

Original Article

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







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Corresponding author: Ting Guan;

Email: tguan02@sy.edu

Oncology social workers' involvement in palliative care: Secondary data analysis from nationwide oncology social workers survey

Ting Guan, ¹ , Karlynn BrintzenhofeSzoc, ² , Alyssa Middleton, ² , Shirley Otis-Green, ³ , Tara Schapmire, ^{2,4} , Makeeta Rayton, ⁵ , Krista Nelson, ⁶ , Michael L. Grignon, ⁷  and Brad Zebrack, ⁸ 

¹Syracuse University School of Social Work, Syracuse, NY, USA; ²University of Louisville Kent School of Social Work and Family Science, Louisville, KY, USA; ³Collaborative Caring, Toluca Lake, CA, USA; ⁴University of Louisville School of Medicine, Louisville, KY, USA; ⁵Georgia Cancer Center for Excellence, Atlanta, GA, USA; ⁶Cancer Support Services & Compassion, Providence Cancer Institute, Portland, OR, USA; ⁷Association of Oncology Social Work, Chicago, IL, USA and ⁸University of Michigan School of Social Work, Ann Arbor, MI, USA

Abstract

Objectives. Social workers are vital in delivering psychosocial services in palliative care, yet their specific roles in palliative oncology remain undefined. This study aimed to delineate the current practice role of oncology social workers involvement in palliative care in the United States.

Methods. This study utilized a cross-sectional design and involved secondary analysis of data from a nationwide survey focused on workforce conditions for oncology social workers. The participants were social workers who were directly involved in providing care to cancer patients and delivering palliative care services. They completed an online survey in which they indicated the relevance of 91 tasks related to their practice. The survey also collected individual demographic and work-related characteristics. Exploratory factor analysis was used to achieve the study objective.

Results. Responses from a secondary data set of 243 oncology social workers involved in palliative care results in a 6-factor solution comprising 34 tasks. These factors were identified as: Therapeutic Interventions for Individuals, Couples, and Families; Facilitate Patient Care Decision-making; Care Coordination; Assessment and Emotional Support; Organization and Community Service; and Equity and Justice. All 6 factors demonstrated good internal reliability, as indicated by Cronbach's alpha scores above 0.70.

Significance of results. The findings can be used to develop job descriptions and education for social workers employed in palliative cancer care. The clear role descriptions also make social work visible to other professionals in palliative oncology. By clarifying the roles of oncology social workers, this study contributes to the improvement of palliative care delivery and enhances interprofessional collaboration within cancer care teams.

Introduction

The fields of palliative care, including hospice, has long been linked to social work. Dame Cicely Saunders, known as the “founder of the modern hospice movement” was at once a social worker, nurse, and physician (Harper 2022). The palliative care profession has been recognized as a medical specialty, but, as Saunders stated, “because it ideally goes far beyond symptom control alone, it demands the whole [interprofessional] team (Saunders 2001, 792).” Social workers are considered important members of these interprofessional teams (Blacker and Deveau 2010; Head et al. 2019). According to the National Palliative Care Registry, 68% of palliative care programs reported having a social worker in their teams in the United States (U.S.) (Rogers and Heitner 2019).

Historically, social workers have faced challenges in claiming their own roles. The clarity of the social worker's role in palliative care has become increasingly complex due to shifts in scope of practice, the variation and breadth of social work roles in oncology and palliative care, and the diverse settings within oncology and palliative care. This lack of clarity extends beyond the social work profession itself to impact interprofessional understanding (Ambrose-Miller and Ashcroft 2016; Head et al. 2019). This means that social workers' specialty training and skills are underutilized within palliative care delivery (Reese 2011).

Studies have been conducted in recent years to delineate the roles and responsibilities of social workers in the fields of palliative and end-of-life care (Glajchen et al. 2018;

Gwyther et al. 2005), pediatric palliative care (Jonas et al. 2022; Jones et al. 2011), oncology (Zebrack et al. 2024, 2008), and pediatric oncology (Middleton 2022). While there are not exact numbers of oncology social workers and social workers in palliative care in the U.S., there are more than 1300 professional and student members in the U.S.-based National Association of Oncology Social Work (AOSW) (Association of Oncology Social Work n.d.) and over 900 members in the Social Work Hospice & Palliative Care Network (SWHPN) (Social Work Hospice & Palliative Care Network n.d.). Until now, however, no study had specifically examined the roles of social workers within palliative oncology. This study aims to delineate the current practice role of oncology social workers involvement in palliative care in the U.S.

Methods

Study design and data collection

In this cross-sectional study, we conducted secondary analysis of data derived from a nationwide survey of workforce conditions for oncology social workers – Oncology Social Work Competencies, Opportunities, Roles, and Expertise (CORE) (Zebrack et al. 2024). Using a non-probability purposive and snowball sampling procedure, participants were recruited through collaboration with 3 professional organizations: AOSW, the Association of Pediatric Oncology Social Work, and the Association of Community Cancer Centers. Specifically, the 3 organizations distributed survey invitation to their membership Listserv. An anonymous, Internet-based questionnaire was administered from August to September 2020 via Qualtrics. Participation was entirely voluntary, and respondents were eligible for a drawing to receive 1 of 60 gift cards worth \$50, \$25, or \$10. A total of 1055 respondents provided useable data. The study protocol was submitted for Institutional Review Boards (IRB) review at a large university in the Midwestern US and determined “exempt-not regulated” as human subjects research in 2020. As a result of exemption, we were not required to obtain informed consent. Details about the study design and procedure have been published elsewhere (Zebrack et al. 2024). For this study the sample included a subset of oncology social workers who responded to the workforce study and indicated that they were involved in direct practice, and specifically in palliative care service provision, across a variety of cancer care settings in U.S.

Measurement

As the primary outcome, social workers’ roles were measured using the 91 tasks that distinguish the oncology social work role in cancer care and reflect service to patients and families, institutions and agencies, communities, and to the profession itself. The 91 tasks were generated through the Concept Mapping exercise published previously (Zebrack et al. 2022) and had been evaluated among the oncology social workers (Zebrack et al. 2024). For each task, respondents were instructed to consider whether they performed each task as part of their work and to indicate how significant the task is by selecting an appropriate response. Responses were rated on a 6-point scale ranging from 0 (“not applicable to my job”) to 5 (“extremely significant to my job”).

Individual demographic characteristics and work-related characteristics were included. Demographic characteristics included age, gender, education, race, and ethnicity. Work-related characteristics included years of experience in cancer care, organization type (e.g., National Cancer Institute (NCI)-designated

comprehensive cancer program, comprehensive community cancer program), work setting (inpatient only; outpatient only; combination of inpatient and outpatient; other), and licensure and credential status (e.g., social work license, Oncology Social Work Certification, and Advanced Palliative Hospice Social Worker Certification [APHSW-C]).

Statistical analyses

All analyses were performed using SPSS Statistics version 26.0. An exploratory factor analysis (EFA) was conducted to achieve the study aim because we have no a priori hypothesis about factors or domains of measured variables (i.e., 91 tasks) determined by theory or conceptual framework. Following the published EFA guidelines and previous study (Zebrack et al. 2024), the first step involved identifying the standard normal distribution by examining histogram, skewness, and kurtosis for each of 91 items (Watkins 2018). We examined the floor and ceiling effects and excluded the items with floor effects greater than 1. To determine the appropriateness of the data for EFA, we examined the Kaiser–Meyer–Olkin (KMO) and Bartlett’s test of sphericity. According to Tabachnick and Fidell, KMO should be 0.60 or above, and the chi-square value of Bartlett’s test should be significant (Tabachnick et al. 2013).

Following examination of data, an EFA using the maximum likelihood estimation with oblique (Promax) rotation was conducted on the remaining items to evaluate pattern matrices. The criteria used for retaining items was based on absolute factor loading. Items with absolute coefficients <0.30 on all factors, communalities <0.30, and those that loaded on more than 1 factor with a coefficient ≥ 0.3 were eliminated. The decision for the number of factors was based on the following criteria: eigenvalue >1, scree test, rejection of a factor with fewer than 3 items (Watkins 2018). Factor analyses were repeated until a solution in which all the items included in the analysis met all criteria was attained. The factors were named through comprehensive discussions among team members to accurately represent the tasks within each factor. Internal reliability was analyzed using Cronbach’s α , with 0.70 indicating a good reliability (DeVellis and Thorpe 2021).

Results

Demographic and work-related characteristics

Among 1055 respondents who completed the CORE survey, 243 participants (23%) indicated involvement in palliative care. Table 1 summarizes the demographics and work-related characteristics for the sample. The majority of participants were female (94%) and self-identified as White (89.3), with an average age of 45.77 years of age (SD = 12.41). Approximately 25.1% worked in NCI-designated cancer programs, 24.7% worked in comprehensive community cancer programs, 16.0% worked in academic or university-affiliated cancer programs, and 16.0% worked in community cancer program. Sixty-three percent reported covering outpatient service only and 8.6% of all respondents indicated advanced-level training by being in possession of APHSW-C.

Oncology social worker involvement in palliative care

The EFA was conducted on the data from the 243 oncology social workers whose positions included palliative care. In this study, the KMO was 0.871, which indicated that the sample was adequate for performing factor analysis, and the Bartlett’s test of sphericity was

Table 1. Demographic results of social workers in palliative care ($N = 243$)

Sample demographics	Frequency (%)
Gender	
Female	229 (94.2)
Male	9 (3.7)
Transgender, non-binary or queer	2 (0.8)
Prefer not to answer	3 (1.2)
Race (check all that apply)	
American Indian, Native American, Alaska Native	4 (1.6)
Asian, Asian American, Pacific Islander	10 (4.1)
Black or African American	9 (3.7)
White or Caucasian	217 (89.3)
Other	11 (4.6)
Ethnicity	
Hispanic	21 (8.6)
Highest academic degree	
Bachelors	6 (2.5)
Masters (e.g., MSW, MSSW, MS)	233 (95.9)
Doctoral (e.g., DSW, PhD)	3 (1.2)
Years of experience in cancer care	
Less than 2 years	32 (13.2)
2–5 years	62 (25.5)
6–10 years	57 (23.5)
11–20 years	57 (23.5)
More than 20 years	35 (14.4)
Licensure and credentials (indicating “Yes”)	
Full Social Work license or equivalent (LCSW, LMSW, LICSW, etc.)	212 (87.2)
Oncology Social Work Certification (OSW-C)	86 (35.4)
Advanced Palliative Hospice Social Worker Certification (APHSW-C)	21 (8.6)
Type of health system, cancer program, organization or agency	
NCI-Designated Comprehensive Cancer Program	61 (25.1)
Comprehensive Community Cancer Program	60 (24.7)
Academic or University-affiliated Cancer Program	39 (16.0)

(Continued)

Table 1. (Continued.)

Sample demographics	Frequency (%)
Community Cancer Program	39 (16.0)
Pediatric Cancer Program	13 (5.3)
Non-profit agency, patient service or advocacy organization	9 (3.7)
Integrated Network Cancer Program	8 (3.3)
Free-Standing Cancer Program	5 (2.1)
Veterans Affairs Cancer Program	5 (2.1)
Other	4 (1.2)
Services covered	
Out-patient cancer only	155 (63.8)
Both in-patient and out-patient cancer only	46 (18.9)
In-patient cancer only	18 (7.4)
Mixed cancer and non-cancer patients (in-and/or out-patient)	12 (4.9)
None of the above	12 (5.0)
Mean age (standard deviation)	
	45.77 (12.41)

significant ($\chi^2 = 3382.75$; $df = 561$, $p < 0.001$), indicating that the relationship among the items was strong and the data were suitable to conduct an EFA. Responses derived a 6-factor solution consisting of 34 tasks (Table 2, Figure 1). The model accounted for 58.3% of total common variance.

The 6 factors were named as follows: Therapeutic Interventions for Individuals, Couples, and Families; Facilitate Patient Care Decision-making; Care Coordination; Assessment and Emotional Support; Organization and Community Service; and Equity and Justice. Table 2 shows the specific tasks associated with each factor. Appendix 1 lists the 57 items eliminated throughout the statistical analytic process. Reliability of the factors was ensured with the Cronbach's alpha, with all 6 factors having a score above 0.70, suggesting a good internal reliability.

Discussion

As both the demand for palliative care and social workers continues to increase in the United States (Center to Advance Palliative Care 2022), it is important to delineate the roles of social workers involved in palliative care in cancer settings. This study builds upon previous efforts to define the role of social work in palliative care and provides more in-depth insight into the role in cancer settings. The findings show that social workers play critical roles in 6 domains, including: Therapeutic Interventions for Individuals, Couples, and Families; Facilitating Patient Care Decision-making; Care Coordination; Assessment and Emotional Support; Organization and Community Service; and Equity and Justice. These 6 domains offer meaningful insights into the nature and diversity of social work roles involved in palliative care, as they

Table 2. Factor analysis results (34 items)

Factors	1	2	3	4	5	6
Factor 1. Therapeutic Interventions for Individuals, Couples, and Families (Cronbach's $\alpha = 0.890$)						
14. Help patients manage mental health conditions that impact treatment adherence	0.405					
47. Provide crisis intervention/crisis counseling	0.359					
49. Problem-solving therapy or counseling	0.823					
68. Help patients talk to their children about cancer	0.390					
78. Family therapy	0.816					
80. Mediate conflict within families	0.414					
81. Cognitive behavioral therapy	0.876					
84. Offer counseling and support on intimacy issues, body disfigurement, fertility, and sexual health	0.700					
85. Treat depression and anxiety	0.924					
Factor 2. Facilitate Patient Care Decision-Making (Cronbach's $\alpha = 0.803$)						
6. Facilitate communication between family members and medical care providers		0.821				
9. Promote communication between patient and spouse/partner/caregivers		0.755				
25. Teach patients and caregivers skills to manage disease and symptoms		0.397				
45. Assist patients and families with planning for long term or end-of-life care and medical treatment needs, including advance directives		0.450				
46. Help patients make treatment decisions		0.418				
52. Assess patient understanding of treatment options		0.456				
83. Facilitate goals of care discussions		0.440				
Factor 3. Care Coordination (Cronbach's $\alpha = 0.788$)						
28. Coordinate access to cancer care for patients with underlying mental health issues			0.626			
32. Facilitate patient and family ability to navigate the medical system			0.483			
44. Case management			0.709			
60. Monitor and ensure that patient and family needs are assessed and met over time			0.449			
73. Facilitate patient and family access to community and public resources (e.g., mental health services and support groups, in-home care services, legal aid, financial and benefits assistance programs such as SSDI/SSI, FMLA, food banks, etc.)			0.680			
77. Coordinate patient care between service lines (e.g., med/onc, surg/onc, rad/onc), respective departments (e.g., urology for a GU patient, geriatrics for an elder oncology patient), and consult teams (e.g., palliative clinic, wound clinic, psychiatry)			0.634			
Factor 4. Assessment and Emotional Support (Cronbach's $\alpha = 0.786$)						
11. Offer supportive care/supportive counseling				0.552		
40. Provide emotional support				0.793		
51. Assess patient psychosocial needs				0.821		
87. Assess patient coping skills				0.581		

(Continued)

Table 2. (Continued.)

Factors	1	2	3	4	5	6
Factor 5. Organization and Community Service (Cronbach's $\alpha = 0.795$)						
19. Evaluate social work programs or services					0.698	
20. Plan or participate in community events (e.g., health fairs, cancer prevention efforts, cancer awareness or wellness programs, Cancer Survivorship Day)					0.627	
67. Assure that my agency/organization is in compliance with psychosocial care guidelines (for e.g., Commission on Cancer Patient-Centered Standards of Care, QOPI standards, NCCN guidelines)					0.785	
79. Participate on or report to Cancer Committee					0.688	
Factor 6. Equity and Justice (Cronbach's $\alpha = 0.759$)						
72. Acknowledge and address issues of power, privilege, and implicit bias in my institution or agency						0.748
82. Support colleagues who experience discrimination, racism, microaggression, or any other form of social injustice from patients, families, agency, health-care system						0.823
89. Participate in professional activities that elevate persons of color and other minority/oppressed groups (e.g., participate on a Diversity, Equity, and Inclusion initiative at your institution or agency)						0.674
90. Seek out and use consultation and supervision						0.485

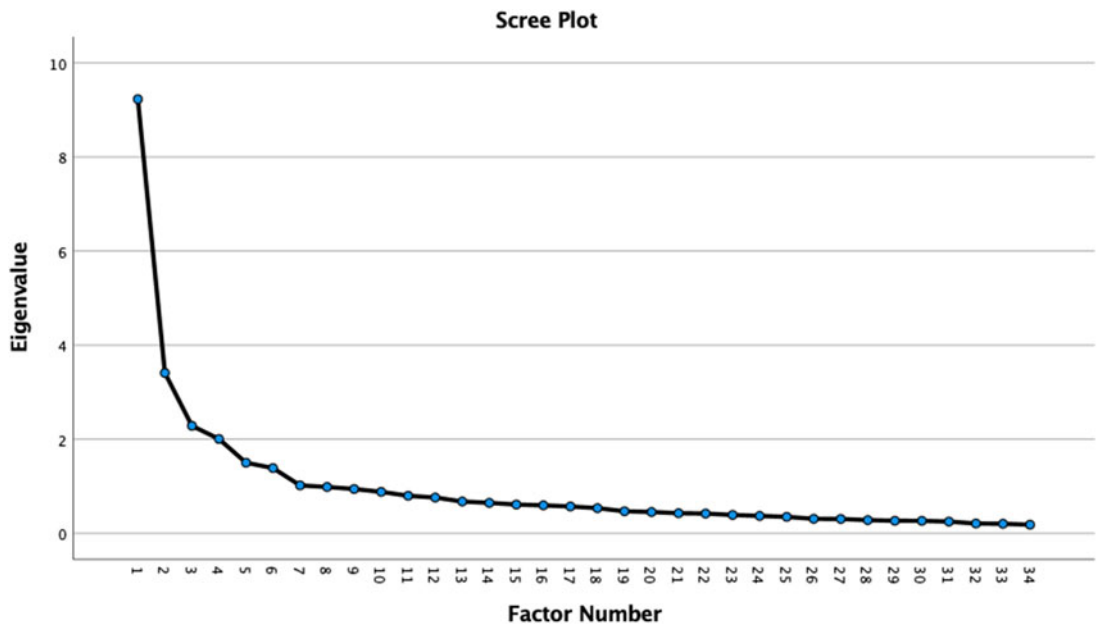


Figure 1. Scree plot.

collectively account for a substantial portion (58.3%) of the variability observed in the tasks. Our results align with the 8 domains for *Clinical Practice Guidelines for Quality Palliative Care* emphasizing the importance of social workers in psychological and social domains of care (National Consensus Project for Quality Palliative Care 2018).

Social workers play a crucial role in addressing the psychosocial aspects of palliative care, reinforcing their position as primary providers of behavioral health and psychosocial services in the U.S.

(Whitaker et al. 2006). Our study has revealed common techniques employed by social workers, including problem-solving therapy, family therapy, crisis intervention and counseling, and cognitive behavioral therapy. Additionally, our findings underscore a wide array of unique tasks that social workers can offer to meet the needs of cancer patients and their families. These services include support for coping with body disfigurement and sexual health as well as assistance in facilitating conversations about cancer with children. As indicated in the study, social workers reported providing

evidence-based interventions such as crisis intervention, problem-solving therapy, family therapy, and cognitive behavioral therapy. Moreover, the growing recognition of social determinants of health reinforces the critical role of social workers that has a deeply rooted history and expertise in addressing the social needs of patients and families in palliative care. Our findings highlight the contribution of social workers in addressing social needs that grow out of social determinants of health. These needs that social workers are prepared to assist cancer patients include, facilitating patient and family access to community and public resources, such as in-home care services, legal aid, financial and benefits assistance programs. These findings provide empirical support to the *Clinical Practice Guidelines for Quality Palliative Care*, emphasizing the importance of social workers in psychological and social domains of care, such as the mental health assessment and support, and assessment of social supports, relationship, practical resources of the care environment (National Consensus Project for Quality Palliative Care 2018).

In addition to addressing the psychosocial needs of cancer patients, our findings also highlight the essential roles of social workers in facilitating patient care decision-making. This involves assessing patient understanding of treatment options, facilitating goals of care discussions, and assisting with the completion of advance directives (Otis-Green et al. 2019). Patients with cancer and their families often face barriers in making important decisions, such as unmet information needs and unrealistic expectations (Belanger et al. 2011). Social workers are specifically trained to identify gaps in communication with palliative care team members, assess patients' and family members' understanding of the treatment, help them clarify their preferences, values, and goals of care, and support them in obtaining resources to achieve their care goals.

Social workers also make an important contribution in addressing disparities in palliative care. Disparities in palliative care have been consistently reported in the literature (Bazargan and Bazargan-Hejazi 2021). Research has indicated that racial and ethnic minorities and underserved groups are less likely than their non-Hispanic white counterparts to have access to palliative care (Griggs 2020). Recognizing the social determinants of health is crucial in eliminating palliative care disparities that reinforce social vulnerability. Now and since its inception, social workers have been defined by their advocacy for vulnerable populations and for working from a social justice lens. Our study findings also demonstrate that social workers play a critical role in helping support health equity in palliative care. This is exemplified by their active engagement in addressing power dynamics, privilege, and implicit biases within their institution or agency, as well as their involvement in professional activities aimed at elevating individuals from marginalized and oppressed communities. As advocates, social workers acknowledge the plight and psychosocial needs of those who are disproportionately affected by inequities and can educate communities and hospitals to implement policies reduce health disparities and improve access to palliative care.

Clinical implications

This study delineated the current practice role of oncology social workers involvement in palliative care in the U.S. First, the findings can be used to portray the roles of social workers in job descriptions for those employed in palliative cancer care. Professional associations, such as the SWHPN and the National Association of Social Work can use these results to inform development of job

descriptions and disseminate them to HR departments or post for public use. Secondly, the clear role description also can make social work visible to other professionals. Social workers can use the findings to help other professionals and administrators understand the knowledge and skills utilized by social workers in palliative care. Social workers should place the appropriate effect into advocating their roles via training, interprofessional learning, team meetings, grand rounds, etc. Clearly defining and claiming the practice domain of social work in palliative care also provides a framework for further analyzing how the role of social work impacts patient and organization outcomes and advocating for changes that promote the integration and utilization of social workers in palliative care (Tael et al. 2021). As Munn and Adorno mentioned: "Without a clear definition of what social workers bring to the table, it is difficult to place a value on the social work contribution" (Munn and Adorno 2008, 349). Additionally, exploring the specific roles and experiences of social workers in palliative care delivery can inform social work education and training, ensuring that future social workers are equipped with the necessary knowledge and skills to deliver high-quality, person-centered palliative care services.

Strengths and limitations

This study has limitations that need to be acknowledged. First, the sampling procedure used purposive and snowball sampling to recruit respondents who were connected to professional membership groups, perhaps limiting the generalizability of the study's findings. Secondly, since the majority of participants report covering outpatient service only, it indicates a necessity to test our findings among a more diverse group of social workers. Another limitation of this study is that due to the nature of secondary data analysis, a predetermined list of tasks does not enable participants to indicate roles that are not included in the list. Finally, the *Clinical Practice Guidelines for Quality Palliative Care* recognizes 2 levels of palliative care delivery: specialty palliative care and primary palliative care (National Consensus Project for Quality Palliative Care 2018). However, this study was unable to differentiate between social workers employed in specialty palliative care and those in primary palliative care. To address this limitation, the team is planning to conduct further research to differentiate the roles of social workers in these 2 levels of palliative care in cancer settings. Despite these limitations, this study has the following strengths: it expanded on the prior work defining core competencies social work (Glajchen et al. 2018), specifically focusing on cancer settings and the study results were based on a nationwide survey of social workers employed in a variety of cancer settings.

Conclusions

Social workers play an important role in the delivery of palliative oncology. The study findings illustrate the roles of social workers in palliative cancer care where they are engaged as part of an interprofessional care team. By clarifying the roles of oncology social workers, this study contributes to the improvement of palliative care delivery and enhances interprofessional collaboration within cancer care teams.

Supplementary material. The supplementary material for this article can be found at <https://doi.org/10.1017/S1478951524000622>.

Data availability statement. The data are currently used for other studies and manuscript development. The data that support the study may be available upon request with permission from the researchers who collected the data.

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Author contributions. Conceptualization: Ting Guan, Karlynn BrintzenhofeSzoc, Brad Zebrack; collection and assembly of data: Shirley Otis-Green, Tara Schapmire, Makeeta Rayton, Krista Nelson, Michael L. Grignon, Brad Zebrack; data analysis and interpretation: Ting Guan, Karlynn BrintzenhofeSzoc; manuscript writing: Ting Guan, Karlynn BrintzenhofeSzoc, Alyssa Middleton; manuscript review and editing: all authors; final approval of manuscript: all authors.

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Completing interests. No potential conflict of interest was reported by the authors.

Ethical approval. The study protocol was submitted for IRB review at a large university in the Midwestern US and determined “exempt-not regulated” as human subjects research in 2020.

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