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Interprofessional team members' perceptions of palliative social workers' contributions to patient-centered care

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High-quality patient-centered palliative care: interprofessional team members' perceptions of social workers' roles and contribution

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ABSTRACT

A core tenet of interprofessional collaborative practice (IPCP) is that efficient and effective teams are critical for the delivery of high-quality, patient-centered care. Although palliative care has a history of excellent care, increasing demands and larger patient loads are challenging teams to adapt and strengthen team functioning in hospital settings. The purpose of this qualitative study was to better understand the IPCP contributions of advanced palliative social workers (PSWs) through the eyes of their colleagues. Twenty-four interprofessional palliative care (IPPC) team members from other professions (i.e. nurse practitioners, physicians, physician assistants) from 16 hospitals across the U.S. participated in 20-minute semi-structured interviews. The Patient-Centered Clinical Method (PCCM) was used as a conceptual model to aid in the interpretation of the data. This model illuminated the centrality of PSWs' role in building and sustaining a therapeutic alliance between the patient and the IPPC team, through assessing and promoting care that centers the patient's experience with illness, creating space to initiate, process and revisit difficult healthcare conversations and helping to modulate the pace and intensity of emotionally laden discussions. PSWs also support the therapeutic relationship with the IPPC team by providing continuity and connection across and during the hospital experience and supporting the well-being of the IPPC team. This study offers novel insights into how PSWs contribute to patient-centered IPPC and furthers the articulation of the role of PSWs in hospital settings.

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Introduction

Interprofessional collaborative practice (IPCP) is fundamental to the delivery of high-quality palliative care that achieves patient satisfaction as well as positive patient outcomes (Interprofessional Education Collaborative Expert Panel, 2016). By attending to the physical, functional, psychological, social, and spiritual consequences of serious and life-limiting illness, interprofessional palliative care (IPPC) teams seek to improve the quality of life for patients and their families (Ferrell et al., 2018). Reflecting the broad scope of care, IPPC teams are typically composed of multiple healthcare providers, including chaplains, nurses, physicians, physician assistants, and social workers (Ferrell et al., 2018).

The focus on hospital-based IPPC teams is timely; the demand for palliative consultations in inpatient settings has grown exponentially in the two last decades and has expanded beyond its origins in oncology to all disease types and healthcare settings (Dumanovsky et al., 2016). In 2000, fewer than 25% of hospitals had a palliative care program, by 2017 over 75% of medical centers offered this resource (Schoenherr et al., 2019). Additionally, as palliative care has expanded, the number and scope of practice of palliative social workers (PSWs) has also increased (Altilio et al., 2022). A 2021 study of IPPC teams reported an 83% increase in PSW consults and a 133% increase in social work staffing between 2015 and 2019 (Edmonds et al., 2021).

Early IPPC research focused primarily on identifying the barriers and facilitators associated with the adoption of this model across healthcare settings (Bain et al., 2014; Brandt et al., 2014; Vestergaard & Nørgaard, 2018). Although studies exploring the processes of IPPC team collaboration are emerging (Schot et al., 2020; Sutherland et al., 2022), few examine the ways in which IPPC teams utilize and integrate the skills and expertise of social workers to increase their overall effectiveness and efficiency. In Schot et al. (2020) systematic review of IPPC studies between 2000 and 2019, they found that IPPC team members work together to contribute to the overall effectiveness of the delivery of patient care through: (a) bridging professional, social, physical, and task-related gaps, (b) negotiating overlaps in roles and tasks, and (c) creating spaces for collaboration to occur. Yet, their review also revealed that most studies focused solely on physicians and nurses; studies typically lumped all other professions in a "general" category. These studies, as well as calls to action by social work leaders, suggest a need to better define palliative social workers (PSWs) roles in IPPC teams (Blacker et al., 2016; Jones et al., 2014; Lynch et al., 2016). There is mounting evidence that other professions' lack of understanding of PSWs' full scope of clinical skills is contributing to their under-utilization on IPPC teams (Ambrose-Miller & Ashcroft, 2016; Blacker & Deveau, 2010; Peterson et al., 2018; Sweifach, 2015). This qualitative research study

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sought to fill this gap through an exploration of how hospital-based IPPC teams utilize the expertise of PSWs' clinical skills to increase the team's effectiveness in providing high-quality patient-centered care.

Background

Social workers' roles in palliative care

PSW has grown into a sub-specialty in the last decade (Altilio et al., 2022; National Association of Social Workers, n.d.; Sumser et al., 2015; Thiel et al., 2021). In 2019, a national certification for Advanced Palliative Hospice Social Worker (APHSW-C) was established, defining the core knowledge, interventions, and clinical skills of the advanced practice specialty (Head et al., 2019). A national study of PSWs' job descriptions identified key responsibilities as including psychosocial assessment, family meetings, decision making support, cultural awareness, advance care planning, dying process support, legacy work, and bereavement support (Glajchen et al., 2018; National Consensus Project for Quality Palliative Care [NCP], 2018; Sumser et al., 2019). However, empirical studies examining PSWs' roles and IPPC team-based contributions are quite limited. Studies have primarily focused on either a single role function (i.e., advance care planning; Stein et al., 2017), ICU medical resident support (Weiner, 2020), family meeting (Jonas et al., 2020), or consider outcomes if a social worker is embedded in a specific practice setting (i.e., acute care; Lakin et al., 2021), geriatrics (Min et al., 2022), and heart failure (O'Donnell et al., 2018). Although reporting positive patient outcomes, these studies did not explore in-

depth the PSWs' behaviors as integrated IPPC team members.

Patient-Centered Clinical Method (PCCM) as a conceptual frame

This study was informed by the Patient-Centered Clinical Method (PCCM; Stewart et al., 2013). Although designed to guide individual family medicine physicians' practice behaviors toward a patient-clinician therapeutic alliance, the PCCM model reflects the principles and processes commonly used in efficacious IPPC palliative care. As seen in Figure 1, the PCCM four components are as follows: Component 1, "Exploring Health, Disease, and Illness Experience," focuses on understanding the patient's perceptions of: (a) disease, which is largely biomedical and diagnosed using the medical model; (b) illness, the personal and subjective experience of the disease; and (c) health, one's global perception of well-being. Component 2, "Understanding the Whole Person," involves sensitivity to the patient's world beyond the disease. It encompasses understanding the psychosocial factors, both proximal factors (i.e., family dynamics, social support, education, religion) and distal factors (i.e., community, culture, social determinants of health). Knowledge gained in Components 1 and 2 allows clinicians to personalize care as they engage in the mutual task of Component 3, "Finding Common Ground," an iterative process "where patients are treated as partners in exploring their health problems and treatment options" (Stewart et al., 2013, p. 107). Each interaction contributes to Component 4, "Enhancing the patient and team relationship" or building a strong therapeutic alliance.

The PCCM highlights the complexity of the patient-clinician relationship and emphasizes compassion, empathy,

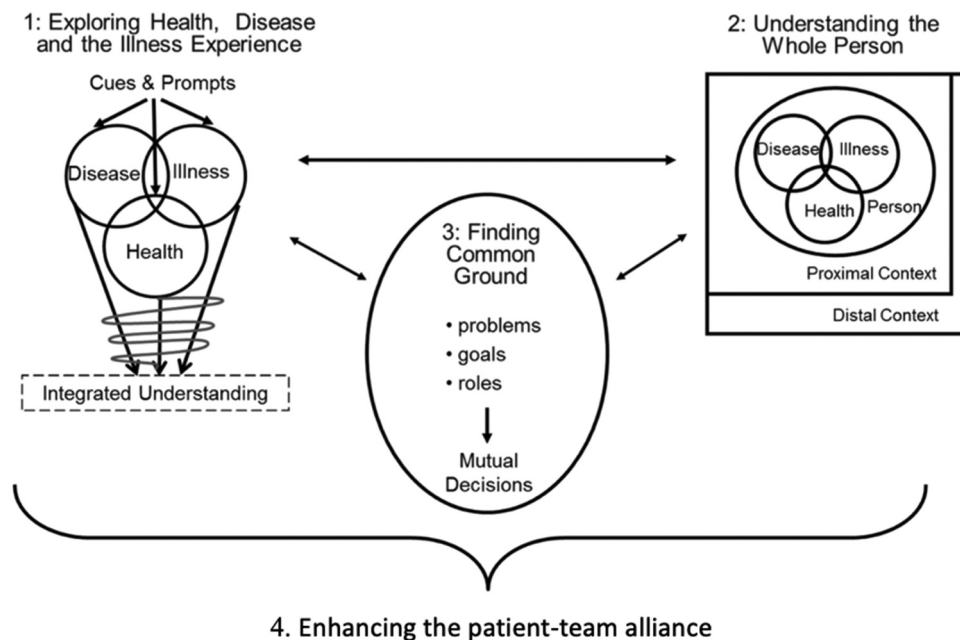


Figure 1. Patient-centered care model. *Source: Figure 1.2. "The patient-centered clinical method: four interactive components." Pg.8. Patient-Centered Medicine: Transforming the Clinical Method (3rd ed.). Stewart, M., Brown, J.B., Weston, W.W., McWhinney, I.R., McWilliam, C.L., & Freeman, T.R. © 2014 by Imprint. Reproduced by permission of Taylor & Francis Group.

trust, sharing power, continuity, consistency, and hope (Stewart et al., 2013, p. 159). The model has been used as a training tool (Fortin et al., 2021) and inspired interventions to improve patient outcomes (Hudon et al., 2012), including medication adherence (Bwala et al., 2020). As a conceptual model in interprofessional care, it underscores the centrality of psycho-social-spiritual aspects of patient-centered care (de Oliveira et al., 2019; Fortin et al., 2021).

Given hospital-based palliative care is typically provided by a rotating team of clinicians, we have broadened the PCCM to consider the development of the therapeutic alliance with a patient and their IPPC team, individually and collectively. The expansion of a therapeutic alliance to a group is a complex construct. It is both difficult to measure and linked to mixed results. Studies of therapeutic alliance with a pain rehabilitation team (Paap et al., 2022) and a palliative care team (Bakar et al., 2020) found that consistency and communication of mutual collaboration were facilitators to building a therapeutic alliance. However, in the rehabilitation setting, rotating clinicians were linked to a deterioration in therapeutic alliance (Paap et al., 2022).

The PCCM provides a conceptual footing for the study's exploration of the ways in which PSWs are perceived as contributing to collaborative, quality palliative care in high intensity healthcare settings. Rather than focusing on a single profession's view on their own roles, our study is unique as it focused on the contributions of PSWs as seen by their IPPC team colleagues. The expansion of this model may offer insights into ways in which IPPC teams create and develop therapeutic alliances as a group.

Methods

Study design

We used the qualitative research methodology of interpretive description (Elliott & Timulak, 2021; Thorne, 2015), with analytic procedures of thematic analysis (Braun & Clarke, 2021; Vaismoradi et al., 2013). Interpretive description has increasingly been adopted by qualitative health researchers as an analytic method for understanding clinical phenomena that yield practice applications and implications (Elliott & Timulak, 2021; Thorne, 2015). Its methodology focuses on language and meanings from the perspective of the participants involved in the social phenomenon.

Sampling and recruitment

Purposive sampling involving a two-step recruitment process was used to create matched samples of PSWs and their IPPC team members. In the first step, the PSW recruitment, participant eligibility was based on two criteria: employment on a hospital-based adult IPPC team in the last 6 months and having met APHSW-C requirements (i.e., passage of an evidence-based test, current clinical licensure, 4000-plus hours in palliative/hospice social work in the previous five years). Working with the APHSW-C accrediting organization, a study announcement was emailed to 250 social workers

nationwide in summer 2020. Twenty-three social workers responded to the request; however, six individuals were eliminated (i.e., four were not in a hospital setting; two failed to follow-up). A total of 17 PSWs participated in the study.

The second step, IPPC team member recruitment, began at the end of the PSWs' interviews (to be used in a future analysis). PSWs were asked to provide the names and contact information for one to three IPPC team members from different professions with whom they worked within the prior 6 months. All PSWs provided at least one name; those who only offered one name typically cited the stress of the COVID pandemic as the limiting factor. A total of 32 IPPC team members were identified; of whom 24 (75%) responded to the PI's e-mail request and participated.

Data collection

A single Zoom™ interview, averaging 20 minutes, was conducted by the principal investigator (PI); informed consent was obtained at the interview's start. The drafting of the interview guide was informed by the literature and a PSW focus group; subsequently, the developed instrument script was reviewed by two national PSW leaders and piloted with three experienced PSWs to assess question clarity and face validity. Our analysis focused primarily on the two case scenarios. The first was a PI-provided case (see online supplement) of a 63-year-old man, diagnosed 5 months prior with Stage IV pancreatic cancer with liver metastasis with low prognostic understanding and the goal of attending his daughter's wedding. Open-ended questions probed the participant's views of their IPPC team approaches in such a case, with targeted questions on the PSW's role. The second case was a participant-shared scenario which illustrated the PSW's contributions. Although some participants recalled a specific case, many highlighted several cases.

Participant characteristics

As reflected in Table 1, the 24 participants, who included 16 physicians, 6 nurses, and 2 chaplains, were all experienced palliative care clinicians – roughly 60% had been in the field for over 5 years. The participants were diverse in terms of gender and age; however, most identified as White. All participants were from medical settings across the United States, the majority worked in urban teaching hospitals.

Data analysis

The recorded Zoom™ interviews were transcribed; people/institution names were replaced with pseudonyms to ensure confidentiality. Reflexive thematic analysis, a six-phase structured analytic process (i.e., familiarization, open coding, generation of initial themes, developing and reviewing themes, refining, and naming themes, and interpretation/analysis), was adopted (Braun & Clarke, 2021). Triangulation coding was used; coding was conducted by two researchers using Dedoose™ software, and these thematic codes were then independently reviewed by a third researcher to assess interpretive validity. In the final phase, the three researchers collaboratively

Table 1. Demographic characteristics of interdisciplinary team members.

Baseline Characteristic	n	%
Professional discipline		
Physician/PA	16	66%
Nurse Practitioner/Nurse	6	25%
Chaplain	2	8%
Gender		
Female	14	58%
Male	10	42%
Race		
White	17	70%
Latinx	2	8%
Asian/Southeast Asian	5	20%
Years in Palliative Care		
1–4 years	9	37%
5–10 years	9	37%
11 + years	6	25%
Hospital Setting		
Community Hospital	4	16%
Urban Teaching Hospital	20	83%
Geographic Area		
New England	6	25%
Midwest	6	25%
Southeast	9	37%
West Coast	3	12%

Note: $N = 24$.

interpreted the emergent themes into the PCCM four core components.

Ethical considerations

Prior to conducting research, human subjects' approval was obtained from the Boston University Institutional Review Board.

Results

Table 2 presents the six themes that emerged from the interviews on the perceived PSW roles and contributions to IPPC team's effectiveness and connects each PSW identified role to the associated PCCM core concept. Each theme is then described in detail and illustrated with excerpts from participant interviews.

Table 2. Six emergent themes of psw roles and contributions to the IPPC team's delivery of Patient-Centered Care Using the PCCM Framework.

Theme	PCCM Core Component
Theme 1: Assessing and promoting care that centers the patient's experience (particularly their experience of the illness) and is sensitive to psychosocial needs of the patient/family.	Component 1: Exploring Health, Disease, and Illness Experience Component 2: Understanding the Whole Person
Theme 2: Providing clinical expertise and support to patients with complex psychosocial needs (i.e., anxiety, depression, trauma histories).	Component 2: Understanding the Whole Person
Theme 3: Creating time, space, and an environment to initiate, process, and revisit difficult and emotionally laden clinical and medical conversations with the patient/family.	Component 3: Finding Common Ground
Theme 4: Modulating the pace and intensity of emotionally laden medical conversations with patient/family.	Component 3: Finding Common Ground
Theme 5: Providing continuity and connection for the patient/family throughout and across admissions.	Component 4: Enhancing the patient and team relationship
Theme 6: Supporting the well-being of the IP team.	Component 4: Enhancing the patient and team relationship

PSW = Palliative Social Worker; IPPC = Interprofessional Palliative Care; PCCM = Patient Centered Care Model.

Themes

Theme 1. Assessing and promoting care that centers the patient's experience of illness and is sensitive to psychosocial needs of the patient/family

Participants emphasized the importance of the initial palliative care consultation and described it as a shared role with several IPPC team members exploring the patient's illness experience. However, after the initial joint consultation, participants spoke about role delineations (or role boundaries) in which health-care providers (i.e., physicians, nurses) focused primarily on patients' symptoms management and disease-based decision-making while the PSWs concentrated on the patients' lived experiences with the illness.

I think sometimes with nurses and physicians we tend to skim over some of the psychosocial parts after the initial assessment, some may be our medical focus, but some of it is just lack of time . . . [A]s a nurse I am going to start by looking at labs and vitals . . . whereas our social worker . . . is very skilled at exploring the deeper meaning of illness. Nurse, urban teaching hospital

IPPIC team members often identified the PSW's biopsychosocial assessment as instrumental in assuring that the IPPIC team has a full understanding of the patient, their family system, and proximal and distal factors affecting the patient's life.

A good social work assessment provides the whole team a better understanding of the patient and family's information preferences, their dynamics, and the way that they've approached important decision-making in the past so the team can have a sense of how they share information amongst themselves – from a family dynamics lens. Physician, urban teaching hospital

Several team members spoke of a PSW's role in re-centering the IPPIC team toward treatment of "the whole person," including assuring that cultural aspects of illness and health beliefs remain central to the team's understanding of the patient. As one nurse noted, "Our social worker also really keeps an eye on the cultural differences. Sometimes, personally, I can start to focus on the disease and forget about the differences . . . they expose that and remind us of those important aspects."

Theme 2. Providing clinical expertise and support to patients with complex psychosocial needs (i.e., anxiety, depression, trauma histories)

Participants spoke about their reliance on the PSW's clinical expertise for leadership in responding to patients' complex psychosocial needs. Of particular importance was the PSWs' counseling of patients and families whose levels of distress were impeding their ability to process illness information or decision making. Many cited the PSW's effective crisis management in supporting overwhelmed patients and families.

We look to our social worker when we have a sense that psychosocial and emotional distress are fueling the disease presentation or how the person is experiencing their life-limiting illness . . . such as, if a patient or family member is not taking in what we are saying. . . . [M]any of these patients have history of trauma and uncovering and working on those aspects is essential work to move conversations forward. Physician, urban teaching hospital

Also highlighted was how PSWs guide IPPC team members' understanding of the patient's strengths and coping skills as well as the patient's capacity for growth, which can inform the team's focus.

I have continually observed their [PSWs'] ability to really appreciate the strengths or potential opportunities for improvement of coping strategies that the patient might have. They explore the coping and bolster it- it might be based off their [the patients] previous life experiences, level of education, work experience, or level of independence that they've achieved in their adulthood . . . [S]ocial workers have a better understanding of how much room for improvement in coping or adjustment to illness is achievable . . . Physician, Veterans Administration (VA) hospital

IPPC team members identified the PSW's expertise as essential with patients and families with histories of interpersonal violence, significant mental health issues, and/or at high risk for complicated bereavement.

Theme 3. Creating time, space, and an environment to initiate, process and revisit difficult and emotionally laden clinical and medical conversations with the patient/family

Exploring a patient's goals and values is a collaborative and iterative process involving multiple conversations, especially if the patient faces difficult medical decisions (Jain & Bernacki, 2020). Family meetings are a common method by which IPPC teams provide medical updates, discuss treatment options, and share illness trajectory and prognosis. Participants spoke about the PSWs' key role in preparing families for these discussions. As one physician shared, "Oftentimes our social worker sort of lays the groundwork for our discussions . . . [they] help families formulate questions in preparation for difficult family meetings or they prepare the patient for upcoming conversations."

Participants highlighted PSWs' role in creating space and supporting the patient and family in processing medical information as well as the emotions linked to their illness and healthcare experience.

One way social workers really help is to check in with families after family meetings and to provide that emotional support which allows the family to process or vent. They can also assess what the family heard, to make sure it's aligned with what we wanted to say. I see them staying after and just acknowledging, "I know that

was a hard meeting" and just seeing where they are. . . Physician, urban teaching hospital

Participants also noted that PSWs, as non-physician providers, have the ability (or power) to create a "non-threatening" or "safe" environment that benefits both the family and the IPPC team.

I think patients talk to social workers differently . . . Maybe some patients wouldn't want to say something to a medical provider. Like, if they complained to the doctor, they might think they wanted to stop treatment or might try to change their pain medicine. . . . [W]ith the social worker, they may feel just safer . . . the social worker is seen more as someone who is an unbiased player in the game. Physician Assistant, urban teaching hospital

Theme 4. Modulating the pace and intensity of emotionally laden medical conversations with the patient/family

IPPC team members felt that PSWs play an essential role in assuring that information sharing is person-centered. Participants highlighted PSWs' role in modulating the pace and intensity of medical conversations and balancing patient/family emotional needs with the IPPC team's need for medical decisions.

[Social workers] do a good job of ensuring that we're having the conversation in a measured fashion and are not running rampage over the emotional capacity of a patient at that point in time . . . I see them try to slow the conversation down and say something like, "Let's, summarize what's been said so far." Or even stopping the conversation and saying, "Let's give you time to process this information." Physician, urban teaching hospital

The PSW was cited as the IPPC team member who, during emotional conversations, can enter the conversation on behalf of the patient to ask a clarifying question to ensure patient understanding or cue the IPPC team to the level of emotions present in the room.

[F]rom a team perspective sometimes it helps especially when the physicians are going through the medical information that sometimes the social worker is able to hear what we're missing, or watch for the reactions of the family members, so then they are able to ask the right questions . . . kind of reframing it or maybe asking a clarifying question. . . maybe they have seen a look of confusion . . . sort of putting the medical speak on pause and just then kind of acknowledging how difficult this is . . . Physician, VA hospital

IPPC team members recognized the PSW's role in advocating for patients' and families' understanding of the medical information to deepen their understanding of their illness and/or care options.

Our social workers play a huge part in moving patients and families forward in terms of understanding disease trajectory. You know it's initially about establishing a rapport, but then it is about being an advocate, making sure they understand the information. Physician, community hospital

Theme 5. Providing continuity and connection for the patient/family throughout and across admissions

In the inpatient setting, the PSWs are often the only clinicians who are on service 50 weeks of the year. Their consistent presence was cited as contributing to team functioning as well as patient-centered care. Participants spoke of how the

PSW's constancy contributes to the IPPC team's efficiency, particularly in developing a therapeutic alliance.

Our social workers really play a role in continuity. Palliative care has longitudinal relationships with patients and families. . . Our social worker is present when we initially explore the patient's symptoms and quality of life. Over time, the conversation evolves from one about symptom management to more about making tough treatment decisions. . . [I]ncluding our social worker provides a familiar face, even if the physician has changed, they are trusted. Physician, community hospital

PSWs' continual presence is particularly important for patients with serious, chronic health conditions who have repeat admissions. As one physician at a VA hospital shared,

. . .often the social worker really is the person who can stay and be consistent. I mean. . . sometimes we'll do a consult, and you feel like you've done nothing big medically, but if we build rapport over admissions . . . it builds trust. And social workers can play that role for some of these patients over 5 or 6 admissions. There's definitely been wins with that, especially with the families.

Another physician spoke about how the bond that a PSW established with the patient provided a foundation for his own relationship.

And if they know and trust the social worker, that can help overall, because the patient is like, "I know [insert SW name], she's good people." Then I kind of can build on their work and say, "I know that you and [name] have talked [and I have] an understanding of where we are, but I'd love to hear from you about [patient's thoughts and goals] . . . I guess it is like appropriating part of their relationship and proceeding from there. Physician, urban teaching hospital

Theme 6. Supporting the well-being of the IPPC team

Although "taking care of the team" was not part of the PSW formal job description, participants valued PSWs' attention to the IPPC team's well-being, including their skills in supporting members' interactions with patients, and/or the processing of members' own reactions in difficult case decisions. The skilled presence of a PSW in the room when a doctor is disclosing difficult information, for example, was identified as valued resource.

If it's the doctor's role to have to break bad news, like to tell someone they're dying, that is hard to do, even as a doctor, and it's really helpful to have someone help manage the emotion that comes out after it. If I am going to deliver hard news, then the social worker recognizes that their role may be to collect the emotion afterward, while that person who said that thing kind of recovers themselves, right? . . . [Y]ou can go to a hard place because you've got great, absolute master in the room of helping to manage the emotion that comes out around it. Physician, urban teaching hospital

Stewart et al. (2013) emphasized that conscious self-awareness is needed in developing an authentic relationship with patients. Participants spoke of relying on PSWs who are clinically trained in transference and countertransference reactions, for advice on boundary-setting with psychologically complex patients.

One of the skills that I'm continually struck by is [the PSW] being able to diagnose what's going on within a patient or family system . . . [W]hen one of my social work colleagues will go into that situation, they can come out with a little bit more tangible information such as the name of that dynamic. And then they can give

really good strategies to help the team, like how to set boundaries, or assigning a point person. Physician, urban teaching hospital

Finally, PSWs were noted to play a role in supporting the IPPC team in reflection and taking the time to discuss the emotional and difficult aspects of cases.

I know social work has a supervision model where you decompress and talk about the patient encounters. And physicians really don't have that when we train. I think it helps a lot in to debrief and reflect on the difficult cases . . . I see our social worker doing that with the team, which feels sort of therapeutic and really helpful. Physician, urban teaching hospital

Discussion

This is the first study, to the best of our knowledge, that explored how different professionals on hospital-based IPPC teams view PSWs' roles in the delivery of patient-centered care. In doing so, this study provides insights into the scope of PSWs' clinical skills and practices as articulated by professions with whom they work closely.

Additionally, the use of the PCCM as a conceptual framework for understanding professional members' roles on IPPC teams was an innovative contribution; it illuminates the centrality of the PSW's role in establishing, building, and sustaining a therapeutic alliance between the patient and their IPPC team throughout the patient's care experience (across all four PCCM components). This is significant, as the presence of a strong therapeutic alliance has been associated with better quality of life in cancer patients (Thomas et al., 2021), better caregiver bereavement outcomes (Trevino et al., 2015) and enhanced goal-concordant care (Sanders et al., 2018). It shows the PSW's role as an integral part of the IPCC team for not only the patient, but also for the team's functioning. Our results indicate that IPPC team members depend on PSWs' psychosocial assessment as a team tool used to gain a deeper understanding of the whole person (Component 2) and how this has affected their illness experience (Component 1). This knowledge (or information) opens more avenues for the IPPC team to "find common ground" (Component 3). This assessment may serve to humanize the patient, supporting the team to shift from patient-centered to person-centered care (Håkansson et al., 2019).

Literature suggests that other professions appreciate PSWs holistic psychosocial assessments and clinical skills, however, few articulate the specific psychological underpinnings and range of their clinical skills (Maramaldi et al., 2014). Although our study also found this to be generally true, several IPPC team members did highlight specific skill sets such as strength-based assessment of coping skills and reflective counseling.

The PSW's role in modulating the pace and intensity of medical conversations appears to be a unique role for the PSW. Hospitalizations are overwhelming experiences; individuals often report high levels of anxiety, frustration, insomnia, and fear (Palmer et al., 2021). When faced with urgent decision making, persons can be emotionally overwhelmed and have difficulty comprehending complex medical information (Jain & Bernacki, 2020). This may be most significant in patients

with trauma histories, who often present with greater emotional distress, challenges in communication with and trust of healthcare providers, difficulty accepting a life-limiting prognosis, and increased reports of pain (Ganzel, 2018; Ricks-Aherne et al., 2020). Even though it is essential for all IPPC team members to take a trauma-informed approach, PSWs are viewed as well suited to take a leadership role in the modeling and teaching of trauma-informed care and providing more targeted clinical interventions (Ricks-Aherne et al., 2020).

PSWs were identified as having a central role in recognizing and addressing communication gaps stemming from anxiety, fear, distrust, or low health literacy. This is an important health equity issue; over 50% of U.S. adults have low health literacy with the greatest disparities occurring among racial and ethnic minorities (Chou et al., 2015; Johnson, 2013). Participants identified a reliance on, as well as respect for, PSWs' attentiveness and resources brought to patients/families.

This study's revelations align with the Schot et al. (2020) systematic review findings that professionals contribute to the IPPC team by "boundary spanning" or bridging professional, social, physical, and task-related gaps. Boundary spanning emerged as a key role that PSWs performed as part of "finding common ground" for the patient and IPPC team in hospital settings where there is distrust and isolated clusters of professionals in need of connectivity (Oliver, 2013). Boundary spanners facilitate the flow of information between people or groups separated (or hindered) by some gap or barrier (i.e., geographic, cognitive, cultural; Long et al., 2013). Interestingly, boundary spanners rarely hold direct authority in organizations or over the groups they are "spanning," which may be a place PSWs can leverage their identified "non-threatening" presence. This perception may be associated with their position in the hospital-based hierarchy, but likely also reflects their facilitative leadership skills and communication expertise.

Finally, the COVID-19 pandemic has raised concerns about the increasing stress and burnout among healthcare professionals, including those in palliative care (Prasad et al., 2021). Our findings revealed that IPPC team members recognize the role PSWs play in supporting the well-being both individual and group functioning; cited examples included providing space for debriefing on difficult interactions and potential transference and countertransference reactions as well as education on self-care practices to combat stress (Renzenbrink, 2011). Yet, the lack of inclusion in PSWs formal job descriptions means that this important role of the socio-emotional support of the IPPC team is an area of potential invisible labor for the profession.

Study limitations

It is important to note several limitations of the study. First, we focused on IPPC teams that employ APHSW-C PSWs; this group may not be representative of all PSWs thus caution must be taken in generalizing the findings. The choice to focus on APHSW-C level social workers, however, reflects an interest in gaining knowledge about this new specialization, which is responding to a healthcare workforce need. Second, the names of the IPPC interviewees were provided by the PSWs,

and it is likely they identified colleagues with whom they had positive working relationships. Third, the majority the participants were from urban teaching hospitals across the U.S. and smaller, less resourced hospitals could produce different results.

Conclusion

Taken as a whole, the study's findings suggest that IPPC team members regard PSWs as valuable colleagues in the development of a therapeutic alliance with patients and their families and their ability to deliver goal concordant palliative care. PSWs are viewed as important IPPC team members who can support patients and families, individual IPPC team members, and the IPPC team's collective functioning. The tremendous growth of palliative care programs underscores the need for institutional support directed toward increasing the pipeline of highly skilled, APHSW-C social workers.

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