Exploring the 'social' of social work in palliative care:

working with diversity

ABSTRACT

Social work is one of a number of caring professions that contribute to the practice of palliative care that is now delivered in hospitals, hospices and in the community. Most palliative care social work is undertaken as part of a medical speciality that draws on the multidisciplinary professional team that has as its aim the meeting of practical, psychological, physical and spiritual needs of dying people and their families. This article reports case study research that explored the practice of one social worker with experience of working as part of a hospital and hospice palliative care team, both located in a diverse inner city environment. In-depth semi-structured interviewing explored the complexity of palliative care social work in this setting. Findings reveal the importance of building positive relationships with clients and the highly labour-intensive nature of this work, particularly in relation to supporting the culturally diverse needs of some dying and bereaved people. The requirement for person-centred interventions is highlighted, so as to avoid stereotypes and misunderstandings in pursuit of providing appropriate and 'respectful care'.

Keywords: cancer; culture; death; diversity; dying; hospice; palliative care; social work

Introduction

Social work, as one of the 'psy' professions that include psychologists and psychiatrists as well as social workers (Foucault, 1977), is practised in a variety of sectors including education, the criminal justice system and health care. Palliative care, as a specialist form of health care practice with people who have life-limiting illness, has a multi-professional approach to care drawing on the expertise of clinicians, physiotherapists, complementary health practitioners and social workers. Delivered in hospitals, care homes, hospices and in the community, palliative care has been widely lauded for its holistic person-centred approach that addresses social, spiritual and physical care needs of the dying person. Because this approach has the family as the 'unit' of care, it is argued that the dying person experiences a greater depth of psychosocial support and those that are grieving can benefit from ongoing bereavement care (Randall and Downie, 2006).

However, the benefits of effective pain-control and the management of symptoms to enable dying people to have a 'good death', has led to an increased emphasis on the medicalised aspects of the palliative care model (Author's own, 2010) such that Payne et al (2004: 4) ask 'is palliative care about dying or symptom control?' The role of social work has thus received a lower profile in the palliative care literature, this despite claims for the importance of multi-professional working. Family conflict, unresolved and anticipatory grief and relationship breakdown are some of the issues that

1

social workers must address as they support individuals and families in regaining control of their situations at, what is often, a very stressful time in their lives.

This article reports case study research that explores the ways in which social work contributes to palliative care as multidisciplinary professional practice. The aim of the research was to investigate elements of palliative care social work practice in a multicultural setting to potentially inform the design of a larger research project. Questions concerning inter-professional working, models of practice and effective use of resources are considered. A range of case examples, that draw on the practice of one social worker in a diverse UK urban setting, are used to highlight the complex and challenging nature of social work practice in this often sensitive and highly charged context. The article opens with a brief conceptual critique of the 'social' within social work drawing principally on the ideas of Dominelli (2010). This is followed by discussion of the role of social work within palliative care drawing out both its range and complexity. The article proceeds to describe the case study research method and then draws upon the interview material to firstly consider the challenge of building relationships with dying people. The work of supporting vulnerable families is then discussed, illustrating how social difference, inequality and cultural diversity materially shape palliative care social work practice in an inner city multicultural environment. Finally, the article discusses some conclusions including some limitations of the research.

Reflecting on the 'social' of social work

In the UK the development of modern day social work can trace its history from the Victorian era when the huge influx of workers and their families into the cities resulted in many living in hardship with slum housing, inadequate sanitation and widespread poverty giving rise to concerns about how a potentially unruly population could be controlled (Rendall, 1990). The work of educating and supporting the poor and disadvantaged (often originally as part of a moralising function) became the concern of the new social or 'psy' professions (see above), mainly social workers and health professionals. The focus on the 'social' that 'exists in the interstices between the private and the public domains' Dominelli (2010: 31), began to take hold and continues to be central to social work practice.

The terrain of the 'social', however, does not have clearly mapped boundaries because so many aspects of life have both private and public dimensions. Central to the concept of the 'social', is the interaction between individuals, between communities and the relationship between the individual and the state. This is complex and multi-layered such that the arena of the 'social' is an inevitably contested 'space' wherein the rights of the individual are balanced against those of the family, community and wider social good (Dominelli, 2010). This is the disciplinary domain of social policy that acts as the means by which services are shaped and delivered and scarce resources are distributed. For those in need, negotiating a web of bureaucracy, establishing entitlement and just generally finding their way through a plethora of formalities, can be very daunting. And so, whilst as Reith and Payne (2009:

193) comment, substituting inappropriate medicalization with inappropriate psychologization should not be advocated, an emphasis on social work intervention that helps people navigate across the boundary of the personal and the public to fully participate in dying as a natural life process is distinctive and underpins use of the term 'social' for the purposes of the discussion that follows below.

The place of social work within palliative care

At its core, 'social work is a profession with roots in caring for others' (Dominelli, 2010: 2) and operates alongside other practitioners delivering health and social care in a range of settings (Holloway, 2007). It has the key goal of empowering individuals to take control of their lives in ways that enhance their well-being and the well-being of others with whom they have relational connection. Most social work practice is shaped by loss of some kind, be it clients' diminished physical and/or mental health, reduced capacity to parent children or loss of home and country. With loss comes vulnerability that Gitterman (2009) contends is characterised by an individual's lack of capacity to meet their own needs. Reith and Payne (2009: 7), however, counsel against seeing loss as just an individual problem, arguing that loss is always both personal and social. The awareness and impacts of loss and vulnerability are particularly heightened by the experience of life-limiting illness, death of a loved one and the bereavement that follows (Weinstein, 2008). It is this kind of loss that is the focus of social work practice within palliative care.

The concept and practice of palliative care have been widely discussed in the literature and there now exists a number of definitions and meanings of this philosophy of end of life care. For the purposes of the discussion herein, the World Health Organisation's (WHO) definition of palliative care provides a useful framework.

'Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual' (WHO, 2002).

The WHO definition is underpinned by the philosophy of palliative care that embraces multidisciplinarity; affirms life and accepts death as a normal process; intends neither to hasten nor postpone death and sees the application of palliative care principles as relevant early in the course of illness. Palliative care is, thus, not just concerned with care in the last days or weeks of a person's life, but has relevance at every stage of the disease process from diagnosis onwards. In general terms, palliative care can be understood as inter-professional co-ordinated care of the whole person when curative treatment is no longer possible (Author's own, 2010). The concept of 'total pain', as a central tenet of palliative care practice, is based on the way in which a dying person's symptoms impact on their physical, emotional, social, spiritual and psychological well-being with the goal of palliative care being

achievement of the best quality of life for patients and their families within the constraints of a life-limiting illness.

The work of the multidisciplinary/inter-professional team is an underpinning precept of palliative care practice; the roles of doctors, nurses, chaplains, occupational therapists, complementary therapists and social workers contribute to a co-ordinated programme of care for individuals who have been referred for palliative care. Reith and Payne (2009: 162) highlight how, as a practice community, the multidisciplinary team works best when there is a commitment to shared learning amongst team members. Whilst the literature has devoted much space to discussing the nature of the work of clinical and pastoral practitioners within the multidisciplinary palliative care team (see for example, Payne et al, 2004; Nolan, 2012), information available about the work of palliative care social workers is more limited.

Drawing on the professional literature, palliative care social work is positioned as very diverse to include: facilitating advance care planning; advocacy on behalf of the patient and family; leading community education workshops; counselling and psychotherapy for individuals, couples and families and intervening in crises (NASW, 2010). This is not an exhaustive list of functions but serves to illustrate the myriad ways in which social workers contribute to the support of dying people and their families. The information from the National Association of Social Workers (NASW, 2010) emphasises that usually palliative care social workers find themselves working in a medical specialty and often have to justify the value of social work interventions. Parker (2005) notes that the role of social workers may be wider than that of other palliative care professionals and that it has a 'socio-educative' component that is directed towards the reintegration of death and dying into our vision of society.

Focusing on specific social work skills, Sheldon and Firth (2008) argue that social workers have significant expertise to offer psychosocial palliative care with their understanding of social issues that can lead to distress in individuals and families. Negotiating the sensitive social terrain of family splits, social isolation and social inequality is part of mainstream social work and is also required in the context of death and dying. Writing about the role of the social worker in palliative care, Monroe (1994: 252) develops this point arguing that 'social workers' training helps them to locate the patient and family within a social and cultural context and thus to exploit resources which may help the family to resolve the difficulties they face'. Related to this, Parker (2005) cites, for example, how common it is for palliative care social workers to receive requests for assistance completing benefit forms or for advice about charitable awards. These and other problem-solving functions contribute to the development of a relationship between the social worker and the client/family and this is highly valued by clients (Beresford et al, 2006). All social work is relationship work and the establishment of positive relationships between social workers and palliative care clients is particularly crucial where life and time are limited and the future uncertain. Mallon (2008: 31) calls attention to the importance of professionals working in this area 'building a

relationship which offers safety, emotional warmth, consistency, commitment and genuine care'.

The very practical contribution of social work within palliative care is drawn out by Connor (2009) who, writing in the US context, paints a vivid picture of the different types of help provided by social workers. He explains: 'if insurance coverage is confusing, they straighten it out. If the phone is disconnected they are the patient's advocate to see that it gets turned back on. If respite is needed, a volunteer or short inpatient stay is arranged. When it's time to leave the hospital, the social worker helps to do the discharge planning' (Connor, 2009: 26). The emphasis here is very much on problem-solving action to resolve difficulties as they crop up.

Within the palliative care model, care also extends to patients' family and friends and Connor (2009) comments that families can be severely disrupted by the impending death of one of its members and sometimes the role of the social worker is to act as the listener of difficult and anguished emotions. Leming and Dickinson (2007) comment that family members may find it difficult to communicate with each other, such is the level of their distress, and the social worker is the primary provider of emotional support in helping families come to terms with the death of their relative. Connor (2009: 26) notes that the social worker 'functions as both counselor and practical guide to the dying process'.

Some commentators question the emphasis on the family as the unit of care within palliative care practice. Randall and Downie (2006: 75), for example, note that the 'belief in obligations to relatives is rarely questioned in palliative care' and argue that this potentially may involve ethical dilemmas for the health care team with, for example, the interests of patient confidentiality compromised by assumed responsibilities to the family. The balance between making the patient comfortable and keeping the family comfortable may thus come into play here. They make the further related point that where the emphasis is on family-centred care, this may not take account of conflicts of interest that can arise between patient and family. Both policy and practice cannot thus be applied in a standardised way but should consider each patient in his or her family context (Author's own, 2010).

Method and background

The research, on which this article is based, adopted a case study approach using in-depth qualitative interviewing of a very experienced palliative care social worker as the data collection method. The case study was intended as a pilot interview to inform the design of a wider project to explore the development and place of social work within palliative care practice. Case studies can be used for a variety of research purposes such as exploring (new areas), describing (events, behaviour or interventions) and explaining (complex phenomena) (Kohn, 1997; Yin, 2009). Simons (2009) characterises a case study research method as being context-specific whether in terms of organisation or individuals or collections of individuals. Stake (1995) stresses that it is the study of the particularity and complexity of a single case that can

yield insights of universal significance. Simons (2009: 20) argues that, whilst case study research tends to use qualitative methods, it is not the method that defines the approach, but rather it is its singularity in relation to the phenomenon being studied that is its key characteristic.

Interviewing is one of the most widely used methods in generating qualitative research data (Rubin and Rubin, 2005) and is often a preferred method for sensitive research topics (Liamputtong, 2007). Kvale (2007) contends that interview research is a craft that is learned and refined through practice and that this practice has theoretical, epistemological, ethical and practical dimensions. Whilst all these elements cannot be addressed in this discussion, it is relevant to highlight how the interactive nature of one-to-one interviews can provide opportunities to develop or deepen the discussion in particular areas, according to the material that arises and the interests and judgement of the researcher. It is this feature that shapes the in-depth semi-structured interview as guided conversation (Mishler, 1986), with interviewees positioned as partners in the research process rather than subjects to be tested or examined (Rubin and Rubin, 2005: 12).

Byrne (2012) discusses both the flexible and unpredictable nature of interviewing within social research, highlighting this most importantly as a form of communication. As a discursive and dialogic research tool, the interview is where knowledge is co-constructed in the interaction between the interviewer and interviewee (Kvale, 2007). Although the perceptions and experience of the interviewee's life world are key components of this knowledge, it is the interviewer who has control over the knowledge creating interaction that is a professional interaction rather than just a spontaneous exchange of views as in everyday conversation (Kvale, 2007: 7). I was reminded of the power of the interviewer as close scrutiny of the transcript revealed how prompts from the interviewer steered the interviewee to stay focused in her responses.

The social worker, who for the purposes of this article will be known as Janice, agreed to be interviewed about her nine years of professional experience working in a hospital and hospice palliative care team, both located in an English inner city environment. Janice was aware that the interview was a pilot that would be used to inform research design of a wider study. Currently Janice is employed as a hospice social worker. She is white British and in her early fifties. The interview, that took a semi-structured form, lasted for almost two hours, was audio-recorded and subsequently transcribed and the transcription then sent to Janice for comment. Full information and consent protocols were followed including an assurance of anonymity in terms of the identity of the interviewee and of individuals and circumstances discussed in the interview. An outline interview topic schedule had been prepared, with this as one type of impositional strategy aimed at 'getting at the *real* in interviews' as outlined by Barbour and Schostak (2005: 42). Topics covered included career history and educational background, development of palliative care and the place of social work within the multidisciplinary team, challenges and rewards of working in this sector and training and support needs. Open-ended prompts were also included after the

main topics had been discussed with the aim of capturing unexpected issues and information (Barbour and Schostak, 2005). The interview data was thematically analysed drawing on some of the principles set out by Braun and Clarke (2006) involving systematic coding of key categories.

Building relationships: at the centre of palliative care social work

Monroe et al (2011:3) argue that 'responsiveness to individual need and circumstance and attention to issues of cultural sensitivity have been at the heart of palliative care from its inception'. Social differences and inequalities experienced by individuals and families throughout life are often heightened in the context of illness and death and dying. Diversity is a theme of much of the interview data and the social distinctions of class, gender and culture were particularly prominent in the data case examples. A thread running throughout the data was the challenge of establishing relationships, both amongst professionals and between social workers and clients that is core to the provision of appropriate, individualised and supportive end of life care.

The emphasis on dying as a social relationship is argued for by Howarth (2011) who draws on Glaser and Strauss (1965) in characterising the dying process as a series of status passages and transitions for the dying person. Where the dying person is located on this status trajectory helps to guide the behaviour of health and social care professionals and this was very much evidenced in Janice's description of two individuals she had been supporting. The first is that of a woman who had had breast cancer over a twelve-year period and during that time had cut herself off from her wider family. She was the mother of two teenage children who from a very young age had seen their mother live through the various illness/wellness cancer episodes. On a number of occasions this woman had been told that she was dying, but had managed to continue to survive and Janice explains how this 'deferment' of death impacted on her role.

The second case Janice described involved a man in his forties who she was supporting in the community. She had visited him in his home a few weeks previously against a background of some resistance from him to her presence and ongoing support. She explains thus:

"I just sensed that there was some sort of problem, the brains mets. I just knew he wasn't right; he was still walking but he was just odd and I felt that he needed to be somewhere to be held and looked after for a little while and for us to find out what was going on. The other thing was that his pain wasn't under control and he was very horrible to me. He always tested me. I tried to analyse our relationship afterwards. He was a building labourer type person and had not had anything to do with social work before or anything like that and I wasn't his type at all. You know he had this middle-aged wifey type of person coming in. He had a picture of Che Guevara with a kalashnikov and one of Mohamed Ali and I think he didn't like the idea of me coming in. He seemed to test me but in the end he was pleased to come into the hospice and get sorted out and he never left".

Maintaining independence and continuing to manage their particular situation in their own way is as important to those who are dying as it is more generally. Becoming involved with professionals and health and social care systems is alien to many (see, for example, Author's own, 2009) and, despite the offer of interventions to materially improve the quality of life that remains, such *official* help may be keenly resisted. As the examples above illustrate, this is in part a relationship issue, but it is also a power issue because letting go of some of one's autonomy can signal a slippery slope towards a wholly dependent status.

The work of building relationships between professionals and the issue of social work being accorded equal respect alongside other professions in the multidisciplinary team was also cited as an important factor in trying to ensure the best outcomes for palliative care service users. Janice raised this issue focusing on the institutional context of both the acute hospital and the hospice.

"I think as far as hospitals go, social workers are seen by many as bed blockers. They prevent discharges rather than facilitate discharges. I think to a certain extent in a hospice that's also seen as being so. It's difficult because sometimes it is about personalities and relationships as well so I think that some people are valued as social workers and some people are not valued. Some teams can really value their social workers because they are working closely together and they can see what they are doing and other teams don't. What makes me laugh is that when there is a really serious situation on the ward, the first person they call is the social worker".

An incident, involving a man who has died in the hospice, is recounted by Janice to illustrate how situations can become highly emotionally charged where complex family dynamics exist and these have to be negotiated as part of the dying and bereavement process. The deceased man had sixteen children by former partners and one child with his then current wife. The sixteen children were in one room and his then current wife in another and each *group* was insistent on their sole right to be in the room with the dead body. Janice described the scene as "just a general war on the ward" and one that she was suddenly called upon to resolve. She explains "I go into this room with sixteen angry people who don't want the wife to go into her husband and sort this out". Janice interprets the anger displayed by the sixteen children in terms of what has not been. She says "the sad thing was that they knew that they hadn't had a relationship with their father and the hours count down to the time that they have got left in a way to have that relationship. During the actual dying stage they wanted to try and have that pseudo-relationship and take on that relationship that they never had in life and it is that that causes conflict. A lot of times it is about money but not always; sometimes it is about a pseudo type of relationship built on that last day".

The incident described by Janice is in sharp contrast to the calm, well-managed 'good' hospice deaths that have been the subject of numerous commentaries on palliative care. The origin of the modern hospice movement,

with its roots in middle class philanthropic Christian values, has propagated an idealised image of death centred on a peaceful, dignified and reconciled dying process (see Lawton, 2000). Murphy (1993: 131) develops this point suggesting that proponents of hospice care argue that it enables dying to be a period of 'growth and reconciliation' with an emphasis on making 'good' or 'better' impaired relationships. Clearly, this may be far from attainable for some dying people who, in death, are caught up in a web of tangled relationship patterns, just as they were in life. Or, to put it another way, the 'social' in the well world is transported into the setting of the hospice and the dying world.

Supporting vulnerable families

A second major theme of the interview data was the challenge and reward of working with marginalised ethnic minority families facing death and bereavement and a potentially fragile future. Janice saw this as an opportunity to do what she called "real social work" that involves both working therapeutically with individuals and being very "outcomes focused". Providing end of life care for increasingly diverse communities within the UK is now recognised as a demographic imperative and is perceived as a major challenge for the hospice movement (Richardson and Koffman, 2011). Access to quality end of life care, however, is just one aspect and Cskai and Chaitin (2006: 58) emphasise how 'respectful care' depends on professionals thinking through how race, culture and gender impact on an individual's value system and life circumstance. This thinking through approach was conceptualised by Janice as working in a holistic way with some South Asian families, attending to their practical, psychological and spiritual needs. She recounts in some detail her experience of working with one young Bangladeshi family, drawing out the very practical and sensitive approach she adopted. The story begins thus:

"I have been working very closely in the last few weeks with a young Bangladeshi family with girls aged eleven, fourteen, sixteen, eighteen, twenty-one and twenty-five. Their father had a very serious brain tumour and first of all I had to prepare those children because I knew that he was going to die. I didn't know whether it was short weeks or short months, I just knew that he was going to die. So first and foremost I had to make sure that the family knew what was happening and prepare the children for the death. So, the first five weeks was really doing that and on the fifth week I said 'your dad is going to die'. I actually said the word 'die', whereas I had been saying short-term life and things like that. Also, this man had controlled everything in the house so there were multiple facets of other things going on that they were worried about as well. I had to look after all those other issues, the practical issues that were coming forward at that time".

The importance of both the emotional and the practical is highlighted in this account of preparing the family for the impending death of the family patriarch. Because of the dominant cultural significance of the role of family male head, it was particularly important for Janice to engage with the family about how they could begin to take some control of matters about which they had had no

previous knowledge or experience. Through this careful preparation, the girls (particularly the older ones) and their mother gradually began to develop confidence in becoming owners of their future, both as individuals and as a family. The story continues:

"And then we got to the death and I have been seeing them ever since. We talk about the mosque and how great it was, a thousand people praying that day their dad died. I look at the spiritual aspects as well as all aspects of their development in the future, their psychological health, their education. The house that they live in, they don't feel secure now so in a practical sense the man of the house, their protector who would save them if somebody breaks in, he is dead so now they are scared to come back downstairs, particularly at night. So I say, let's look at the locks. Are these locks secure on these windows and doors? That's about their psychological health. Right now they are scared and we need to look at what we can do. So we look at the lock on the door.....is it secure? OK it's secure so we don't need to get anyone round to put a new lock on. I just look at every aspect; I have been down there for hours sorting out benefits, the TV licence cos I don't want them to get fined".

The fear of this Bangladeshi family about how they will manage without their male figurehead is expressed in many ways and it is not possible here to recount all the issues that Janice found herself dealing with. A key approach, however, was to work *with* the family and not just on their behalf, so that some learning by doing could empower them for the future. Janice summarises this approach below:

"I am also thinking of the strengths perspective of social work where what I want this family to do is stand on their own feet at the end of it so I see that as a kind of teaching role but also looking at their strengths and also trying to ensure that they are set up for the future. It is completely about being self-sustaining in the end and, although it would be lovely to support these people for years on end, you are disabling them if you don't think about how they will operate in the future".

The final element of this detailed case study concerns the impact of both the role and person of the social worker, particularly as role model for the personal development of those who receive services. This 'social' impact may not be directly tangible but its potential is revealed in the following data narrative from Janice:

"I also think that my role here is an example to these girls. You know they are Bangladeshi and have been very cosseted. But they have got dreams and goals and by seeing me, I think that they know that maybe they could do something. They say 'why are you doing this for us?' They were so damaged when I got them. They thought that xxxx (the hospital) was dreadful, and were so disempowered by the whole scenario. The key thing is to be really person-centred because even one Bangladeshi family can be very different to another Bangladeshi family, so you literally have to take each unit, each person as an individual". This accords with Gunaratnam's (1997) thesis that warns against palliative care health and social care professionals adopting a 'fact-file'

approach, involving making assumptions and generalisations about the beliefs and values of individuals and families based on cultural identity. Professionals drawing on preconceived notions or patterns, she argues, can lead to the development of prejudices, stereotypes and misunderstandings. Alongside and more widely, the professional philosophy of openness advocated by palliative care practitioners, may be experienced as intrusive and oppressive, particularly by people in some minority ethnic groups, as they strive to protect their privacy about what they see as essentially private matters (Reith and Payne, 2009).

Discussion and conclusion

Death is a process rather than an event and, although universal, it has become highly individualised even within wider cultural prescriptions. The extent to which dying is controlled by the dying person is contingent upon the life circumstances of the individual as well as upon their readiness to acknowledge that they are dying (Reith and Payne, 2009). The role of social work in mediating the transitions towards death, both for the dying person and those who are bereaved, is often significant, particularly for those with difficult life histories. However, as the case studies discussed above illustrate, there may be many layers of significance and death is inherently complicated both as phenomenon and experience.

Working at the interstices of the public and the private, social workers find themselves dealing with the 'social' realities of death, but also find that they are often struggling to master its meaning for those affected. Meaning, however, has to be created and renewed in light of post-death changes in the lives of the bereaved. Language has a part to play here and can be crucial in aiding an understanding of death, the dying process and what follows. Richardson and Koffman (2011: 82), writing about the influence of ethnicity and culture on the experience of dying, comment that 'the language of understanding difference is complex yet fascinating' and this has been richly demonstrated by the data presented above. Thus, it is the meaning and impact of death for those who go on living that can pose the greatest practical demands on social work practice in this area. An outcomes-based approach focused on quality and consistency, as advocated by the research interviewee, is one way of providing support that makes a positive material difference to the lives of those impacted by death. Assessment of what is uniquely required in a particular situation is central to offering tailored interventions that are appropriate to meet the needs of individuals and families (Reith and Payne, 2009). The boundary of this work, however, may, in the end, present the greatest ethical and professional challenge of all given the ongoing debate about the use and distribution of scarce resources, particularly in a time of financial austerity.

The market economy for health in the UK means that all forms of health services have a cost, both economic and social and the intensive model of palliative care social work practice discussed herein merits scrutiny both in terms of its cost effectiveness and its sustainability. This is a complex area

and, although beyond the scope of this article, it is important to acknowledge the need for the audit and evaluation of services in this sector.

Finally, this article has used the personal stories of individuals and families as recounted by one social worker, to discuss some of the key issues that impact on palliative care social work practice within diverse communities. A limitation of the article, however, is that it includes only the 'voice' of the social worker and other research is needed to explore perspectives of service users and peer professionals within the multidisciplinary team on the contribution of social work to palliative care.

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