

Hospital-Based Social Workers' Perceptions of Generalist- and Specialist-Level Palliative Social
Work Activities

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Abstract

Summary: A social work advisory group recently proposed 41 generalist-level palliative social work activities applicable to any venue, including hospital-based social work, but this applicability has not been empirically tested. Therefore, we used critical realist grounded theory analysis of qualitative interviews to explore whether the activities proposed by the advisory group reflect inpatient social workers' perceptions of their generalist-level palliative activities when caring for patients alongside specialist-level palliative social workers. Fourteen Masters educated social workers from six hospitals in the Midwest United States participated.

Corresponding concepts from interview data of hospital-based social workers' perceptions of what facilitates or hinders collaboration with specialist-level palliative social workers were identified and mapped onto the 41 generalist-level palliative social work activities. We used NVivo to organize and track data.

Findings: Inpatient social workers find it challenging to engage in specific generalist-level palliative social work activities; provision of generalist-level palliative services is shaped by discharge planning duties, the consultation model, and the concentrated role of specialist-level palliative social workers. Competency in cultural and spiritual aspects of care could be lacking.

Applications: Most of the 41 generalist-level palliative social work activities are present in hospital-based social workers' clinical practice. However, not all activities may be applicable or realizable in the inpatient venue. In the hospital, an emphasis on discharge planning and related time-barriers can mean seriously-ill patients and their families lack access to generalist-level palliative social work services. Clarification is needed about which of the 41 activities are relevant to and actionable within the inpatient venue.

Key Words: Generalist social work activities; Specialist palliative care; Care management; Hospital-based palliative care; Core competencies

Hospital-Based Social Workers' Perceptions of Generalist- and Specialist-Level Palliative Social Work Activities

In the hospital, specialist-trained palliative care physicians, nurses, chaplains, social workers, and other healthcare professionals, provide an added layer of support towards maximizing patients' and families' quality-of-life during serious illness (Dhillon et al., 2008; D. E. Meier, 2006; National Consensus Project for Quality Palliative Care, 2018; Ryan & Johnston, 2019). However, given the large number of patients with palliative care needs and the limited number of specialist-trained palliative care professionals, many countries have called for all healthcare professionals caring for seriously-ill patients and their families to have generalist-level palliative knowledge and skills (Gamondi, Larkin, & Payne, 2013; National Consensus Project for Quality Palliative Care, 2018; Ontario Palliative Care Network, 2019; Ryan & Johnston, 2019). In Europe, Canada, and the United States (U.S.), various professional groups have begun to propose competencies for all generalist- and specialist-level palliative providers, and for social workers specifically (Bosma et al., 2009; Gamondi et al., 2013; Glajchen et al., 2018; Hughes, 2014, 2015; Ontario Palliative Care Network, 2019). Considerable research has explored physicians' and nurses' generalist-level palliative activities when caring for patients alongside hospital-based specialist-trained palliative physicians and nurses (Firn, Preston, & Walshe, 2016; Ryan & Johnston, 2019). Empirically, inpatient social workers' generalist-level palliative activities in this context are under reported (Altilio & Otis-Green, 2011; Blacker, Christ, & Lynch, 2007; Blacker & Deveau, 2010; G. Christ & Blacker, 2006a, 2006b; G. H. Christ & Blacker, 2005; Firn et al., 2016; Firn, Preston, & Walshe, 2017; Glajchen et al., 2018; Gwyther et al., 2005; Hughes, 2014, 2015; Leighninger, 1980; D. Meier, Beresford, & Gaisman, 2008; Payne, 2009).

Recently, a U.S. social work advisory group, guided by the National Consensus Project for Quality Palliative Care's (NCPQPC) framework for essential palliative skills for all clinicians (Table 1), proposed 57 generalist-level palliative social work activities applicable across all clinical contexts, with the aim of informing best practices and developing standards of care, evaluation tools, and outcome research for social workers (Ahluwalia et al., 2018; Glajchen et al., 2018). The proposed generalist-level social work activities share similarities with those proposed by the Ontario Palliative Care Network (OPCN) in Canada (Ontario Palliative Care Network, 2019). Via Delphi method, 41 achieved consensus as generalist-level activities (Figure 1); 16 did not (Figure 2) (Glajchen et al., 2018). While the advisory group postulated that the 41 activities are applicable in any venue, their applicability has not been systematically explored in the hospital setting for inpatient social workers working alongside specialist-level palliative social workers (Firn et al., 2016, 2017; Glajchen et al., 2018).

To utilise the advisory groups' proposed generalist-level palliative activities as an evaluation tool and/or to guide social work clinical practice specific to the hospital setting, greater knowledge is needed about how inpatient social workers' perceptions of their generalist-level palliative activities compare to those proposed by the advisory group. Such knowledge could lend empirical support to the advisory group's findings, reveal service barriers or gaps, guide social work education and professional development, and inform decisions regarding division of generalist-specialist social work labour within the United States. Furthermore, the NCPQPC framework greatly overlaps with what the European Association for Palliative Care (EAPC) and Ontario Palliative Care Network (OPCN) have outlined as generalist- and specialist-level palliative competencies for health- and social care professionals; additional knowledge in this area could also have applications for social workers in other countries (Gamondi et al., 2013;

Ontario Palliative Care Network, 2019). In this paper, we use coded excerpts from a project on inpatient social workers' experiences collaborating with specialist-level palliative social workers (Firn et al., 2017) to see whether the advisory group activities are captured in these empirical data and/or if there are additional items not captured.

Methods

Data from a critical realist grounded theory qualitative study on inpatient social workers' experiences collaborating with specialist-level palliative social workers were used to explore whether the advisory group's proposed activities are reflected in clinical practice. The methods and resulting theory from the larger study are published elsewhere (Firn et al., 2017). As part of the larger study, we asked participants to describe their generalist-level palliative activities versus those of the specialist-level palliative social worker. We did not explicitly prompt them to address the individual NCPQPC Domains. Data from inpatient social workers' responses to this question (not the resulting overarching theory) are reported here.

Sampling Strategy

Upon ethics approval from the University of Michigan Institutional Review Board (HUM00077521) and Lancaster University Ethics Committee, we recruited master's degree educated social workers (MSWs) from hospitals in the Midwest, United States. English-speaking inpatient social workers caring for adult patients (≥ 18 y.o.) in profit and not-for-profit hospitals with specialist-level palliative social workers were eligible to participate.

Social work directors at 12 hospitals in the state of Michigan that have specialist-level palliative social workers, identified through the National Palliative Care Registry, were approached for permission to recruit inpatient social workers from their departments (Center to Advance Palliative Care, 2014). Six directors responded and provided contact information for

potential participants. Theoretical sampling was used; recruitment was initially open but became more focused over time. To meet theoretical sampling and saturation needs diversity was sought in participant age, years of hospital social work experience, disease type, intensive care unit (ICU) vs. floor, hospital size (number of beds), type (academic, private, public), and location (urban, rural). Participating and non-participating hospitals had similar characteristics (size, location, type). The total number of inpatient social workers at participating and non-participating hospitals was not attainable.

Data Collection and Analysis

Participants completed a written informed consent. Data were collected via one-time, in-person qualitative interviews (conducted between February 2014 and January 2015) and digitally recorded. Interviews ranged from 17 to 53 (mean 33) minutes. Data collection ended when we reached theoretical saturation (described below). When theoretical saturation was reached, theoretical sampling ceased; no new social workers were recruited although additional social workers at participating hospitals could have been invited to participate.

JF analysed interviews in discussion with NP and CW using Charmaz's grounded theory approach (Charmaz, 2006). We regularly discussed coding, thematic development, and data interpretation. We used reflexivity to avoid previous knowledge interfering with data interpretation and reduce bias, and NVivo to organize and track data (McGhee, Marland, & Atkinson, 2007; QSR International Pty Ltd, 2012). Concurrent data collection and analysis occurred throughout theoretical development. Analysis was iterative, interviews were analysed as completed; proceeding interviews were informed by those that preceded. Theoretical saturation occurred when no new codes emerged (Charmaz, 2006). From the larger data set, for the purposes of this study, we then identified coded data corresponding to the concepts proposed

by the advisory group and mapped these extracts onto the proposed generalist-level palliative social work activities.

Results

Fourteen inpatient social workers from six Michigan hospitals participated in the study (Table 2), representing many inpatient areas: physical medicine and rehabilitation, surgical, medical, cardiology, and neurology ICUs, ICU stepdown units, and oncology, general medicine, general surgery, cardiology, neurology, and dialysis wards. One participant previously worked in hospice. Identified coded data are mapped onto the advisory group's proposed generalist-level palliative social work activities, organized by NCPQPC Domain. Quotes are used to illustrate activities within each Domain. Each quote is attributed to an individual social worker identified by the abbreviation 'SW' followed by a number (1-14).

Domain 1: Structure and Process of Care

Inpatient social workers describe a traditional U.S. medical consultation model (D. E. Meier & Beresford, 2007) in which they and the specialist-level palliative social worker operate. *'I have to request that the consult go through my doctor.'* SW1. Inpatient social workers do not have the ability to consult specialist-level palliative healthcare providers or control what services the specialist-level palliative social worker provides when involved. *'I think [specialist] palliative care comes up with what the palliative care social worker will do...'* SW9. This consultation model and participants' discharge planning duties influence their availability for depth of involvement in patient care, and the types and frequency of generalist-level palliative services they provide.

'My responsibility as [inpatient] social worker is to discharge plan for those patients the minute they walk in the door... The inter-personal moments that I might not have time for or that goals in my job that I'm supposed to do, it takes away from it [providing generalist palliative care services]; it makes me feel like 'Oh crap!' I missed it, for what? I had to do things of paperwork, that's not fair.'

SW5

Upon admission to the hospital, inpatient social workers complete general assessments of patients' and families' needs which inform their interventions. *'We assess all of our patients within 24 hours. And we write it up, we include an assessment tool and we have questions that we ask. It's part of the standards for the department.'* SW13. Throughout admission, inpatient social workers coordinate with a number of different parties to facilitate care for patients and families. The medical record is an important tool for information gathering and communication with other healthcare providers.

'When a patient is new to the unit I usually tend to take a look at their chart when was last time they were in a hospital. What did [we] do for them last time they were here? Was there home care... or facility, how did they get home? That kind of stuff just to kind of see on paper what kind of supports do they have... Then applying socially appropriate interventions...' SW4

Inpatient social workers provide a number of generalist-level palliative services. They assess patients' and families' understanding and facilitate information sharing regarding diagnosis, treatment, prognosis, and/or options for care outside the hospital. *'...you're meeting with the families all by yourself often, you have to be able to explain at least some of the [medical] things that are going on if they have questions.'* SW7. This includes requesting that

specific providers speak with patients and/or families if inpatient social workers are unable to address the information gap themselves. *'I might be doing things on the unit that are specific to the unit, like if they're not—if the family's not feeling like they're getting answers from the doctors, or there's some miscommunication, then I would address those kind of things.'* SW10.

They also connect patients and/or families to available resources when identified needs are beyond inpatient social workers' skill set, including using specialist-level palliative social workers as a resource. *'If I have questions about whatever, I can go call and ask her. Even if the palliative care team is not involved, I can use her as a resource.'* SW12.

Inpatient social workers also report the importance of being knowledgeable about hospice and palliative care and related resources. This knowledge allows participants to know when to recommend and advocate for specialist-level palliative care involvement, especially if patients and families are struggling with quality-of-life or medical decision-making, and/or the medical team is hesitant to involve specialist-level palliative providers.

'I feel like that's a good position for the social worker to be in, to bring it [a specialist-level palliative care consult] up, even if you have to do it quite a few times, and reminding that it's not because they're deciding to end treatment... having a good understanding of palliative care, and when it might be helpful [is] beneficial.' SW10

Participants frequently provide education to the medical team, patients, and families about the applicability of palliative services over the disease trajectory and correct misperceptions.

'...what is a) The best situation for the patient, b) What is the payer source going to do for me, and c) How can we get this patient to the next and least and

restrictive level of care as quickly and efficiently as possible... How do we get everybody on the same page... ' SW5

They also advocate for care plans that are patient and family centred within the restrictions of what is covered by insurance or other types of constraints, such as family availability for caregiving.

Because of their discharge planning responsibilities, inpatient social workers play a distinct role in coordinating patients' transitions of care. To facilitate transitions for seriously-ill patients and their families requires knowledge of community resources, outpatient/community palliative or hospice services, and insurance coverage for various levels of care (i.e. sub-acute rehabilitation, inpatient hospice, etc.) medications, medical equipment, and ambulance transportation.

'... the struggle as a social worker for me is – really wanting to hear what the patient wants and trying to help them, empower them to make their own choices. Although sometimes what they want isn't realistic and that balance of setting expectations and things like that, but also not trying to give them an agenda of what they should do.' SW14

Facilitating sustainable discharge plans includes helping patients and families anticipate what care outside of the hospital could look like. And, having to learn terminology participants had not been exposed to previously to facilitate palliative and/or hospice discharges.

'It was kind of a big learning curve for all of us to say, ... What's the certificate of terminal illness? What do I have to do with this? What's a button? I don't know

what a button is so teach me.' I think that was a big learning curve... things are just different when somebody is in palliative care or hospice.' SW2

Finally, participants disagree about whether it is a generalist-level or specialist-level palliative social workers' role to address advance care planning discussions, educate patients about what to expect at each disease stage, or facilitate family meetings.

'...we're helping people with advanced care planning: if the social worker following has already addressed that issue and they see a palliative care consult, we're supposed to call palliative care to let them know... so we're not double doing it.' SW7

'I would, kind of, take the hands off role and just be the supportive person... and she would be involved in... goals of care discussions, code status... making sure that they paid attention to the family, that they knew what was really going on, what's really happening with this person, and understood what the long-term impact is...' SW14

Domain 2: Physical Aspects of Care

Inpatient social workers utilize knowledge of patients' physical needs and functional limitations to facilitate discharge plans. They assess families' ability to support patients outside the hospital.

'...remember the confines in which you need to work, whether it's body physical limitations of the patient, care limitations, caregiver limitations.' SW5. Inpatient social workers also help patients and families understand medical language related to their diagnosis and treatment. *'I'll go back into the room with the family later and say, '...Tell me what you heard. Tell me what you understand...'* because often times you don't know what they're hearing.' SW6.

Domain 3: Psychological Aspects of Care

Amidst time constraints, inpatient social workers support patients and families as they emotionally adjust to illness and/or prognosis and make various decisions. *'My role is essentially setup so that part of it is to do the adjustment to illness, to do the discharge planning, to do some education around what is going on.'* SW1. Participants use active listening, knowledge of patients' and families' mental health needs, and awareness of family dynamics to provide emotional support. *'...you have to know if they have any kind of mental illness... to help someone think through different processes, and to process their thoughts and... to help them to deal with all the crisis that they're dealing with... That allows you to love your job.'* SW11. Most participants find this type of work professionally satisfying, although acknowledge that not all social workers are equipped or desire to address the complicated grief issues that arise with difficult end-of-life situations. *'I feel comfortable, like I know some people don't feel comfortable talking about death at all... the most challenging for me to do every day would be the ante-partum loss, like still born births, and terminations and miscarriages.'* SW10

Domain 4: Social Aspects of Care

To effectively facilitate transitions, inpatient social workers assess families' ability to provide care for patients and broader family system needs. *'Who do you have to support you? Who's going to take care of him when you get home? What do you need at home? What can we do to plug you into the right people... resources, whether it's making referrals or whatever the case may be.'* SW5. They assist patients and families in accessing health and social services, and assess patient and family comprehension and whether information is provided in a clear and logical manner.

'... if they needed a nurse to follow up, if they needed referrals sent outside agencies... or some other kind of outside source that would be able to provide in home services. If the family wasn't looking for placement. If the family chose placement, then I would be the one to follow-up with that from there... And what are we going to do long-term.' SW4

Domain 5: Spiritual, Religious and Existential Aspects of Care

Two participants raised the concept of spiritual aspects of care. *'A lot of the support that a social worker gives from palliative care is more of a psycho-spiritual support and we do the discharge planning.'* SW7. However, they viewed addressing this area for seriously-ill patients and their families as a specialist- rather than generalist-level skill.

'...we don't give them enough... spiritual counselling... Whatever it is that gives you that sense of finding inner peace and figuring out what are the last couple of things they need to do, what do I need to do to finish my business, so I can go. I'm ready. That's probably what I'd like to see palliative care do more of that.' SW1

Domain 6: Cultural Aspects of Care

One participant mentioned cultural aspects of care, also viewing this aspect as more a specialist- rather than generalist-level skill. *'...you're dealing not only with family dynamics that are very intense and cultural issues that are very important that do come up quite a bit in hospice.'* SW7

Domain 7: Care of the Patient at the End-of-Life

Broadly, participants distinguished their role, describing it in terms of addressing patients' and families' discharge planning needs, from the specialist-level palliative social work

role, one that emphasizes comprehensively addressing patients' and families' psycho-social-spiritual needs at end-of-life. '*...she [palliative care social worker] goes through the whole life history of a patient, look at quality of life and so forth... and then I will follow-up after [to help with discharge].*' SW9. In their discharge planning role, inpatient social workers provide education about palliative care and hospice to patients, families, and healthcare providers. '*I think knowing how hospice works in the home can be helpful... talking with patients and families about what to expect.*' SW7. Participants use knowledge of in-home and community services, including hospice, to support patients' and families' informed-decision making and expectations for end-of-life care outside the hospital.

Inpatient social workers report sometimes deferring end-of-life conversations and related emotional support needs to the specialist-level palliative social worker.

'I let [palliative social worker] take kind of the lead on that because that's typically end-of-life... a lot of grief in the palliative care work, so for myself, I don't like handle so much of that grief work... sometimes it's like it's just too heavy with the amount of other heavy things that I have going on.' SW2

Reasons for deferring include lack of time, complexity level, and discomfort talking about death and grief. '*She has the time to sit down and really process with the patient, process with the family whereas I don't have that amount of time.*' SW1. Other tasks participants identify as within the specialist-level palliative social work role include guiding complex end-of-life decision-making, awareness of and ability to address issues impacting end-of-life decision-making, facilitating life review, and providing bereavement counselling. However, observing the

palliative team and social worker improved participants' ability to address generalist-level end-of-life needs.

'I actually am so much more comfortable talking about end-of-life... I saw the way [palliative care social worker] interacted with the doctors...[it] has helped with my whole palliative skill set... Palliative care is for patients ... throughout the disease process... and treats symptoms to make you more comfortable, give you the highest quality of life... A lot of families don't even know what palliative is. So it's easy just being able to come in and to explain... whereas, doctors... get hospice and palliative confused all the time...' SW8

Domain 8: Ethical and Legal Aspects of Care

Inpatient social workers identify and address a number of legal and ethical issues when caring for seriously-ill patients. *'I think that definitely ethical questions come up.. I will make an ethics referral if there is an ethical question in the patient care.'* SW6. Inpatient social workers place the patient at the centre of ethical decision making, seeking to maximize patient self-determination. *'In the ICU trying to also advocate for the patient... sometimes the patients get left out [the family or medical team takes over] ... sometimes I've had health psychology involved to do competency evaluations... just because somebody's on a vent doesn't mean they can't...make their own decisions..'* SW14. They advocate for involvement of other hospital specialty services, such as Psychology for capacity evaluations, refer to ethics consultants, and help patients and families access legal services. *'I'm the unofficial expert on guardianship ...people call me constantly, like 'what do you think about this?',' because I deal with that [guardianship] almost daily.'* SW12

Discussion

This study, the first inpatient application of the advisory group's proposed generalist-level palliative social work activities, reveals that hospital-based social workers' use of generalist-level palliative skills when sharing care with the specialist-level palliative social worker reflect many of those proposed by the advisory group, although areas with notable differences exist, particularly within Domains 1, 5 and 6 (Figures 1 & 2). Inpatient social workers understand the value of palliative care and can articulate an overview of palliative care principles and practices, often recognise when generalist-level palliative skills are not enough to meet patients' and families' needs, and advocate for specialist-level palliative or others' involvement (National Consensus Project for Quality Palliative Care, 2018; Ryan & Johnston, 2019). However, the current hospital workflow, which prioritizes discharge planning, specialist-level palliative consultation model, and individual comfort level challenge inpatient social workers' regular engagement in the full range of proposed activities under each Domain.

Within Domain 1, Structure and Process of Care, inpatient social workers demonstrate use of all consensus-based activities, including establishing patient-centred care plans, anticipating needs and achieving smooth transitions between settings, and understanding insurance eligibility (Glajchen et al., 2018). Similar to the advisory group, inpatient social workers do not have consensus about whether advance care planning is part of their role (Glajchen et al., 2018). This finding differs from a recent systematic review which found consensus among social workers from different countries that advance care planning is their responsibility (Wang, Chan, & Chow, 2017). The presence of the specialist-level palliative social worker may influence this perception. Inpatient social workers also demonstrate use of the consensus-based activities in Domain 2, Physical Aspects of Care, assessing caregivers'

resources, ability, and willingness to assist patients with activities of daily living. Moreover, within Domain 2 they frequently engage in tailoring information to patients and families and assuring understanding of medical language regarding the disease course. This finding differs from the advisory group, who did not have consensus about these skills falling within the generalist-level purview (Glajchen et al., 2018).

Inpatient social workers engage in the consensus-based activities within Domain 3, Psychological Aspects of Care, including providing support and counselling to patients and families and enhancing patient care through collaborative practice, with the exception of establishing support groups for patient and family (Glajchen et al., 2018). Given the inpatient setting and primary role of discharge planning, it is not surprising that establishing support groups was not identified by inpatient social workers (Hajek, 2012). Additionally, participants' reports correspond to the advisory group's opinion; they rarely address complicated grief (Glajchen et al., 2018). Issues of sexual functioning, fertility, or body image were also not mentioned (Glajchen et al., 2018).

Within Domain 4, Social Aspects of Care, inpatient social workers describe engaging in the consensus-based activities except addressing issues of confidentiality and privacy (Glajchen et al., 2018). Very few inpatient social workers mentioned spiritual or cultural issues (Domain 5, Spiritual, Religious, and Existential Aspects of Care, and Domain 6, Cultural Aspects of Care) (Glajchen et al., 2018). This finding differs from the advisory group who reported a high rate of consensus for both categories. While this omission could be from lack of awareness or direct interview guide prompt, for so few participants to raise these concepts unprompted prompts concern about a disconnect in social work values, education, and practice integration. Even though social work Codes of Ethics in England, Canada, and the United States (British

Association of Social Workers, 2014; Canadian Association of Social Workers, 2005; National Association of Social Workers, 2015) highlight the importance of diversity, including cultural and spiritual awareness, for many people talking about spirituality or religion can be as uncomfortable as talking about sex, death, or finances (Crompton, 1998; Gilligan & Furness, 2006). Furthermore, cultural competency is a difficult concept to teach and translate into practice (Carpenter, 2016; Saunders, Haskins, & Vasquez, 2015). Social work educators in the United States, Europe, and Canada may believe they have achieved culturally competent social work education and practice because diversity and cultural competency are written into their mission statements and curricula (Carpenter, 2016; Saunders et al., 2015). However, these alone have been shown to be insufficient to promote dialog and self-reflectivity regarding cultural and diversity issues (Saunders et al., 2015).

All of the consensus-based competencies in Domain 7, Care of the Patient at the End-of-Life, are evident in inpatient social workers' responses (Glajchen et al., 2018). While inpatient social workers demonstrate working knowledge of hospice services and when to refer to hospice, they vary in practice in talking with patients and families about dying, with some desiring to avoid it if possible. As talking about death is difficult, variation in practice is not surprising (Black, 2005; Wang et al., 2017). Participants agreed with the advisory group that legacy-building and life-review activities were not part of social workers' generalist-level palliative skill set (Glajchen et al., 2018).

Finally, in Domain 8, Ethical and Legal Aspects of Care, inpatient social workers' responses show familiarity with common ethical and legal issues patients with serious illness and their families face and knowledge of who to contact to assist with conflict resolution (Glajchen et al., 2018). As in previous studies, (Firn et al., 2017) social work Codes of Ethics (British

Association of Social Workers, 2014; Canadian Association of Social Workers, 2005; National Association of Social Workers, 2015) appear to be the framework that informs inpatient social workers' ethical decision-making (Glajchen et al., 2018). While inpatient social workers did not discuss advance directives specifically, these could be addressed by some within advance care planning (Domain 1).

Education, Practice, and Research Implications

Future qualitative exploration of the individual advisory group's proposed generalist-level palliative activities via in-depth interviews using more focused interview questions is needed in the inpatient context, as well as a variety of other venues. While there is general alignment between inpatient social workers' current practice and the advisory group's proposed activities, differences exist. Some variation in practice could be explained by differences in education and exposure to specialist-level palliative social workers and/or the inpatient setting. To more effectively shape clinical practice and be useful as an evaluation tool further tailoring and/or clarification is needed about which of the advisory group's proposed activities are actionable within a given context. Social work education courses in palliative and end-of-life care need to be more widely offered; reviews of curricula in the United States and Canada show these courses are primarily elective, with most graduates having little to no training (Berkman & Stein, 2018; Blacker et al., 2007; Csikai & Raymer, 2005). Courses also need to be reviewed for content related to all of the proposed generalist-level palliative social work activities, particularly spiritual and cultural aspects of care.

As identified by participants here and elsewhere, inpatient social workers frequently learn palliative skills through observation and collaboration with specialist-level palliative social work colleagues (Sumser, Remke, Leimena, Altilio, & Otis-Green, 2015). Inpatient social workers

with no prior palliative-related education at hospitals without a dedicated specialist-level palliative social worker could lack the necessary proximity for learning generalist-level palliative social work skills (Firn et al., 2016). Finally, institutional value for cycling patients through the hospital quickly, and inpatient social workers part in accomplishing that goal, could drive hiring practices and define social work scope of practice (Chan, Farias, Bambos, & Escobar, 2011; Lee et al., 2014; Lovett, Illg, & Sweeney, 2016). This process-driven focus is occurring with greater frequency in Europe, Canada and the United States, as therapeutic casework and counselling models are replaced with case management models (Altilio & Otis-Green, 2011; Hughes, 2014). Thus, hospitals might not employ social workers who are equipped or have a desire to engage in generalist-level palliative activities, even if they had time to provide such services, as generalist-level palliative care is less an institutional priority than efficiently moving patients out of the hospital. To address this barrier and expand access to generalist- and specialist-level palliative services, social work administrators should actively scrutinize inpatient social workers' case-load size and scope of practice and hospital specialist-level palliative consultation processes, and consider hiring a specialist-level palliative social worker if the position does not currently exist.

Limitations

Using inpatient social workers' perceptions provides limited information about specialist-level palliative social work responsibilities. Exploring specialist-level palliative social workers' views could increase the empirical understanding of generalist- and specialist-level social work activities, expand on expert knowledge, and have additional implications for clinical practice. Recruitment could have limited results; not all hospitals or social workers responded. Results could change if participants from other locations, healthcare delivery models, countries, and cultures were included. The interview guide asked non-directive, open-ended questions about

generalist-level palliative activities; it is not possible to tell if inpatient social workers' lack of mentioning specific generalist-level palliative activities is due to not engaging in them or not being explicitly prompted. Finally, while interviews occurred in the context of U.S. healthcare, the generalist-level palliative social work activities proposed by the U.S. advisory group share similarities to those proposed by groups in other countries, thus social workers, social work educators, and social work administrators in Europe and Canada also could potentially utilise these results to inform social work practice in their respective countries (Bosma et al., 2009; Ontario Palliative Care Network, 2019).

Grounded theory methodology was strictly followed during the interview, analysis, and writing process. An iterative approach was applied to refine and develop data collection, analysis, and results. Constant comparison, combined with discussion among authors was used to reduce bias. Discussions contributed to in-depth analysis over the course of coding, memo-taking, and writing of results. Even without explicit prompts, inpatient social workers' identification of generalist-level palliative skills aligns well with the advisory group's expert opinion.

Conclusion

Inpatient social workers engage in many generalist-level palliative activities. In the inpatient setting, a focus on hospital throughput and subsequent time constraints inhibit inpatient social workers' ability to provide some generalist-level services. Social work professional organisations, educators, and healthcare institutions must critically examine the relevance of the proposed 41 generalist-level activities in a given setting, and inpatient social workers' ability to meet patients' and families' palliative needs within the current healthcare and education context.

Reimagining education requirements, job descriptions, and case-load modifications may allow inpatient social workers to more comprehensively provide generalist-level palliative services.

Research Ethics

The University of Michigan Institutional Review Board (HUM00077521) and Lancaster University Ethics Committee gave ethical approval for this study.

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The authors do not have ethical permission to disseminate transcripts at an individual level.

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Table 1: NCP Guideline Domains (National Consensus Project for Quality Palliative Care, 2018)

1. Structure and Process of Care: describes the elements of the palliative care assessment and care plan, as well as systems and processes specific to palliative care.
2. Physical Aspects of Care: describes the palliative care assessment, care planning, and treatment of physical symptoms with emphasizing patient- and family-directed holistic care.
3. Psychological Aspects of Care: describes the processes for systematically assessing and addressing the psychological and psychiatric aspects of care in the context of serious illness.
4. Social Aspects of Care: outlines the palliative care approach to assessing and addressing patient and family social support needs.
5. Spiritual, Religious, and Existential Aspects of Care: describes the spiritual, religious, and existential aspects of care, including the importance of screening for unmet needs.
6. Cultural Aspects of Care: outlines how culture influences both palliative care delivery and the experience of that care by the patient and family, from the time of diagnosis through death and bereavement.
7. Care of the Patient at the End-of-Life: focuses on the symptoms and situations that are common in the final days and weeks of life.
8. Ethical and Legal Aspects of Care: includes advance care planning, surrogate decision-making, regulatory and legal considerations, and related palliative care issues, focusing on ethical imperatives and processes to support patient autonomy.

NCP = National Consensus Project for Quality Palliative Care

National Consensus Project for Quality Palliative Care. (2018). Clinical Practice Guidelines for Quality Palliative Care, 4th edition,. In. Richmond, VA: National Coalition for Hospice and Palliative Care.

Table 2: Participant and Hospital Characteristics

Participant characteristics (n=14)
Sex: All Female*
Race: 1 African American, 13 White
Age: 25-55 years, median 40 years old
Years worked as MSW: 3-32 yrs, median 12.5 yrs
Patient case-load: 20-50 patients/social worker, median 36 patients/social worker
Hospital characteristics (n=6)
Hospital size: 300-1100 beds, median 640 beds
Hospital location: <ul style="list-style-type: none"> - 2 Small community areas - 2 Larger urban areas - 2 Inner-city

* Social workers in the U.S. are predominantly female (82%); sample homogeneity is not unexpected (U.S. Department of Labor. (2014). *Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity*. Bureau of Labor Statistics)

STRUCTURE AND PROCESSES OF CARE	<ol style="list-style-type: none"> 1. Use best practices to assess patients and families based upon a biopsychosocialspiritual approach 2. Communicate results of biopsychosocialspiritual assessments to members of the interdisciplinary team and other providers involved in the care of the patient and family 3. Establish patient-centered care plans 4. Help patients and families anticipate needs and achieve smooth transition between settings 5. Understand specifics of eligibility and benefits for Medicare, Medicaid and commercial insurance 6. Advocate for patients and families within health care and social service systems to maximize benefits 7. Use best practices to communicate with professionals, patients and families 8. Develop safe and sustainable discharge plans based on patient and family preferences and available resources 9. Establish positive working relationships with other professionals 10. Resolve conflicts among patients, family members, professionals, or administrators 11. Use medical record to communicate with other professionals involved in patient's care 12. Use assessment to identify complex situations that require attention by social worker or other team member
PHYSICAL ASPECTS OF CARE	<ol style="list-style-type: none"> 13. Assess caregivers' resources, ability and willingness to assist with activities of daily living
PSYCHOLOGICAL ASPECTS OF CARE	<ol style="list-style-type: none"> 14. Provide support to patients and families 15. Provide counseling to patients and families 16. Tailor basic interventions to address concerns identified during assessment 17. Enhance patient care through collaborative practice with other professionals 18. Address assumptions and biases of other professionals' as they relate to patients and family 19. Establish support groups for patient and family
SOCIAL ASPECTS OF CARE	<ol style="list-style-type: none"> 20. Facilitate access to health and social services 21. Address capacity of support network to provide emotional, financial, and instrumental support 22. Assess amount of information patient and family are able to comprehend 23. Communicate information in a clear and logical manner 24. Respect patient and family's concerns about confidentiality and privacy
SPIRITUAL, RELIGIOUS AND EXISTENTIAL ASPECTS OF CARE	<ol style="list-style-type: none"> 25. Identify religious and spiritual beliefs of patients and families 26. Refer to spiritual care providers 27. Provide support for existential distress within scope of practice
CULTURAL ASPECTS OF CARE	<ol style="list-style-type: none"> 28. Evaluate fluency in English 29. Address cultural influences on family communication 30. Provide care within scope of patient's and family's culture 31. Understand impact of the setting on patient care delivery 32. Assess and address health literacy needs of patients and families 33. Advocate for interpreter to be present as needed 34. Acknowledge impact of own and other team members' cultural values on treatment 35. Recognize different cultural values, beliefs and attitudes surrounding illness and death
CARE OF PATIENT AT THE END OF LIFE	<ol style="list-style-type: none"> 36. Support patient and family participation in shared-decision making 37. Respect culturally diverse end-of-life rituals 38. Educate patients and families about palliative care and hospice
ETHICAL AND LEGAL ASPECTS OF CARE	<ol style="list-style-type: none"> 39. Consult with other professionals to meet the needs of vulnerable patient groups (youth, cognitively impaired, isolated, developmentally disabled, imprisoned) 40. Support the decision-making of patients and families within the context of laws, regulations and ethics 41. Use ethical decision-making framework to address needs and concerns of patients and families

Figure 1: Advisory group generalist-level palliative social work activities with consensus

From: Glajchen, M., Berkman, C., Otis-Green, S., Stein, G. L., Sedgwick, T., Bern-Klug, M., . . .

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STRUCTURE AND PROCESSES OF CARE	<ol style="list-style-type: none"> 1. Conduct advance care planning discussions 2. Educate patients and families about treatment options at each stage of disease 3. Organize family meetings regarding care at the end of life
PHYSICAL ASPECTS OF CARE	<ol style="list-style-type: none"> 4. Tailor information about treatment and side-effects to patients and families 5. Assure patient understanding of medical language regarding disease course of major illnesses 6. Assess impact of physical symptoms on patients and families
PSYCHOLOGICAL ASPECTS OF CARE	<ol style="list-style-type: none"> 7. Provide anticipatory bereavement intervention or referral for complicated grief 8. Identify and address complicated grief 9. Identify impact of illness of sexual functioning, fertility, body image 10. Assess psychosocial impact of symptoms on patients and families
CARE OF PATIENT AT THE END OF LIFE	<ol style="list-style-type: none"> 11. Assist patient and family in completion of advance directives (living will, health care proxy, MOLST, POLST) 12. Apply therapeutic techniques for rapid engagement and crisis intervention 13. Administer legacy-building activities 14. Understand the dying process and educate patients and families what to expect 15. Provide anticipatory bereavement, intervention, or referral for complicated grief 16. Discuss funeral and post-death arrangements with family

Figure 2: Advisory group generalist-level palliative social work activities without consensus

From: Glajchen, M., Berkman, C., Otis-Green, S., Stein, G. L., Sedgwick, T., Bern-Klug, M., . . .

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