THE SOCIAL WORK ROLE ON HOSPICE INTERDISCIPLINARY TEAMS

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A Project

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Division of Social Work
Abstract

of

THE ROLE OF SOCIAL WORK ON HOSPICE INTERDISCIPLINARY TEAMS

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Abigail Marie Bowers

Social workers interact with registered nurses, chaplains, and other team members in their work on the hospice interdisciplinary team. Teamwork is integral to the social worker’s role in working with the patients and families. Research has discovered that the nature of a hospice interdisciplinary team includes collaboration, interdependence, and role blurring. The purpose of this study is to examine the experience of different hospice team members and explore the role of social work on the hospice interdisciplinary team. A qualitative research design was chosen for this study. Ten professionals employed at hospice in Northern California were asked to participate in the study. The researcher developed and used an interview guide with ten open-ended questions. The interview data was coded and the following five themes emerged: communication, the medicalization of hospice, collaboration challenges, spiritual connection and teamwork, rewards from hospice teamwork. Implications for social work practice were discussed.

_______________________, Committee Chair
Andrew Bein, Ph.D., LCSW

_______________________
Date

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Chapter 1

THE PROBLEM

_The truth is that teamwork is at the heart of great achievement._

- John Maxwell

_We don’t accomplish anything in this world alone... and whatever happens is the result of the whole tapestry of one’s life and all the weavings of individual threads from one to another creates something._

- Sandra Day O’Connor

On a typical hospice team, each member has a distinct role and understands the role of other team members. The social worker works with the patient and family in dealing with the psychosocial issues of dying and impending death. Chaplains journey with the patient through spiritual concerns and offer encouragement. The case managing nurse is an R.N who attends to the patient’s plan of care, and ensures that medications and equipment are ordered relating to the patient’s terminal illness. In addition to these members, the patient may have a Home Health Aide, Volunteer, Speech or Physical Therapist. Volunteers are trained to provide respite to the caregivers, companionship and support to the patient and caregivers. The Home Health Aide provides personal care to the patient such as bathing and linen changes in the home setting.

It has been established that effective hospice interdisciplinary teams include the elements of communication, interdependence, and collaboration. However, there is little
information about how these elements are integrated in the role of social work as they interact with other professionals who have expertise in other disciplines. During an Interdisciplinary Team (IDT) meeting, the discussion does seem to focus on the progression of the patient’s disease and re-certification of the patient’s hospice services. The hospice team members also problem solve around issues with the patient’s family or caregiver in the IDT meetings. Also, there is information sharing about rituals or prayers that are important to patient and family. Chaplains contact local clergy. With respect to the patient’s spirituality, the Chaplain will mention which church or faith community will perform rituals, blessings, or prayers that are important to the patient and family. The Chaplain is available at the request of the patients, and they discuss with them issues of spirituality, religion, end-of-life and afterlife concerns. The patient shares with the chaplain beliefs he or she has that bring comfort and also beliefs that are bothersome. For any reason, the patient can decline the encouragement and support that the Chaplain offers. This can become a challenge to the IDT, though the Chaplain can still offer suggestions and guidance in the meeting relating to the patient’s care.

Background of the Problem

According to the American Hospice Foundation (AHF, 2005) only about 25% of Americans die at home, however, about 70% of Americans report that they want to die at home. The National Hospice and Palliative Care Organization (NAPCO, 2008) reports that 38.8 % of all deaths in the U.S were under the care of hospice, they state that this was an increase as the previous year’s report was 35%. In addition, 30.8 % of those
served by hospice died or were discharged in seven days or less (NAPCO, 2008). The Community Services Planning Council (CSPC, 2004) notes a rapidly growing senior population in Sacramento County. They state that by the year 2040, Sacramento County will experience a 157.7% increase in the group aged 60 and older and a 316.2% increase of those 85 and older. With this dramatically increasing senior population in Sacramento County, it becomes crucial that accurate information be available about hospice services. Given the overall short amount of time that patients receive hospice care, the response calls for smooth and efficient teamwork among the hospice team members.

Statement of the Research Problem

This study seeks information about the role of social work on hospice interdisciplinary teams. The personal experience of being on the interdisciplinary team will be explored to gain information about the positives and negatives of teamwork. Research has indicated that the nature of interdisciplinary teams includes collaboration, interdependence and role blurring. More information is sought for social work regarding the strengths and challenges of teamwork as it interfaces with difficult client situations, and spirituality.

Purpose of the Study

The purpose of the study is to explore the role of social work on hospice interdisciplinary teams. Ten team members (social workers, nurses, and chaplains), employed at a hospice in Northern California were interviewed using an interview guide that guided discussion about their experiences on the hospice team to gain a better
understanding of how the team members work with one another. This project will contribute to the profession of social work by bringing forth strategies, suggestions, and information about the positive and challenging experiences that others can utilize in the teams that they work with.

Definition of Key Terms

The following terms are the key terms in this project. Definitions for the key terms are presented below to provide further clarification to the study.

Palliative Care- Care for persons at the end of life that focuses on comfort and support instead of cure for a disease, illness, or condition. One example of palliative care is hospice, a program for persons who are not seeking aggressive medical treatment and have an estimated prognosis for life expectancy of 6 months or less (Jensen, 2008).

Person In Environment (PIE)- Karls and O’Keefe (2008) provide the following definition: PIE is a system for identifying and recording problems that clients experience in their social functioning in relationships with others and relation to the community institutions that generally serve to maintain social functioning.

Holistic- The term holistic describes a practice perspective that takes into account the health, mental health, educational, and spiritual aspects of clients within their environments (Jensen, 2008).

Care Planning- Care planning refers to a process, including clients and caregivers, that translates information collected during assessment into a plan of care, identifying services
to be delivered, formal and informal providers, frequency of service delivery, and cost. Care planning is a resource allocation process (Jensen, 2008).

Communication Skills- Yeager and Shorter (2009), note that the effective social worker faces the task of communicating with an unprecedented number of persons involved in the care of a single patient. Communication with collateral information sources, including but not limited to families, employers, employee assistance programs, other health care professionals, social service agencies, managed care entities and the patient is critical to the care of the individual.

Strengths- An individual’s intellectual, physical, and interpersonal skills, capacities, interests, and motivations (Jensen, 2008)

*Justification*

This project will utilize interdisciplinary team members to gain better understanding of the role of social work on a hospice interdisciplinary team. Information gleaned about the rewards, challenges, and the interface of teamwork with difficult patient situations and spirituality may contribute to better service to the patients that the social worker interacts with. According to the National Association of Social Workers (NASW) Code of Ethics, service is one of the core values of social work. They describe this value as: “Social workers elevate service to others above self interest. Social workers draw on their knowledge values and skill to help people in need and to address social problems” (NASW, 2006, p. 5).
Delimitation

In the scope of this project the researcher will be interviewing team members employed by a hospice in Northern California. The researcher will not be focusing on team members who work outside of the Sacramento County. Literature may be cited from other parts of the country but all subjects will be from Sacramento County. The sample is a convenience sample and thus findings from this study are not generalizable to the larger population.

Summary

The purpose of this study is to examine the experience of hospice interdisciplinary team members to gain information about the role of social work. One to one interviews of hospice team members were conducted to explore collaboration, interdependence, as well as the positives and challenges of teamwork. The researcher will then will transcribe the interviews and use appropriate interpretive approaches for this qualitative study. This will guide the researcher in identifying emergent themes from the interview data. The interviews of the ten participants will be presented in Chapter 4 and the conclusions, emergent themes, and recommendations will be presented in Chapter 5.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

This study seeks to uncover the social worker’s experience as a member of the hospice Interdisciplinary Team (IDT), and what it means to bring a spiritual self to teamwork. Most of the focus regarding spirituality in the social work profession seems to be on direct practice with the clients. In hospice IDT meetings, there is information shared about the progression of the patient’s disease, medications, caregiver issues, funeral arrangements, and chaplain visits. IDT members include the case managing nurse, social worker, chaplain, and other support staff such as volunteers, home health aide, physical therapist and speech therapist. Each team member has knowledge and skills in their area of expertise, which contributes to the discussion, and each professional helps to find creative solutions for the patient’s presenting problem. There is little research done that is specific to the roles of different people on the hospice interdisciplinary team in terms of it’s interface with spirituality. Some aspects of the nature of interdisciplinary teams are relevant to spirituality.

Hospice interdisciplinary team members deal with serious illness, impending deaths, the dying process and other issues related to end-of-life, as well as family issues pertaining to the patient’s terminal illness; thus IDT members are believed to be more “spiritual” than those in other work settings; with the exception of clergy (Clark, et. al, 2007). Is this because these IDT members become aware of their own spirituality as a
result of grappling with patient issues? What does it mean to bring a spiritual self to interdisciplinary team work? In this chapter, the writer hopes to explore these issues. The first part of the literature review explores topics related to interdisciplinary teamwork: collaboration and interdependence. The second part examines hospice itself, spirituality, and the role of social work.

**Collaboration**

Social workers who engage in interdisciplinary teamwork put forth energy and effort along with the other team members to achieve a common goal. Interdisciplinary teamwork is distinct from multidisciplinary teams in that the team members are cooperating in and coordinating their work; they operate together toward the same end (Fort-Cowles, 2003). The members of the IDT collaborate by sharing information, and communication, they coordinate their work as a means to support each other. In a qualitative follow up of social workers, the themes of trust, communication, and understanding were identified as crucial to effective collaboration in the team process (Oliver & Peck, 2006). Communication was indicated as having bearing on the effectiveness of the interdisciplinary team to meet the goal of providing palliative care to the patient. When miscommunication occurs among members of the team, the team members then have to build up trust. The degree to which the social worker experiences communication and trust in the team process may affect the attitude the social worker has about his or her role on the team. If the social worker or another team member views the
role of social work on the team in a negative way, this impacts the hospice team’s smooth collaboration.

Collaborating can involve “role blurring”, meaning that the IDT members often take on varying roles in their work with the patients. This requires the social worker and other team members to be flexible in their work. Flexibility means that the team member reaches a productive compromise in the face of disagreement with other team members, altering their professional roles, and responding creatively to what’s called for (Bronstein, 2003). The team member’s ability to maintain a positive attitude may correspond with the individual’s willingness to be flexible with other members of the team as decisions are made and problems are solved. Flexibility can also translate to the social worker being flexible in their work with the patients. A social worker may discuss with the caregiver basic medical instructions that the nurse had educated the caregiver about. For instance, a caregiver may feel uncomfortable giving the patient an increase of morphine as instructed by the nurse, because of the belief that the medication will make the patient drowsy. The caregiver may choose to discuss the medication increase with the social worker which may serve to be a point of emotionally processing how this caregiver feels about care-giving for his or her family member. The discussion can lead to the caregiver’s understanding and acceptance of the reasons that the medication increase has been ordered. This ultimately makes the nurse’s work with the patient easier.

However, there are challenges, which result from role blurring, regarding the ways in which the different team members support each other. These challenges hinder
the effectiveness of collaboration. Role blurring can be considered a source of miscommunication about role expectations (Parry, 2001). The miscommunication can cause the IDT member to be uncertain about his or her role and affects how successful the team is in working with the patient. The patients and families then become confused as to what the different members of the team have to offer if that is not made clear to them by hospice staff. Numerous barriers to effective collaborative work include role confusion, value conflicts, theoretical differences, and lack of commitment to teamwork, power differentials, stereotyping, and administrative concerns (Oliver, 2003). It is critical for the IDT members to collaborate to lessen the impact of these barriers when they occur so that this does not have an adverse affect on services for the patients and their families.

Collaboration includes coordinating services that may create a sense of connection among the members of the team. Each individual member becomes more aware of what other team members do. For example, funeral arrangements can be made by the social worker, the chaplain, or by a member of the patient’s family. The chaplains and social workers have to coordinate and discuss who will initiate this task since both team members do have the resources to complete the task. A phone survey, that involved 100 chaplains, indicated that 95 percent reported that they participate in funeral arrangements for patients (Wittenberg-Lyes et al., 2008). Social workers also initiate the conversation with the family members about funeral arrangements. Both social workers and chaplains provide outreach to the larger community and provide information to other IDT members. Perhaps, facing similar challenges with community outreach can serve to foster a bridge of commonality between the chaplains and social workers. The sense of
commonality can also be cultivated as the different team members learn from each
other and the ways that the different team members handle difficult situations with
patients and their families. The worker’s participation and learning are driven by the
social practices that make up the workplace and require the worker to secure the purposes
and goals of the workplace (Billett, 2008b). Team members who have developed
commonality with other team members may become more secure in the goals of the
workplace. When the workplace community encourages participation in learning and
community, collaboration becomes more effective.

*Interdependence in Interdisciplinary Team Work*

Interdependence is present in interdisciplinary team work, and is relevant to
collaboration. Interdependence refers to the occurrence of and reliance on interactions
among professionals whereby each is dependent on the other to accomplish his or her
goals and tasks (Bronstein, 2003). Interdependence is displayed in interdisciplinary team
work when the nurse and social worker make a joint visit to the patient’s home.
Individuals on the team share important information through written and oral
communication, which other members of the team rely on to accomplish their work with
the patients. Communication helps to build a team member’s respect for the input of
other members of the team. Social workers need the correct information about what the
other members of the team can offer the patient in order to successfully work with them.
In their article, *Inside the Interdisciplinary Team Experience of Hospice Social Workers*,
Debra Parker Oliver and Marlys Peck note that barriers to effective hospice teamwork
include the overemphasis of the patient’s medical issues as well as the workers’
caseload size (2006). Interdependence among team members serves to lessen the impact
of times when a team member’s caseload is high and when challenging situations with
patients and their families come to the surface.

Interdependence is compromised when collaboration is not successful because of
value conflicts, or when a team member is resistant to new ideas. For instance, a social
worker might have an objective of giving the patient opportunity to talk about how he or
she is affected emotionally by the terminal illness, as the social worker views this
conversation as beneficial. Facing pain is often worth the peace, freedom, and comfort
with one’s self that results (Epple, 2003). This may not be taken as seriously by the nurse
who does not understand the principle of partnering with the social worker. Moreover, a
team member may not be receptive to the different ideas that other team members discuss
as possible solutions when problem solving. After some time, this can affect the social
worker’s commitment to the purpose of hospice. It is essential to note here that hospice
philosophy includes holistic care of the patient. Holistic care recognizes the biological,
psychological, social and spiritual aspects of the individuals. Individuals who are facing
the last phase of a life limiting illness or injury turn to hospice when a cure for the illness
is no longer possible. In order for the patient to be eligible for the hospice benefit, the
patient’s primary care physician and hospice medical director confirm a life expectancy
of less than six months (Fort-Cowles, 2003). Through hospice services, care and comfort
is aggressively sought for the patient during this last phase of life. The interdisciplinary
team members work together, to provide compassionate services in order to ease the
patient’s pain from the disease. This does not simply refer to the patient’s physical pain, but also the individual’s spiritual and emotional pain. The hospice nurse orders medications to ease the patient’s physical pain and provides supplies and equipment for the patient’s comfort. Hospice team members coach the family on how to care for the patient at home. The patient is also given the opportunity to reminisce about his or her life with the hospice staff. If the patient or family member requests, hospice staff make arrangements for the patient to receive prayer or a blessing from the patient’s faith community as a way to encourage and support the patient. The client and hospice providers need humility, surrender, hope and belief in the transcendence, openness, willingness, and courage to face pain (Epple, 2003). The therapeutic relationship between the patient and social worker then does not occur in a vacuum and occurs simultaneously with the social worker’s engagement with team work. The services are rendered to treat the patients as whole persons and not just as terminally ill people.

Additionally, interdependence in team work includes the team member’s strong sense of self. Spirituality is relevant to interdependence because it involves the team member’s self awareness. One of the first tasks of competent practice is the enhancement and growth of self awareness, self understanding, and self acceptance (Rotham, 2009). These same tasks hold true when interacting with team members on the job. Social workers, as a member of the team, and with a sense of belonging, gain understanding of what they have to offer to team work as well as the patients. A sense of self was strongly articulated by these workers in most instances as providing a basis to be themselves through their work (Billet, 2008a). The activities that form interdependence also shape
the culture of the workplace. The social worker’s level of participation in hospice IDT work may be fostered by the amount of commitment they feel to the purposes and goals of the team.

Interdependence is also relevant to spirituality in the sense that a hospice provider’s interactions with other team members contribute to the hospice provider’s sense of belonging and community as the hospice team works together. Spirituality can give meaning and purpose to life, can guide action and choice, enhance awareness and provide a ground for connectedness among people (Rothman, 2009). During an IDT meeting, a candle is lit and a team member reads the names of the patients who have died; each member of the team at that point shows respect and reverence for the patient in the moment of silence. This communal experience contributes to a powerful dimension in the individual team member as they remember the patient and the life that the patient led. Moreover, a member of the team may be asked to lead the team in a reflection which increases the self awareness of the individual team members and provides for the team members’ grounding so that the needs of the current patients can be met.

The Social Work Role in Hospice

It has been established that social workers play a key role in hospice IDTs. Social workers bring understanding and concern to the patient’s social world as a counterbalance to the emphasis of health care on the patient’s physical body. The discussions in the IDT meetings seem to emphasize the patient’s medical condition, and interventions are included that are specific to the patient’s disease. Omission of the social
worker in the IDT excludes the psychosocial and quality of life issues as aspects of the patient’s care (Claiborne & Vandenburgh, 2001). Social workers shed light on the client’s social world or spiritual view to other members of the team so that the services of hospice demonstrate respect to the client.

Social workers contribute to the interdisciplinary team meetings as they report to the other team members about the status of the patients and their families. The extent to which social workers feel they participate in interdisciplinary team meetings has been explored. According to a national survey, most social workers, 77.8 percent, reported feeling like active participants in the team meetings. About one half, 51.5 percent, of those surveyed stated they had provided leadership for the team meetings (Parker, & Oliver et al., 2009). The information that the team members receive from social workers becomes valuable to the entire team as decisions are made about how best to care for the patient. Social workers perceive the social context of dying patients and families and understand the environmental concerns (Parry, 2001). Thus, social workers present the emotional and social issues of the patient and family to the team while collaborating in the interdisciplinary team meeting. Furthermore, the information about the patient’s social and emotional issues gives the team a context for how the patient is coping with the terminal illness or how the patient will respond to the ways that hospice supports them.

The profession of social work and hospice programs both operate under a systems perspective and both recognize the importance of biological, psychological, and social
systems and the various levels of community and society (Fort-Cowles, 2003). Social workers perform their role with a person-in-environment view of working with the patients. This view stresses that to understand and influence how people react to events in their lives, it requires consideration of the social networks and institutions they are a part of. These networks involve family, community, work, and education supports and institutions (Reith, & Payne 2009). In other words, the patient exists within a family system and this has influence on their understanding of the world, as well as their goals for care. It is within this perspective that the hospice social worker makes home visits to the hospice patient and provides community resources as needed.

The services that are conducted by hospice IDT members are often done in the patient’s own home. This delivery method goes along with the aim of hospice and the social worker to preserve important human relationships and support the client’s sense of integrity/control over decisions of importance to them (Fort-Cowles, 2003). When the patient is being cared for in the home, he or she is with family and in an environment that is familiar to them. Interdisciplinary team members ask permission to gain access into the home, implying that the patient/family is in charge (Lawson, 2007). The hospice IDT, engages in discussion with the patient and family in their home regarding the goals of care and decision making (Lawson, 2007). Hospice is established in the United States as a concept of caring rather than a place for care and thus services provided by hospice can be implemented in the patient’s home, hospital, skilled nursing home, or residential care facility. It is the common goal of each IDT member to provide quality palliative care for
patients and families. Providing services in the patient’s own home aligns with the social work value of the importance of human relationships:

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities (NASW, 1999).

Hospice also supports the patient’s quality of life as they work with the patient and family to carry out their wishes during the terminal phase of the illness. These services include managing the patient’s pain and symptoms, but also assisting the patient with the emotional, psychosocial and spiritual aspects of dying. Hospice offers speech and physical therapy to the patient when needed. Social workers who work in hospice make short-term inpatient care available when the patient’s pain or symptoms become too difficult to manage in their home or when the caregiver needs respite time. It has been established that the demands of family care giving often results in depression, anxiety, sleeplessness, and other signs of emotional strain (Kovacs, Bellin, Fauri, 2006). The respite service is available to caregivers to ease the emotional strain of caring for their loved one. Hospice also provides bereavement care and counseling to surviving family members and friends.
Social workers provide supportive services that are culturally sensitive and respect the inherent dignity and worth of the person. The National Association of Social Workers describes this value as:

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients’ socially responsible self-determination. Social workers seek to enhance clients’ capacity and opportunity to change and address their own needs (NASW, 1999).

The root of hospice then is, “a moral imperative, rooted in the value of concern about human suffering and the ethical responsibility to help relieve that suffering” (Fort-Cowles, 2003, p.284). The hospice goal of caring and relief of suffering is connected with the patient’s quality of life. As such, case managing nurses, social workers, and chaplains all assess the patient’s pain when they visit the patient. Social workers discuss with the other members of the team the patient’s quality of life issues, including the level of pain the patient is experiencing. Pain can be experienced by the patient physically, emotionally and spiritually. For example, a patient who had expected that radiation treatments would combat her cancer and who wasn’t told that the therapy would cause a blister on her skin may be experiencing both physical and emotional pain at the time she is admitted to hospice. In this case, the patient’s sense of betrayal along with the failure of the treatment would contribute to the patient’s emotional pain. Pain comes from the failure of interpersonal relationships to meet the individual’s needs, sense of belonging,
connectedness, longing for love, a desire to be special (Epple, 2003). If the social worker does not inform the other members of the team about the level of emotional pain that the patient is experiencing, the jobs of all the individual team members become more difficult.

_Death Anxiety and Cultural Context_

Services by the IDT members in hospice are rendered in light of the philosophy that hospice upholds regarding death. In hospice, all the members of the IDT view dying as a normal process in life. In contrast, American society generally considers death a taboo, and many people do not talk about it. When one experiences the loss of a loved one, it does have effect on how they think about their lives (Reith & Payne, 2009). Social workers and other interdisciplinary team members all face the patient and family member’s anxiety towards death as they deal with people who avoid discussing the death of a relative with others in the family, or those who don’t share information about death and bereavement with their children. It is the skilled social worker who will work with the patient and family to bring these difficult and important conversations to the surface. A helpful framework for social workers to use in the face of anxiety as well as grief or anticipator grief is the strength’s perspective. This perspective highlights aspects of the person and their environment that can be used and enhanced to assist in the grieving process (Pomeroy, Bradford-Garcia, & Green, D. 2008). Additionally, strengths influence one’s sense of well-being, empowerment, and life satisfaction (Pomeroy,
Bradford Garcia, & Green 2008). The strengths perspective grounded in the view that grief, in response to the death of a loved one is normal.

According to the National Hospice Organization, “Hospice exists in the hope and belief that, through appropriate care and the promotion of a caring community sensitive to their needs, patients and families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them” (Saucier- Lundy, K., Utterback, K., Lance, D., & Purvis- Bloxsom, I., 2009, p. 995). Related to cultural competency is the issue how the patient sees the interventions. What may be viewed as compassionate support to one patient may be offensive to another. This social validity is defined as the degree to which various client populations perceive interventions to be valid, relevant solutions to their problems (Hodge, Wolfer, Limb, Nadir, 2008). When the team works together and the social worker works with the client coming from a place of curiosity and respect, this will increase the social validity. Hospice is usually viewed as positive and compassionate by the larger community.

Social workers and other members of the team may benefit from more knowledge about how individuals from different cultures respond to the impending death of a loved one or loss. A state audit of hospices noted that there are insufficient trainings regarding death and dying as well as spiritual assessment and implementation of interventions (Oliver, 2003). Social workers are in a role where they give information about the progression of the patient’s disease as well as the process of death, which makes them an asset to the hospice team. It is the skillful social worker that can work with the patient
and families to reduce their overall anxiety that they may be experiencing and so they are more prepared to face the challenges of terminal illness. The patient’s end-of-life experience is unique, and must be understood within the bio-psycho-social-cultural-spiritual context of the individual (Rothman, 2009). Not all patients will feel comfortable talking to a chaplain, and thus they may feel less hesitancy with a social work visit. In fact, in some cultures it is seen as a lack of faith to accept that one is dying (Reese, 2006).

Juliet Rotham (2009), in her article, *Spirituality; What We Can Teach and How We Can Teach It*, discusses that practitioners must be aware of their own religious and spiritual beliefs in order to maintain and respect the difference between the social worker and the client. Dona Reese, Cecelia Chan, David Perry, Diane Wiersgalla, and Jennifer Schlinger (2005) suggest that training should include preparation to honor diversity between professionals and their clients as well as professional disciplines. The social work profession values cultural sensitivity and social workers can use the same skills in working with patients and families in a culturally sensitive manner to find characteristics in the team members that they work with. Awareness of one’s own cultural and religious beliefs is a prerequisite for honoring the beliefs of others (Reese, et al., 2005). It is this awareness that supports the social worker in making treatment recommendations to clients that are objective. Perhaps social workers can use the same self-awareness to guide their interactions as a member of the interdisciplinary team.
Social Work and Spirituality

Many of the studies about spirituality in social work have defined spirituality, as distinct from religion. Spirituality can be understood as an individual’s existential relationship with God, or perceived transcendence (Hodge, 2005). Spirituality is defined as transcendence in terms of having a philosophy of life, and a sense of connection (Resse et al., 2006). Dorthea Epple (2003) notes that transcendence can simply mean the capacity to move beyond one’s limitedness. Other definitions mention that spirituality includes the sense of knowing oneself and others (Clark, et al, 2007), involves search for meaning (Canda, Nakashima, & Furman, 2004).

Many social workers consider their vocation to be a calling and find personal meaning in the work that they do with the clients. Those who are concerned with the spiritual, including social workers, maximize this personal energy through study, meditation, and religious beliefs (Reith, Payne 2009). These efforts can give the individual a sense of meaning or purpose in regards to their place of work. Social workers who view their occupation as a calling may also mention feeling committed to social responsibility and claim that this calling guided their choice of profession. Those who do not consider themselves to be spiritual may mention that they enjoy activities such as art, music, or nature which some may consider spiritual activities. Social workers who consider themselves to be non-spiritual are not precluded from working in the area of spirituality and religion and can make a significant contribution to this area of social work (Hodge, Wolfer, Limb, Nadir, 2008).
The profession of social work has recently increased its recognition of the crucial role that spirituality plays in the lives of many clients. Social workers recognize the positive and negative role that religion and spirituality plays in the lives of some clients (Wagengeld-Heintz, 2009). There has been more interest in the positive aspects of spirituality in the practice of social work (Clark, et. al, 2007). In a national qualitative study two hundred and thirty six respondents supported the inclusion of religious and spiritual content in social work education, giving the following rationale:

A variety of religious and/or non-religious spiritual beliefs and practices should be understood in the context of human diversity; knowledge about negative and positive impacts of religious and nonreligious forms of spirituality is critical to understanding human behaviors and coping and ethical issues of handling spiritual issues in practice should be discussed (Canda, Nakashima, & Furman 2004, p. 30).

In the above-mentioned study, some (social workers) indicated their reasons for incorporating discussions of spirituality into the initial assessments:

(a) to identify spiritually (religious and nonreligious) based strengths, supports, and resources for coping as part of a comprehensive psychosocial understanding of the client; (b) to discern spiritual aspects of the healing and recovery process, especially for clients dealing with issues of crisis, loss, death, trauma, substance abuse, and serious illness; (c) to deepen knowledge about dynamics relating to
cultural diversity (d) to shed light on the context of presenting problems (e) to treat the clients as whole persons (Canda, Nakashima, & Furman, 2004, p. 31).

Social workers are given the opportunity to examine their biases regarding spiritual beliefs when courses are offered in education. Professional education should include content about awareness of one’s own cultural and religious beliefs (Reese, 2005). This contributes to the social worker’s self-awareness and skill; thus they become more of an asset to the agencies they work for, and interdisciplinary teams.

It is critical to address the spiritual concerns of patients and their family members in hospice, as they are generally prone to depression and anxiety. Religious and spiritual systems of thought give great significance to birth and death as important sources of meaning in people’s lives (Reith & Payne, 2009). The spiritual intervention, however, must be in line with the client’s interests and goals (Canda, Nakashima, & Furman 2004). Many social workers feel cautious about imposing their own beliefs or values on the client. It has been noted that when clients do present religious or spiritual issues, social workers frequently refer to or collaborate with religious helping professionals, such as clergy and support systems (Canda, Nakashima, & Furman, 2004). Social workers without religious faith or with a faith different from that of their client may find it helpful to approach this discussion by focusing on spiritual issues that are universal rather than the expression of them within a particular religion (Reith & Payne, 2009). Social workers may also express their religious view with clients in generic ways, for the purpose of supporting clients who already disclosed their beliefs (Wagengeld-Heintz, 2007).
A study, which utilized a cross sectional survey, found that the most highly used spiritual practices to working with palliative care clients by social workers included yoga, guided imagery, and prayer (Dane & More, 2005). The respondents, however, were drawn from New York residents, and from members of a professional society, which limits generalization to other regions of the nation.

**Spiritual Assessments**

Social workers have general methods to assess the spirituality of the client and develop plans for appropriate interventions. Spiritual assessments are used to gain understanding of the role that spirituality and spiritual practices play in the lives of an individual client and assist in utilizing spiritual strengths and resources in addressing needs (Rotham, 2009). The client’s distinct spiritual perspectives can serve as a protective factor or strength (Hodge, Wolfer, Limb, Nadir, 2008). The client’s coping, well-being, and recovery can be facilitated by spiritual assets such as prayer, meditation, worship, scripture reading, clergy consultation, and spiritual groups (Hodge, 2005). The spiritual assessments are used by social workers to explore with the client use of these spiritual assets as resources to address their problem. Discussion of the clients’ spiritual world view highlights to the social worker their attitudes about communication norms, diet, marital relations, medical care and gender interactions (Hodge, 2005).

In his article, *Developing a Spiritual Assessment Toolbox: A Discussion of the Strengths and Limitations of Five Different Assessment Methods*, David Hodge (2005) asserts that a comprehensive assessment should be considered when spirituality plays a
central role, an organizing principle in the client’s life. Hodge (2005) describes five assessment tools; this writer will focus the discussion on the spiritual life map, spiritual history, and eco grams. The spiritual life map displays the client’s relationship with God (or transcendence) over time through illustrations. This assessment method is highly client directed and the social worker plays a secondary role (Hodge, 2005). This approach allows the social worker to focus on building the therapeutic relationship, and thus learns about the client’s worldview. The client directed nature of this assessment falls in line with the hospice goal of self determination and may result in the client feeling empowered as the pictorial expression of their spiritual journey is generated. The spiritual history uses two sets of questions to help the client tell their story moving from childhood to adulthood, and it elicits spiritual information as the clients relate their stories. Spiritual histories are easy to conduct and work well with clients who are verbally oriented (Hodge, 2005). This spiritual assessment may not be appropriate for hospice patients who are diagnosed with a mental impairment such as dementia.

The client’s immediate family system is portrayed with squares and circles and drawn on a piece of paper to begin the spiritual eco map. Spiritual eco maps focus on that portion of the clients’ spiritual story that exists in the present space (Hodge, 2005). This puts the clients’ current spiritual story in context of their family system and other domains of significance such as involvement with a faith community. Thus social workers should generally seek to explore clients’ relationship with God or transcendence, rituals, faith communities, and transpersonal encounters (Hodge, 2005). Many hospice patients may express existential wonderings regarding their terminal illness or other
painful life situations and this spiritual assessment puts emphasis on strengths and relationship so that the patient can cope. Social workers have more strength in their role on the team by using these tools with patients and their families. The information gathered by these assessments is important to the nurses and chaplains as they provide background and a context to how the patient responds to the diagnosis of life threatening illness and the different stressors that come in hand with that.

In the following chapter, the methods that the researcher used will be described and discussed. This includes the research design, the subjects, sampling procedures, instrumentation, data gathering procedures, and the protection of human subjects.
Chapter 3

METHODS

The purpose of this study is to help social workers and others working with terminally ill patients and their families to better understand the personal experiences of the individual hospice interdisciplinary team members (social workers, nurses, chaplains). The results of this study may shed light on what makes a hospice team effective; gain more understanding of the social worker’s role on the team. When the social worker and other team members know what elements are critical for smooth collaboration, this makes the hospice services to the patient and family more effective. The findings of this study may help the hospice team members and the community at large to come to a stronger awareness of what hospice has to offer. This researcher will describe the methodology used in this study.

Research Design

There is little information about the experience of different hospice team-members, and regarding the nature of the hospice team. Therefore this study used a qualitative design to explore the experiences of members of the hospice team. Team members were interviewed about their experience on the team and the extent that interdependence and communication occur in the team. The interviewee was also asked about what qualities in other team members they found helpful in working with them.
Subjects

Interviews were conducted by this researcher with four social workers, two chaplains, and four nurses employed at a hospice in Northern California. This was a convenience sample of ten professionals.

Sampling Procedures

Qualitative interviews were conducted with each participant and open-ended questions were used for the interview. Prior to conducting the interviews, this researcher gained written permission from a relevant supervisor on letterhead to conduct the interviews. It was clarified that the interviews would not be done during the researcher’s working hours for field. The ten interviews were audio-recorded with the signed consent of the participants. This researcher did not offer any formal inducements to the participants of this study.

Instrumentation

The researcher used an interview guide (See Appendix B and C) that contained ten open-ended interview questions. An open-ended interview was used to explore the experience of the different hospice interdisciplinary team members. The interview included topics such as: the interviewee’s experiences on the interdisciplinary team, strengths of the team, hospice team interdependence, collaboration, team conflicts, nature of spiritual connection for the interdisciplinary team, the interviewee’s spirituality, and rewards of team work. These topics were used to guide and direct the interview with the
participant. Social workers were asked what qualities or characteristics of other team members they find beneficial in working with them. Chaplains and nurses were asked what they see as the role of social work on the interdisciplinary team. The interviews included demographic questions.

Data Gathering Procedures

The first step in the process of collecting data for this study was to recruit ten willing professionals to participate in this study. After verbal consent from each participant, the researcher arranged a date and time to meet the interviewee at a place of their choosing. At the time of the interview, the researcher provided a consent form (see Appendix A) and also verbally reviewed the critical issues of consent: the nature of the study, the procedures of the interview, the risks and benefits for the participant, and that it’s requested that the interview be taped. The researcher also explained to each interviewee that all notes and audio recordings would be kept in a locked cabinet in the researcher’s home. The consent form was in English. Participants were then asked to sign the consent form if they wished to participate in the study.

Upon the consent form being signed, the interview started. All the interviews were conducted in English. While taping the interview, the researcher took notes to better assist with data gathering and writing down themes. Due to the exploratory nature of this study, the researcher was focused on seeking information and themes. No names of participants or patients were used and the interviews consisted of ten sessions that lasted approximately one hour.
Data Analysis

The researcher gathered information regarding the rewards and challenges of hospice teamwork. The process of data analysis included playing back the audio taped interviews and writing down answers to questions and verbatim quotes. Given that the questions were open ended, the researcher recognizes the importance of accurately portraying and understanding the viewpoints of the participants. Johnson (2003) notes that interpretive validity is relevant to qualitative research, and describes that interpretive validity refers to accurately portraying the meaning attached by participants to what is being studied by the researcher. To analyze the interviews, this researcher used content analysis to identify emergent themes. The researcher debriefed with her project advisor, Andrew Bein to begin to identify emergent themes.

Protection of Human Subjects

Prior to starting this project, an application was submitted to the California State University, Sacramento Committee for the Protection of Human Subjects in the Division of Social Work. Approval of the application for the proposed study, The Social Work Role on Hospice Interdisciplinary Teams, was received on Wednesday, April 14, 2010. The approval number of the human subjects granted was 09-10-111. The letter indicated that the application was approved as Minimal Risk.
Chapter 4

DATA ANALYSIS

Introduction

This thesis explores the experience of different members of a hospice interdisciplinary team. This chapter is organized to provide an overview of the responses regarding the strengths and challenges of the hospice team. Additionally the interviews provide insight as to the nature of the hospice team. The first section of this chapter presents the demographic data of the participants. In order to protect anonymity and confidentiality no names will be used.

Participants

The ten participants included four social workers, four case-managing nurses, and two chaplains. Nine participants stated that they are Caucasian, with the remaining interviewee identifying as Black. All participants are over the age of 32 years old, with at least three and a half years experience working in hospice. The social workers that participated are all masters’ level social workers. Both of the chaplains have a master’s in theology, are board certified, and are endorsed by their faith traditions. The nurses are all registered nurses with either an associates or bachelor’s degree.

The Hospice Worker Experience

With respect to their experience working on the hospice team, all of the participants reported this it was positive experience. Among various factors, they noted
that there is opportunity to learn from the other disciplines. A nurse expressed her hospice team experience as “rewarding”. A social worker described that she likes that she can gain understanding about the perspectives of the other professionals. She elaborated on this, “I think the social work perspective on the team adds some color and life into what’s sometimes just diseases”. One of the nurses used the word “phenomenal” to describe her experience on the hospice team and expressed that she loves what she does and has others to rely on when faced with “ambiguity” and “dysfunctional families”. A chaplain described the hospice experience this way, “I don’t think you survive working in hospice without the interdisciplinary team”. This participant also mentioned the “camaraderie” and “support” between the team members, and that the different areas that the interdisciplinary team covers is important for all the needs of the family.

In addition to these positive descriptors of the hospice team experience, several team members also mentioned the hospice experience as “challenging”. One participant, a nurse, stated that sometimes there are “personality conflicts”. A social worker stated, “its a little testy right now” to describe that communication is sometimes a challenge. A chaplain explained that sometimes the “assumption” is that the chaplain doesn’t need to know the medical or social aspects of the patient and family. So sometimes she is left out of the loop with respect to communication.

All of the social workers described that they are “active”; try to give comments in the team meetings and they communicate with the nurses and chaplains. One of the social
work participants described that she usually calls “during and after visits” to “check in” and “relay information”. Another social work interviewee conveyed,

I feel like my role as a social worker, my job is to really show how the environment is impacting the patient and the family just as much as the physical symptoms are.

For one of the social workers, the question of how actively she participates in the team meetings prompted her to discuss communication in depth and describe her experience as a team member,

You have to butt your way in and I feel very okay about doing that. And usually the nurses have already asked me opinions or asked me there, if need be.

The researcher asked if this social worker felt that informal kinds of communications, such as phone calls, are helpful for teamwork. This participant responded,

Yes, because the team meeting only comes every other week so I depend upon those, and then sometimes not physical meetings but they can be at patients’ homes, or it can be communication by voice mail, sometimes it’s a conversation of voicemails going back and forth … as you know, you’ve heard my big battle-cry is communication, communication, communication. So yes, I believe in that-and I would like more of that somehow, because we’re adjusting and getting bigger it’s not happening as much. So patients don’t fall through the cracks, that’s my biggest thing.
The researcher asked the interviewee what she needed in order for communication to be improved. She elaborated about the importance of communication in the following excerpt from the interview:

I need nursing reports. I need, you know, after their visits- not every time but I need, any time there’s a change, or a potential discharge, that if I’m in on it, or if there’s an event that occurs in the family or if the patient maybe getting closer to death. I’m not getting all that information, you know, that’s the type of thing. We’ve (hospice team) talked about all this excellence, and having these people have confidence in us yet I don’t always get return calls from people and it is not excellent. And there were two families where I had examples where things did not get communicated, that made a difference, and could make a difference on how people view hospice because it was unsettling to the families. And that’s the whole point… these things happen, just lapses of people not thinking. I think they have to think more; you can’t be thoughtless in this job. You have to think, about your co-workers. And I like two of the nurses, who don’t give a lot of information, are excellent nurses and I like them very much. But they must not be used to reporting, in other jobs, nurses, in fact this is really odd when I was in graduate school there was a big to-do about then we’d have a health module, one of the big issues was, in one of the semesters, was how in the hospitals nurses declare territory and they don’t like social workers bugging them. And I have never experienced that ever in hospice and so I think some of these people come in with that mind set from the hospital and they really like to do their own work
without someone pester ing them. Of course I don’t think I’m being a pest anyways… but I never saw the turf war. They said it was there so I figured it had to be there. So I don’t think it’s a turf war here, I just think a lot of these nurses here aren’t used to communicating that much.

When the researcher asked about how actively a different social work interviewee participated in the team meetings, she stated, “Not as much as I would like” and referred to the “restricted” structure of the meeting. She recalled the effect of the time constraints on the team members.

I think the social workers and chaplains often felt pushed to the side, and their contributions weren’t, heard as much, because skilled nursing has to talk about the medical, clinical issues, they have to review the medications, there’s a certain amount of clinical/medical that has to be discussed in IDT and we seem to run out of time a lot. And my first supervisor on the job, she was less supportive, (current supervisor) is extremely supportive, wants us to participate more, that’s her goal, she wants to include us more. And realizes in the past, we’ve been kind of a you know, uh a nice “fluff” to have in IDT meetings, but the meat of the matter was always the nurses presenting their cases. But things are better, because of the new format. And we feel like we do have more time to contribute. Which is positive.

In regards to participation in the team meetings, all of the nurses described that they are actively involved in the meetings, and report on the patients assigned to them. One of the interviewees, a nurse, stated that she tries to listen to everyone else’s input to
learn how problems are solved so she is “more equipped to deal with” patients and families. One nurse spoke about her participation in the team meeting and her experience in the following excerpt from the interview:

I try to actively listen, I try to use my memory in terms of past experiences or situations that we had that might be helpful in terms of offering some suggestions with symptom control, symptom management issues, it’s really important for me when I feel like a person is asking for help to ask for clarification so that we can get a better understanding of what they’re asking for and whether they got the question that they had answered in a way that feels comfortable or acceptable to them, so those are the kinds of things I’m looking for. A lot of times I think our history has been that the nurses have kind of pushed the issues and there’s been a desire on my part that the social workers and chaplains offer their experience more because I value that and I know that their experience with patients and families are very involved in a professional way and that they have information.

_Hospice Team Strengths_

The researcher found that all of the participants had different descriptions of the strengths of the hospice team. Two of the social work participants discussed communication in regards to strengths of the hospice team. One of the social workers described the team working like a “good piece of machinery” and related this happening when she is confident about the outcome of communication. A nurse stated, “I think we have a cohesive team”. Many of the team members interviewed described, “problem
solving” as a strength. Furthermore many interviewees mentioned feeling “not alone” when working with other professionals and that the team was “comforting”. Others mentioned the feeling that members “had your back”. One interviewee, a social worker, explained the benefits of peer support:

I think one of the main strengths is peer support, knowing that we’re all doing this really life altering work in the patient’s home. It’s nice to be able to share those experiences with other members of the team. To be able to get their input… there’s nothing worse feeling like you’re the only person that has to solve the situation and it’s nice to know that you can bounce ideas off of other professionals and maybe get the validation that you’re doing the right thing or get the guidance, to put you on a better path on how to deal with something differently.

Another social worker related that the strength of the team includes providing patients and families with “comprehensive care” and “continuity of care”, and that this helps in avoiding crisis situations with patients and families.

The chaplain discussed the team strengths in terms of how the different team members have “different expertise” to offer. This participant mentioned how team members such as home health aides, and volunteers also work with patients and families. The interviewee also described a program the hospice offers to patients where dogs can visit the patients, and how this offers comfort to some patients. The other chaplain expressed the strengths being “competent people on the team”, and that the “team tries to
include others”. One of the nurses interviewed discussed collaboration and how that interfaces with values:

I think the strengths are the collaboration, and I think that strength can be different for different people depending on how much they collaborate or value that. But I very much value the collaboration and when that is being done the strength for me is that I feel like I am not the only person involved with that particular patient and family that I don’t have to be the end-all for all their questions and for the chaos and for the problems that they’re dealing with, you know. By having the other disciplines involved it’s not only a support for the patient and their families but it’s an incredible support for myself.

**Hospice Team Challenges**

The researcher asked the participants about conflicts within the team and how they are handled. A social worker responded by stating that she has felt challenged by the medical director when she first started out in hospice. She stated that it was a “positive” experience and elaborated,

People want to know, okay what kind of social worker are you? How are you going to be effective? So I think he’s coming from a place of, what do you know? What can you do here?

She stated that handled this challenge by telling the medical director how she will link the family to the “appropriate resources”, provide “counseling”, and can engage in “difficult
conversations” with the patients and families. Another social worker stated she’s had no conflict except one, when she worked at a different hospice. She explained that the nurse was “not doing what she said she would do”. She handled this conflict by talking to the nurse then talking to the supervisor when it was not “resolved”. Another participant, a social worker, stated that she had a personality conflict where a nurse was not using a “team perspective” in the past. She stated that she left voicemails making clear what she needed in order to make a “team effort”, and also talked to the supervisor. Another social worker identified differences of opinion she’s had:

We all have our different takes on things, and because we come from different paradigms, different clinical backgrounds, treatment focuses, there’s going to be differences of opinion about things which is healthy. I think that’s positive... I mean everybody’s respectful there’ve been differences in opinion about certain patients and families, and we always seem to respect each other’s different takes on it…To give an example would be… some of the other staff, I perceive them as very lenient in terms of not following through with mandated reporting that sort of thing… They give the patient and family so much leeway because they see the reporting as a punishment, whereas, I see reporting as more, it is an obligation, and I see it more as an opportunity for things to change in a good way, to shake it up a little bit and call it what it is. And to give the families and patient an opportunity to make good things happen. I may be kind of tough in some ways compared to maybe some of the other staff, and maybe that comes from my mental health background where you deal with clients who are challenging,
manipulative, you know sometimes don’t follow through. But I’ve never felt that anyone has held that against me.

In regards to handling various conflicts that arise at the agency, this social worker stated “you can agree to disagree”.

One of the chaplains stated that the most conflicted thing is “communication” and that the nurses’ schedules are no longer put in the staff’s boxes. This participant stated that the supervisors have positive ideas but no time to implement anything. The researcher asked how this conflict is handle, this chaplain responded by stated that if you “keep calling” and if no answer, call the supervisor. The other chaplain that the researcher interviewed described two “hurtful experiences” which resulted in this chaplain not feeling like an equal or being treated as an equal. This participant spoke about the issue as social worker “they chose to go off and do their own thing” and “it really was them who wasn’t willing to work with the chaplain because they felt they carried more of a weight then the chaplain did.” This chaplain handled the conflict by talking to the supervisor.

When interviewing the nurses regarding conflicts and how they handle them, two of the nurses mentioned the medical director as a mediator and a source. One of the participants stated that she only has conflicts “sometimes” with the medical director but did not describe any specific problems. She stated that the medical director has gotten “better” which reduces conflict for her. Another nurse stated there was a time where she had a different opinion about how things would progress with a patient and talked to the
medical director about it. Another nurse stated that sometimes there is not enough communication, and it helps to give staff opportunity to “process”, and mentioned, “respect”, as being important in handling the conflict.

**Elements Of Collaboration**

When faced with difficult client situations, many team members described collaboration and communication as solutions. One of the social workers mentioned “friendliness” and “openness to work with you” and “respect”. Another social worker stressed the importance of “constructive criticism” and “feedback”, the ability to give it as well as receive it. This social worker explained that “honesty” is crucial, honesty about one’s own biases about the difficult client situation. Additionally, she noted that it is helpful to know what other outside or other community resources the client is already involved with. Another social work participant described that it is helpful when other team members are willing to be “direct” and that “availability” and “accountability” is important as well. She elaborated that “strong”, “consistent”, and “early” communication is essential to avoid crisis situations.

The chaplains also described a team approach collaboration when facing difficult situations with clients. One chaplain mentioned that “joint visits” help where she and another team member visit the patient and family. The other chaplain stated that it’s important to make phone calls to other team members “right away” and elaborated on a “team approach” using the metaphor of a stool in the following.
If you have the nurse, you have a one legged stool, if you have the social worker, you have a two legged stool, if you have a chaplain you have a three legged stool, if you have a volunteer, there’s a four legged stool, home health aide, a five legged stool. And the more legs you have on a stool, the more steady, and the more grounded that’s going to be. It’s a great illustration as I talk to people about the need for support services in all areas of the disciplinary team.

Many of the nurse participants mentioned having a family meeting. A nurse relates that it’s helpful to “get all parties involved” together. One of the nurses stated that she feels that there is “more interaction” that happens in the IDT and this is helpful with faced with difficult situations. One nurse stated “if you have a difficult patient, then you have a difficult patient” and stated that you just do the best you can to make the patient and family “happy” and be “patient” with them.

All of the nurses and chaplains the researcher interviewed had rather complete answers that demonstrated strong understanding of the social work role in hospice. All of the nurses related that the social workers have understanding of the “family dynamics” and this benefits them as they interact with the family and patients in their role. Several of the participants mentioned that social workers provide “emotional support” and help the family with “medical insurance”, “community resources”, and have knowledge about “financial resources” for the family. One of the nurses stated that the social workers are very “knowledgeable” about skilled nursing facilities and assisted living facilities.
Hospice Team Interdependence

The researcher examined the idea of interdependence among the hospice team members. One of the social workers expressed that there are “inherent checks and balances among the team members” and explained that the nurse expects her to “accomplish certain things” with the patients and families. Another social worker described that the team is “inter-connected” and there seems to be “stress” experienced by the team members when the “interdependence” is not there. One participant viewed interdependence as “covering all basis for the patient”.

In terms of team support, the chaplains had strong descriptors for interdependence. A chaplain relates that interdependence, “it’s the ideal”, and described that the team supports each other as “time” and “caseload” permits. Another interviewee, a chaplain expressed that “we’re stronger as a team than we are as individuals”. This individual described a metaphor to illustrate interdependence:

I love the illustration of a team of horses. One horse can pull a certain amount of weight, two horses as a team can pull three times that amount of weight because they are encouraging each other and they are working together. So if you’ve got three people, four people, five people working together, then you have a much stronger team, and you can be much more valuable to the family. Plus you have the opportunity to connect with the other team members and ask them what their opinion is.
The researcher found that the nurses related interdependence to communication. One participant, a nurse expressed that phone calls help to get updates and in that way she is interdependent “on a daily basis”. Another nurse conveyed, “We all gain little pieces of the puzzle, pieces of knowledge, that we need in order to figure out what’s going on.” One nurse stated that she doesn’t use the term but that to her, everybody is “equal” except it seems that the medical director is “above” the rest of the team members.

_Hospice Teamwork And Spirituality_

The social workers discussed spirituality in terms of it interfacing with teamwork. None of the social workers shared that they practiced a specific religion. One of the social workers stated that her spirituality is “broad. She also mentioned that other team members are “accepting” as she debriefs with them. Another social worker relates that she finds herself to be “more spiritual than religious” and expressed that she sees her work being about “celebrating life” and sees death as a celebration of life. Another participant, a social worker spoke about bearing witness and stated:

I think part of it steams from us as a group bearing witness on the most profound intense events in patients’ and families’ lives, and we all witness those and help families through that process.

This social worker relates that she likes to bring in something “concrete” like a plant or a reflection to help the team be “grounded” and as a way of “renewing … hope”.
With respect to the nature of spiritual connection for the team, both of the chaplains spoke about how spirituality “drives” a person to do what they do. Furthermore, a chaplain stated that some of the stories from the patients and families are hard to hear and so support from the team is important. This chaplain related that it is important to “debrief” with other team members. One of the chaplains discussed teamwork:

I believe that we all have our own spiritual connection and my desire is to complement the rest of the team.

This chaplain elaborated on the purpose behind his role on the hospice team:

It’s not just a job but it’s a job that we seek to do because we want to help other people. We want to bring greater understanding and peace and care to people’s lives, and I think that has a spiritual dimension to that…But my job and the ministry that I provide is helping families discover their spirituality and not let my spirituality get in the way, thinking that they have to be like me, but helping them find where they are comfortable, listening to what they experienced at their spirituality and then celebrating. Whether I agree with it or not is not important, what’s important is that they feel comfortable in their spirituality, and that they feel comfortable in their own skin so to speak..

The researcher received a variety of answers from the nurses when asking about the nature of spiritual connection for the interdisciplinary team. One of the nurses stated that she doesn’t believe in God or an “afterlife” and just “goes along” with what the
patients and families believe. This nurse stated that the chaplains are helpful in working with the patient to assist and “support” the patient because she can’t. Another nurse stated that she is a “Christian” and feels that she has an “understanding” of where the chaplains are “coming from” as she interacts with them. Another nurse related that she considers herself to be spiritual and not religious, and encourages the patients and families to accept the support of the chaplain. This nurse states that she uses “humor” and “builds trust” to connect with patients and families. She explained that sometimes humor is appropriate in her work with patients and families, and sometimes it is not. One of the nurses spoke about forgiveness and how her belief system contributed to her work:

You know I would say that my belief system is that we are loved, and we are forgiven, and so the message that I want to impart on people is openness to who they are as a person, being non judgmental. If there are errors or mistakes, if you want to call them that strong of words. I want it to be an environment where one can say ‘hey, I don’t think I met my own standards here, but I really learned and I would make it different next time’ I really support that. I guess that’s part of what my spirituality is, for people, patients, you know it’s like if they’re burdened by their guilt or their thoughts of not being good enough, I want to assure them again that they are loved… Sometimes the hardest part is being able to forgive yourself there’s something much bigger out there that’s already forgiven you. You can acknowledge that.
Hospice Teamwork Rewards

All of the participants identified a variety of rewards from their work on the team, as well as from their work with the patients and families. Two of the social work interviewees discussed that it makes them feel good to offer “coaching”, “encouragement”, “options”, and “comfort” to families during a difficult situation. One of the social workers noted, “It’s that feeling knowing that someone’s died a good death and that families feel really proud that they’ve been able to provide that for their loved one”. One of the social work participants recalled lessons she learns from the patients and families in terms of its rewards:

I would say some of the biggest rewards are learning more about myself. It seems like every patient and every family, you take something away from them. You learn something from every case, and whether it’s learning to be more patient, learning to be more tolerant, learning to be less judgmental, learning to look at the bigger picture, or learning to appreciate spirituality more in their lives… Even with the patient and families that really challenge me..., also I see the families and patients, they really rise to the occasion and it always amazes me, how people are able to do that, in the worse of circumstances. I mean we have some people that have no resources, there has been maybe some conflict in the family in the past, the patient may be not a real lovable patient, but by gosh, the family pulls it together and does the best they can to care for their loved one, and that’s very heart warming to see people do that.
Another social worker discussed the reward of considering the impact she wants to make in her own life and legacy she wants to leave:

Learning about living, and how I want to live my life… in a nutshell… I think that’s powerful enough, I mean, how many of us get up every morning and go through the motions of life, versus getting up in the morning and being thankful that you have the time to be up to call your family and tell them you love them. To enjoy meals and dinners, with friends, and family, and loved ones. To know that your time, is just as limited as the next person. So how do you want to spend it? What do you want your legacy to be when you’re gone? … How do want to impact this life, do you just kind of want to mosey on through it or do you really want to make a difference, maybe that difference is in yourself maybe that difference is in other people. But you’re doing something, other than moseying through life.

The nurse participants described rewards from hospice team work that were similar to other team members. They also identified that it’s rewarding to make a difficult time for patients and families easier:

I was a critical care nurse, it’s nice to see the patient have dignity, honoring their wishes, having the patient and family go from anxious and upset to a calm acceptance is rewarding.

One of the nurses spoke about how she feels close to the social workers that she works with and that she is assigned to the same patients, in the same geographical area, as
these social workers. She mentioned that it is nice to be told by the social workers that she is doing a good job, nice to get cards from the families and be told verbally that she is appreciated. Another nurse described how she has an opportunity for personal growth and mentioned the relationships she developed as rewarding:

I would say, meeting the diversity of people that we have at the level of vulnerability people experience in the situation of dealing with a loved one dying. I love the diversity of whatever their life has been, whatever their life is now, and my opportunity to experience that even just in a little way, it keeps my mind open and growing. I think there’s been a tremendous opportunity for personal growth and development. There’s the sense that life is short even if you live to be one hundred, helps you to identify purposes and goals setting those purposes and goals and trying to accomplish them. And those can be playful, joyful, fun things to hard work, kinds of things, how precious a day is. I don’t like to end the day with conflict or problems, you know, it’s like, let’s work through this, make it what it can be, get through it together. I have a tremendous amount of friends, co-workers that I’ve worked with. People that have left or retired, and those are good things.

One of the chaplain participants also discussed that relationships with the families and with co-workers are rewarding. This chaplain elaborated:

I think the biggest reward is the relationships and the connections that I get with the families. Because we’re willing to go the extra mile because we know we’re
helping people in a significant way… But I would also not discount the relationships that we have with the interdisciplinary team. We can be a confidant that we can celebrate the happy things in their lives and when they struggle that we can be there to struggle with them. I find that it’s not just the team that I’m working with today. And I think that’s the rewards that come. It’s not the money; it’s not the hours; it’s those amazing relationships that last for the rest of your life. Because you have journeyed many journeys together with other people and I think those journeys are what bring joy to our life as we see that we have helped other people and we have journeyed difficult places. One of the things that I believe about Hospice… is that not everybody is willing to work in hospice because it’s not always a nice place. It’s difficult when people are dying and family issues are coming out and family secrets are coming out and to be able to work with them and help them find peace in that and journey that journey with them is an amazing experience. And you find friendships and bonds that will last for the rest of their life and the rest of your life.

The other chaplain that the researcher interviewed related, “most of it is presence, it’s not about rewards”. The participant explained, “I feel like I’m doing what is asked of me to do by God”.
Chapter 5

SUMMARY AND IMPLICATIONS

Summary

In this study, the researcher sought to highlight the experiences of interdisciplinary team members who worked in a hospice located in Northern California. Through a qualitative study of different members of the hospice interdisciplinary team, the researcher asked each team member open-ended questions about the participant’s level of participation in the team meetings, and their opinions regarding team collaboration, interdependence, and spirituality. The researcher recorded the interviews and coded the hospice team member responses. Examination and analysis of the hospice team experience provides a greater understanding of the role of social work in hospice.

The following themes emerged in this study: (1) communication; (2) the medicalization of hospice; (3) collaboration challenges; (4) spiritual connection and team work; (5) rewards from hospice team work

Communication. Every one of the participants made reference to communication as integral to collaboration and interdependence. Each of the participants saw value in interacting with others who work on the team in a different role. Whether research participant discussions involved discussing the frequency and nature of their phone contacts with other team members, communication skills as a strength, or challenges with communication, each interviewee viewed communication as a crucial part of their role on
the team. Furthermore, several participants discussed the concepts of honesty and trust among the team members and how important those elements were to communication and collaboration.

_The medicalization of hospice._ Several of the participants identified that they, in their role are equal to the other professionals, with no professional having higher status than the other professional. However, one of the participants described the medical director as being “above” the nurses, social workers, and chaplains. There was also reference to their being “strong direction” from the medical director and mention that the medical director “fine tunes” the individual’s skill sets. The medical director was described as “helpful” and having knowledge about managing the patient’s pain and symptoms.

_Collaboration challenges._ The team member’s support and services offered to the patients and families were discussed as in hand with the hospice team member’s interactions with other team members. Many interviewees discussed a variety of challenges to collaboration. It seems that teamwork becomes restricted when there is less time and service delivery is not as effective when working with a team member who does not value contacting other professions to consult with them. Effective collaboration is more difficult to execute as this hospice grows in the number of patients that they serve. It seems that all of the team members are adjusting and adapting to this challenge.
Spiritual connection and teamwork. The participants described their own spiritual identities, and all of the participants stated that this element related to the patients’ and families’ quest to be comfortable in their own spiritual journey.

Rewards from hospice teamwork. The researcher gleaned much information as to the rewards from hospice teamwork. The participants readily discussed and elaborated on rewards in spite of the challenges that they face. Many of the interviewees made reference to the relationships that they have with their co-workers as well as the setting’s opportunities provided to learn about life.

Implications

These findings suggest some practice and educational implications for the social work profession. It may be helpful to implement teamwork concepts in social work education to promote awareness around collaborative efforts. It may benefit social workers to consider the advantages, facilitating factors, and barriers to teamwork in the face of the multi level challenges clients face. The aspects of communication, honesty, and trust are useful to work with clients and other professionals. Furthermore, it would be advantageous for social work to explore the status of medical versus social in the medical or hospital settings. The goal would be for social workers to learn how to work with, and respond in a medical setting. Additionally, it would be beneficial to examine teamwork in a non-hospice setting as compared to the hospice setting.
APPENDICES
Consent to Participate in Research

You are invited to participate in a research study that will be conducted by Abigail Bowers, a graduate student at California State University, Sacramento. Abigail Bowers is a student in the Division of Social Work performing research as a fulfillment of Masters of Social Work program. This study will explore the role of social work in hospice. As a vital member of the hospice team, you will be given the chance to describe how the team works together and your experiences on the interdisciplinary team.

**Procedures:**

After reviewing this form and agreeing to participate you will be given the opportunity to set up a time for an interview at your convenience. The interview should last 45 minutes to 1 hour. It is asked that the interview be recorded by microcassette tape recorder, but the interview can be conducted without this. The voice file will be transcribed and then promptly destroyed. As a participant in the interview, you can decide at any point to not answer any specific question, stop the interview entirely, and/or withdraw from the study.

**Risks:**

Although the questions do not cover personal or sensitive topics, the discussion of some of the topics in the interview may cause some distress. In order to reduce risk to you as a participant the following resources are available to you to access.

1. Mercy Medical Group: Behavioral Health Department
   1792 Tribute Road Ste 350 Sacramento, CA 95815
   (916) 924-6430
   (916) 924-6446 (voicemail for intake appointment)

2. Catholic Social Services: New Pathways Counseling
   5890 Newman Court Sacramento, CA 95819
   (916) 452-7481

**Benefits:**

By being part of this study you will be given an opportunity to discuss your experience as a member of the hospice team. This research will contribute to social
work’s knowledge regarding the role of social work on interdisciplinary teams and the strengths social workers bring to teamwork.

**Confidentiality:**

Interviews can take place at a location of your choosing. To protect confidentiality, no names of interviewees or patients will be used in this research project. Consent forms, notes, and audiotapes will be kept in a locked cabinet in the researcher’s home. All data will be destroyed upon completion of the study.

**Right To Withdraw:**

If you decide to participate in this interview, you can withdraw at any point. In addition, during the interview you can choose not to answer any specific question(s). I have read the descriptive information on the research participation cover letter. I understand that my participation is completely voluntary. My signature indicates that I received a copy of the research participation cover letter and I agree to participate in the study.

I, agree to participate in this research project, The Social Work Role On Hospice Interdisciplinary Teams.

Signature ____________________________ Date

I agree to have my responses audio tape recorded

Signature ____________________________ Date

If you have any questions you may contact me at (916)230-6460 or email me at abigail.m.bowers@gmail.com Or if you need further information you may contact my thesis advisor: Andrew Bein, PhD., LCSW c/o California State University, Sacramento (916) 278-6170  abein@csus.edu

Thank you for taking the time to participate in my study!
APPENDIX B

Interview Guide, Social Worker

The Social Work Role On Hospice Interdisciplinary Teams:
Social Worker Interview Guide

Interview Questions:

1. What has your experience been like working on the interdisciplinary team?

2. How actively do you participate in the interdisciplinary team meetings?

3. What do you see are the strengths of your interdisciplinary team?

4. What qualities or characteristics in other team members do you find helpful in working with them?

5. In what ways is your hospice team interdependent?

6. What is essential for smooth collaboration when facing difficult client situations?

7. Have you encountered any conflicts in your work on interdisciplinary teams? If so, how were these conflicts handled?

8. What is the nature of spiritual connection for the interdisciplinary team?

9. How does your own spirituality contribute to this connection?

10. What would you say are the biggest rewards you receive from your work on the hospice team?

Quick Demographics:

How long have you worked as a social worker in hospice?

What is the highest level of education you have completed?

What is your age?

What is your ethnic background?
The Social Work Role On Hospice Interdisciplinary Teams:
Other Team Member Interview Guide

Interview Questions:

1. What has your experience been like working on the interdisciplinary team?
2. How actively do you participate in the interdisciplinary team meetings?
3. What do you see are the strengths of your Interdisciplinary team?
4. What do you see as the role of social work on the hospice team?
5. In what ways is your hospice team interdependent?
6. What is essential for smooth collaboration when facing difficult client situations?
7. Have you encountered any conflicts in your work on interdisciplinary teams? If so, how were these conflicts handled?
8. What is the nature of spiritual connection for the interdisciplinary team?
9. How does your own spirituality contribute to this connection?
10. What would you say are the biggest rewards you receive from your work on hospice team?

Quick Demographics:

How long have you worked as a hospice nurse (or chaplain)?
What is the highest level of education you have completed?
What is your age?
What is your ethnic background?
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