported in the literature (Skovholt et al., 1997, Tan, 1997, Dreyfus, 2004). The literature also supports generalists' views that not every social worker has the ability, desire, or opportunity to attain the 'expert' level of professional practice (Lesgold et al., 1988, Tan, 1997, Trevithick, 2012). Social workers develop the competencies needed to be experts in a specific domain by working in that domain (Skovholt et al., 1997, Trevithick, 2012). They have an extensive knowledge base gained over time and from experience for a specific task or tasks, and are able to appropriately apply their knowledge to a given situation (Tan, 1997, Trevithick, 2012). In social work expertise occurs when social workers have had time to cultivate a professional working style, internalise theory and research, develop a way to measure success, and shed pieces of the professional role which are incongruent with the self (Skovholt et al., 1997). However, the existing literature also indicates that experience and time, whilst part of expertise, are not sufficient on their own for its development; other abilities are needed (Lesgold et al., 1988, Tan, 1997, Trevithick, 2012).

In addition to experience and time, experts clinicians also organize and store the knowledge they gain in structured patterns in their long-term memory (Chase, 1973, Tan, 1997). This structure allows complex information to be accessed easily and readily applied (Leinhardt and Greeno, 1986, Tan, 1997). These strong pattern recognition skills enable experts to see details and information that others would

miss, and swiftly extract meaningful pieces of information from confusing and complex situations (Tan, 1997). Experts are then able to predict the next series of events, anticipate where contingencies are needed, and develop an action plan built on the potential outcomes (Chase, 1973, Tan, 1997). When faced with a problem experts seek to understand it, then use their extensive knowledge to infer relationships between items, possible limitations, identify contributing factors, and assess and validate potential solutions (Cooke, 1992, Tan, 1997). Experts are self-aware, monitoring their progress and shortcoming, assess where they may need to grow, and work with mentors to improve practice (Skovholt et al., 1997, Tan, 1997, Sandberg, 2000). This reflexivity and active reflection are key components of growth in ability (Skovholt et al., 1997, Trevithick, 2012). As only generalists' perceptions were explored in this study, conclusions about how closely the specialist palliative care social workers resemble these more formal definitions of 'expertise' cannot be made from these data alone, further research is needed.

The reason for the discrepancy between generalists' responses and the existing literature regarding what is required for expertise in palliative care social work is unclear, and warrants further investigation. One explanation for the generalists' view that more time spent doing specialist palliative care tasks is sufficient to build expertise in specialist palliative care may be their perceptions of their own abilities and skills related to their generalist role (Sandberg, 2000). Not having done the work of the specialist, generalists' conceive of what it is like based on their current positions and abilities (Sandberg, 2000). It is common for people to overestimate their own competence, abilities, and expertise and be unaware of where they are lacking in skill (Kruger and Dunning, 1999, Dunning et al., 2003, Ehrlinger and Dunning, 2003, Burson et al., 2006). Moreover, expertise in one area is not thought to be generalisable to another (Glaser, 1988). Whether these phenomena are at work in the generalists' responses and understanding of expertise in specialist palliative care

needs further exploration. Understanding the nuances involved in building expertise in social work is important as it has implications for social work education and clinical practice.

Lastly, the literature supports that within generalist social work practice advanced levels of knowledge and skill can be acquired (Skovholt et al., 1997, Trevithick, 2012). Generalists can be experts in their own right by having specific knowledge and skills related to hospital discharge planning. The scope of practice, skill set, and experience needed for discharge planning differs from that of the specialist palliative care social worker (Monroe, 1994, Sheldon, 2000, Meier et al., 2008). The reasons stated for expertise in specialist palliative care social work could also be used to support why the generalist roles require specialised knowledge. If the generalist and specialist palliative care social workers were to trade roles for a day it is likely all would experience challenges picking up an unfamiliar set of tasks. In unfamiliar roles both would struggle to ascertain the context specific information and cues needed to expertly address patients' needs. Consequently, in order to meet the complex needs of patients both the generalist and specialist palliative care social work roles are important and necessary for the delivery of quality patient care.

6.2.2.4 Benevolence

Benevolence as a component of trust is well supported in the literature (Solomon, 1960, Mayer et al., 1995, Tan and Lim, 2009, Knoll and Gill, 2011, Wasti et al., 2011). As outlined in the previous sections, Mayer et al.'s (1995) understanding of benevolence was developed as a result of studying relationships of managers and line staff. It is understandable that line staff would have more trust in their managers when managers clearly demonstrated having the staff's best interest at heart. This study adds to the theoretical understanding of the role of benevolence in trust by highlighting the importance of benevolence as an aspect of trust with peers.

Social workers have struggled with needing to prove their relevance and usefulness as part of the interdisciplinary team (Macdonald, 1991, Davies and Connolly, 1995). Being both readily identifiable and accessible and providing a valued service to the medical team helps social workers be viewed as 'one of the team', and positively contributes a sense of collaboration (Davies and Connolly, 1995). As interpersonal behaviours can be ambiguous and open to interpretation, without a clear demonstration of benevolence the specialist palliative care social worker could be perceived as undermining or threatening the generalist social worker's place within the ward team (Brown et al., 2014). This finding is similar to a study of community palliative care providers which found that developing strong relationships facilitates perceptions of cohesion and contributes to generalists' ability to do their own work (Walshe et al., 2008b). Whilst upholding and supporting the generalist physicians' and nurses' roles and expertise as a facilitator of collaboration is endorsed in the palliative care literature (Walshe et al., 2008b, Firn, 2015), this study is the first to report the importance of specialist palliative care social workers upholding and supporting generalist social workers' roles and expertise. Identifying similarities between the existing literature on nurses and physicians, which offer a wide body of knowledge, and that of social work, is noteworthy. Where similarities arise knowledge may be applicable across professions. Broadly applicable knowledge could then lead to a more overarching generalised theory.

6.2.2.5 Integrity

Mayer et al. (1995) reported that integrity between superiors and subordinates involves each adhering to a set of values that the other finds acceptable. They did not identify the importance of integrity in peer relationships. This study adds to the exiting theoretical understanding of trust by identifying the role of integrity in trusting peers. Integrity within the peer relationships, as demonstrated in this study, also involves each peer adhering to a set of values that the other finds acceptable.

Social work values include: service, respecting the right to self-determination, empowering people, the importance of human relationships, providing information, and professional competence (British Association of Social Workers, 2014, National Association of Social Workers, 2015b). The extent to which the specialist palliative care social worker is perceived as operating out of these values facilitates the degree to which the generalist social worker trusts and wants to collaborate with her. This finding confirms the theoretical understanding of the role of integrity in trust, and the role of trust in collaboration.

Previous literature on interdisciplinary teamwork with healthcare personnel has similarly identified the importance of shared values for effective collaboration (Canadian Interprofessional Health Collaborative, 2010, Interprofessional Education Collaborative Expert Panel, 2011, Blackmore and Persaud, 2012, Nancarrow et al., 2013). In these papers elements of effective collaboration were pinpointed but theoretical models were not developed. Thus, unlike this study, they are limited in their ability to describe the relationships between elements or make predictions about future behaviours.

These findings have indications not only for specialist palliative care social workers but also the entire specialist palliative care team. Whilst specialist palliative care teams, in principle, share values similar to social work, seeking to empower patients and families to make autonomous decisions, it seems there is room for improvement. From an organisational level, particularly in the United States, specialist palliative care teams are viewed as a way to save the hospital money through decreasing length of stay, preventing admissions, and lowering costs (Morrison et al., 2008). Specialist palliative care teams must vigilantly maintain their focus to provide patient-centred care, otherwise they risk losing their purpose and discouraging other healthcare professionals' from collaborating with them.

The discussion of trust and the components of trust: *ability*, *benevolence*, and *integrity* is now concluded. An overview of information sharing is outlined in the next section.

6.3 Information Sharing

The results from this study confirm the findings identified in the literature review regarding the importance of communication to generalist-specialist palliative care collaboration. These results are consistent with findings from the broader literature on the centrality of communication in effective *inter-disciplinary* collaboration. In *inter-disciplinary* interactions sharing information consists of verbal, written, and non-verbal communication with team members and is demonstrated through listening, negotiating, consulting, interacting, discussing or debating with one another (Canadian Interprofessional Health Collaborative, 2010, Nancarrow et al., 2013). More importantly, the findings from this study show that the elements of good communication are similar for *intra-disciplinary* and *inter-disciplinary* interactions. Like *inter-disciplinary* teams, generalist social workers from this study also report experiencing higher levels of collaboration with specialist palliative care social workers when they have good communication skills and are given regular, formal opportunities to communicate, as well as informal opportunities for communication (Blackmore and Persaud, 2012, Nancarrow et al., 2013, Giladi et al., 2014). The similarities between *inter-disciplinary* and *intra-disciplinary* team communication allow for information about what improves and facilitates one type of interaction to be applied to the other, and vice versa.

Collaboration cannot occur when communication is lacking. Poor communication negatively effects patient outcomes, leads to errors, and drives up healthcare costs (Institute of Medicine, 2001). Communication (written and verbal) aids collaboration when done in a timely manner; is clear, concise, and information rich (Blackmore and Persaud, 2012, Nancarrow et al., 2013, Giladi et al., 2014, Albert et al., 2015).

Positive perceptions of collaboration are further enhanced when the *quality* of the information is maximised in terms of accuracy, timeliness, and usefulness, and the *quantity* of information is adequate enough for the need to be addressed or the task completed (Thomas et al., 2009). When communication was slow, lacking in relevant content, too little or too much, or relayed in a confrontational manner, collaboration was hindered.

Social workers view themselves as being a profession of 'good communicators' (Koprowska, 2014). The same is true for specialist palliative care teams, who are often called upon to be involved in situations of difficult team, patient or family dynamics because of their communication skills (Hockley, 2000). There is evidence from this study and others that despite social work or specialist palliative care experience there is room for improvement in communication (Richards et al., 2005, Forrester et al., 2008). Assumptions about having the needed skills for communication based on profession or team membership may be dangerous to collaboration. It is not enough to be a 'good communicator' with patients and families, these skills must be carried into interactions with other staff members as well (Arber, 2008). Careful attention to communication will go far to facilitate collaboration.

The discussion will now move from information sharing to role negotiation.

6.4 Role Negotiation

Generalist social workers reported a lack of organisational clarity and direction for their job responsibilities leading to role confusion and the need for role negotiation. In the literature review role confusion was also mentioned by generalist nurses and physicians as a concern when collaborating with their specialist palliative care counterparts. Historically, role definition, the way social work is different from other healthcare professions, has been an important aspect of social work's professional identity (McDonald 1991; Kadushin and Kulys 1995; Davies and Connolly 1995; Payne 2006). These historical aspects of professional identity impact the quality of

generalists' interactions with specialist palliative care social workers. Master's trained social workers (MSWs), in particular, may perceive themselves as skilled in providing counselling services, and obtain a high level of job satisfaction from being able to utilise these skills regularly (Kadushin and Kulys 1995). Moreover, MSWs report a high sense of achievement and personal accomplishment when they are able to 'rise to the challenges' of the job to effectively intervene in complex psychosocial situations (Kadushin and Kulys 1995). Although MSWs report some satisfaction with providing tangible resources, they report a higher level of satisfaction with being able to provide counselling services, such as those required when working with patients and families at end of life (Kadushin and Kulys 1995; Goldsmith et al., 2010). With or without clarity about roles the generalist's desire to do professionally (and personally) meaningful work may be challenged by the involvement of the specialist palliative care social worker, clouding decision making and complicating role negotiation.

A number of studies on interdisciplinary collaboration and teamwork have concluded that clear and distinct job descriptions promote better collaboration (Canadian Interprofessional Health Collaborative, 2010, Interprofessional Education Collaborative Expert Panel, 2011, Blackmore and Persaud, 2012, Nancarrow et al., 2013). However the ways people actually work often differs from the organisation's description of the job responsibilities or organisational chart placement (Brown and Duguid, 1991). Because of the diversity of tasks and the unpredictability of patient and family care needs, the generalist and specialist palliative care social workers may need to assess each case individually (Hudson, 2002). A high degree of flexibility in roles may be needed to appropriately meet patient, family, ward team, and organisational needs. Having a more defined job description and delineation of services at an organisational level that still allows for some flexibility, may add additional functionality to the generalist and specialist palliative care social work roles. Division of labour should take into account the needs of patients, families, ward teams, and the institution. Additionally, whenever possible both generalist and

specialist palliative care social workers' job responsibilities should account for personal and professional satisfaction by including a mix of tangible and counselling services.

The next section is an overview of the implications of psychological ownership and the influence of negative judgments on generalists' relationships with specialist palliative care social workers and their influence on role negotiation.

6.4.1 Implications of Psychological Ownership and Negative Judgments on Role Negotiation

Psychological ownership is described as 'a feeling of possessiveness and attachment to a variety of objects in organisations' including ownership of the actual work, products created, work areas, or, in the case of healthcare professionals, patients (Brown et al., 2014, p. 463). Trusting a peer deters territorial responses which in turn enables a healthy sense of psychological ownership, allows for flexibility in roles, and permits interdependence amongst team members, which in turn facilitates collaboration (Nancarrow et al., 2013, Brown et al., 2014). With a few exceptions, generalists describe trusting the specialist palliative care social worker. This level of trust gives them a healthy sense of professional ownership, which in turn facilitates collaboration.

Trust is context and situational dependent, thus territorial or defensive responses may be too, appearing under some circumstances or interactions but not others (Gabarro, 1978, Blackmore and Persaud, 2012, Brown et al., 2014). It is possible, therefore, to cooperate with someone who is not perceived as trustworthy if there are external processes in place that make it necessary to interact (Mayer et al., 1995). The decision to have specialist palliative care involved is made by the generalist physician. Generalist social workers do not have control over involving the specialist palliative care team or specialist palliative care social worker. The workflow process of generalist and specialist palliative care social workers and the lack of

control over the referral to specialist palliative care could act as an external (and unwelcome) force on cooperation.

Whether or not the generalist social worker desires the interaction will influence the contact with the specialist palliative care social worker. Interactions that are merely cooperative at best, or extremely uncooperative at worst, will influence the tenor of the relationship. When trust is lacking psychological ownership becomes detrimental to collaboration with team members exhibiting territorial and defensive behaviour (Brown et al., 2014). A study by Walshe et al. (2008b) of English generalist and specialist palliative care physicians and nurses in the community cite nurses' readiness to assign negative intent, negative comments about nurses by nurses were common.

Nurses from Walshe et al.'s (2008b) study also reported holding strong judgments about what constitutes a "good" or "bad" physician. The nurses perceptions of 'good' or 'bad' were related to how responsive and available the physician was to the nurse's needs, rather than the physician's level of skill or technical expertise (Walshe et al., 2008b). Whilst Walshe et al. (2008b) found more negativity between generalist and specialist palliative care providers, Gott et al. (2012) found a range of responses with providers from England and New Zealand. The New Zealand respondents reported more animosity within generalist-specialist relationships, and those from England reported little animosity within the generalist-specialist relationship (Gott et al., 2012). The English cohort in Gott et al.'s (2012) study attributed the improved relationships to trust built over time reducing the tension and power struggle that had previously occurred with the different professional groups. Why these dissimilarities exist is unclear. They may be due to cultural differences, length of time working together, or variation in roles or role clarity.

The social workers in this study are less inclined to assign negative intent; instead they attribute positive intent towards the specialists with little exception

(Respondent 5 and Respondent 6). Even though questions relating to negative feelings were asked in the interview process (see Appendix F), for the most part generalists did not express negative judgments about their specialist palliative care social work colleagues. Participants were not told that the researcher is a specialist palliative care social worker, although they may have been aware. If they had awareness, it could have impacted their responses, leading them to withhold negative judgments.

This more positive attitude towards their specialist palliative care social work colleagues materialised notwithstanding evidence showing people are more likely to attribute positive events to themselves whilst negative events are attributed to other people (Mezulis et al., 2004). The lower prevalence of negative judgments by generalist social workers here may be attributed to sharing similar perceptions, values, and experiences with the specialist palliative care social workers. These parallels may have resulted from similar training or shared professional principles, leading to higher congruence in how they approach patient care needs and decision making (Hudson, 2002).

As healthcare continues to become more multifaceted, technology increases in complexity, and the available scientific and social care knowledge surges forward it will become more challenging for one person or one profession to hold all the necessary information to address patient needs. To meet these rapid changes, new and more diverse 'specialties' may be needed in the future. From both a policy and practice standpoint, one way to mitigate the negative impact of diversity between specialties and with generalists and specialists is to have integrated multiprofessional education and training. Integrated education and training may allow for similar experiences, shared professional principles, appreciation of different roles, and greater collaboration to address patient care needs (Parsell et al., 1998, Masterson, 2002, D'amour et al., 2005, D'amour and Oandasan, 2005, Reeves et al., 2013).

6.4.2 Influence of the Social Worker-Patient Relationship on Role Negotiation

Psychosocial care is a major focus of social work practice in the United States (Sexton and Whiston, 1994). Provision of psychosocial care is also a key aspect of palliative care (Onyeka, 2010). Developing rapport and establishing a therapeutic relationship with the patient and family creates the space in which psychosocial care can occur. "The quality of the counselling relationship has consistently been found to have the most significant impact on successful client outcome" (Sexton and Whiston, 1994)(p6). Expertise in building a therapeutic relationship consists of the ability to establish, maintain, and creatively use a positive working relationship with highly distressed individuals (Skovholt et al., 1997). Generalists in this study spoke of the importance of giving attention to which social worker (generalist or specialist palliative care) was most familiar to the patient and family and using this information to determine who would be the most appropriate social worker to provide palliative care services. Similarly, generalists and specialists in Gott et al.'s (2012) study reported a perception that patients want continuity of care, meaning that patients want consistency in the providers they see. Too many providers fragment care, confuse patients, and add an additional level of burden to patients (Gott et al., 2012). This belief about continuity of care and reducing confusion and burden for the patient is also held by the generalist social workers in this study.

The assumption behind the beliefs held by the respondents here and in Gott et al.'s (2012) study, is that the familiarity which arises from the existing patient-social worker relationship best facilitates the provision of psychosocial support, prevents additional burden, and reduces confusion, when patients and families are facing end of life. Previous studies regarding the significance of relationships for addressing psychosocial needs, like this study, are mainly based on self-report by the clinician and have not studied the client's perspective (Roberts and Snowball, 1999, Cohen et al., 2001, Taylor et al., 2001, Willard and Luker, 2005, Bedi, 2006). A more recent

mixed-methods observational study of nurses found just the opposite to be true, familiarity and an established relationship are not necessary for the provision of psychosocial support (Hill, 2014). Furthermore, the presence of an established relationship does not guarantee that it is effectively therapeutic such that psychosocial needs are appropriately addressed (Hill, 2014). Whilst, Hill's study was done with nurses it raises interesting questions about the assumptions about relationship and familiarity that may be influencing generalist and specialist palliative care social workers' decision making related to role negotiation. Their assumption is problematic because it is known that clients' perceptions regarding the strength of the therapeutic relationship are stronger predictors of outcome than clinicians' judgments, and clients and clinicians seem to have different understandings both in quality and in strength of the relationship (Horvath, 2001, Ardito and Rabellino, 2011).

Not only are there assumptions being made by the generalist social workers about the quality and effectiveness of their relationships with patients and families, there are also assumptions about the time needed to establish an effective relationship. The literature suggests that familiarity and professional-patient relationships are created over time, but the growth of a relationship in therapy is not always a linear process (Janzen et al., 2008). The amount of time needed to develop an effective therapeutic relationship cannot therefore be pre-determined. Results from this study reveal an underlying assumption by generalist social workers about the length of time it takes to develop rapport and a therapeutic relationship. At the time specialist palliative care is introduced into patients' care, the patients and families are often at a crisis point, dealing with an advanced illness and facing a potential transition in the focus of care. Being attentive to patients when psychosocial needs are expressed is sufficient for providing psychosocial support (Hill, 2014). Moreover, when the generalist social worker was not familiar with the patient the specialist social worker would take the primary support role. The specialist, without having met the

patient or family beforehand, would then participate in patient and family meetings. In these meetings the emotionally charged topics of prognosis or end of life are discussed. The specialist palliative care social worker's role is to provide psychosocial support. That is, the patient and family express psychosocial distress and the specialist palliative care social worker addresses their need moments after meeting the patient and family. Crisis intervention theories support the concept of rapid rapport and relationship building. Crisis intervention theories suggest that rapport is built when the social worker shows genuineness, respect, and acceptance of the client (Westefeld and Heckman-Stone, 2003, Roberts, 2005). The use of good eye contact, a non-judgmental attitude, creativity, flexibility, and reinforcement of small gains and resiliency help to establish an effective therapeutic relationship swiftly (Westefeld and Heckman-Stone, 2003, Roberts, 2005). Thus, meaningful psychosocial support could be provided through a minutes old relationship.

Discussed in the following sections are the limitations and strengths of the study, implications for practice and policy, and areas for future research.

6.5 Study Limitations

Although the study has a number of strengths, limitations to the study remain. Utilising the results from this study to understand the role of the specialist palliative care social worker is potentially limiting. The generalists' descriptions of the specialist palliative care social workers' abilities are only as good as their own level of conceptualisation and the attributes, skills, and knowledge that they themselves possess (Tan, 1997, Sandberg, 2000). Using the generalist social worker's description of skills to understand the expertise and skills of the specialist palliative care social worker will provide limited information about what competencies and level of expertise are required to be an effective specialist palliative care social worker. Additionally, existing literature shows that every person has a different propensity level or general willingness to trust others (Mayer et al., 1995). This study was not

designed to assess each respondent's individual propensity to trust. It is possible that some respondents are less willing to trust anyone; their base-line propensity to trust may have influenced their perceptions of collaboration with the specialist palliative care social worker.

The context of the study and who participated could be a limitation as well. Participants are from the United States, located in only one state, predominately Caucasian, and all women. The theoretical model may change or expand if respondents from other states, countries, ethnicities, and cultures were included. The addition of male respondents may also alter the theoretical model. Participant responses are self-reported, actual observation of participants did not occur. From a critical realist standpoint, the lack of observation does not necessarily hinder the applicability or accuracy of the theory, as perceptions on their own are able to provide windows into reality (Houston, 2001, Oliver, 2011).

Recruitment may have limited the results as well. Attempts were made to contact a number of hospitals and social workers, not all responded. For those who did respond but who declined to participate most cited workload and lack of time as reasons. Important elements may not have been incorporated into the theory by their lack of inclusion. As social work managers served as gatekeepers for accessing the line staff, they may have introduced bias by the way they identified or requested participants. Some potential participants may have been excluded. Generalists who participated may not have felt free to decline participating if specifically asked to do so by their superiors. This dynamic may have impacted their responses. Moreover, participants who had a predominantly positive or a predominantly negative view of collaborating with specialist palliative care social workers may have chosen to participate, thereby skewing the data in a particular direction.

Finally, despite attempts to minimise the risk of bias being introduced into the study by the researcher, bias may have occurred. The area of generalist and

specialist palliative care social work is well known to the researcher. There exists the potential that the personal experiences of the researcher coloured the questions asked of the generalists during the interviews, as well as the interpretation of results. Additionally, participants were aware that the researcher is a social worker and PhD student. They were not explicitly informed that the researcher works as a specialist palliative care social worker. There remains the potential that bias was introduced even without this information being known, awareness of the researcher being a social worker may have been enough to bias participants' responses.

6.6 Study Strengths

This study has a number of strengths. The study rigorously adhered to the grounded theory methodology throughout the interview, analysis, and writing process. Rich data were collected that allowed for the emergence of themes, which in turn made it possible to interpret the data and construct an original theory. The resulting theory provides a good understanding of generalist social workers' perceptions and attitudes about collaborating with specialist palliative care social workers. Consequently, it comprehensively addresses the research question.

An iterative approach was applied throughout to continue to refine and develop the data collection, analysis, and results. Constant comparison, combined with supervisory discussions was utilised to reduce bias being introduced by the researcher. Over the course of the interviews, coding, memo taking, and writing of results these supervisory discussions contributed to more in-depth analysis. The coding process was robust and comprehensive (see Appendix J: Codes, Appendix K: Memos, Appendix L: Categorical Codes, and Appendix M: Theoretical Modelling). Theoretical sampling facilitated reaching theoretical saturation. Having a variety of respondents representing a range of ages and work experiences, from several hospitals in different locations, caring for different populations of patients made it possible to reach theoretical saturation. Almost all of the codes could be placed

within a category, thus the majority of the data are incorporated into the final theoretical model (see Appendix L: Categorical Codes).

Findings from this study are supported in the existing literature. The constructs of trust, communication, and role negotiation described in this study have similar features to those found in previous studies. In the literature, these elements of collaboration appear in a number of workplace environments and amongst different professions. Whilst the theoretical model of collaboration in this study is specifically derived from social workers in-hospital interactions in the Midwest United States, it may be applicable to a number of settings and types of healthcare professions. The diversity of settings and cultures from these previous studies on the role and weight of ability, benevolence, and integrity indicate that the components of trust may also be present across cultures. Additionally, the barriers to collaboration identified in this study are not unique to the field of social work; they have been noted in the literature to be present in a variety of interdisciplinary interactions. Therefore, it is possible that the components of trust and collaboration described in this study are also applicable, not only to generalist and specialist palliative care social workers in other settings across the United States, but to other professions in different countries, working in diverse environments.

6.7 Implications for Policy and Social Work Practice

Implications from this study can be divided into two areas: implications for policy and implications for social work practice. Each area is outlined in this section.

6.8.1 Implications for Policy

Most developed countries have a limited number of specialist palliative care providers (Center to Advance Palliative Care, 2012, Australian Institute of Health and Welfare, 2014, Federation of the Royal Colleges of Physicians of the UK, 2014). More limited still are the number of hospital-based specialist palliative care social workers, as the literature review and recruitment process for this study revealed. Whilst policy calls

for an interdisciplinary team approach to the provision of specialist palliative care services, and specifically addresses the necessity of providing psychosocial support, many hospital-based specialist palliative care teams do not have an imbedded psychosocial professional (Firn, 2015). With the current limited specialist work force, policy in these countries often refers to the use of generalist palliative care providers to address the day-to-day palliative care needs of patients and families (Payne and Radbruch, 2009, Gott et al., 2012). Based on the results of this study it is questionable whether the policy guidelines can be a reality. Generalist social workers report no time to provide palliative care services, and do not view palliative care as a key component of their role or scope of practice.

All members of the multidisciplinary specialist palliative care team are charged to address psychosocial needs (Payne and Haines, 2002, Skilbeck and Payne, 2003, Meier, 2006, Rome, 2011). The specialist palliative social worker provides an additional aspect of psychosocial support not met by other disciplines (Monroe, 1994, Sheldon, 2000, Meier et al., 2008). The current state of most developed countries' specialist palliative care services means that an unsatisfactory number of hospital-based specialist palliative care teams have embedded psychosocial support professionals. One way to improve the quality of specialist palliative care services in these countries is to include a psychosocial professional within the specialist palliative care team. For specialist palliative care teams without an embedded social worker, a variety of patient care needs could be missed if the generalist social worker is not supported at the organisational level to provide palliative care services. More worrisome still, are situations where both generalist and specialist social workers are not available.

Training and education of generalist social workers is needed but is still insufficient for addressing the problem. Generalist social workers report most of their time is spent addressing hospital discharge needs, they are unavailable to attend

family meetings or provide counselling. Due to caseload size generalist social workers have a limited amount of time to give each patient. This inability to address palliative care needs is not unique to social workers; other generalist healthcare providers also report similar difficulties (Gott et al., 2012). Policy makers need to critically examine generalists' and specialist palliative care teams' ability to meet patients' palliative care needs within the current system. Job descriptions, roles, and patient case load modifications will be required to allow generalists the time to participate in family meetings, address psychosocial needs at end of life, and coordinate services for patients and families. Without system level changes generalists will be unable to meet the existing policy guidelines.

6.8.2 Implications for Social Work Practice

Expertise is context specific. Hiring managers may want to pay close attention to the ways in which potential candidates conceptualise their work in order to identify the most appropriate person for a specific job. Highly skilled candidates will be able to apply their knowledge to specific cases. Within their area of practice these clinicians should have the ability to discuss their own professional working style, how they measure success, and demonstrate reflexivity and active reflection about their strengths and weaknesses. As part of the interview process the use of case examples, which ask the candidate to relate what they did in past jobs or life situations to specific job-relevant knowledge, skills, and abilities, may help hiring managers assess candidates' experience and ability to problem solve (Pulakos and Schmitt, 1995). Strong candidates should be able to identify how they managed potential limitations and discuss their decision-making process.

The relationship of trust to effective collaboration cannot be overlooked in the hiring process. Understandably, hiring managers explore potential employees' social work skills, training, and education when determining candidates' appropriateness for a specific job. Hiring managers often also seek out candidates who are highly

motivated and have had previous experience doing a similar job. Results from this study indicate that congruency with social work values is another important dimension to assess in a potential employee. When hiring, choosing people who strongly conform to the values of the profession will assist with building trust and collaboration with social work colleagues. Exploring candidates' approaches to teamwork and their readiness to help teammates be successful may be helpful for identifying candidates who are able to foster collaboration through benevolence towards their peers. Additionally, assessing candidates' commitment to professional growth and advancing the social work profession may give insight to their ability to collaborate well with other social workers.

Another implication from this study relates to the significance of using the pre-existing generalist social worker-patient relationship to decide which social worker provides palliative care services. The primacy of the relationship and its necessity for the provision of psychosocial support is over estimated by generalists. It is possible that using the generalist social worker-patient relationship as a deciding factor for which social worker delivers care is less about what is best for the patient and more about what feels good for the generalist. Generalists and specialist palliative care social workers need to be aware of this potential bias when determining which social worker participates in palliative care conversations. Determinations should be based on patient need rather than on the relationship with a particular provider. The social worker with the skill set and knowledge base that can best meet the patient's needs is the appropriate person to address them.

Within the peer-to-peer relationship of generalists with specialist palliative care social workers, the importance of upholding and supporting the role and expertise of each social worker to achieving effective collaboration cannot be overemphasised. In particular, viewing the generalist as an expert in her own right

facilitates collaboration and is something to which the specialist palliative care social worker must pay attention if true collaboration is to take place.

The results indicate that generalist social workers currently approach each case individually and collaborate with the specialist palliative care social worker to meet the demands presented, without clear organisational guidelines for role differentiation. The lack of formal, organisational job differentiation gives rise to concerns that institutions may not value or understand the social work skill set. Whether intentionally or inadvertently, institutions are undermining what it means to be a specialist or generalist in social work by failing to define their roles. Organisations need to thoughtfully assess in what manner more well-defined job descriptions and a stricter delineation of services will impact the generalist and specialist palliative care social workers' abilities to effectively function in their roles. Too little clarity is detrimental, as are rigidly defined roles. To appropriately meet patient, family, medical teams, and organisational needs some flexibility in roles is needed. Attentiveness to the ingrained ambiguity of the work with some broad clarifications regarding the differentiation in roles, will ease anxiety, reduce conflict, and increase job satisfaction for generalists and specialist palliative care social workers alike (Rizzo et al., 1970). Improvements in these areas will increase efficiency and enhance communication, which may have a positive impact on patient care (Rizzo et al., 1970, Knaus et al., 1986, Rafferty et al., 2001, Nancarrow et al., 2013)

Lastly, since no official licensing or regulatory requirements are in place for specialist palliative care social workers, it is efficacious to have agreed upon standards of practice. In the United States and the United Kingdom several professional social work organisations and palliative care groups have set forth standards for specialist palliative care social workers (Gwyther et al., 2005, National Association of Social Workers, 2006, Bosma et al., 2010, Hughes, 2014, Hughes,

2015). Specialist palliative care social workers, as well as generalist social workers, can benefit from referring to these documents. Maintaining a consistent and high standard of palliative care delivery is good for the profession of social work and for patients and families.

6.8 Areas for Future Research

There are several areas for future research. By design this is a unidirectional and uniprofessional study which resulted in a unidirectional, uniprofessional theory. The study intended to only describe generalists' perceptions of collaborating with specialist palliative care social workers. It does not address specialists palliative care social workers' views of collaborating with generalist social workers. It also does not explain generalists' perceptions of collaborating with the multidisciplinary specialist palliative care team as a whole. Exploring collaboration from these directions could alter the existing theory.

Further research on peer-to-peer relationships and trust is needed as well. Disagreement continues to exist in the literature about the primacy, importance, and inclusion of all three components of trust. Additional exploration of the importance and weight of each of the components of trust in different settings across cultures and with different team members would be informative.

Existing literature shows a positive impact by specialist palliative care teams on patient outcomes. Further research exploring generalist social workers' impact on patient outcomes compared with the specialist palliative care social workers' impact is needed. As is a better understanding of patients' perceptions of care received by the generalist and specialist palliative care social workers. More knowledge of what the generalist and specialist each bring to the patient encounter and patients' preferences may provide guidance for decision making about roles.

Additional research is also needed to explore the relationship between specialisation and expertise for social workers in palliative care. Whilst social work expertise has been written about, further study is needed to explore the gap between generalists' responses and previous findings on expertise.

Finally, the generalist social workers in this study expressed a range of feelings about the specialist palliative care social worker. Overall, generalists reported positive rather than negative perceptions. Previous studies indicated that length of time working together may enhance generalists' positive feelings about specialist palliative care providers (Gott et al., 2012). Conclusions about length of time working together and how it impacts generalists' relationships with specialist palliative care social workers are not able to be drawn from this study. Further exploration of how the generalist's relationship with the specialist palliative care social worker changes over time and the impact on collaboration is needed.

6.9 Conclusion

The novel model of collaboration which emerged from the study consists of trust, information sharing, and role negotiation. Prior to this study knowledge regarding generalist social workers' challenges collaborating with specialist palliative care social workers was limited to observational comments made by experts in the field (Blacker et al., 2007, Meier and Beresford, 2007, Meier et al., 2008, Blacker and Deveau, 2010). As a result of this study generalists' collaboration with specialist palliative care social workers is better understood. This new awareness must inform clinical practice. The information from this study should be incorporated into the development of social work practice guidelines. It is standard practice in other professions to utilise evidence-based practices for generalist-specialist shared-care of patients (Gardiner et al., 2012). Until now social work was lacking the evidence needed to create these types of guidelines. Once in place, collaboration guidelines should minimise fragmentation, improve efficiency, and ultimately enhance patient outcomes.

In developing the guidelines it is important to note the findings from this study regarding information sharing and role negotiation confirm that, in these areas, generalist-specialist social work interactions are similar to those of other professions. Whilst it was surmised that there were similarities, now there is empirical evidence on which to base decisions. Social work can now draw more liberally upon and apply information about communication best practices and role negotiation from the existing literature on teamwork to develop their own guidelines. Guidelines should address the roles of the generalist and specialist palliative care social workers within the organisation, division of labour between each social worker, and provide recommendations for formal and informal communication. Guidance about which social worker is best suited to care for a patient in a given situation, based on the need of the patient rather than the relationship of the social worker with the patient, ought to be included as well.

In addition to identifying the importance of information sharing and role negotiation, this study also identified that peer-to-peer trust is particularly important for social work collaboration. The components of trust which emerged during the study, *ability*, *benevolence*, and *integrity*, are similar to Mayer et al.'s (1995) theoretical descriptions of trust, with a key exception. Mayer et al.'s (1995) theory of organisational trust focused solely on hierarchical relationships. The area of trust identified in this study expands their theory. The study establishes that *ability*, *benevolence*, and *integrity* are all central to trusting peers by providing empirical evidence that all three components function in peer-to-peer relationships working in close proximity to one another.

These findings on trust also may have far-reaching implications for professions beyond social work. Further exploration of the role of the three components of trust in peer-to-peer relationships is needed both in other settings and with different professions to understand these implications. Within social work,

awareness of how each component of trust operates provides opportunity for targeted education interventions to address and grow social workers' skill levels, as well as foster generalists' relationships with specialist palliative care social workers. It also may guide hiring practices, as some areas of *ability*, *benevolence*, and *integrity* cannot be taught or may not be transferrable. With attention to the development of clinical practice guidelines and an awareness of the role of trust in close-working peer relationships, social work collaboration will be more efficient and effective. This result will ultimately have an impact on patient outcomes: a result that is desirable to social workers, the organisations where they work, and the patients which they serve.

Appendix A: U.S. Medical Social Work

A.1 Education and Licensure

Social work differs internationally in role and scope depending on the country and within each country could also vary in role and scope between hospitals. This research study takes place in the United States. Most U.S. hospitals employ master's (MSW) trained generalist social workers to provide day-to-day casework services on the medical, surgical, and intensive care wards (Bureau of Labor Statistics, 2013). These social workers collaborate with a variety of health care providers on a daily basis to meet the care needs of patients (National Association of Social Workers, 2005, Bureau of Labor Statistics, 2010). Hospital-based clinical social workers must have a master's degree from a university accredited by the Counsel on Social Work Education (CSWE) and be licensed through the Association of Social Work Boards (ASWB) to practice in the hospital setting (Council on Social Work Education, 2008, Bureau of Labor Statistics, 2013, Association of Social Work Boards, 2014). The licensure process and oversight for clinical social workers varies by state (Bureau of Labor Statistics, 2013).

The CSWE sets standards for master's level training, providing a 'generalist' base for all clinical social workers irrespective of practice setting (Council on Social Work Education, 2008). Underpinning the curriculum and training are the profession's core values for service, social justice, the dignity and worth of the person, the importance of human relationships, integrity, competence, human rights, and scientific inquiry (Bisman, 1994, National Association of Social Workers, 2005). Context, however, also impacts the specific mission of the institution in which the program is located, and the needs and opportunities associated with the setting (Council on Social Work Education, 2008). Regardless of context or mission, no formal 'specialist' courses in palliative care or end of life are required by the CSWE as part of the Master's level degree requirements (Csikai and Raymer, 2005, Blacker et

al., 2007). Social work education courses in end of life are primarily offered as electives, resulting in most graduates having little to no formal training in providing end of life services to patients and families (Csikai and Raymer, 2005, Blacker et al., 2007). Although some variations between education, skills training, roles, and practice setting exist, many similarities remain (National Association of Social Workers, 2005).

A.2 Role

Many hospitals in the United States utilise social workers in the traditional clinical role, whilst other hospitals employ them in a case management role (National Association of Social Workers, 2005, Case Management Society of America and the National Association of Social Workers, 2008). As with clinical social work, the practice of case management is influenced by the setting and context in which it is operationalised. Regardless of the job title the clinical and the case management education programmes and skill sets are fairly equivalent (National Association of Social Workers, 2005, Atilio et al., 2008). In either role healthcare social workers help patients and families understand diagnoses and make the necessary adjustments to their lifestyle, housing, or healthcare (Bureau of Labor Statistics, 2013). They help patients and families adjust to changes in their life caused by an illness by working with them to develop strategies to change behaviour or cope with difficult situations (Gregorian, 2005, Bureau of Labor Statistics, 2013). Social workers in healthcare settings assess patient and family histories, backgrounds, and situations to identify needs, as well as strengths in order to develop a treatment plan (Donnelly, 1993, Gregorian, 2005). Treatment plans will involve the patient, as well as the family, doctors, and other healthcare professionals as appropriate (Bureau of Labor Statistics, 2013). When indicated social workers arrange, coordinate, monitor, evaluate, and advocate for services to meet patients' and families' complex needs (Huber, 2000, National Association of Social Workers, 2013). Effective interventions

require the social worker to develop and maintain a therapeutic relationship with the patient and the family (Marziali and Alexander, 1991). As part of the services they offer, healthcare social workers may provide individual, group, family, and couples therapy (Bureau of Labor Statistics, 2013). In addition to the services they provide themselves, healthcare social workers may refer patients and family members to other resources or services in the community, such as other mental health professionals (National Association of Social Workers, 2005). Healthcare social workers also assist other health and social care professionals to understand how illness impacts patients' mental and emotional health (Clarke et al., 1986, Donnelly, 1993).

All social workers in the acute hospital setting will inevitably work with patients and families facing situations involving life-limiting illness, and as such will seek to align themselves with the patient's and family's goals, to understand what the patient and family understand about the disease process, and to address issues of grief, loss, and death (Gwyther et al., 2005, National Association of Social Workers, 2005, National Association of Social Workers, 2006). In the United States every hospital-based social worker is held to a high standard of competency and service delivery for dying patients and their families, as reflected by the National Association of Social Work's (NASW) Guidelines for Palliative and End of Life Care (National Association of Social Workers, 2006). By applying these guidelines and their unique skills social workers in the hospital are well-situated to provide multidimensional interventions and support services to assist individuals and their families receiving palliative care and facing end of life (Gwyther et al., 2005, National Association of Social Workers, 2006).

Appendix B: Database Rationale, Search Terms and Results

Database Rationale

- PsychINFO contains literature in the behavioural sciences and mental health.
- PubMed houses a large range of biomedical literature from MEDLINE and additional life science journals.
- Web of Science contains a wide range of literature with multidisciplinary content.
- CINAHL covers a wide range of topics including nursing, biomedicine, health sciences librarianship, alternative/complementary medicine, consumer health and 17 allied health disciplines.
- Social Service Abstracts covers current research focused on social work, human services, and related areas, including social welfare, social policy, and community development.

Search Terms & Results

PsycINFO: Peer-reviewed journals, dissertations, and reviews. 01/01/1990 to 30/11/2015, Searched 1 March 2014, 20 December 2014, 18 November 2015.

Thesaurus: *palliative care; hospice; terminally ill patients; professional consultation; social workers; medical personnel; interdisciplinary treatment approach; professional specialization; communication; collaboration; attitude; perception; decision making; team; roles;*

Search Results: ((((((((((DE "Professional Consultation") OR (DE "Social Workers")) OR (DE "Medical Personnel")) OR (DE "Interdisciplinary Treatment Approach")) OR (DE "Professional Specialization")) OR (DE "Attitudes")) OR (DE "Perception")) OR (DE "Communication")) OR (DE "Decision Making")) OR (DE "Roles")) OR (DE "Teams") AND ((DE "Palliative Care") OR (DE "Terminally Ill Patients")) OR (DE "Hospice") **Limiters** - Published Date: 19900101-20151130 = 1629 articles

PubMed: searched 18/11/2015, articles published from 01/01/1990- 30/11/2015, English Language, Searched 1 March 2014, 20 December 2014, 18 November 2015.

MeSH headings: *Palliative Care; Terminal Care; Hospice; Patient Care Team; Consultants; Hospital Medical Staff; Hospital Nursing Staff; Allied Health Personnel; Social Work; Cooperative Behavior; Interdisciplinary Communication; Attitude of Health Personnel; Interprofessional Relations.*

Palliative Care includes: Care, Palliative; Palliative Treatment; Palliative Treatments; Treatment, Palliative; Treatments, Palliative; Therapy, Palliative; Palliative Therapy; Palliative Surgery; Surgery, Palliative; Palliative Medicine; Medicine, Palliative

Terminal Care: Care, Terminal; End of Life Care; Care End, Life; Care Ends, Life; Life Care End; Life Care Ends

Hospice: Care, Hospice; Hospice Programs; Hospice Program; Program, Hospice; Programs, Hospice; Bereavement Care; Care, Bereavement

Patient Care Team: Care Team, Patient; Care Teams, Patient; Patient Care Teams; Team, Patient Care; Teams, Patient Care; Medical Care Team; Care Team, Medical; Care Teams, Medical; Medical Care Teams; Team, Medical Care; Teams, Medical Care Interdisciplinary Health Team; Health Team, Interdisciplinary; Health Teams,

Interdisciplinary; Interdisciplinary Health Teams; Team, Interdisciplinary Health; Teams, Interdisciplinary Health; Healthcare Team; Healthcare Teams; Team, Healthcare; Teams, Healthcare; Health Care Team; Care Team, Health; Care Teams, Health; Health Care Teams; Team, Health Care; Teams, Health Care

Consultants: Consultant; Services, Advisory; Advisory Services; Advisory Service; Service, Advisory

Hospital Medical Staff: Hospital Medical Staff; Hospital Medical Staffs; Staff, Hospital Medical; Staffs, Hospital Medical; Medical Staffs, Hospital; Physicians, Junior; Junior Physician; Junior Physicians; Physician, Junior; Registrars, Hospital; Hospital Registrar; Hospital Registrars; Registrar, Hospital; Attending Physicians, Hospital; Hospital Attending Physicians; Attending Physician, Hospital; Hospital Attending Physician

Hospital Nursing Staff: Nursing Staffs, Hospital; Staffs, Hospital Nursing; Hospital Nursing Staff; Hospital Nursing Staffs; Staff, Hospital Nursing

Allied Health Personnel: Health Personnel, Allied; Personnel, Allied Health; Paramedics; Paramedic; Paramedical Personnel; Personnel, Paramedical; Population Program Specialists; Population Program Specialist; Program Specialist, Population; Program Specialists, Population; Specialist, Population Program; Specialists, Population Program

Social Work: Work, Social; Social Service; Service, Social; Services, Social; Social Services; Social Workers; Social Worker, Worker, Social; Workers, Social

Cooperative Behavior: Behaviour, Cooperative; Behaviours, Cooperative; Cooperative Behaviours; Compliant Behaviour; Behaviour, Compliant; Behaviors, Compliant; Compliant Behaviours; Collaboration; Collaborations

Interdisciplinary communication: Communication, Interdisciplinary; Communications, Interdisciplinary; Interdisciplinary Communications; Multidisciplinary Communication; Communication, Multidisciplinary; Communications, Multidisciplinary; Multidisciplinary Communications; Cross-Disciplinary Communication; Communication, Cross-Disciplinary; Communications, Cross-Disciplinary; Cross Disciplinary Communication; Cross-Disciplinary Communications

Attitude of Health Personnel: Health Personnel Attitude; Health Personnel Attitudes; Staff Attitude; Attitude, Staff; Attitudes, Staff; Staff Attitudes

Interprofessional Relations: Relations, Interprofessional; Etiquette, Medical; Medical Etiquette

Search Results: (((((((("Patient Care Team"[Mesh]) OR "Consultants"[Mesh]) OR "Medical Staff, Hospital"[Mesh]) OR "Social Work"[Mesh]) OR "Nursing Staff, Hospital"[Mesh]) OR "Allied Health Personnel"[Mesh])) AND (((("Interprofessional Relations"[Mesh]) OR "Attitude of Health Personnel"[Mesh]) OR "Interdisciplinary Communication"[Mesh]) OR "Cooperative Behaviour"[Mesh])) AND (((("Hospice Care"[Mesh]) OR "Terminal Care"[Mesh]) OR "Palliative Care"[Mesh])) AND ("1990/01/01"[Date - Publication] : "2015/11/30"[Date - Publication]) = 1226 articles

Web of Science: Articles from 01/01/1990 to 30/11/2015, Searched 1 March 2014, 20 December 2014, 18 November 2015.

Key Words: palliative care; terminal care; hospice; end of life; professional consultation; cooperat*; collaborat*; interdisciplinary team; interprofessional; attitude*; perception*;
social work*; medical team; allied health; physician*; doctor*; nurse*

Search Results: ("palliative care" OR "terminal care" or "end of life" or "hospice") AND ("professional consultation" OR cooperat* OR collaborat* OR "interdisciplinary team*" OR interprofessional OR attitude* OR perception*) AND (social work* OR medical team OR allied health OR physician* OR doctor* OR nurse*) Timespan=1900-2015 = 2954

CINAHL: Academic journals and dissertations from 01/01/1990-30/11/2015, Searched 1 March 2014, 20 December 2014, 18 November 2015.

Headings: Palliative care; terminal care; hospice care; multidisciplinary care team; medical staff hospital; collaboration; joint practice; interprofessional relations; intraprofessional relations; consultants; referral and consultation; attitude of health personnel; communication.

Search Results: (MH "Palliative Care") OR (MH "Hospice Care") OR (MH "Terminal Care") AND (MH "Medical Staff, Hospital") OR (MH "Multidisciplinary Care Team") AND (MH "Joint Practice") OR (MH "Interprofessional Relations") OR (MH "Intraprofessional Relations") OR (MH "Consultants") OR (MH "Referral and Consultation") OR (MH "Attitude of Health Personnel") OR (MH "Communication") Limiters - Published Date: 19900101-20151130 = 2412

Social Services Abstracts (ProQuest): peer-reviewed, academic journals and dissertations from 01/01/990 to 30/11/2015, Searched 1 March 2014, 20 December 2014, 18 November 2015.

Subject coverage: Community and mental health services; Crisis intervention; The family and social welfare; Gerontology; Poverty and homelessness; Professional issues in social work; Social services in addiction; Social work education; Social work practice; Violence, abuse, neglect

Thesaurus: palliative care; terminal care; hospices; professional consultation; cooperation (use for Collaborate/Collaboration/Collaborative); interdisciplinary approach (use for interprofessional); attitudes; perceptions; health professions; paramedical personnel; physicians; nurses; social work.

Search Results: (SU.EXACT("Palliative Care") OR SU.EXACT("Terminal Care") OR SU.EXACT("Hospices")) AND (SU.EXACT("Professional Consultation") OR SU.EXACT("Cooperation") OR SU.EXACT("Interdisciplinary Approach") OR SU.EXACT("Perceptions") OR SU.EXACT("Attitudes")) AND (SU.EXACT("Health Professions") OR SU.EXACT("Paramedical Personnel") OR SU.EXACT("Physicians") OR SU.EXACT("Social Work") OR SU.EXACT("Nurses")) between 1990 and 2015 = 5

Appendix C: Table of Journal Search Results

Journal	Results – search completed on 5 April 2014
The American Journal of Hospice and Palliative Medicine	Results 644 found for "hospice care" or "terminal care" in all fields or "end of life" or "palliative care" in all fields and attitudes or perceptions in all fields and interprofessional or "interdisciplinary team" in all fields or "social work" or "medical team" in all fields and "professional consultation" or consult* in all fields or collaborat* or cooperat* in all fields, from Jan 1990 through Nov 2015 in selected journals: American Journal of Hospice and Palliative Medicine
European Journal of Palliative Care	You searched for '("palliative care" OR "terminal care" OR "end of life" OR hospice) AND ("professional consultation" OR consultat* OR cooperat* OR collaborat*) AND ("interdisciplinary team" OR inter-professional OR "medical team" OR "social work") AND (attitudes OR perceptions))' in European Journal of Palliative Care from year 1994 to year 2015. There are 1234 results.
Journal of Hospice and Palliative Nursing	Results 44 (("palliative care" OR "terminal care" OR "end of life" OR hospice) AND ("professional consultation" OR consultat* OR cooperat* OR collaborat*) AND ("interdisciplinary team" OR inter-professional OR "medical team" OR "social work") AND (attitudes OR perceptions)) from 2006 to 2015
Journal of Pain and Symptom Management	You searched for You searched for "palliative" AND "care" OR "terminal" AND "care" OR "end" AND "life" OR "hospice" AND "professional" AND "consultation" OR "consultat*" OR "cooperat*" OR "collaborat*" AND "interdisciplinary" AND "team" OR "inter-professional" OR "medical" AND "team" OR "social" AND "work" AND "attitudes" OR "perceptions" within Journal of Pain and Symptom Management, from January 1990 to December 2015, Results=70
BMC Palliative Care	13 item(s) found for: (("palliative care" OR "terminal care" OR "end of life" OR hospice) AND ("professional consultation" OR consultat* OR cooperat* OR collaborat*) AND ("interdisciplinary team" OR inter-professional OR "medical team" OR "social work") AND (attitudes OR perceptions)) (All words) in All fields (full text) from 1997 to 2015
Palliative Medicine	Results 441 found for palliative care or terminal care in all fields or end of life or hospice in all fields and attitudes or perception in all fields and professional consultation or consult* in all fields or collaborat* or cooperat* in all fields and interprofessional or medical team in all fields or social work or interdisciplinary team in all fields, from Jan 1990 through Nov 2015 in selected journals: Palliative Medicine: The Research Journal of the EAPC - A Multiprofessional Journal
Journal of Palliative Medicine	You searched for: [Full Text: "palliative care"] OR [Full Text: "terminal care"] OR [Full Text: "end of life"] OR [Full Text: hospice] AND [Full Text: attitudes] OR [Full Text: perception] OR [Full Text: "professional consultation"] OR

	[Full Text: consultat] OR [Full Text: cooperat] OR [Full Text: collaborat]] AND [[[Full Text: "interdisciplinary team" OR [Full Text: "inter professional" OR [Full Text: "medical team" OR [Full Text: "social work" AND [Publication Date: (01/01/1990 TO 11/30/2015)] AND [in Journal: Journal of Palliative Medicine] 599 articles matched your search criteria.
Journal of Social Work in End-of-Life and Palliative Care	Results 65, (("palliative care" OR "terminal care" OR "end of life" OR hospice) AND ("professional consultation" OR consultat* OR cooperat* OR collaborat*) AND ("interdisciplinary team" OR inter-professional OR "medical team" OR "social work") AND (attitudes OR perceptions)) from 1 January 1990 – 30 November 2015

Appendix D: Study Quality Scores (Hawker et al., 2002)

The scale has 9 items assessing the following: Abstract and title; Introduction and Aims; Method and Data; Sampling; Data Analysis; Ethics and Bias; Results; Transferability and Generalizability; and Implications and Usefulness. Each item is rated with a 4-point Likert scale (Good=4, Fair=3, Poor=2, and Very Poor=1). All 9 items are then totaled for an overall combined score (9-36). *Of note: the authors report a range in scores from 10 to 40. However, when calculating the score based on a 9 item scoring key (below), the actual possible scores range from 9 to 36. The wording in the original paper is ambiguous.*

Author and title: _____ Date: _____

	Good	Fair	Poor	Very Poor	Comment
1. Abstract and title					
2. Introduction and aims					
3. Method and data					
4. Sampling					
5. Data analysis					
6. Ethics and bias					
7. Findings/results					
8. Transferability/generalizability					
9. Implications and usefulness					
Total					

1. Abstract and title: Did they provide a clear description of the study?

- ☐ Good - Structured abstract with full information and clear title.
- ☐ Fair - Abstract with most of the information.
- ☐ Poor - Inadequate abstract.
- ☐ Very Poor - No abstract.

2. Introduction and aims: Was there a good background and clear statement of the aims of the research?

- ☐ Good - Full but concise background to discussion/study containing up-to-date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions.
- ☐ Fair - Some background and literature review. Research questions outlined.
- ☐ Poor - Some background but no aim/objectives/questions, OR Aims/objectives but inadequate background.
- ☐ Very Poor - No mention of aims/objectives. No background or literature review.

3. Method and data: Is the method appropriate and clearly explained?

- ☐ Good - Method is appropriate and described clearly (e.g., questionnaires included). Clear details of the data collection and recording.
- ☐ Fair - Method appropriate, description could be better. Data described.
- ☐ Poor - Questionable whether method is appropriate. Method described inadequately. Little description of data.
- ☐ Very Poor - No mention of method, AND/OR Method inappropriate, AND/OR No details of data.

4. Sampling: Was the sampling strategy appropriate to address the aims?

- ☐ Good - Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates shown and explained.

- ☐ Fair - Sample size justified. Most information given, but some missing.
 - ☐ Poor - Sampling mentioned but few descriptive details.
 - ☐ Very Poor - No details of sample.
5. Data analysis: Was the description of the data analysis sufficiently rigorous?
- ☐ Good - Clear description of how analysis was done. Qualitative studies: Description of how themes derived/respondent validation or triangulation. Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.
 - ☐ Fair - Qualitative: Descriptive discussion of analysis. Quantitative.
 - ☐ Poor - Minimal details about analysis.
 - ☐ Very Poor - No discussion of analysis.
6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?
- ☐ Good - Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed. Bias: Researcher was reflexive and/or aware of own bias.
 - ☐ Fair - Lip service was paid to above (i.e., these issues were acknowledged).
 - ☐ Poor - Brief mention of issues.
 - ☐ Very Poor - No mention of issues.
7. Results: Is there a clear statement of the findings?
- ☐ Good - Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.
 - ☐ Fair - Findings mentioned but more explanation could be given. Data presented relate directly to results.
 - ☐ Poor - Findings presented haphazardly, not explained, and do not progress logically from results.
 - ☐ Very Poor - Findings not mentioned or do not relate to aims.
8. Transferability or generalizability: Are the findings of this study transferable (generalizable) to a wider population?
- ☐ Good - Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).
 - ☐ Fair - Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.
 - ☐ Poor - Minimal description of context/setting.
 - ☐ Very Poor - No description of context/setting.
9. Implications and usefulness: How important are these findings to policy and practice?
- ☐ Good - Contributes something new and/or different in terms of understanding/insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice.
 - ☐ Fair - Two of the above (state what is missing in comments).
 - ☐ Poor - Only one of the above.
 - ☐ Very Poor - None of the above.

Appendix E: Recruitment Email

HUM00077521

Dear <<Social Worker>>:

You are invited to participate in a qualitative interview to explore themes related to palliative care consultation and the social work role. Non-palliative care social workers who work in the inpatient hospital setting covering ICU, medical, and surgical services are being recruited. This study is being undertaken as part of the requirements for a PhD in Palliative Care through Lancaster University.

As you know, many patients facing end of life have complex emotional and psychosocial needs. In most inpatient hospital care models the ward, floor, or ICU social workers have primary responsibility for the patients on their units. With the involvement of the social worker from the palliative care consultation team confusion about responsibilities may arise when roles overlap. This study is aimed at helping social workers better understand and define the areas of practice where this overlap occurs, with the goal of establishing some recommendations for best practices and consultation etiquette. Themes identified during the interview will be utilised to inform future social work practice.

The interview will be done in person at a location of your choosing and will take approximately sixty minutes. During the interview, you will have the opportunity to share your experiences and thoughts about what works well and what does not work well when sharing a patient's care with the palliative care social worker. As someone who is currently practicing in the field your views and insights are extremely valuable sources of information.

Participation is voluntary. Please be assured that anything you say during the interview will be kept strictly confidential, and that no information that can be linked to you will be released to others.

Please reply to this email if you are interested in participating. If you have additional questions about the study I can be contacted via email or at the number listed below.

Sincerely,

Janice Firn

734-936-4637

jfirn@med.umich.edu

Appendix F: Interview Questions

Participant ID:

Years of experience as a master's trained social worker practicing in health care:

Length of time employed in the current position:

Professional raining and background experience:

Previous palliative care training/exposure:

Medical/surgical services and/or diagnoses served in the primary position:

Frequency of encountering end of life situations in the inpatient hospital setting:

Frequency and duration of interactions with palliative care social workers:

Hospital palliative care model:

Number of palliative care social workers at your institution:

Initial Interview Questions

1. Describe your experiences sharing cases with the specialist palliative care social worker.
2. Describe a specific case you shared with the palliative care/ward social worker. What went well? What did not? Why?
3. Describe what an 'ideal' interaction would look like and why. What does effective collaboration look like when sharing a case?
4. How are roles defined and differentiated when sharing a case? Who does what and why?
5. What do you consider the 'best practices' are for sharing care?
6. How does sharing care impact the provision of services to the patient/family? Challenges? Benefits?
7. How does sharing care impact your knowledge of end of life care and clinical skills?
8. How do you think sharing care affects your team's perception of you as a clinician? How does sharing care affect your perception of yourself as a clinician?

9. What advice or recommendations do you have for other generalist social workers in similar situations?

10. What advice or recommendations do you have for specialist palliative care social workers to keep in mind when sharing a case?

Modified Interview Questions (based on iterative process and previous interviews)

1. Describe your experiences sharing cases with the specialist palliative care social worker.
2. Describe a specific case you shared with the palliative care/ward social worker. What went well? What did not? Why?
3. Describe what an 'ideal' interaction would look like and why?
4. What does effective collaboration look like when sharing a case?
5. How do you know the palliative care social worker is involved?
6. How are roles defined and differentiated when sharing a case? Who does what and why?
7. What do you consider the 'best practices' are for sharing care?
8. How does sharing care impact the provision of services to the patient/family? Challenges? Benefits?
9. How does sharing care impact your knowledge of end of life care and clinical skills?
10. How do you think sharing care affects your team's perception of you as a clinician?
11. How does sharing care affect your perception of yourself as a clinician?
12. What advice or recommendations do you have for other generalist social workers in similar situations?
13. What advice or recommendations do you have for specialist palliative care social workers to keep in mind when sharing a case?
14. Anything I didn't ask about that I should know?

Appendix G: Written Informed Consent Form

UNIVERSITY OF MICHIGAN CONSENT TO BE PART OF A RESEARCH STUDY

Name of Study and Researchers

Title of Project: Inpatient Hospital Based Generalist Social Workers' Experience of Sharing End of Life Care with Specialist Palliative Care Social Workers, HUM00077521

Principal Investigator: Janice I. Firn

General Information

We are conducting research about the interaction and collaboration between palliative care social workers and ward/floor/ICU social workers when providing end of life care to patients and families in the hospital with the aim of identifying best practices.

To gather information we are asking hospital-based social workers to participate in an in-person, 60 minute audio interview. The interview will explore key themes related to situations where both the palliative care and ward/floor/ICU social worker share the same case. The audio interviews will be digitally recorded. Audio files will be transcribed by a professional transcription company. Some basic demographic information will also be collected immediately prior to the initiation of the interview.

There are very few risks associated with this study. You might feel some uncomfortable emotions while participating in the interview and reflecting upon the quality of your interactions with colleagues. At any point during the interview you can decide to stop the discussion.

This research is voluntary. You do not have to take part in this study. Choosing not to be in this research study will not affect you in any way. There are no direct benefits to you for taking part in this study. In the future social workers and patients and families may benefit by the information learned.

This study requires a one-time commitment of a 60 minute (approx.) interview. Identifying information will be stored in a secure database. While there is a potential risk for a breach in confidentiality, precautions are in place to minimise that risk and to protect the security and anonymity of your information. All information will be stored in secure, password protected servers at the University of Michigan. At the time of publication your responses will be anonymised.

Contact Janice Firn, 1500 E. Medical Center Drive, Box 5233, University of Michigan Health System, Ann Arbor, Michigan 48109-5233, telephone 734-936-4637 if you have questions or concerns about this study or feel that the study has caused you any harm. If you have any questions or concerns about your rights as a research subject, or any grievance, you may also contact the Institutional Review Board for Human Subject Research (IRBMED), University of Michigan, 2800 Plymouth Road, Building 520, Room 3214, Ann Arbor, MI 48109-2800; telephone 734-763-4768.

Signatures

Research Subject:

I understand the information printed on this form. I have discussed this study, its risks and potential benefits, and my other choices with Janice Firn, LMSW. My questions so far have been answered. I understand that if I have more questions or concerns about the study or my participation as a research subject, I may contact one of the people listed above. I understand that I will receive a copy of this form at the time I sign it and later upon request. I understand that if my ability to consent for myself changes, either I or my legal representative may be asked to re-consent prior to my continued participation in this study.

Signature of Subject: _____ Date: _____

Name (Print legal name): _____

Study ID: _____ Date of Birth: _____

Permission to audio record:

I agree to be audio taped as a subject in this research study. I also agree that the recording may be used for the purpose of this research. I understand that I can stop the recording at any time and discontinue participation in this research study.

Signature of subject: _____ Date: _____

Appendix H: Research Proposal

Inpatient hospital-based generalist social workers' experiences of sharing end of life care with specialist palliative care social workers

1. Introduction

Whilst other professions have started to develop 'Best Practices' for generalist-specialist shared-care of patients, the social work profession has yet to adequately address this area (Gardiner et al., 2012). This study aims to explore generalist (ICU, floor, and/or ward) social workers' views about where their roles overlap with specialist palliative care social workers, and their perceptions of the associated problems or benefits of this overlap on the provision of end of life care services in the hospital. A better understanding of the ways in which generalist and specialist palliative care social workers interact when sharing care of a patient at the end of life will inform clinical practice, assist with the development of guidelines for how best to share care, could minimise fragmentation of care, and ultimately lead to enhanced patient care outcomes.

2. Aim

To explore generalist social workers' experiences of sharing end of life care with specialist palliative care social workers in in-patient hospital settings.

3. Objectives

- To explore generalist social workers' perceptions of their interactions with specialist palliative care social workers in the inpatient hospital setting.
- To explore generalist social workers' perceptions of the issues associated with sharing care with specialist palliative care social workers.
- To explore generalist social workers' views of how sharing care with specialist palliative care social workers impacts their knowledge, skills, and attitudes towards providing end of life care services.

4. Literature Review

The National Association of Social Work's (NASW) Guidelines for Palliative and End of Life Care (National Association of Social Workers, 2006) hold every hospital based social worker to a high standard of competency and service delivery for dying patients and their families. In the United States, palliative care became a recognised medical specialty in 2006 (American Academy of Hospice and Palliative Medicine, 2014). This recognition has led to specialisation amongst various medical professions, including social work, in their approach to end of life care. As palliative care specialisation becomes more widespread in social work, the number of shared cases between specialist palliative care and generalist social workers will continue to increase (Blacker et al., 2007).

Current knowledge regarding social work challenges in sharing end of life care originates from observational comments made by experts in the field (Blacker et al., 2007, Meier and Beresford, 2007, Meier et al., 2008, Blacker and Deveau, 2010). No individual studies examining the interaction between specialist palliative care and generalist social workers sharing the same case at the same time have been conducted (Gardiner et al., 2012). Existing evidence about the factors that facilitate collaboration derive from studies of physicians and nurses (Gardiner et al., 2012). Whilst a few of these studies include some information from social workers, it is in regards to collaborating with other, non-social work professions (Abramson and Mizrahi, 1996, Gardiner et al., 2012). Therefore, this study seeks to better understand generalist social workers' experiences of sharing end of life care with specialist palliative care social workers in the hospital.

5. Study Design and Methods

Qualitative interviews will be utilised to explore the research question. Interviews will be conducted over a 9 month period. Completed interviews will be analysed using a grounded theory approach. As no literature exists on consultation etiquette for

specialist palliative care social work a grounded theory approach will allow the topic to be studied in depth and will facilitate the emergence of key themes, concepts, and ideas.

6. Sample

Generalist Masters trained social workers working in the inpatient hospital setting who share cases with specialist palliative care social workers will be invited to participate in the study. In Michigan all social workers providing therapeutic, clinical interventions to patients in the hospital are required to be masters trained and licensed with the state (State of Michigan, 2013).

6.1 Inclusion criteria:

- Generalist social workers working in the inpatient hospital setting,
- Generalist social workers working with adult patients (patients 18 years old and older), Generalist social workers from both for-profit and not-for-profit hospitals,
- Generalist social workers working in hospitals that have palliative care consultation teams which include a specialist palliative care social worker,
- Generalist social workers who spend 100% of their time in the inpatient setting,
- both part-time and full-time generalist social workers from medical and surgical wards, and intensive care units
- Generalist social workers who speak English

6.2 Exclusion criteria:

- Military and children's hospitals,
- social workers working with patients 17 years old or younger,
- social work students,
- social workers who have not been masters trained (BSWs),

- generalist social workers who do not share care with specialist palliative care social workers,
- generalist social workers who are employed at hospitals which do not have a palliative care consultation team,
- specialist palliative care social workers
- non- English speaking social workers

7. Recruitment and Sample Size

This study will use a sample of convenience, recruiting 15 to 30 inpatient non-palliative care mater's trained social workers working at hospitals in the state of Michigan. Participants will be recruited through sequential e-mail invitation based on geographical distance, starting with those social workers working in hospitals located within one hour of the researcher.

There is no all-encompassing e-mail repository containing the necessary contact information for these social workers. Contact information is available via the Registry for directors of the palliative care consultation teams and their administrative staff. A phone conversation will be held with these points of contact explaining the research and to obtain permission to recruit from their employees. Next, an e-mail will be sent to the administration staff listed on the Registry with a request to forward the invitation to participate to social workers at the hospital. Potential participants will be given one week to respond to the researcher. At one week a follow up, reminder email will be sent, after which no further attempts to recruit from that site will be made. Participation is voluntary.

Defining the population size is difficult. The report focuses on hospitals utilising palliative care teams which contain fifty or more beds (Center to Advance Palliative Care and National Palliative Care Research Center, 2015). Hospitals with fewer than fifty beds were excluded from the national survey, and therefore will also be excluded from this study, as these hospitals treat only a small number of patients with serious

or life-threatening illnesses. Due to their small size they are unlikely to be able to support an interdisciplinary palliative care consultation team model that includes, at minimum, a specialty-level palliative care physician, nurse and social worker. Also excluded from the national study, and therefore this study, were rehabilitation hospitals; psychiatric hospitals; eye, ear, nose and throat hospitals; sub-acute and chronic-care facilities; Military hospitals; children's hospitals; and hospitals that did not respond to the American Hospital Association Annual Survey Database and are therefore not listed in the Registry (Center to Advance Palliative Care and National Palliative Care Research Center, 2015). Excluding these types of care centres results in 26 Michigan hospitals verified by the National Palliative Care Registry as providing inpatient palliative care services (Center to Advance Palliative Care and National Palliative Care Research Center, 2015). As the researcher works as a specialist palliative care social worker at one of these hospitals, to avoid a conflict of interest the researcher's hospital will be excluded from the study. Therefore, a total of 25 Michigan hospitals have social workers who meet the inclusion criteria for the study. Of these 25 hospitals, 15 are within one hour of the researcher's location. As the number of generalist social workers can vary from hospital to hospital the goal will be to recruit up to 5 social workers from each hospital until up to 30 participants have been recruited. Recruitment will also conclude when data analysis ceases to reveal any new themes or all of the relevant participants have been recruited. As recruitment is sequential, based on geographic distance, not all 15 hospitals may be utilised.

8. Data Collection

To explore hospital based generalist social workers' experiences of sharing end of life care with the specialist palliative care social worker a qualitative interviews generalist Masters trained social workers working in the inpatient hospital setting who share cases with specialist palliative care social workers will be used. Interviews will be digitally recoded and will be conversational in style; utilising open-ended questions

derived from conversations with generalist and specialist palliative care social workers at the researcher's institution and subject matter experts in palliative care consultation (see Interview Guide below). An iterative, reflexive approach will be used throughout the interview process, allowing the interview questions to change and develop over time.

Prior to the initiation of the interview participants will complete a basic demographics sheet including years of experience as a master's trained social worker practicing in health care, type and setting of clinical practice, length of time employed in the current position, training and background experience, medical/surgical services and/or diagnosis served in their primary position, frequency of encountering end of life situations, and the frequency of interactions with the specialist palliative care social worker. Gathering this information will provide context for their responses. Once the demographic information has been collected, the interview will be conducted.

9. Analysis

Interview recordings will be transcribed and analysed by the researcher for key themes using the grounded theory techniques outlined Charmaz which support both an inductive and deductive approach to analysis (Charmaz, 2006). An iterative analysis process will be applied with interviews being analysed as they are completed, allowing each proceeding interview to be informed by those which have preceded it. NVivo (version 10) will be used to organise the data and uphold the rigor by establishing a chain of evidence through tracking data. An initial thematic framework will be developed and applied to the data. Over the course of the analysis process this framework will also change iteratively as new themes are identified.

10. Potential Challenges

Recruitment could pose a challenge. As described above, there is no single repository containing the contact information for these social workers. Requests for

participation will be made through hospital social work or palliative care administrators rather than directly to the social workers themselves. There is an increased risk for a poor response rate with this approach to recruitment. Attempts to identify and contact non-responders would need to go through similar channels. Adding an additional e-mail contact to already busy medical directors' or department heads' inboxes would be unwelcome and unlikely to produce successful responses or increase participation. If the initial email request does not produce any participants after one week, the researcher will make one additional attempt to contact social workers at these institutions after which consecutive attempts to contact participants will not be made.

Another challenge facing the researcher is the lack of a single, accepted framework for engaging in and reporting the results of qualitative research (Snape and Spencer, 2003). A clear description of the underlying philosophical beliefs driving the design, as well as being explicit about the methods, analysis process, and the ways in which conclusions relate to the existing theoretical knowledge, will be crucial in order to demonstrate the quality, rigour, and applicability of the study (Elo and Kyngas, 2007). Repeated reading of the transcripts, with constant contrasting and comparing between themes throughout the process will also improve the rigor (Elo and Kyngas, 2007). Documenting the details of the analysis process will further support the rigor of the study, thereby contributing to the validity of the results (Elo and Kyngas, 2007). Throughout the research process the Consolidated Criteria for Reporting Qualitative Research framework will be applied in order for the key pieces of the research to be clearly reported (Tong et al., 2007).

The rigor of the study and the validity of the results will also be impacted by the degree to which the researcher can be reflexive (Patton, 2002, Elo and Kyngas, 2007, Green et al., 2007). In qualitative research complete objectivity and neutrality are not possible, nor are they necessarily desirable (Patton, 2002, Bailey and

Jackson, 2003, Srivastava and Hopwood, 2009). The researcher's own experiences, awareness of subject matter theory, and involvement in the research process can add to and inform the research findings (Patton, 2002, Elo and Kyngas, 2007). Whilst the researcher's voice is heard, and total impartiality is not possible, the researcher is careful that the research does not become too subjective, constantly striving for balance and relating the findings back to the larger body of theoretical knowledge (Patton, 2002).

Inherently, analysis includes some synthesis and the recognition of how identified themes dynamically influence each other (Sandelowski and Barroso, 2002, Green et al., 2007). Reporting the findings of a quantitative analysis study must move beyond simply reporting themes x, y, and z to arrive at an explanation of the issue under investigation (Green et al., 2007, Srivastava and Hopwood, 2009). The study will also be limited to the extent of the researcher's ability to analyse and interpret the data.

Another limitation for this study arises from the intrinsic nature of the doctoral thesis. Ideally, coding of qualitative data involves several researchers with themes and interpretation of data being developed and discussed together over the course of the research project. This study will be coded by one person and the analysis discussed with a supervisor, allowing for a consistent approach to the methodology but potentially limiting the rigor.

11. Ethical Issues

Ethical considerations for the interview participants include confidentiality and data storage. Interviews will be conducted in a private place to protect confidentiality. As participation is voluntary, only those social workers who are comfortable discussing the positive and negative aspects of shared-care with the researcher will agree to participate. Self-selection could limit the results as those social workers who choose not to participate may have had the most negative experiences of shared-care. Conversely, as the aim of the study is to identify 'best practices', hearing from those

social workers who have had collaborative experiences with shared-care will still yield useful information.

All participants will complete a written informed consent process. There will be no direct benefit to the respondents from participating in the study. The indirect benefits of participating in the study could be increased knowledge and identification of what constitutes 'best practices' when specialist and generalist social workers collaborate in providing comprehensive end of life care services to patients and families. Results from this study may also inform future research endeavours.

Data will be collected during interviews. Interviews will be digitally recorded. Immediately following the completion of the interview the digital data will be transferred to an encrypted, password protected computer. The recordings will be sent via encrypted files to a professional transcription company. The transcription company does not retain digital files after the order has been completed. Identifying information such as participants' names and basic demographics will be stored separately from the recordings in a secure, locked cabinet at the University of Michigan. The demographic information will not be sent to the transcription company to protect participants' information. The typed narratives and documentation related to the thematic analysis will be stored in a locked cabinet (paper format) or on a secure, password protected server at the University of Michigan (electronic format). At the time of publication participants' responses will be anonymised. Identifying information will be retained for 18 months after the completion of the study, at which time it will be destroyed.

12. Anticipated Application to Clinical Practice

Information from this study will assist in the development of guidelines and recommendations for generalist and specialist palliative care social workers on how to best approach sharing the care of a patient, and could lead to improving practice and ultimately enhancing patient care outcomes.

13. Future Directions

This study seeks to explore generalist social workers' perceptions of sharing end of life care with specialist palliative care social workers. Future studies exploring specialist palliative care social workers' perceptions of sharing end of life care with generalist social workers would provide additional information that could be useful for developing 'best practices'.

14. Interview Guide

1. Describe your experiences sharing cases with the specialist palliative care social worker.
2. Describe a specific case you shared with the palliative care/ward social worker. What went well? What did not? Why?
3. Describe what an 'ideal' interaction would look like and why. What does effective collaboration look like when sharing a case?
4. How are roles defined and differentiated when sharing a case? Who does what and why?
5. What do you consider the 'best practices' are for sharing care?
6. How does sharing care impact the provision of services to the patient/family? Challenges? Benefits?
7. How does sharing care impact your knowledge of end of life care and clinical skills?
8. How do you think sharing care affects your team's perception of you as a clinician? How does sharing care affect your perception of yourself as a clinician?
9. What advice or recommendations do you have for other generalist social workers in similar situations?
10. What advice or recommendations do you have for specialist palliative care social workers to keep in mind when sharing a case?

Appendix I: Interview Timetable

Interviews were conducted from February 2014 through January 2015. Interviews were coded as they were completed. An iterative process was utilised which facilitated theoretical sampling.

Interview 1 – 17/2/2014

Interview 2 – 20/2/2014

Interview 3 – 25/2/2014

Interview 4 – 6/5/2014

Interview 5 – 6/5/2014

Interview 6 – 8/7/2014

Interview 7 – 9/7/2014

Interview 8 – 30/7/2014

Interview 9 – 1/8/2014

Interview 10 – 5/1/2015

Interview 11 – 5/1/2015

Interview 12 – 5/1/2015

Interview 13 – 8/1/2015

Interview 14 – 14/1/2015

Appendix J: Codes

Name	Sources	References
accountability	3	4
advice	12	28
advocating for pt or family	14	77
advocating for SPC involvement	14	58
agenda	3	17
agree with SPC SW	9	21
appropriateness of referral to SPC	12	34
assessment	11	25
availability of SPC SW	13	45
availability of SPC team	9	21
awareness of SPC involvement	15	61
badgering family	9	19
balance	11	15
being available	8	28
being on the same page	10	42
benefit of SPC education	9	14
benefits of SPC involvement	10	39
best practice	13	110
boundaries	1	3
case example	12	47
challenges to collaboration	12	79
change in roles	6	12
changes in care services over time	10	30
clinical skill	13	101
collegial	14	69
comfort with end of life	11	48
communication	15	194
conflicting goals	6	15
continuity of care	14	104
coping pt and family	13	49
disagree with SPC	6	13
duplication of services	14	39
ego	5	15
ethics	2	3
expertise	11	46
face to face contact between social workers	8	15
family confusion	13	50
family meeting	11	33
feelings about SPC involvement	13	69
flexibility in SW roles	15	64
frequency of contact w SPC team	14	38
frequency of eol cases	12	25
giving feedback to others	11	25
goals	8	14
having perspective	12	60
healthy detachment	9	21
hospice unit in house	2	2
how primary SW knows SPC SW is involved	12	40
how the work impacts SW	14	42

impact on self-perception	9	26
interaction with SPC SW	13	78
interaction with SPC team	12	65
interruption	7	32
laziness	2	3
learning	9	31
learning from SPC	8	23
length of time SPC active at hospital	4	4
motivation	14	54
negotiating SW roles	14	79
number of SPC SWers at the hospital	12	16
organisational role differentiation	13	43
over-react	2	2
patient and family ambivalence	8	13
patient confusion	13	48
patient focused self determination	13	83
perception of referring team	13	62
perception of skill set	10	36
phone call	6	17
placing SPC consultation request	12	31
power differential	7	9
primary SW approach to care	13	67
primary SW current position	13	23
primary SW experience with hospice SWer	3	3
primary SW interaction w nonPC SW	7	16
primary SW personal approach to eol	10	20
primary SW personal experience with end of life and or SPC	7	13
primary SW philosophical drivers	13	57
primary SW religious views	1	1
primary SW training	11	23
primary SW years in current position	10	13
primary SWer uses SPC consult as intervention	10	36
primary SW's interaction with referring team	11	84
primary SW's perception of patient and family	9	16
primary team SW role	15	253
professional humility	10	33
professional satisfaction	10	52
quality of life	4	6
readiness to face death	5	7
relationship	14	38
relief from burden of care	12	48
resolving conflict	8	18
respect	10	45
respondent previous work experience	14	40
respondent's years post MSW	13	16
responsiveness	9	18
self-care	4	7
setting expectations re SW roles	8	26
shared case	11	58
sharing information with each other	12	55
SPC adds complexity to patient care	10	24
SPC has specialised knowledge	7	21

SPC lacks necessary knowledge	6	15
SPC members' roles	10	40
SPC membership	12	21
SPC offers formal education	8	12
SPC services	11	60
SPC supports primary team SW	14	54
SPC SW role	14	151
specialist palliative care is a hard job	4	11
spiritual support for pt family	2	3
systematic barrier to care	8	35
teaching hospital	5	20
team case conference (rounding)	8	21
territorial	9	28
time	14	92
timing of SPC involvement	13	26
trust	11	34
truth telling	7	14
vacation and coverage	4	4
variability	5	11
who owns the case	14	94
wish list	12	53

Appendix K: Memos

Memo: Codes to combine

"SPC support SW role" and "Support SW" and "SPC supports clinician": are these the same? Should they be combined?

"SW work history" and "SW previous work experience": are these the same? Should they be combined?

"SW approach to care" and "SW philosophical drivers" and "SW motivation": are these the same, should they be combined?

Memo: Agenda

the word agenda seems to come up a lot - go back and code "agenda" 2/28/2015 done.

The focus should be on what the pt wants not on what you want or what the hospital wants, do not approach pt/fam with your own agenda, let them set the agenda. Don't be pushy.

SPC can sometimes be viewed as the hospital pushing and agenda on pts, especially just to move them out of the hospital faster (when SPC should be on the side of the pt).

Memo: collaboration

There are the more surface pieces of collaboration which include communication, negotiating roles, and willingness to be flexible, being aware of SPC involvement.

Underlying or facilitating the collaboration which occurs through communication and role negotiation are social work values from NASW code of ethics. Key pillars are respect for patient/family decision making even if the social worker does not agree with the decision, and that the SPC social worker be competent and skilled

Memo: respect

divide into yes and no categories?

Respect seemed to be fostered when the SPC social worker was perceived as available, responsive, competent, and operating out of a desire to do what is best for

the patient (over what they would choose for themselves, and over what is best of the institution).

Memo: Primary SW role

- advocate for SPC involvement
- communicate with SPC and other team members
- support patient and family with coping and adjustment to illness
- assess pt and family understanding of diagnosis, treatment options, and prognosis
- discuss resuscitation options
- identify community resources
- facilitate discharge
- understand insurance coverage
- be the voice of the pt
- educate pt/fam and other team members about palliative care and hospice
- be with pts/families when they are going through difficult things, getting difficult news
- comfort pts/families
- identify and correct misinformation that pt/fam might have, get the right person to come speak with them
- participate in family meeting to discuss goals of care or discharge
- damage control
- order medical equipment or ambulance
- referral to outpt palliative care services
- round with the interdisciplinary team to discuss pts

Memo: relief from burden of care

Related to time? Compare codes.

Floor/ICU/Ward social workers had responsibility for 20 to 50 patients a day.

Conversations about goals of care and end of life decision making were seen as time consuming and not always something that would fit well with their other responsibilities and time commitments. Having a separate social worker available to

participate in family meetings and lengthier discussion relieved them of that pressure and allowed them to meet the other requirements of their job. Caveat - goals of care discussions and providing grief support and assistance with coping were seen as desirable and sometimes social workers regretted not being able to provide these services as a result of SPC SW involvement.

Memo: Communication

Communication includes: face to face conversations, informing each other of consultation and important aspects of the case, reviewing electronic medical record, writing notes in the medical record, paging, calling, providing summary of what occurred during consultation if primary SW was not present.

- call, leave voice mail
- page back and forth
- talk to each other
- having all team members in the same room at the same time for face to face communication
- talking with pt/family and being willing to repeat conversations because they are not processing information well whilst dealing with difficult diagnosis/prognosis
- written information for pt/fam and for team members (medical record)
- sharing information you have gathered individually with the team or SPC SWer
- important to communicate family dynamics
- be proactive with communication, don't wait for the other person to call you, if you know something act on it
- lack of communication is when things break down and collaboration do not happen
- clearly communicate who is going to be primary SW on case and if you are going to continue to follow
- communicate summary of what occurred in family meeting to primary SWer
- communication has to be two-way

- when the SPC social worker was not involved in the case the primary SWer may not have been as up to speed on what occurred and was not clear who she was supposed to communicate with on the SPC team
- communicate the different roles each SWer will play to pt and family (and to team if needed)
- communicate the same message
- communicate that you (SPC) have received a consult
- face to face preferable form of communication but others okay too
- communication with outpt providers too, not just inpt team to ensure everyone is on the same page
- tell the truth but do it kindly and don't beat around the bush
- the more people involved the more attention needs to be paid to proactive communication
- need formal and informal opportunities for communication **** check out teamwork article by Nancarrow 2013 (saved in endnote), also look at articles referenced in interdisciplinary teamwork chapter for ONS. ****
- pattern of consistent communication
- minimise delays in response

Appendix L: Categorical Codes

Skills/Competencies/Abilities
Clinical skill/Skill set
Expertise
Specialised knowledge/No specialised knowledge
Assessment
Advocacy
Managing ambiguity, ambivalence, and conflicting goals
Boundaries
Comfort with end of life
Specialist palliative care SW hard job
SPC and SPC SW support primary team
Education
Spiritual support
Counseling
Family meeting

Patient Focused/Values/Integrity/Ethics
Patient centred
Patient autonomy
Patient empowerment
Truth telling
Badgering patient and family
Accountability
Motivation
Philosophy
Professional satisfaction
Work ethic/laziness
Ethics
Perception of patient and/or family
SPC involvement adds complexity
SPC referral as intervention
Balance
Generalists' approach to care
Readiness to face death
Appropriateness of referral to SPC
Personal experience with end of life/SPC/hospice
Agenda

Good Will/Positive Relationship/Benevolence/Positive Intent
Relief from burden of care
Availability
Respect
Collegial
Responsive
Supportive of generalist's role
Being on the same page
Impact on perception of primary team
Relationship
Impact on self-perception
Self-care
Interruption
How work impacts generalist

Information Sharing/Communication
Awareness of SPC/SW involvement
Communication
Information exchange
Giving feedback
Team case conference
Rounding
Wish list
Best practices
Phone call
Face-to-face
Challenges to collaboration

Role Negotiation/Flexibility
Flexibility in roles
Power differential
Organisational role differentiation
Setting expectations about role
Territorial
Time
Systematic barrier to care
Who owns the case
Duplication of services
Confusion of patient and/or family
Variability
Coverage
Professional humility/ego
Continuity of care
Coping of patient and/or family
Having perspective
Healthy detachment
Change in roles

Workflow
Advocating for SPC involvement
Interaction with SPC team
Interaction with SPC SW
Interaction with primary team
Shared case
Placing SPC referral
SPC SW role
Generalist SW role
Teaching hospital
SPC team roles
SPC services
Changes in care services over time
Timing of SPC referral/involvement
Case examples

Demographics
Frequency of contact with SPC
Frequency of end of life cases
Work history, current position
Training and education

Appendix M: Theoretical Modelling

Model version 1

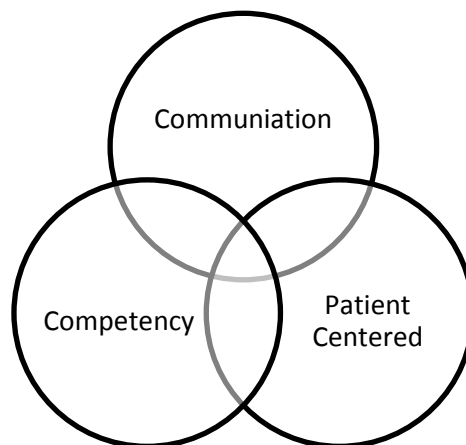
Collaboration is comprised of three main constructs: communication, competency, patient centered. The three “Cs” of collaboration?

Communication consists of formal and informal verbal contact, as well as what is written in the electronic medical record. Proximity/co-location? Role negotiation? Use communication to share information and to decide who does what. Quality and amount of communication? Timing?

Competency consists of having the necessary clinical skills to address patient and family needs: these mainly consist of assessment, advocacy, counselling, education, and knowledge of resources. More than just skills, is SPC SW capable to do job, able to do job? More nuanced than that... not just patient related skills, also team related skills – abilities.

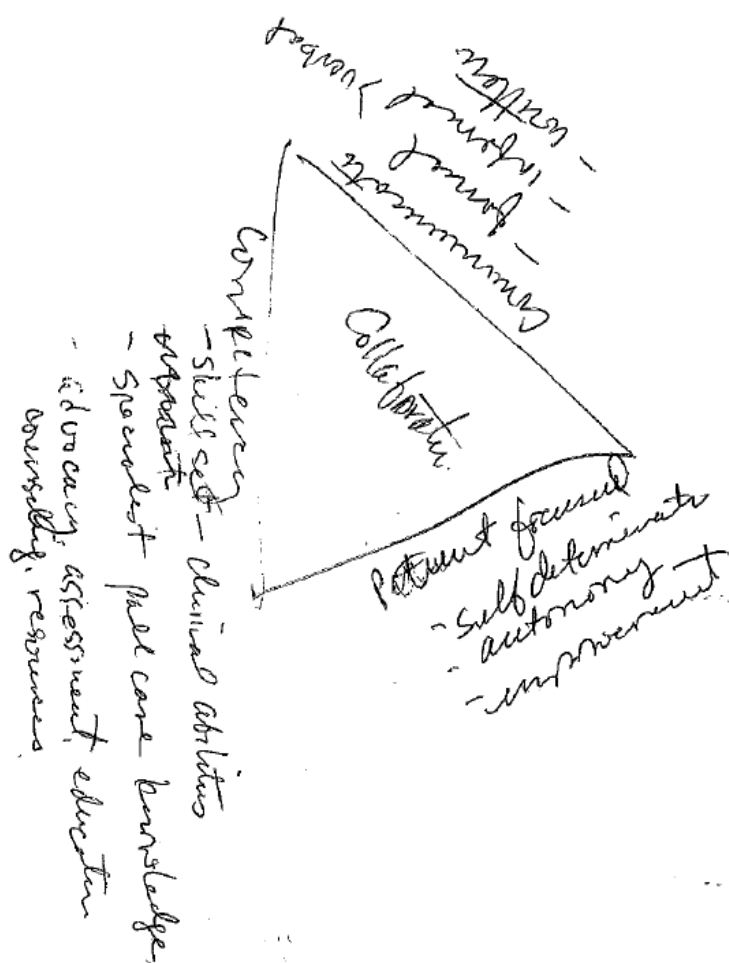
Patient Centered consists of supporting a patient's autonomy and right to self-determination, and empowering them to make their own decisions – using SW values. Is it more than patient centred? NASW core values – code of ethics. Maintain integrity of profession.

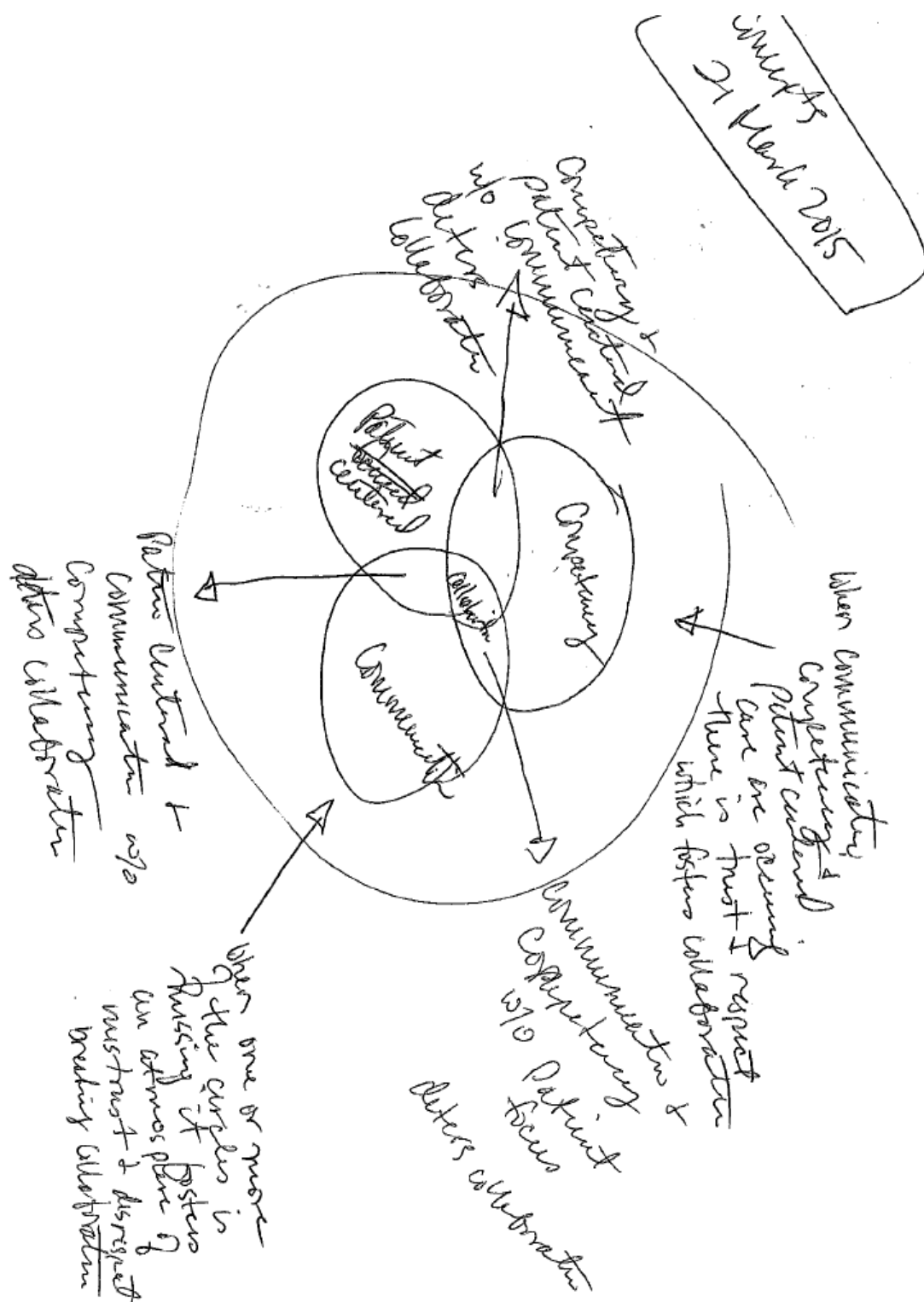
Visual of Concepts -

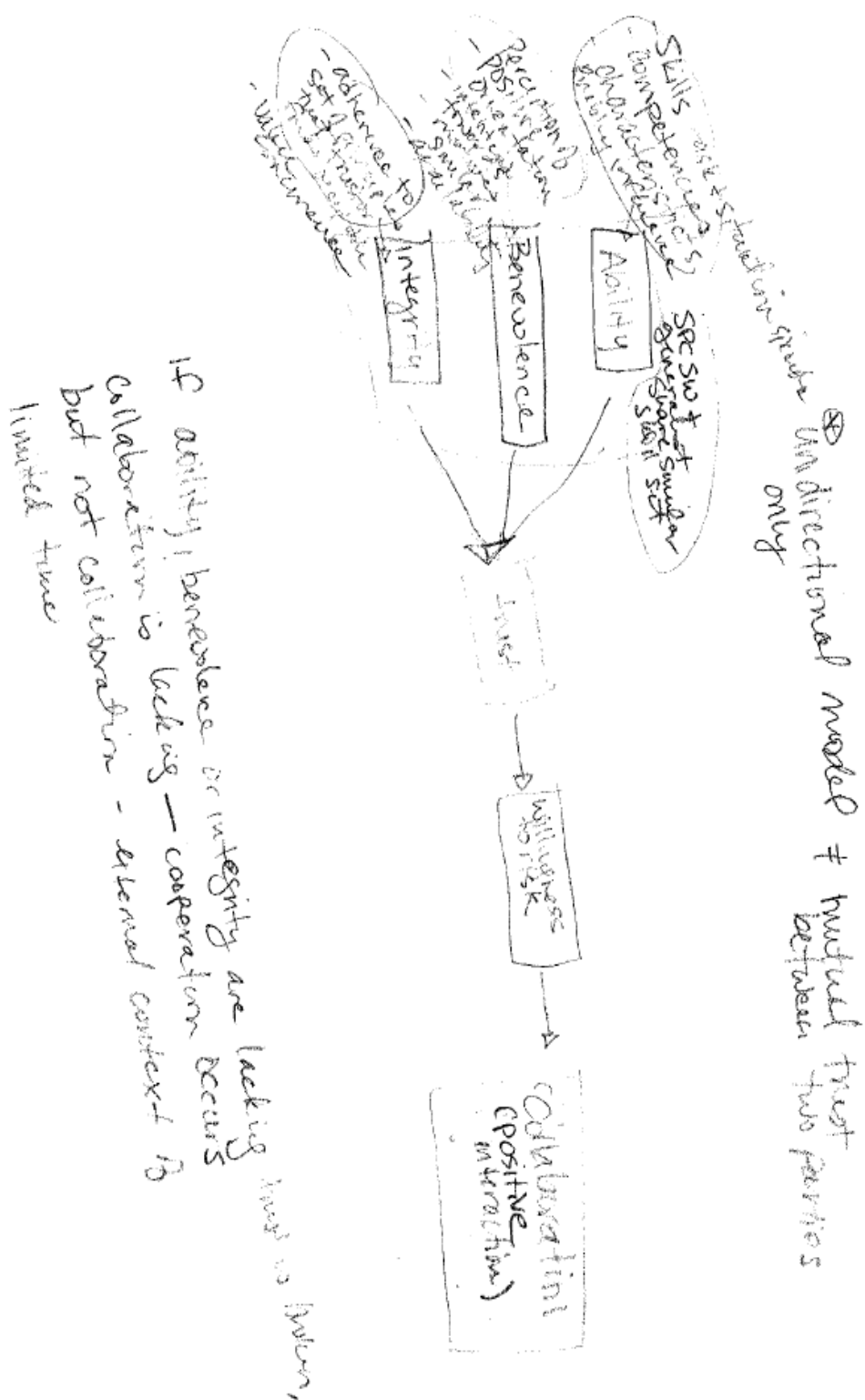


When all three are in place there is an atmosphere of trust and respect that fosters collaboration. How does trust fit? What about mutual respect and relationships? Order of the concepts? Importance of concepts? Does trust come first or do competencies come first? Trust in what – it's more than just skill – intentions? Intentions towards who – social worker? Patients? Best interests of both? What makes SW's willing to engage? Safety? Risks of collaboration?

Concepts
21 March 2015

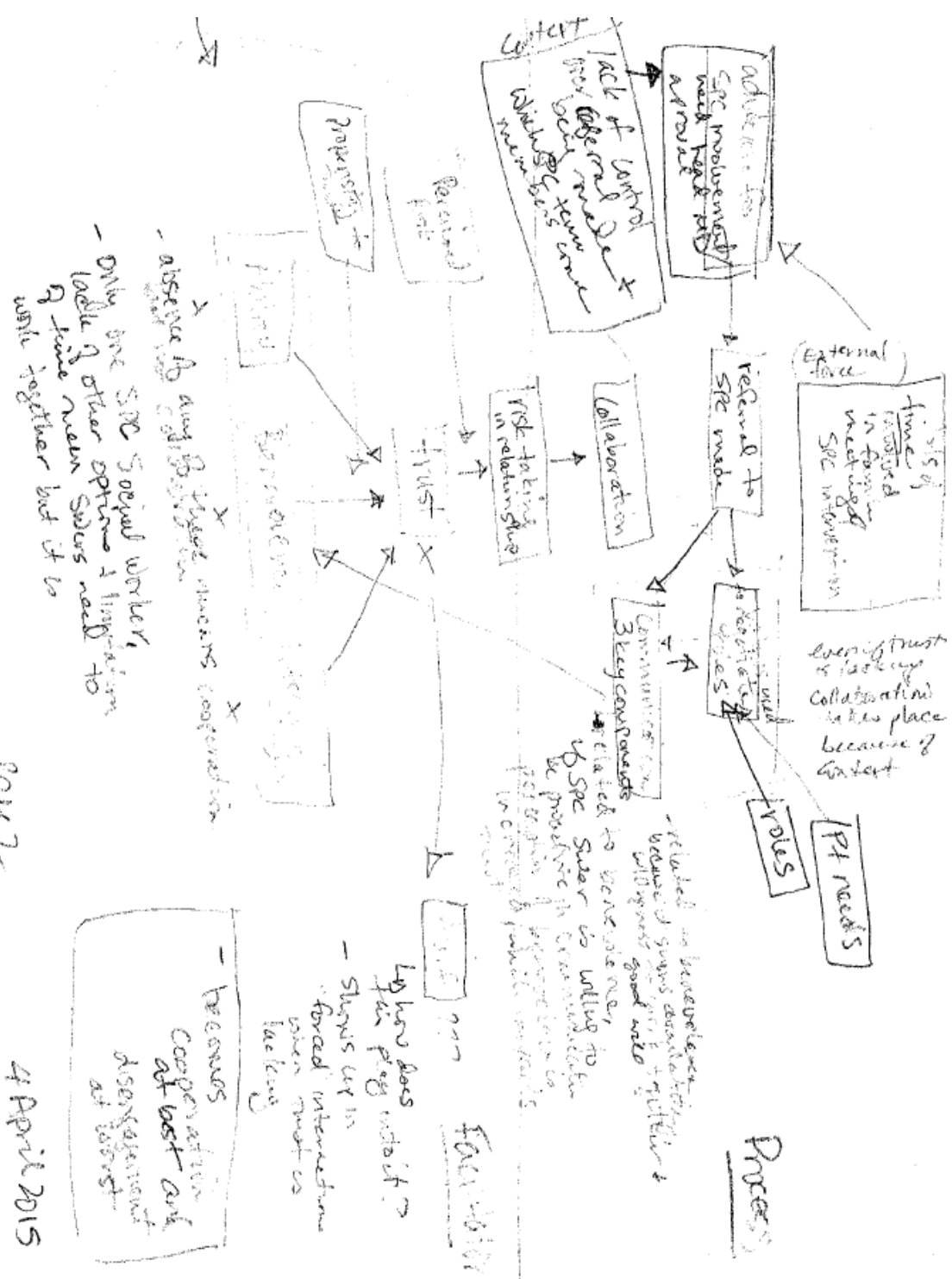






Page 1

4 April 2015



4 April 2015

trust \rightarrow collaboration

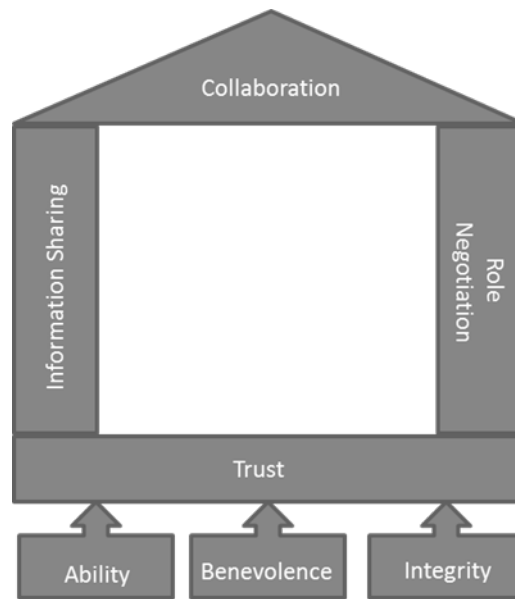
lack of trust \rightarrow cooperation only

- at best is social interaction
- at worst is uncoordinated interaction.

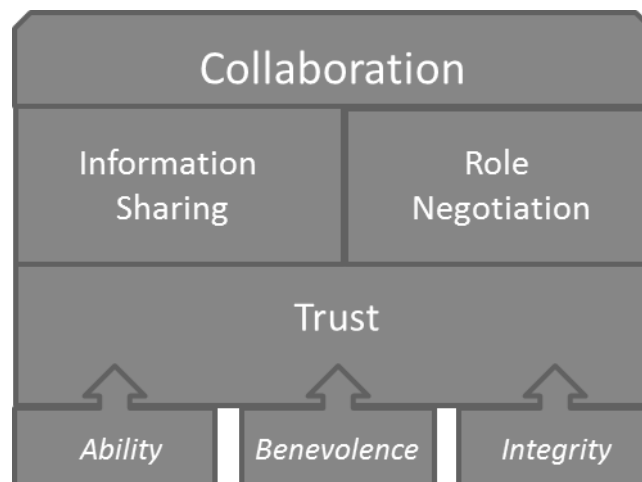
- ⑦ lack of trust could give lead to no cooperation either,
instead of a desire to cooperate + try to solve the problem
on their own. ~~But~~ ~~there are~~ ~~efforts~~ ~~to~~ ~~do~~ ~~both~~ ~~roles~~
less desire to adhere for SPE involvement

Page 3


Model version 5



Model version 6



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

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Abstract

Background: Hospital-based specialist palliative care services are common, yet existing evidence of inpatient generalist providers' perceptions of collaborating with hospital-based specialist palliative care teams has never been systematically assessed.

Aim: To assess the existing evidence of inpatient generalist palliative care providers' perceptions of what facilitates or hinders collaboration with hospital-based specialist palliative care teams.

Design: Narrative literature synthesis with systematically constructed search.

Data sources: PsycINFO, PubMed, Web of Science, Cumulative Index of Nursing and Allied Health Literature and ProQuest Social Services databases were searched up to December 2014. Individual journal, citation and reference searching were also conducted. Papers with the views of generalist inpatient professional caregivers who utilised hospital-based specialist palliative care team services were included in the narrative synthesis. Hawker's criteria were used to assess the quality of the included studies.

Results: Studies included ($n=23$) represented a variety of inpatient generalist palliative care professionals' experiences of collaborating with specialist palliative care. Effective collaboration is experienced by many generalist professionals. Five themes were identified as improving or decreasing effective collaboration: model of care (integrated vs linear), professional onus, expertise and trust, skill building versus deskilling and specialist palliative care operations. Collaboration is fostered when specialist palliative care teams practice proactive communication, role negotiation and shared problem-solving and recognise generalists' expertise.

Conclusion: Fuller integration of specialist palliative care services, timely sharing of information and mutual respect increase generalists' perceptions of effective collaboration. Further research is needed regarding the experiences of non-physician and non-nursing professionals as their views were either not included or not explicitly reported.

Keywords

Palliative care, integrated, interprofessional relations, attitude of health personnel, communication, referral and consultation

What is already known about this topic?

- Effective collaboration leads to better patient outcomes, improved patient satisfaction, reduced hospital length of stay, lower healthcare costs and decreased delays in care provision.
- Barriers to and facilitators of collaboration between generalist and specialist palliative care professionals have been identified in both the outpatient and community settings.

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What this paper adds?

- This review identifies barriers to and facilitators of collaboration between generalist and specialist palliative care professionals when integrating specialist palliative care services in the inpatient hospital setting.
- Hospital-based generalist palliative care professionals experience similar barriers to and facilitators of collaboration as their outpatient and community setting counterparts.
- Full integration of specialist palliative care services in the hospital setting remains limited.

Implications for practice, theory or policy

- Integration of hospital-based specialist palliative care services into patients' end-of-life care is increased when specialist palliative care teams communicate effectively, are open to role negotiation, are readily accessible and share problem-solving responsibilities with and recognise the expertise of generalist palliative care providers.
- The frequency of contact between generalists and specialist palliative care teams in the inpatient setting provides increased opportunities for collaboration, enhances the frequency of communication and aids in the development of mutual knowledge.
- The urgency of patient need in the hospital and the on-site location of the specialist palliative care team may increase the value generalists place on the responsiveness of the specialist team, making timely responses and frequent communication even more important.

Introduction

Integration of multiprofessional specialist palliative care teams into hospitalised patients' end-of-life care is becoming the norm.^{1–5} These types of specialist palliative care teams serve a supporting role to generalist teams who have primary ownership and responsibility for the patient. In the hospital setting, integrated specialist palliative care 'seeks to improve the quality of care for patients by ensuring that services are well coordinated around their needs' through effective professional collaboration.⁶ Effective professional collaboration achieves better patient outcomes, improves patient and provider satisfaction, reduces length of stay, lowers costs and contributes to fewer and shorter delays in the provision of care, as well as increases staff work efficiency and lowers staff stress.^{7–14} Professionals' perceptions of collaboration are strongly correlated with achieving these outcomes.^{15–18} Studies of providers' perceptions of collaboration in the broader healthcare arena show that the greatest impact on patient outcomes occurs when physicians, nurses and social workers are satisfied with their professional relationships with one another.¹⁵ In the palliative care literature to date, there has been no systematic assessment of the evidence regarding hospital-based generalists' perceptions of collaboration with integrated specialist palliative care teams.

This paper is the first to systematically review the evidence of generalists' experiences collaborating with specialist palliative care teams in the hospital. Previous systematic reviews looking at collaboration between generalist and specialist palliative care providers have focused on the community setting.^{19–22} The results from these earlier reviews may not apply to a hospital-based care setting. The inpatient hospital setting differs greatly from that of the community: the acuity of patients is higher, immediacy

of patient needs and response time from providers is more pressing and providers episodically care for patients rather than follow patients for the entirety of their disease process. Specialist palliative care professionals have proposed several strategies for effective collaboration with generalist providers in the hospital related to communication, being accessible and responsive, and respecting the authority of the referring providers.^{23,24} Evidence about generalists' perceptions of these efforts towards collaboration has been highlighted in the literature but not systematically assessed. A systematic review of the literature will provide a greater understanding of generalists' perceptions of collaborating with specialist palliative care teams and the conditions under which collaboration is facilitated or hindered.

Methods**Aim**

To identify and assess the current evidence to determine what is known about hospital-based generalist providers' perceptions of what facilitates or hinders collaboration with inpatient multiprofessional specialist palliative care teams.

Review design

The review follows the Guidance for Narrative Synthesis.²⁵ Narrative synthesis is a rigorous review approach which facilitates synthesis of heterogeneous studies. The existing evidence on integrated hospital-based palliative care is diverse, and thus an approach that facilitates the synthesis

Table 1. Key terms.

-
- An *acute care hospital* is a 'short-term hospital where medical staff and all necessary personnel provide diagnosis, care and treatment of a wide range of acute conditions'.²⁷ Patients admitted to an acute care hospital are considered 'inpatient' when they spend at least one night in the hospital.²⁸
 - *Hospital-based specialist palliative care teams* do not assume full responsibility for or take over the care of the patient, rather they liaise with the ward team to provide care to patients by meeting with the patient and making recommendations based on patient needs and goals which the ward team then operationalises.
 - *Professional collaboration* in health care can be defined as health- and social care providers (physicians, nurses, social workers, etc.) taking on complementary roles to cooperatively work together through sharing problem-solving responsibilities and making decisions to formulate and carry out plans for patient care.^{29,30}
 - *Multiprofessional teams* are defined as a group of professionals from a variety of health and social care disciplines, that is, specialised nurses and a specialist physician in palliative care, psychologist, physiotherapist and/or spiritual counsellor and social worker, who collaborate to provide patient care.³¹
-

Table 2. Terms used in search strategy.

-
- 1) Identification of palliative care
Terminally ill patients OR Palliative care OR Terminal care OR Hospice OR End of life OR Death OR Dying
 - 2) Professional personnel
Social work OR Doctor OR Physician OR Nurse OR Medical staff OR Medical personnel OR Team OR Patient care team OR Health team OR Consultants OR Hospital medical staff OR Hospital nursing staff OR Allied health personnel OR Specialist palliative care OR Generalist palliative care OR Multidisciplinary OR Interdisciplinary OR Interprofessional
 - 3) Attitude
Attitude OR Perception OR Attitude of health personnel OR Experience OR View
 - 4) Action
Professional consultation OR Interdisciplinary treatment approach OR Communication OR Collaboration OR Decision making OR Cooperation OR Cooperative behaviour OR Interdisciplinary communication OR Interprofessional relations OR Joint practice OR Referral and consultation OR Shared care
 - 5) Location
Inpatient OR Hospitalized patients OR Acute care OR Hospital-based
-

of heterogeneous literature is needed. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA)²⁶ guidelines are followed in the reporting of the review. The definitions of terms used in the review are listed in Table 1.

Search process

Database searches

The databases of PsycINFO, PubMed, Web of Science, Cumulative Index of Nursing and Allied Health Literature (CINAHL) and ProQuest Social Services Abstracts were searched for articles published from 1 January 1990 to 31 December 2014. Data about integrated palliative care produced before 1990 are scarce and may no longer be relevant as the palliative medicine field has evolved, and therefore were not included. The major palliative care journals were also hand searched: *The American Journal of Hospice and Palliative Medicine*, *European Journal of*

Palliative Care, *Journal of Hospice and Palliative Nursing*, *Journal of Pain and Symptom Management*, *BMC Palliative Care*, *Palliative Medicine*, *Journal of Palliative Medicine* and *Journal of Social Work in End-of-Life and Palliative Care*.³² Finally, citation tracking was completed using Web of Science and the included studies' reference lists were reviewed for relevant articles. The searches were conducted in April/May 2014 and updated in December 2014.

Database search terms

For those databases that use medical subject headings (MeSH) or a thesaurus, these were employed to initiate the search. Included search terms and the Boolean operators used are listed in Table 2. Where the same terms did not exist, the closest substitutive terms were chosen to maintain as much consistency as possible throughout the search process. The search strategies for each database can be found in Appendix 1.

Selection criteria

Inclusion criteria

- English language research studies reporting empirical data published in peer-reviewed journals.
- Studies describing the interaction, perceptions, attitudes and experiences of hospital-based generalist care providers with at least one member of the hospital specialist palliative care team when simultaneously caring for a patient, even if the topic is only a minor focus of the study.
- Studies describing generalists' perceptions of the factors that facilitate or are barriers to collaboration with the hospital-based specialist palliative care team.
- Studies focusing on generalists and specialists providing care to adult patients within the acute hospital setting.
- Studies with a quality score of 20 or above on the scoring tool created by Hawker et al.³³

Exclusion criteria

- Grey literature, newspaper articles, editorials, non-peer-reviewed articles, theoretical papers and publications consisting of subject matter expert opinions.
- Studies with paediatric palliative care providers or occurring in paediatric hospitals, taking place in the outpatient ambulatory care, community-based palliative care or free-standing hospice settings, and studies of obstetrics and maternity wards.
- Studies exploring *intra*-team interactions between specialist palliative care team members, or the interactions between specialist palliative care providers and patients and carers, or interactions between generalist palliative care providers and patients and carers or describing only generalist palliative care.

Data extraction and analysis

The search strategy was designed by J.F., C.W. and N.P. Papers were identified and assessed by J.F., and decisions regarding inclusion of papers were discussed with and reviewed by C.W. and N.P. The narrative synthesis guidelines recommended by Popay et al.,²⁵ that is (1) preliminary analysis, (2) exploration of relationships and (3) assessment of the robustness of the synthesis, were carried out by J.F. and reviewed by C.W. and N.P. Preliminary synthesis entailed extracting the descriptive characteristics of the studies in a table and generating a textual summary of the results. Thematic analysis was then used to extract the main themes. Data from the studies were extracted into a table and thematically analysed by J.F. and discussed with C.W. and N.P. The five themes

developed in the results section represent the main areas of knowledge available about collaboration between hospital-based generalist and specialist palliative care providers. Identification of themes was arrived at after deliberation and discussion between J.F., C.W. and N.P. The review was written by J.F., with guidance and editing provided by C.W. and N.P.

Results

A total of 23 articles met the inclusion criteria and were included in the synthesis (Figure 1: PRISMA flow diagram).

Assessment of quality

Hawker et al.'s scale was used to assess the quality of the 23 studies.³³ The scale was created to assess heterogeneous studies.³³ Previous palliative care-related systematic literature reviews have utilised the scale.^{21,22,33,34} The overall score for each study can be as low as 9 to as high as 36. Scores of the 23 identified studies ranged from 25 to 36, with a median score of 31. All the studies were included in the synthesis as they met the inclusion criteria of a score of 20 or higher.

Overview of studies

The publication dates of the studies ranged from 2001 to 2014 and were heterogeneous, with 12 being qualitative,^{35–46} six quantitative^{47–52} and five mixed methods.^{53–56} Of the 23 studies, 10 were from the United Kingdom,^{35–38,41,44,47,50,51,54} 5 from the United States,^{39,40,43,52,55} and 3 from Australia.^{42,46,56} New Zealand,⁵³ France⁴⁸ and Japan⁵⁷ all had one study each. There were two multi-country studies, one which included respondents from Australia, United States, Asia, Africa and Europe;⁴⁹ the specific Asian African, and European countries were not identified, and one which included respondents from both England and New Zealand.⁴⁵ Study hospitals ranged in type from small secondary care centres to large tertiary teaching hospitals. One specialist cancer centre⁴¹ and one acute stroke centre⁴⁴ were also included. The smallest hospital had 240 beds⁵² and the largest had 1300 beds.³⁷ Hospitals were located in urban, inner city and rural settings. Specialist palliative care team membership varied considerably (Table 3). Half of the studies did not identify the professional membership of the specialist palliative care team. Study specialist palliative care teams had been active for as little as 1 year⁴⁰ to as much as 11 years.^{41,57} The referral models ranged from hospitals where any member of the ward team could make a referral to specialist palliative care,⁵³ to hospitals where referrals could only be made with the approval of the attending (head) physician.⁵⁵ No consistency existed in the titles or terms used to refer to the hospital-based specialist palliative care teams.

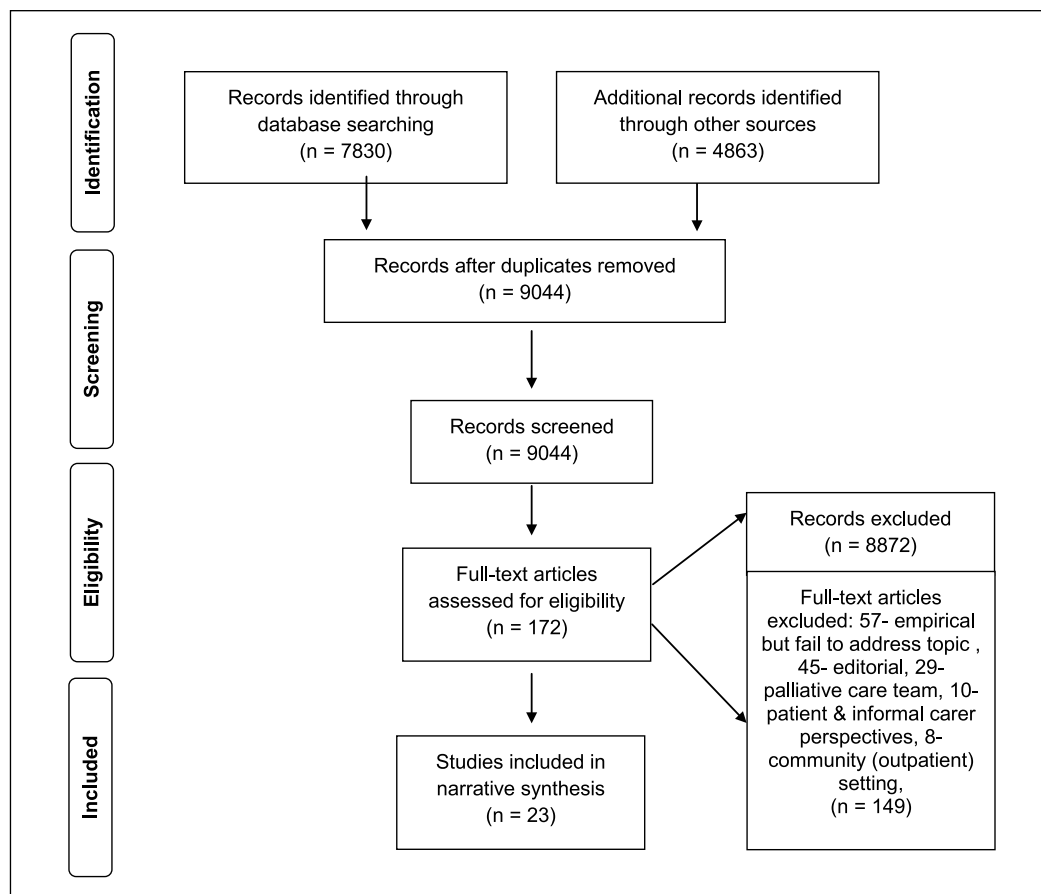


Figure 1. PRISMA flow diagram study selection.

Themes

Analysis produced the following five themes: model of care (integrated vs linear), professional onus, expertise and trust, skill-building versus deskilling and specialist palliative care operations. Each study contributed to different number of themes, with some studies having multiple themes and some only two or three (Table 3). The five themes are discussed below.

Model of care: integrated versus linear

Two models of care emerged from the literature review: an 'integrated' model and a 'linear' model. While formal definitions of integrated and linear care exist, the descriptions of each model used here have risen from the studies themselves and are not formal definitions. Here, 'integrated care' is concurrent care between generalist and specialist palliative care providers. It consists of a multiprofessional approach to patient care, combining various health and social care specialties, services and professionals to meet the need of the patient at different points in time throughout the course of an illness. Studies reporting a more integrated approach to care noted higher utilisation of multiprofessional specialist

palliative care services, viewed palliative care as applicable throughout the disease process and deemed it appropriate for use in a variety of life-limiting illnesses (i.e. not just cancer).^{38,40–43,47,48,53,56} 'Linear care' here views transitions to different specialties as a passing of the 'care baton'. In linear care, one type of care ends before another begins. An integrated care approach was preferred and implemented in 12 studies.^{37–41,46,47,49,51,54–56} Four studies consisting of cardiology^{36,47} and neurology^{44,50} professionals found these providers preferred and took a more linear approach to palliative care involvement. Of the seven remaining studies, three did not provide enough information to determine model of care,^{35,38,57} three reported that integrated care is desired but not actualised into patient care^{42,46,51} and one reported a mixed response about which model of care was preferred.⁴⁵

Of those studies which reported generalist providers as viewing an integrated care model positively, integrated care was seen as a means to address patient and family needs while still fulfilling the professional's obligation to remain involved in the patient's care.^{40–43,47,49,55,56} Integrated care model providers preferred an 'unequal' partnership with specialist palliative care, one where the referring team claims the leadership role, and the specialist palliative care team answers to the leader. In the majority

Table 3. Data extraction and study quality.

Author (year), country, score	Research question	Participants	Method	Palliative care team	Themes	Key findings
Dharmasena and Forbes (2001), ⁴⁷ Wales, 25	Will doctors refer non-cancer patients to palliative care?	78 Consultants	Postal survey, 8 items. Analysis not described.	Not described.	Model of care; professional onus; expertise and trust; skill building versus deskilling	Integrated care preferred. Cardiology concerned palliative care may not have the disease-specific expertise needed. All doctors should be skilled in palliative care. Concern for deskilling and patient abandonment.
Salomon et al. (2001), ⁴⁸ France, 30	To describe the current management of terminally ill patients from care providers' viewpoint.	31 Physicians 16 nurses	Structured self-administered 33 item survey. SPSS used for analysis.	Physician, nurse, psychologist.	Model of care; skill building versus deskilling; specialist palliative care operations	Integrated care provided for skill-building opportunities. Ward team desired expertise of specialist palliative care. Availability of specialist palliative care important.
Carter et al. (2002), ⁵³ New Zealand, 29	To determine health professionals' perception of the service's impact on patients, families and staff and areas that need improvement.	127 Doctors 242 nurses 11 social workers	Postal survey, 5 point Likert scale and Yes/No questions. EPI6 used for analysis.	Full-time nurse, part-time physician.	Model of care; skill building versus deskilling; specialist palliative care operations	Integrated care desired. Skill-building, communication, availability of services and ease of access important aspects of involving specialist palliative care.
Dowell (2002), ⁵⁴ England, 27	To establish a baseline of palliative care knowledge, attitudes and practices of multidisciplinary hospital staff.	Focus group: 2 nurses, 1 doctor, 1 pharmacist, 3 chaplains, 1 social worker, 1 OT, 1 PT Questionnaire 30 people.	Focus groups, 16 item survey. Analysis not described.	Not described.	Model of care; professional onus; expertise and trust; skill building versus deskilling; specialist palliative care operations	Integrated care desired by some but experienced as challenging by others. Role differentiation unclear. Ward and specialist palliative care team expertise sometimes at odds or of concern. Trust impacted by lack of inclusion of or communication with ward team in planning for patient care.
Jack et al. (2002), ³⁵ England, 29	To explore generalists' perception of deskilling.	19 Nurses, managers and ward staff, 4 consultants, 4 doctors, 4 CNS SPC.	Open-ended interviews. Analysed using case/cross-case analysis.	4 CNSs, a consultant and specialist registrar.	Professional onus; expertise and trust	Concern for deskilling. Junior staff less concerned than senior staff. Desire from ward team to maintain generalist palliative care skills.
Cherny et al. (2003), ⁴⁹ Europe, USA, Asia, Australia, Africa, 35	To describe oncologists involvement and attitudes toward palliative care of patients with advanced cancer.	895 Physicians	Postal survey. Multivariate analysis.	Not described.	Model of care; professional onus; expertise versus trust	Integrated care highly valued and sought by most. Want to share responsibility of care. Role conflict and confusion about who is best at managing oncology patients' palliative care needs. Issues of expertise and trust, unsure palliative care can manage their patients.

Table 3. (Continued)

Author (year), country, score	Research question	Participants	Method	Palliative care team	Themes	Key findings
Hibbert et al. (2003), ³⁶ England, 30	Explore doctors' views of developing palliative care for patients with heart failure.	7 Focus groups of physicians	Open-ended interviews. Thematic analysis.	Not described.	Model of care; professional onus; expertise and trust; skill building versus deskillling; specialist palliative care operations	Linear care more the norm. Referral to palliative care means failure for cardiologist. Two-way learning process between palliative medicine and other specialties is positive experience. Concern that cardiology will not address palliative needs, trust and expertise are issues.
Jack et al. (2003), ³⁷ England, 32	Explore the impact of hospital-based palliative care clinical nurse specialists on doctors and nurses.	23 Nurses 8 physicians	Open-ended interviews. Case/cross-case analysis.	4 Clinical nurse specialists, consultant and registrar available for advice via phone.	Model of care; professional onus; expertise and trust; skill building versus deskillling	Integrated care seen as a positive. Skill-building and deskillling concerns voiced by staff. Appreciation of palliative care expertise cited.
Mytton and Adams (2003), ³⁸ England, 35	Examine how specialist and generalist nurses work together in the care of terminally ill patients.	8 Generalist nurses 2 nurses from SPC	Open-ended interviews, case vignette. Thematic analysis.	5 Clinical nurse specialists.	Model of care; professional onus; expertise and trust; skill building versus deskillling; specialist palliative care operations	Integrated care helpful, however, concern for abdication of responsibility, deskillling and role confusion led to more linear approach to care. Appreciation for specialist expertise.
Rodriguez et al. (2007), ³⁹ USA, 36	Explore how physicians and other healthcare providers in acute care hospital perceive and utilise palliative care services.	129 Participants: administrators and ward staff	Semi-structured interviews, ethnographic observation. Thematic analysis.	Not described.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Linear care preferred. Role confusion and view that involves palliative care means failure and abandonment. Generalists view symptom management as their responsibility. More referrals to specialist care made when specialists were seen as being experts and respecting referring teams' expertise and role.
Turner-Stokes et al. (2007), ⁵⁰ UK, 28	To explore the interaction between SPC, neurology and rehabilitation services.	82 Neurologist, 149 SPC, 53 rehab physicians	Postal survey. Analysed w/ SPSS, chi-squared stats, expected frequency > 5.	Not described.	Model of care; professional onus; expertise and trust; specialist palliative care operations.	Linear care common. Role confusion, belief that it is generalist's responsibility to manage symptoms. Easy access and appreciation of skill needed for specialist palliative care enabled referrals.

(Continued)

Table 3. (Continued)

Author (year), country, score	Research question	Participants	Method	Palliative care team	Themes	Key findings
Enguidanos et al. (2009), ⁴⁰ USA, 34	To explore physician and nurse perceptions of an inpatient palliative care team consultation service after 1 year of operation	33 Participants 16 physician, 17 nursing	Focus groups. Analysed using grounded theory.	2 Quarter time physicians, one nurse and one social worker.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Integration seen as valuable. Responsiveness of specialist team increased utilisation. Expertise desired, collaboration enhanced through good communication. Trust increased by collaboration, inclusion and skill-building, decreased by exclusion.
Ewing et al. (2009), ⁴¹ England, 33	Referrers and providers' views of multidisciplinary SPC in the acute hospital setting.	5 Junior doctors, 13 consultants, 6 clinical nurse specialists	In-person interviews, observation. Analysed thematically using framework analysis.	2 Consultants, associate specialist in palliative medicine, 2 specialist registrars, 5 CNS, 2 staff.	Model of care; professional onus; expertise and trust; skill building versus deskillling; specialist palliative care operations	Integrated care desired. Oncologists view their role as first line for symptom management; collaborate with specialist services if unable to control symptoms themselves. Want to maintain ownership of and relationship with patient. Some concern for deskillling. Ease of access important.
Snow et al. (2009), ⁵⁵ USA, 32	To better understand the utilisation of palliative care consultative services and to identify specific factors that might influence physicians' referral practice.	74 Physicians, 50 who had referred to SPC, 24 who had not referred	Interviews and 11-item, Likert scale survey, univariate statistics, interviews. Analysed using a standard method.	Physician, nurse practitioner, social worker.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Integrated care viewed positively. Majority want to maintain relationship and role with patient. Some want to turn over care to specialists at end of life. Specialists seen as experts for advanced disease symptom management.
Ward et al. (2009), ⁵⁶ Australia, 33	To investigate the attitudes of oncologists and trainees toward SPC and collaboration with SPC services.	115 Total, 78 oncologists, 37 trainees	Web survey, Likert and open-ended questions, descriptive statistics. Thematic analysis.	Not described.	Model of care; expertise and trust; skill building versus deskillling; specialist palliative care operations	Frequent integration of specialist services, although frequency could increase. Some role confusion. Good communication helps to mitigate role confusion. Desire for even more integration. Greater disease-specific expertise desired for specialists.

Table 3. (Continued)

Author (year), country, score	Research question	Participants	Method	Palliative care team	Themes	Key findings
Le and Watt (2010), ⁴² Australia, 31	To assess the care provided to patients dying within the hospital and understand senior clinicians decision-making around referral to SPC.	27 Clinicians: 10 nurses, 11 physicians, 2 social workers, 2 pastoral care, 1 speech pathologist, 1 OT 68 Nurses	Retrospective chart review, semi-structured interviews. Thematic analysis.	Not described.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Integrated care viewed as valuable but not accessed as frequently as it could be. Timing of involvement unclear. Expertise of specialists appreciated. Some role confusion can occur, desire to retain involvement in patient's care, maintain skills.
Sasahara et al. (2010), ⁵⁷ Japan, 31	To clarify the activities, patient outcome and referring staff's view of an established SPC Consultation Team in Japan.		Survey, Likert scale, Yes/No and open-ended questions, descriptive statistics. Thematic analysis.	Physician, certified nurse specialists and psychiatrist.	Expertise and trust; skill building versus deskilling; specialist palliative care operations	Expertise, inclusion of ward staff and responsiveness of specialists facilitate integration.
Norton et al. (2011), ⁴³ USA, 31	To describe the multiple perspectives of administrators and clinicians about the tensions between an SPC and the larger hospital setting.	79 Participants total, 21 hospital leadership, 33 clinicians who used SPC and 25 from SPC team	Ethnographic study, in-depth interviews and 'cultural artefacts'. Analysis not described.	Physicians, nurse practitioners, social worker, chaplain, psychologist, ethicist, massage therapist, bereave. coordinator and a harpist.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Mix of integrated and linear care. Greater utilisation of specialist services led to even higher rates of integration. Desire for mutual respect of expertise. Easy access to specialist services facilitated integration. Concerns about role confusion and meaning of referral on professional identify cited as barriers to integrating care.
Burton and Payne (2012), ⁴⁴ England, 32	To produce explanatory practice model to help clinicians meet the palliative and end-of-life care needs of patients and families through the integration of palliative care within acute stroke services.	29 Total: 1 psychologist, 1 physician, 1 healthcare assist, 2 OT, 2 PT, 5 specialist stroke nurses, 1 speech language pathology, 7 stroke unit nursing, 1 family advocacy, 8 not identified	Semi-structured interviews. Thematic analysis.	Not described.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Linear care common. Involvement of specialist services seen as failure. Involvement of specialist occurring only when ward team has done all they can think of to treat. Concern specialists do not have enough expertise to manage stroke patients.

(Continued)

Table 3. (Continued)

Author (year), country, score	Research question	Participants	Method	Palliative care team	Themes	Key findings
Gott et al. (2012), ⁴⁵ England and New Zealand, 33	To explore understandings of, and perceived roles in relation to, palliative care provision among generalist and specialist health providers in England and New Zealand.	England – 58, 5 of who worked in acute hospital NZ – 80, 10 of who worked in acute hospital. Mix of professions.	Focus groups. Analysed with grounded theory.	Not described.	Model of care; professional onus; expertise and trust; skill building versus deskillling; specialist palliative care operations	Linear care. Integration hampered by role confusion. Specialisation of services seen as fragmenting care and taking responsibility and skills from generalists. All generalists should be able to provide palliative care.
Johnson et al. (2012), ⁵¹ England, 28	To survey Heart Failure Nurse Specialists about their attitudes regarding general PC provision for HF and access to SPC.	152 Nurses in 2005 174 nurses in 2010	Web-based and paper surveys. Analysis not discussed.	Not described.	Model of care; expertise and trust; specialist palliative care operations	Integrated care valued but not actualised. Ease of access important for facilitating integration. Concern that specialists might lack expertise to manage heart failure.
Armstrong et al. (2013), ⁵² USA, 29	To measure the impact of SPC consultation on clinical, customer, operational and financial domains.	18/19 Participants responded. Physicians and other providers.	Survey, 9-item Likert scale. Descriptive statistics.	Not described.	Model of care; specialist palliative care operations	Integration is desired and positive experience. Communication and ease of access make integration possible.
(Lane et al., 2014), ⁴⁶ Australia, 30	To explore healthcare professionals' views and experiences of interdisciplinary interactions when caring for patients with advanced cancer who present to the emergency room.	83 Professionals in focus groups, 11 one-on-one interviews.	Focus groups, semi-structured phone interviews. Analysed using thematic analysis.	Not described.	Model of care; professional onus; expertise and trust; specialist palliative care operations	Integrated care desired but not actualised. Communication and access would improve integration. Lack of trust in other's expertise a barrier to integration.

SPC: specialist palliative care; PC: palliative care; OT: occupational therapist; PT: physiotherapist; CNS: clinical nurse specialist; HF: heart failure.

of studies, integrated care model providers maintain the right to their autonomy in medical decision-making.^{40–43,47,49,55,56} These findings were consistent across the studies regardless of provider type (nursing, physician, etc.), country and hospital size.

Three studies reported that several providers preferred a linear model where they are able to ‘hand over’ their patients’ care to specialist palliative care teams after they had delivered all the interventions at their disposal.^{36,44,50} The ‘linear model’ was more often associated with providers whose skills and options for patient care included a broad range of interventions; those that were most frequently mentioned were cardiology, neurology, oncology, general surgery and vascular surgery.^{36,39,44,46,49–51} In the studies, these providers were more likely to express that their area of responsibility was being invaded when specialist palliative care became involved earlier in the illness trajectory.^{38,39,41,43,45,54,55}

The oncology-related studies spanned a variety of settings and countries, while those studies reporting responses from cardiology, neurology, general surgery and vascular surgery were conducted in the United Kingdom, United States and Australia only and included only one specialist centre (stroke). Findings related to generalist Oncology views may be more broadly applicable as a result. Additionally, while there are bound to be variations among groups of providers, of the five groups listed above oncology was found to be the most polarised in their preferences for integrated versus linear care, half favouring linear and the other half favouring integrated care.^{36,39,41,44,46,49,50,56} Oncology results were persistently polarised across countries, regardless of specialist palliative care team membership or hospital setting (i.e. specialist cancer centre vs secondary hospital).

Professional onus

Professional onus denotes the provider’s professional responsibility towards the patient and the duration of that responsibility. Studies reported a range of results between studies as a whole and within individual studies. Several studies found that some generalist providers were concerned that involvement of the specialist palliative care team was an abdication of responsibility or a sign that they have either ‘given up on’ or ‘failed’ the patient.^{34,35,39,40,42–45,48,49,51,53} A number of studies also reported the opposite finding, with many generalist providers viewing specialist palliative care involvement as an extension of their responsibility and a way to increase the care given to the patient.^{36,38,39,41,42,44,45,47,49,50,55,56} In studies where specialist palliative care involvement was perceived as an extension of their role, providers struggled less with the timing of the referral, involving specialist palliative care earlier in the disease course.^{40–42,48,49,52,53,55} Providers who perceived specialist palliative care involvement as the end of their role in patients’ care had more

difficulty determining when to involve specialist palliative care, sometimes waiting until days to hours before death.^{36,39,42,44,45,47,49,54,55}

Also included in professional onus are the concepts of ‘abdication of responsibility’ and ‘professional laziness’. With the integration of specialist palliative care, studies indicated that generalist providers were concerned with becoming ‘disinclined’ to provide the patient with care which would normally be within their purview.^{37,45,54} Generalists worried that providers would ‘take a back seat’ to specialist palliative care teams, remaining on paper the patient’s provider but in reality being absent.^{38,45} Furthermore, there was a strong sense that every generalist provider should know and be competent providing ‘basic’ palliative care services to all their patients.^{36–39,41–45,47,49–51,54} These findings were consistent regardless of country, hospital size, specialist palliative care team membership or study design. Overall, while generalists were reported to have concerns for abdication of responsibility, these fears were not realised. Generalist providers were able to maintain their role and responsibilities towards their patients if they desired to do so.

Expertise and trust

The themes of expertise and trust appeared in many of the studies.^{35,36,38–41,43–47,49–51,54–56} Expertise and trust were often coupled together, at times used interchangeably, making it difficult to definitively distinguish and report each as separate themes. While formal definitions exist, the meanings of expertise and trust used here are derived from the studies themselves. Definitions here are limited by the conflation of terms within the original studies. Trust relates to the referring team’s ability to rely on the specialist palliative care team to act as desired. Desired behaviours consist of respecting the hierarchy of decision-making, particularly as it relates to treatment planning, recommended clinical direction and goals of care, as well as communicating frequently with the all the ward staff involved in the patient’s care.^{38–40,42–44,50,52,53,56} Expertise refers to the specialist palliative care team having a strong working understanding of specific disease trajectories and available active treatment options for each disease process in order to counsel patients about choices for continuing care.^{36,50,51,55,56} Expertise also consists of having the necessary medical, psychosocial and spiritual skills to adequately address the needs of the patient.^{36,38–40,52–54,56} Irrespective of hospital size, disease type, country and specialist palliative care team membership, trust was increased when the specialist palliative care team was able to consistently demonstrate their expertise and referring teams became convinced of their capabilities.

Many studies reported referrers as having a high level of respect for the specialist palliative care skillset, viewing the services specialist palliative care provided as

requiring extra training and experience to execute.^{37–39,41,42,49} Generalists' perceptions of the level of skill involved in specialist care services directly impacted their willingness to refer and the types of issues they requested be addressed.^{36–39,53} In particular, cardiology, neurology, physical rehabilitation and oncology providers' perceptions of specialist palliative care's disease-specific expertise, or lack thereof, impacted how much they trusted specialist palliative care and directly impacted the teams' willingness to integrate care.^{36,39,43,44,46,47,49–51} This view made it particularly difficult for these providers to trust specialist palliative care's ability to adequately discuss goals of care or make appropriate treatment-related recommendations.^{44,47,49–51,58} Conversely, several studies reported generalists' perception that specialist palliative care was at times dismissive of the ward team's expertise and role in patients' care, as exhibited by failing to include them in the plan of care, discuss recommendations or update them on what was discussed during family meetings.^{35,38,40,53,54,57} Areas where generalist teams were able to acknowledge their own discomfort and lack of expertise mirrored the areas for which they were more likely to integrate specialist palliative care services unrelated to country, disease type, hospital size or specialist palliative care team membership. Trust and utilisation were fostered when both the referring team and the specialist palliative care team were able to express mutual respect and appreciation for each other's roles, expertise and contributions to patient care outcomes, and when communication was high.^{40,41,43,53,54,56,57}

Skill-building versus deskilling

The attention to skill-building versus deskilling was shared by all provider types (nurse, physician, social worker, administrators, etc.), persisted regardless of specialist palliative care team membership, country or hospital size. Skill-building was viewed as desirable by the generalist ward staff and was identified in the studies as being one of the positive products of integrated specialist palliative care.^{35–38,48,54,56,57} Skill-building was especially important for ward team members without formal training in palliative care.^{35,37,48} Studies reported that ward staff found integrated specialist palliative care contributed to their education, with skill-building occurring chiefly through observation of the specialist palliative care team during a consultation.^{35,37,38,48,53,54} Learning and the acquisition of skills by ward staff were demonstrated by an increased understanding of the role of the specialist palliative care team, more appropriate referrals to specialist palliative care and ward staff's increased capacity to provide generalist palliative care services.^{53,54,56}

'Deskilling' refers to the fear that the integration of specialist palliative care could prevent ward staff from learning skills to provide comprehensive end-of-life care

themselves, or that skills once acquired could be lost from lack of regular practice.^{35,37,38,41,43,45,47} Senior-level, more experienced staff reported being more concerned about deskilling than their less experienced, junior-level staff counterparts.^{35,37,41} Study results revealed that deskilling was actually mitigated by specialist palliative care integration, with referrers who partnered with specialist palliative care citing higher levels of comfort with and involvement in the holistic management of symptoms than infrequent or non-referrers.^{40,41,47,49,53,55–57} Respondents were more able to provide front-line, generalist palliative care to their patients as a result of integrating specialist palliative care regardless of disease type, country, hospital size or specialist palliative care team membership.

Specialist palliative care operations

Studies listed several operational items which health and social care providers perceived as facilitating collaboration with specialist palliative care teams. These items included visibility, ease of engagement, access, communication and ability to provide continuity of care. Regarding visibility, ward teams desire specialist palliative care teams to be highly evident throughout the hospital, frequently being seen on the wards, and being available to round or meet with the ward teams.^{40,41,43,53} Studies indicated that ward teams want easy access to the specialist palliative care team, which includes having specialist palliative care be timely and responsive when a request is made, preferably seeing the patient and posting a note the day of the request.^{40,41,43,50–53} Several studies reported staff's desire to have specialist palliative care services available off hours and on weekends.^{40,46,53,56,57} Frequent communication was cited in most of the studies as fostering collaboration with specialist palliative care, allowing the swift implementation of recommendations and producing a workable plan of care for the patient.^{38–41,43,46,52–54,56} Communication consisted of in-person conversations at the initiation of the request, throughout the care of the patient, and at the completion of the referral; formal referrals made via phone, through an electronic medical record or in person; informal referrals via phone or by stopping the specialist palliative care professional in the hallway for an 'off the record' conversation to obtain recommendations for patient care; specialist palliative care team participation in multidisciplinary patient care rounds; and brief, timely (same-day) notes with recommendations for care in the patient's medical record.^{40,41,43,46,53,54} Finally, integrating specialist palliative care was viewed as a means for facilitating continuity of care for patients, as specialist palliative care teams were able to follow patients from one ward to another, and bridge inpatient, outpatient and community settings.^{38,40,42,43,46,50,53,55} The above factors amplified the referring team's perception of specialist palliative care as helpful and increased their willingness to integrate specialist services into patient care.

Studies cited the desirability of multiprofessional specialist palliative care teams.^{40,46,51,54–56} Generalist teams utilised multidisciplinary specialist palliative care teams, when present, as a means to quickly and efficiently involve multiple disciplines to simultaneously give input on a case and impact patient outcomes. Specialist palliative care teams with more than one discipline (i.e. physicians, nurses, and social workers) seemed to be preferred over homogeneous (i.e. only nurses) teams.^{40,46,54–56} Although this preference is difficult to explore further or relate to country, disease type, generalist provider type or hospital size, as half of the studies did not describe specialist palliative care team membership. Regardless of multiprofessional membership, specialist palliative care teams were recognised for their skills in the management of complicated physical symptoms and complex psychosocial and family situations, as well as their ability to assist teams and patients and families with difficult medical decisions.^{36–39,41–44,48,50–52}

Role confusion, however, could also result when a number of disciplines were involved. Several studies indicated ward teams were confused about their own roles versus the role of the specialist palliative care team when two people of the same discipline were involved in a patient's care (i.e. ward nurse vs specialist palliative care nurse).^{36–38,50,54,56} Confusion about roles also stemmed from many teams struggling with the basic definition and understanding of specialist palliative care in these studies, which also contributed to confusion about when and how to integrate specialist services and when to transition from generalist palliative care to specialist palliative care.^{36,39,42,44,45,54–56} The confusion in the definition of and timing for integration of specialist palliative care persisted even for hospitals with well-established specialist palliative care teams.

Discussion

Generalists experienced collaboration with hospital-based specialist palliative care teams as beneficial yet challenging at times. As with studies exploring specialist palliative care collaboration in the outpatient and community settings, the issues of model of care, perception of expertise and professional autonomy, as well as the challenges of determining the necessity and timing of specialist palliative care involvement, were identified.^{20–22,59–64} Consistent with studies conducted outside of the hospital, communication and clarification of roles between generalists and the specialist palliative care team were important for reducing power struggles between providers, minimising role confusion and facilitating multidisciplinary collaboration.^{20,21,59–63,65–67} Additionally, similar to studies in the outpatient and community settings, education and skill-building were recognised as important aspects of satisfaction for referring teams and were viewed as one of the largest benefits of integrating the

multiprofessional specialist palliative care.^{68–70} Including generalist ward staff to the highest level of their ability through encouraging those who are reluctant about their capacity to effectively contribute and allowing those who are more experienced to exercise their own expertise to the fullest extent appeared to foster collaboration between the referring team and specialist palliative care teams.

Unlike the community setting, the opportunities for role confusion and the need for role clarification may be increased as hospital-based generalist and specialist professionals enter a patient's room in quick succession of one another. Likewise, skill-building occasions may also be increased by the inpatient setting. Different professions are in close physical proximity to and frequently interact with each other, often in the same room at the same time, thus able to observe and learn from one another. Greater attention to communication also becomes more necessary in the inpatient setting as the acute nature of the patient's condition may change rapidly throughout the day. A larger number of professional care providers are usually involved in a patient's care at the same time in the hospital setting, potentially leading to higher chances of mistakes and misunderstandings if teams are not communicating well with each other. The busyness of hospital setting also carries an increased opportunity for interruptions and a high amount of competing demands for ward staff who often care for several patients at the same time, additionally making frequent communication essential.

In the community setting, generalists have reported the importance of the responsiveness of the specialist palliative care team.²⁰ In the hospital setting, potentially even more so than in the community setting, responsiveness, visibility and availability of the specialist palliative care team were vital for the successful integration of specialist palliative care. Hospital-based generalists, like community generalist, wanted easy access to specialist palliative care teams, but they often need a much more rapid response to their requests. Patients are admitted to the hospital for acute problems which cannot be managed in another setting. Acute problems require swift reactions. Both the generalist providers and specialist palliative care team are located on site. The urgency of patient need and the location of the specialist palliative care team may increase the value generalists apply to the responsiveness of the specialist team, making timely responses and communication even more important.

Generalists' perceptions of their own role shaped when and how they utilised specialist palliative care services. Integration of specialist palliative care services occurred earlier in the disease process when involvement was viewed as a continuation of generalists' roles. Historically, generalists, such as oncologists, have had established relationships with specialist palliative care; this long-term familiarity may make them more comfortable with early integration.^{71,72} In the future, as other sub-specialties, such

as cardiology, interact and become more familiar with specialist palliative care services, they too may become increasingly more comfortable with earlier integration.^{71,73} Like previous studies on collaboration among interdisciplinary teams, collaboration between generalist and specialist palliative care teams was enhanced when individuals frequently worked together and were able to develop mutual knowledge.^{74,75} This level of collaboration and mutual development of knowledge may have been specifically possible in and facilitated by the hospital setting. More so than the outpatient setting, the inpatient setting may have allowed for increased frequency of contact between generalists and specialist palliative care teams. Similar to other studies on teamwork, joint decision-making and both formal and informal exchanges further improved communication between generalist and specialist palliative care teams.^{75,76} In addition, two-way communication channels across team boundaries and with the larger organisation fostered the effectiveness of the teams' functions.^{7,75}

Limitations

There are several limitations to this review. The synthesis was conducted by only one reviewer which limits the objectiveness and introduces opportunity for error. While a narrative synthesis approach supports and was designed to manage heterogeneous studies, the heterogeneous nature of the studies adds an element of difficulty to synthesising the information well. The potential for bias through over representing one study versus another, while carefully scrutinised, also remains a possibility. The variety in the key terms and working definitions in the literature used to refer to specialist palliative care teams made searching for articles and having a discussion about the role and scope of the services they provide challenging. Responses from the different generalist palliative care professionals were often combined or not specifically identified in the studies. Physicians, nurses, social workers and so on might have dissimilar perceptions of the various themes. These nuances are lost when the results are pooled which limits the results of this review. Further distinction between trust and expertise is also needed. The use of studies with quantitative methods exploring participants' perceptions could be potentially limiting too, as a quantitative approach is not the best approach to answer such nuanced questions. Even with these concerns, the quantitative studies are informative and useful for the purposes of this review. While a qualitative method may be more suited to answering questions of perception, the qualitative studies included in the review also have limitations. From a participant standpoint, the studies were often limited to a single institution where it would not be possible to reach data saturation before all relative participants have been included. Given the practicalities involved in qualitative research

and the confines of a single institution, it appears that the qualitative studies were able to adequately address the research question and their results are informative for clinical practice.

Strengths

Despite the limitations listed above, the included studies and synthesis approach appear to satisfactorily answer the review question. The review was conducted rigorously and is replicable. The synthesis question was well addressed by the narrative synthesis approach. The review findings are useful for practice, albeit they should be applied with a degree of caution. By utilising an identifiable and tested approach to the synthesis, the reliability of the synthesis results is further strengthened. The rigour of the literature search resulted in the comprehensive identification of relevant studies. Inclusion of all applicable studies in the synthesis allowed for a broad and full understanding of the phenomenon under review. While the synthesis was conducted by one person, measures were taken to reduce bias by having all authors discuss the inclusion of relevant articles, as well as the identification and interpretation of themes. Even with the heterogeneous nature of the studies, the findings appear similar. Moreover, the findings from the quantitative studies mirror those of the qualitative studies and vice versa, adding further strength to the synthesis. The themes identified here occur consistently over time, across different populations, and in different countries. The heterogeneity of the populations and the settings gives encouragement regarding the vigour of the findings and their applicability to a variety of countries, hospital settings, specialist palliative care team membership, disease types and healthcare professionals.

Future research

As a result of this review, there are several areas where future research could be conducted. Specialist palliative care activities and the ward team's experiences of integrating specialist palliative care from countries not included in the review studies could be explored. The experiences of allied health personnel (physiotherapy, dietitians, speech and language pathology, etc.) could use further investigation as well as they were minimally represented in the studies' samples and their responses were often combined with other disciplines. Further exploration of the areas of expertise and trust and their roles in facilitating collaboration would also be beneficial. Additional research is also merited about the perceptions and experiences of health and social care providers in other sub-specialty areas of medicine, including further investigation of professionals from the fields identified in the review studies (cardiology, neurology, oncology, surgery, vascular surgery and physical rehabilitation). For example, Kavalieratos et al.⁷³ found

in 2014 that cardiologists wanted to integrate specialist palliative care services and were not concerned that patients might be 'stolen' by the specialist palliative care team.⁷³ It is possible that hospital-based neurology, oncology, surgery, vascular surgery and physical rehabilitation providers' perceptions of specialist palliative care integration may have also evolved since the review studies were published. Finally, the focus of these studies and the review as a whole is on the providers' perceptions of collaboration. Data are not available to draw specific conclusions about the impact of either the integrated or linear care models on patient care outcomes. Research exploring the impact of specialist palliative care integration and collaboration on patient experiences and outcomes continues to be necessary.²⁰

Conclusion

Integration of hospital-based specialist palliative care teams seems to enhance collaboration between the referring generalist ward team and specialist palliative care. Collaboration is fostered when each team recognises and supports the expertise of the other. Facilitators of collaboration include effective communication between both groups of professional caregivers, determination of complementary roles and shared problem-solving responsibilities.

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Appendix I

Database Searches.

PsycINFO: (((((((((DE "Professional Consultation") OR (DE "Social Workers")) OR (DE "Medical Personnel")) OR (DE "Interdisciplinary Treatment Approach")) OR (DE "Professional Specialization")) OR (DE "Attitudes")) OR (DE "Perception")) OR (DE "Communication")) OR (DE "Decision Making")) OR (DE "Roles")) OR (DE "Teams") AND ((DE "Palliative Care") OR (DE "Terminally Ill Patients")) OR (DE "Hospice") **Limiters** – Published Date: 1990/01-2014/12/31 = 1537 articles

PubMed: (((((((("Patient Care Team"[Mesh]) OR "Consultants"[Mesh]) OR "Medical Staff, Hospital"[Mesh]) OR "Social Work"[Mesh]) OR "Nursing Staff, Hospital"[Mesh]) OR "Allied Health Personnel"[Mesh])) AND (((("Interprofessional Relations"[Mesh]) OR "Attitude of Health Personnel"[Mesh]) OR "Interdisciplinary Communication"[Mesh]) OR "Cooperative Behavior"[Mesh])) AND (((("Hospice Care"[Mesh]) OR "Terminal Care"[Mesh]) OR "Palliative Care"[Mesh])) AND ("1990/01/01"[Date - Publication]: "2014/12/31"[Date - Publication]) = 1221 articles

Web of Science: ("palliative care" OR "terminal care" OR "end of life" OR "hospice") AND ("professional consultation" OR cooperat* OR collaborat* OR "interdisciplinary team*" OR interprofessional OR attitude* OR perception*) AND (social work* OR medical team OR allied health OR physician* OR doctor* OR nurse*) Timespan = 1990–2014 = 2686

CINAHL: (MH "Palliative Care") OR (MH "Hospice Care") OR (MH "Terminal Care") AND (MH "Medical Staff, Hospital") OR (MH "Multidisciplinary Care Team") AND (MH "Joint Practice") OR (MH "Interprofessional Relations") OR (MH "Intraprofessional Relations") OR (MH "Consultants") OR (MH "Referral and Consultation") OR (MH "Attitude of Health Personnel") OR (MH "Communication") **Limiters** – Published Date: 1990/01-2014/12/31 = 2381

Social Services Abstracts (ProQuest): (SU.EXACT("Palliative Care") OR SU.EXACT("Terminal Care") OR SU.EXACT("Hospices")) AND (SU.EXACT("Professional Consultation") OR SU.EXACT("Cooperation") OR SU.EXACT("Interdisciplinary Approach") OR SU.EXACT("Perceptions") OR SU.EXACT("Attitudes")) AND (SU.EXACT("Health Professions") OR SU.EXACT("Paramedical Personnel") OR SU.EXACT("Physicians") OR SU.EXACT("Social Work") OR SU.EXACT("Nurses")) between 1990 and 2014 = 5

Individual Journal Search Terms: (("palliative care" OR "terminal care" OR "end of life" OR hospice) AND ("professional consultation" OR consultat* OR cooperat* OR collaborat* AND ("interdisciplinary team" OR inter-professional OR "medical team" OR "social work") AND (attitudes OR perceptions))

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