

# Core competencies for palliative care social work in Europe: an EAPC White Paper – **part 1**

The European Association for Palliative Care (EAPC) Task Force on Social Work in Palliative Care proposes a consensus White Paper on core competencies in palliative care social work, presented by **Sean Hughes, Pam Firth** and **David Oliviere**. This is part 1, and part 2 will follow in the next *European Journal of Palliative Care* (Vol 22, No 1)

**T**his White Paper is the culmination of work undertaken by the European Association for Palliative Care (EAPC) Task Force on Social Work in Palliative Care (hereafter: the Task Force), set up to examine the diversity of roles, tasks and education of palliative care social workers in Europe. One of the stated objectives of this group was to complete a consensus White Paper before considering generalist and specialist social work education curricula. We propose a competencies framework that is applicable to social workers in any role, but specifically

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delineates the advanced competencies appropriate to the specialist work required in palliative and end-of-life care contexts. This paper does not itemise the curricula required

for social work training in palliative care; this will be addressed in a second phase of work.

The Task Force has drawn on the experience of an international group of social workers in palliative care that represents a broad range of organisational contexts. These include well-established interdisciplinary practice exemplars from Western Europe as well as models from other parts of the continent where palliative care itself is an emerging and developing discipline.<sup>1</sup> The challenges facing social work are acknowledged, including those presented by demographic shifts and economic conditions that impact on health- and social care systems generally. The unique role of social workers and their contribution to

palliative care is explored and contrasted with that of fellow professionals in the interdisciplinary team.

A number of other sources which have addressed the needs of palliative care professionals in terms of competencies and education have informed the development of this paper.<sup>2-6</sup> In addition, a worldwide social work perspective had been garnered by drawing on the work of national and international organisations such as the Canadian Hospice Palliative Care Association (CHPCA)<sup>7,8</sup> and the International Federation of Social Workers (IFSW),<sup>9</sup> as well as of leading practitioners and academics in the field. Less formal sources have included opinions canvassed at regular meetings of the EAPC Task Force on Social Work in Palliative Care, which has met annually since 2001. We have also considered a recently published survey among palliative care social workers in the UK.<sup>10</sup>

Throughout this paper, we use the term 'client' to describe the individuals we work with, which is common practice in social work. We recognise that an ongoing debate about terminology describing the relationship between helper and helped persists within the social work profession.<sup>11</sup>

## Contexts

There are considerable variations in the provision of health- and social care across Europe and, in some countries, palliative care services are in their infancy or non-existent, with a marked disparity between the countries

of western Europe and of central and eastern Europe.<sup>12</sup> In recent times, the global financial crisis, and the austerity measures adopted by some European countries in response, have posed significant threats to health- and social care which are, as yet, not fully understood.<sup>13</sup>

In a constrained fiscal climate, cuts in services are perhaps to be expected. Palliative care services in the UK, many of which are provided by the independent (non-statutory) sector, have recently had their state funding reduced and are increasingly reliant on less predictable and more competitive charitable revenue streams.<sup>14</sup> As in several European countries, Sweden has recently changed access to state pensions to try to forestall a huge financial pension bill. In countries where palliative and end-of-life care services are in the early stages of development, funding constraints might be expected to hamper progress – although a higher gross domestic product is not necessarily indicative of better or more developed palliative care services.<sup>12</sup>

Life expectancy is increasing globally, and population aging in our time is described as unprecedented, pervasive in national reach and enduring.<sup>15</sup> In the European Union (EU), while the overall population will increase somewhat over the next three decades, the proportion of those aged over 65 is projected to almost double and the proportion of those over 80 to almost triple by 2060. Over the same period, the proportion of 15–64-year-olds will decline by a projected 14%, leading to a doubling of the old age dependency ratio (those aged over 65 as a ratio of those aged 15–64).<sup>16</sup>

These changes will not be uniform over the member countries of the EU and these figures do not account for those European countries outside the EU. It should also be noted that there is some debate about the accuracy of these projections.<sup>17</sup> However, it is clear that the care needs of a fast-growing aging population will present significant challenges to our health- and social care systems,<sup>18</sup> including those providing palliative and end-of-life care. For example, around 800,000 people in the UK currently have dementia (a figure expected to rise to a million by 2021). Of these, less than half (44%) have actually been diagnosed and an estimated one third live alone in the community.<sup>19</sup> The end-of-life care needs of this group can be complex and made more so: *‘As death is considered a taboo*

*subject not to be talked about, this means the majority of people with dementia often have little opportunity to put plans in place for future and end of life care. While policy encourages planning, it will take time to address the double stigma that surrounds dementia and death.’*<sup>19</sup>

From a social work perspective, it has been argued that, despite evidence of the profession playing, in some places, a significant role in palliative and bereavement work, it has been slow to respond to the increasing care needs of frail older people as they approach the end of their lives.<sup>20</sup>

While palliative and end-of-life care services are generally well developed and established in western Europe, the same cannot necessarily be said of eastern and central Europe, where provision remains uneven and variable.

The following barriers to service development have been identified: financial and resource constraints; problems relating to opioid availability; poor public and governmental awareness of palliative care; and a lack of education and training programmes.<sup>21</sup> There is, however, evidence of progress. For example, in Serbia, the government has recently adopted a national palliative care strategy<sup>22</sup> and a palliative care social work training programme is under way.

The political, social and historical contexts for social work vary widely in Europe and the profession finds itself in differing developmental stages across the continent. Despite this, social workers are said to play a major role – deploying a set of core values, skills and objectives, and working with some of the most vulnerable people in our communities – and are on the increase numerically after some years of decline.<sup>23</sup>

It is to matters of roles, values and the competencies necessary for effective social work practice and the implications for palliative care work that this paper now turns.

### **Knowledge, skills and values of social workers**

*‘The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their*

**Social workers are said to play a major role ... and are on the increase numerically**

### The provision of culturally competent care is given high priority

*environments. Principles of human rights and social justice are fundamental to social work.*<sup>24</sup>

Social workers' knowledge, skills and values underpin their professional practice. They are committed to work in partnership with clients and their families, ensuring that, where feasible, their needs and wishes are met. Key skills and values of a non-judgemental approach using good communication skills, building trust, and establishing effective working relationships through which change is enabled are central to professional social work.

Beyond these core values and skills, social workers – including those in training – need to acquire the knowledge and associated skills required for the level at which they are working. In the UK, the College of Social Work has outlined nine interdependent domains within a 'professional capabilities framework' which details the capabilities expected of the social worker, from entry-level student to advanced practitioner and on to senior managerial and strategic roles.<sup>25</sup> Social workers are required to work within a nationally determined legislative framework and are generally governed by codes of ethical practice.<sup>26,27</sup>

The circumstances in which social workers are asked to intervene may be complicated and involve implementing social legislation and regulations. Ethical and moral issues are a prominent concern for social workers in general<sup>28</sup> and are of particular relevance in palliative and end-of-life care.<sup>29</sup> Social workers are taught to question their value judgements and understand the needs of the family as a system, which may conflict with those of the individual. The provision of culturally competent care is given high priority, as is working with diversity and with marginalised groups in society, operationalising core principles around human rights and social justice.<sup>24,30</sup> In order to respond effectively, social workers need to develop specific attributes such as empathy, trustworthiness, reliability, fairness and the capacity for self-reflection.

A focus on mobilising the strengths and resources of clients, their families and communities, with an underlying belief that this leads to more effective solutions in the unique 'world' of the client, has been a core approach. A more formalised manifestation of this general focus, the 'strengths perspective',

emerged in mental health social work in the USA during the 1990s and has gained some international attention in recent times.<sup>31,32</sup> The strengths perspective challenges deficit models in which, put simplistically, the client's problems rather than their capacities and innate resilience drive the work. This perspective may usefully be applied to palliative and end-of-life care contexts. Here, the 'problem' may be overwhelming and constitute a barrier to the consideration and use of strengths and potentials within the client's self and networks. However, it should also be recognised that structural disadvantage may make it difficult for some individuals and communities to effect change when faced with crisis or chronic adversity.<sup>31</sup> In these circumstances, social workers may need to adopt a more eclectic and responsive approach to practice that takes account of oppression and discrimination.

Working with professionals from other disciplines has always been central to the role. This requires an advanced awareness of role boundaries and the skills to work collaboratively, combined with the confidence to promote the social work perspective in interdisciplinary contexts. This especially applies to palliative care work, which is invariably an interprofessional team endeavour.<sup>33</sup>

Where resources are limited and circumstances emotionally and practically difficult, social workers may be considerably challenged by the needs of their clients. In these situations, access to good management, support and supervision is vital. The College of Social Work is taking the lead in the UK to ensure that social work education fully equips and updates social workers with the knowledge and skill set required for their complex role in a demanding and changing societal environment – one that is replicated across the continent.

At the launch of the European Observatory on Social Work and Social Development in April 2013, leaders of key organisations in social work and welfare welcomed *'this joint initiative to record and promote the social activities that address the major social problems facing Europe. In these times of social crisis and austerity in Europe, it is essential that social workers and social development professionals find effective ways to document what is happening in our continent'*.<sup>34</sup>

Social care and social work – alongside our other health and welfare systems – face uncertain times as noted above. But what of palliative care social work against this general backdrop, and how will adopting the proposed competencies framework outlined below prepare this specialism within the profession for the challenges ahead?

### Palliative care social work

#### *Beginnings and dimensions of the role*

Historically, social workers were involved from the inception of the modern hospice movement (and subsequently, in the development of specialist palliative care), both in the UK<sup>35,36</sup> and elsewhere, such as in the USA.<sup>37</sup> Cicely Saunders, who was instrumental, with colleagues, in setting up what is considered to be one of the first modern hospices in the UK,<sup>38</sup> was herself trained in social work and valued the contribution that social workers could bring to the holistic care she championed.<sup>39</sup>

Within a palliative and end-of-life care context, social workers may deploy a range of skills and techniques pertinent to the changing situation of the client. Sheldon delineates six categories or themes in exploring the dimensions of the role of the palliative care social worker.<sup>40</sup> These are:

- A family focus – communication and relationship issues
- Influencing the environment – practical help and liaison
- Being a team member – role boundaries and collaboration
- Managing anxiety – of family, colleagues and self
- Values and valuing – non-judgemental, empowerment and antidiscriminatory
- Knowing and working with limits – assessment and open communication.

The day-to-day social work tasks will vary from country to country, but the need for palliative care social work to develop alongside the integration of palliative care in healthcare systems globally is acknowledged.<sup>41</sup> Providing a list of social work tasks is unlikely to be exhaustive, and is unhelpful outside of a particular national context. However, in some health- and social care systems, in addition to direct work with clients, palliative care social workers may be responsible for: the provision of counselling and bereavement services; the management of staff and volunteers

connected with supportive services; the provision of psychosocial education; research; and more general leadership and policy development functions.<sup>25,42</sup> Work with children, in preparation for the death of someone close and in bereavement, is often a feature of palliative care social work practice<sup>43</sup> and the primary focus of work for some.<sup>44</sup>

Increasingly, palliative care social workers may find themselves becoming involved in community capacity-building activities, as they endeavour to catalyse social and community networks in the support of dying people at home. The Canadian competencies framework cites this as a core social work competency,<sup>7</sup> while the Irish discipline-specific competencies suggest that palliative care social workers should *'be able to recognise the potential for extending the ethos and practice of palliative care beyond formal health care settings, and work to build the capacity of communities and promote social inclusion'*.<sup>45</sup> The prevailing model of holistic end-of-life care derived from hospice care in the Western world has been criticised as promoting the professionalisation of dying and, as a corollary, the exclusion of lay and community expertise.<sup>46</sup> Whatever the merits of this argument, as resources for health- and social care at end of life are challenged by increasing need, more innovative and less costly ways of supporting people, creating social capital and galvanising a community response are likely to be necessary. The notion of compassionate communities and a public health approach to palliative care are evident in the literature and draw on an international perspective.<sup>47</sup> Social workers, with their focus on family, community and social networks, are well placed to deploy this expertise as new models of end-of-life care provision are developed.<sup>46,47</sup>

**Social workers were involved from the inception of the modern hospice movement**

#### *International perspectives*

There is anecdotal evidence (obtained during meetings of the EAPC Task Force on Social Work and its steering group, and in consultation with wider professional contacts) that, as managing risk has become more central to the work of social welfare agencies in western Europe, social work practice has shifted to more process-driven activities. In many places, traditional casework and

counselling models have been replaced by case management, leaving therapeutic casework practice – particular that with a family and holistic focus – more evident in specialist areas such as palliative care.<sup>48</sup> Research with palliative care service users in the UK has found that they particularly valued the quality of the relationship between them and the social worker and the feeling that they were viewed as ‘whole’ people and treated with a flexible and non-judgemental approach.<sup>35,49</sup> Social workers aim to work with the total experience of clients, including their narratives and community and social networks.

While shifts in service delivery contexts and the nuances of role delineation might be pertinent to palliative care social work in the so-called developed world, the global picture reveals relatively poor or non-existent provision of palliative care.

### There is a degree of overlap between all the roles in the interdisciplinary team

A recent study demonstrates some progress since 2006, but notes that almost a third of countries (32%) worldwide still have no known hospice or palliative care provision, with only 20 countries (8.5%) having achieved an advanced level of palliative care integration with mainstream services.<sup>50</sup>

Against this backdrop, the development of services and inclusion of social work as a core component will undoubtedly vary. However, it is crucial that the models of service provision and education developed elsewhere reflect the local sociocultural context, and are not merely a replication of Western culturally dominant forms.<sup>51</sup> It has been suggested that this might require a more sociological, health-promoting approach to palliative and end-of-life care in which frailty, death and dying are viewed as life course events rather than simply medical problems requiring a treatment plan, with a concomitant service configuration.<sup>39</sup>

During international consultations and meetings with colleagues, it was noted that palliative care social work in France, Italy and Germany appeared to be not as visible as that in the UK, Ireland, the Netherlands, Spain, Portugal and Sweden. Overall, it is clear that social work and palliative care social workers operate within a range of contexts and constraints dependent on nationally determined conditions.

### Role overlap with other professions

Palliative and end-of-life care is an interprofessional team endeavour<sup>5,33,52,53</sup> and ‘requires a multiprofessional team with an interdisciplinary work style’.<sup>6</sup> It should be noted that there is a degree of overlap between all the roles in the interdisciplinary team, this being particularly evident between psychologists, spiritual care workers and social workers, which colleagues at international meetings have described as leading to interprofessional tension at times. It is also clear that, in some European countries, psychologists are seen as essential to the core team whereas, in others, this is not the case.<sup>6</sup> Whatever tension may have been observed, there is evidence of psychologists and social workers working together constructively to provide services for dying people and their families. For example, in Serbia, the Centres of Social Work employ social workers, psychologists and lawyers in order to provide wide-ranging psychosocial care. Greater clarity has been brought by recent work by psychologists which will help social workers – and others – to differentiate their role from that of psychologists in the context of the interprofessional palliative care team.<sup>4</sup> A degree of ongoing role negotiation and good communication are key components of interdisciplinary palliative care team functioning.<sup>54</sup>

This paper will now outline the range of competencies, including interprofessional teamwork, to which palliative care social work practice might aspire.

### A competencies approach

As palliative care social work is subject to health- and social care economies at different developmental stages across Europe, and is itself dependent on country-specific educational and societal contexts, too tight a role description and orientation would fail to account for this complexity. Nonetheless, one of the aims of the Task Force in identifying the diversity of tasks, roles and skills needed in palliative care social work was to complete a White Paper that would provide the basis for consultation and wider debate, before a more detailed outline of educational and curricula need. We drafted this competencies framework with the view that: ‘*Competencies should never be seen as a tool to judge practitioners, but rather as a benchmark that all should aspire to reach over time. Further we*

reiterate the importance of developing competencies appropriate to the level of palliative care provision in each European country.<sup>23</sup>

In order to be considered competent, palliative care social workers need to embody the professional social work values described above, acquire the necessary knowledge and practice advanced skills. They also need to act on a commitment to continually enhance and update their knowledge and skill set to ensure that their practice is of the highest quality.

The next issue of the *European Journal of Palliative Care* (Vol 22 No 1, January/February 2015) will feature the competencies framework that we see as laying the foundation on which palliative care social workers in their various situations across Europe can confidently build their expertise and that will enable them to enhance their professional practice and development.

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#### References

1. Degi CL. Palliative social work in central-eastern Europe: the emerging experience of Romania. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. Oxford, New York: Oxford University Press, 2011: 537–541.
2. Gamondi C, Larkin P, Payne S. Core competencies in palliative care: an EAPC White Paper on palliative care education – part 1. *European Journal of Palliative Care* 2013; **20**: 86–91.
3. Gamondi C, Larkin P, Payne S. Core competencies in palliative care: an EAPC White Paper on palliative care education – part 2. *European Journal of Palliative Care* 2013; **20**: 140–145.
4. Junger S, Payne S. Guidance on postgraduate education for psychologists involved in palliative care. *European Journal of Palliative Care* 2011; **18**: 238–252.
5. Radbruch L, Payne S. White Paper on standards and norms for hospice and palliative care in Europe: part 1. *European Journal of Palliative Care* 2009; **16**: 278–289.
6. Radbruch L, Payne S. White Paper on standards and norms for hospice and palliative care in Europe: part 2. *European Journal of Palliative Care* 2010; **17**: 22–33.
7. Canadian Social Work Competencies for Hospice Palliative Care. A Framework to Guide Education and Practice at the Generalist and Specialist Levels. Canadian Hospice Palliative Care Association, 2008.
8. Bosma H, Johnston M, Cadell S *et al*. Creating social work competencies for practice in hospice palliative care. *Palliat Med* 2010; **24**: 79–87.
9. Global Standards for the Education and Training of the Social Work Profession. International Federation of Social Workers, 2004.
10. Croft S, Chowns G, Beresford P. Getting it right: End of life care and user involvement in social work. Association of Palliative Care Social Workers, 2013.
11. McLaughlin H. What's in a name: 'client', 'patient', 'customer', 'consumer', 'expert by experience', 'service user' – what's next? *Br J Soc Work* 2009; **39**: 1101–1117.
12. Centeno C, Pons JJ, Lynch T *et al*. *EAPC Atlas of Palliative Care in Europe 2013*, cartographic edition. Milan: EAPC Press; 2013.
13. Karanikolos M, Mladovsky P, Cylus J *et al*. Financial crisis, austerity, and health in Europe. *Lancet* 2013; **381**: 1323–1331.
14. *National Funding Survey of Adult Palliative Care Providers, December 2010*. London: Help the Hospices and The National Council for Palliative Care, 2011.
15. *World Population Aging 2009*. New York: United Nations, Department of Economic and Social Affairs, Population Division, 2010.
16. The 2012 Aging Report. European Union, 2012.
17. Spijker J, MacInnes J. Population ageing: the timebomb that isn't? *BMJ* 2013; **347**: f6598.
18. Herrmann FR, Michel JP, Robine JM. Worldwide decline in the oldest old support ratio. *Eur Geriatr Med* 2010; **1**: 3–8.
19. Kane M, Cook L. *Dementia 2013: The hidden voice of loneliness*. London: Alzheimer's Society, 2013.
20. Holloway M. Dying old in the 21st century: a neglected issue for social work. *Int Soc Work* 2009; **52**: 713–725.
21. Lynch T, Clark D, Centeno C *et al*. Barriers to the development of palliative care in the countries of central and eastern Europe and the Commonwealth of Independent States. *J Pain Symptom Manag* 2009; **37**: 305–315.
22. Serbian national palliative care strategy, Ministry of Health of Serbia, 2009. [www.palliativecareserbia.com/home.html](http://www.palliativecareserbia.com/home.html) (last accessed 15/08/2014)
23. Jones DN, Radulescu A. Is there a European social model? Building and promoting social work in Europe. *Int Soc Work* 2006; **49**: 412–418.
24. Definition of social work. International Federation of Social Workers, 2012. <http://ifsw.org/policies/definition-of-social-work/> (last accessed 15/08/2014)
25. Professional Capabilities Framework. College of Social Work, 2013. [www.tcsww.org.uk/ProfessionalCapabilitiesFramework/](http://www.tcsww.org.uk/ProfessionalCapabilitiesFramework/) (last accessed 15/08/2014)
26. The Code of Ethics for Social Work. Statement of Principles. British Association of Social Workers, 2012.
27. Cadell S, Johnston M, Bosma H, Wainright W. An overview of contemporary social work practice in palliative care. *Prog Palliat Care* 2010; **18**: 205–211.
28. Houston S. Engaging with the crooked timber of humanity: value pluralism and social work. *Br J Soc Work* 2012; **42**: 652–668.
29. Borgmeyer T. The social work role in decision making: ethical, psychosocial, and cultural perspectives. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. Oxford, New York: Oxford University Press; 2011: 615–624.
30. Payne M. Inequalities, end-of-life care and social work. *Prog in Palliat Care* 2010; **18**: 221–227.
31. Healy K. *Social Work Theories in Context: Creating Frameworks for Practice*. Basingstoke: Palgrave Macmillan; 2005.
32. Walsh F. Family resilience: a framework for clinical practice. *Fam Process* 2003; **42**: 1–18.
33. Blacker S, Deveau C. Social work and interprofessional collaboration in palliative care. *Prog Palliat Care* 2010; **18**: 237–243.
34. Jones DN. Compiling an international picture of the state of social work. *The Guardian*, 30 April 2013. [www.theguardian.com/social-care-network/2013/apr/30/state-social-work](http://www.theguardian.com/social-care-network/2013/apr/30/state-social-work) (last accessed 15/08/2014)
35. Reith M, Payne M. *Social Work in End-of-Life and Palliative Care*. Bristol: The Policy Press, 2009.
36. Small N. Social work and palliative care. *Br J Soc Work* 2001; **31**: 961–971.
37. Higgins PC. Guess who's coming to dinner? The emerging identity of palliative care social workers. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. New York: Oxford University Press, 2011: 31–40.
38. Clark D, Small N, Wright M, Winslow M, Hughes N. *A Bit of Heaven for the Few: An Oral History of the Hospice Movement in the United Kingdom*. Lancaster: Observatory Publications, 2005.
39. Payne M. Developments in end-of-life and palliative care social work: International issues. *Int Soc Work* 2009; **52**: 513–524.
40. Sheldon FM. Dimensions of the role of the social worker in palliative care. *Palliat Med* 2000; **14**: 491–498.
41. Myers RS, Clark EJ. The need for global capacity building in palliative social work. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. New York: Oxford University Press, 2011: 517–525.
42. Blacker S, Christ G. Defining social work's role and leadership contributions in palliative care. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. New York: Oxford University Press, 2011: 21–30.
43. Paul S. Public health approaches to palliative care: the role of the hospice social worker working with children experiencing bereavement. *Br J Soc Work* 2013; **43**: 249–263.
44. Jones BL, Remke SS, Phillips F. Social work in pediatric palliative care. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. Oxford, New York: Oxford University Press, 2011: 387–396.
45. Palliative Care Competence Framework Steering Group. Palliative Care Competence Framework. Dublin: Health Service Executive, 2014. [www.hse.ie/eng/about/Who/clinical/natclinprog/palliativecareprogramme/Resources/competenceframework.pdf](http://www.hse.ie/eng/about/Who/clinical/natclinprog/palliativecareprogramme/Resources/competenceframework.pdf) (last accessed 23/09/2014)
46. Brown L, Walter T. Towards a social model of end-of-life care. *Br J Soc Work* 2013 [online publication 30 May 2013].
47. Abel J, Walter T, Carey LB *et al*. Circles of care: should community development redefine the practice of palliative care? *BMJ Support Palliat Care* 2013; **3**: 383–388.
48. Payne M, Reith M. Palliative social work in the United Kingdom. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. Oxford, New York: Oxford University Press, 2011: 587–592.
49. Beresford P, Adsheed L, Croft S. *Palliative Care, Social Work and Service Users. Making Life Possible*. London: Jessica Kingsley, 2007.
50. Lynch T, Connor S, Clark D. Mapping Levels of Palliative Care Development: A Global Update. *J Pain Symptom Manag* 2013; **45**: 1094–1106.
51. Askeland GA, Payne M. Social work education's cultural hegemony. *Int Soc Work* 2006; **49**: 731–743.
52. Speck P. Introduction. In: Speck P (ed). *Teamwork in Palliative Care*. Oxford, New York: Oxford University Press, 2006: 1–6.
53. Firth P. Multi-professional teamwork. In: Monroe B, Oliviere D (eds). *Patient Participation in Palliative Care: A Voice for the Voiceless*. Oxford: Oxford University Press, 2003.
54. Maddocks I. Communication – an essential tool for team hygiene. In: Speck P (ed). *Teamwork in Palliative Care*. Oxford, New York: Oxford University Press, 2006: 137–152.

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