



# Achievements and Barriers in Hospice and Palliative Social Work Practice: A Qualitative Study

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**Purpose:** Hospice and palliative care is a multidisciplinary approach to treatment and care designed to meet the needs of patients and their families at the end of life. Social workers are essential members of the hospice team, but their role is not well understood. The purpose of this study was to explore achievements and barriers in hospice social work practice and to suggest strategies for enhancing the role of social workers. **Methods:** The participants were 10 social workers who had worked in hospice institutions for over 5 years and were recruited based on reputational case sampling. Data were collected through two focus group interviews, and were qualitatively analyzed using thematic analysis. **Results:** Through the data analysis, two topics (achievements in hospice social work practice, barriers to achievements in hospice social work practice), five categories, 17 subcategories, and 182 concepts were derived. **Conclusion:** Based on an in-depth discussion of our key findings, we propose several types of institutional support, including expanding the hospice social work workforce, improving competence through education and supervision, developing professional programs and community resources, and refining methods for measuring achievements.

**Key Words:** Achievement, Health services accessibility, Hospices, Social work

Received August 30, 2024  
Revised November 8, 2024  
Accepted November 8, 2024

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## INTRODUCTION

### 1. Background

End-of-life care has emerged as a critical issue on the global health agenda [1], with a growing focus on hospice and palliative care (hereafter referred to as hospice). In South Korea, hospice teams include physicians, nurses, and social workers, and are supported by clergy and volunteers. Social workers are recognized as vital members of these teams under the “Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life” (hereafter “the Life-

Sustaining Treatment Decision Act”), enacted in 2016 [2]. Hospice care is tasked with providing a high-quality, diverse range of services to address the complex needs of end-of-life patients and their families. Consequently, the effectiveness of hospice care relies heavily on the multidisciplinary team, underscoring the importance of each professional’s role and their collaboration [3]. The field of hospice and palliative care social work practice (hereafter hospice social work practice) has developed in tandem with advances in hospice and palliative care. This progression started with the government’s 10-year Cancer Control Plan in 1996, the establishment of specialized hospice institutions in 2008, pilot projects from 2009 to 2015, and the

introduction of health insurance coverage for various services beginning in 2015 [4]. The contribution of social workers within the multidisciplinary team is notably significant [5]. For the purposes of this study, hospice social work practice is defined as the provision of social work services by hospice social workers employed at specialized hospice institutions following the formal establishment of hospice care. Previous research has highlighted the crucial role of hospice social workers in delivering psycho-social counseling, care planning, risk and safety assessments, bereavement counseling, and in facilitating referrals and coordination with community resources, as well as advocacy. These contributions significantly benefit not only the hospice teams but also the patients and their families in end-of-life care scenarios [6,7]. Despite these important roles, the awareness of the contributions of hospice social workers remains limited among patients, families, and even medical staff [8]. Furthermore, there is a notable scarcity of related research in the field of hospice studies in South Korea.

Hospice social workers are welfare professionals employed in healthcare institutions, occupying a unique role with specialized knowledge in health and care [9]. Their practice is grounded in the “person-in-environment” perspective, which promotes an integrated approach to understanding individuals within their environments and utilizes an ecological systems approach to enhance quality of life. This perspective prioritizes patient self-determination and dignity, with a focus on problem-solving at individual, family, and social levels [9]. Additionally, social workers advocate for patients and their families, upholding human dignity and adopting a strengths-based empowerment approach [9]. The principles and values guiding social work are closely aligned with those of the hospice approach, which also emphasizes improving the quality of life for patients and their families [10]. Previous research and guidelines on the role of social workers in hospice settings highlight their responsibilities in addressing the psychosocial needs of patients and families, developing care plans, and providing grief counseling for bereaved families [11]. A recent survey involving 482 social workers across 46 states in the U.S. identified 152 tasks performed by hospice social workers, categorized into four areas: assessment and reassessment, planning and intervention, death/grief/bereavement, and professionalism [8]. In summary, social workers address not only the so-

cioeconomic challenges faced by patients and families but also actively participate in bereavement-related interventions. Their responsibilities include managing family conflicts and crises, advocating for patients and families, providing education and training, coordinating and collaborating between institutions, and developing and connecting community resources [10,12]. According to the 2024 hospice program guidelines issued by the Ministry of Health and Welfare, social workers are tasked with a broad spectrum of responsibilities. These include conducting psychosocial assessments and care planning for terminally ill patients and their families, offering psychosocial and spiritual support and counseling based on the care plan, identifying and linking community resources, managing volunteers, overseeing and operating therapy and care programs, providing end-of-life care, and supporting bereaved families [2].

However, despite these government guidelines, a review of both domestic and international studies from the past decade shows that the roles of social workers in hospice settings remain unclear, with their duties often described as extensive and ambiguous [7,13]. Typically, hospice social workers, who number only one or two per institution, are responsible for managing an overwhelming 30 to 50 cases simultaneously [14]. This highlights the challenges they face in fulfilling their roles due to limited staffing. In South Korea, the shortage of hospice social workers has impeded their active engagement in their roles. Issues such as frequent turnover, driven by contract-based employment, insufficient training, and a scarcity of experienced professionals, have led to concerns about a decline in the quality of social work services [4]. Hospice social workers struggle not only with understanding their roles within the team [7] but also with clearly articulating their unique professional roles and the outcomes derived from them [8]. Despite numerous issues being reported in both domestic and international contexts regarding hospice social work practice, there remains a significant gap in research concerning the roles and achievements of these professionals. Therefore, further studies are necessary to define the roles of social workers, who are vital members of the hospice team, and to improve the quality of their practice.

## 2. The purpose of the study

Recently, the government unveiled the Second Compre-

hensive Plan for Hospice and Life-Sustaining Treatment (2024~2028). This initiative aims to enhance access to hospice care by increasing the number of specialized hospice institutions from 188 to 360 by 2028. Additionally, the plan targets raising the utilization rate of hospice services among eligible patients from 33% to 50% [15]. To support this expansion of end-of-life care infrastructure, it is essential to secure qualified hospice staff and enhance their professional expertise. Consequently, this study focuses on improving the understanding of the role of social workers, who are integral to the hospice team. The first objective of the study is to explore the achievements of hospice social work practice. The second objective is to identify the barriers that impede these achievements, using qualitative research methods. Drawing on the key findings, the study will propose policy plans to support the effective performance of hospice social workers.

## METHODS

### 1. Study design

In this study, qualitative research was conducted to explore the achievements and barriers of hospice social work practice by collecting and analyzing data through focus group interviews (FGIs). Qualitative research is a method that seeks to understand participants' experiences or perceptions on topics that are not well-documented, using an inductive reasoning approach. This method also helps interpret the meaning of specific concepts based on participants' understanding of those concepts. Although social workers have been integral members of multidisciplinary teams in hospice settings, the nuances of hospice social work practice are still not well understood, and there is a significant scarcity of prior research in this area. Therefore, qualitative research is a suitable method for this study.

### 2. Participants and data collection

The research participants consisted of social workers with more than 5 years of experience in hospice settings. This selection was based on the premise that new and senior social workers might have differing experiences, perceptions, and expectations regarding hospice social work practice. To ensure a knowledgeable and experienced participant pool, the re-

search team employed the reputational case selection method. This approach involves selecting participants who are recommended by seasoned professionals in the field [16]. Therefore, 10 social workers were recruited through endorsements from various institutions and experts, including the Korean Association of Medical Social Workers and the Korean Society for Hospice and Palliative Care.

Potential participants were informed via telephone about the study's purpose, the confidentiality of their personal information, the assurance that withdrawing would not result in any disadvantages, and the specifics of the recording and disposal process. Upon providing voluntary agreement to participate, they were sent a written consent form and interview questions by email. Both the research team and the participants retained a copy of the consent form. The study took place over two days in April 2024, utilizing Zoom for virtual interviews. Participants were divided into two groups according to their preferred schedules, with each session lasting two hours. The interviews were facilitated by two researchers, each leading a session. To maintain consistency in data collection, the recorded videos, transcripts, and analysis materials were immediately shared after the interviews. The research team held regular meetings to discuss key findings. The interview questions posed were: "What do you consider to be the achievements of hospice social work practice?" and "What barriers (obstacles or environmental factors) do you think make it difficult to achieve outcomes in hospice social work practice?" The research team included a medical social worker with extensive experience in hospice care. Supervision and regular meetings were held to ensure objectivity and validity throughout the research process, which included establishing participant qualifications and selection, formulating interview questions, conducting the FGI, and analyzing the data.

### 3. Ethical considerations

All members of the research team completed an online training course on the Bioethics Act, provided by the Korean Disease Control and Prevention Agency, before initiating the study. This training ensured their sensitivity to the rights and welfare of research participants and guided them in taking necessary measures to protect these individuals, in accordance with the requirements for human subjects research. The re-

search was conducted only after receiving approval from the Institutional Review Board (KNU–HR2402003).

The principles of credibility, transferability, dependability, and confirmability, as outlined by Lincoln & Guba [17] for ensuring rigor in qualitative research, were adhered to in this study. Initially, to verify the truth value, member checking was conducted by presenting the research findings to the participants to confirm their accuracy. To examine the applicability of the research findings to other contexts, the results were presented to senior hospice social workers who were not involved in the study, and they were asked to evaluate their applicability. To ensure the consistency of the study, the research team comprised field practitioners with over nine years of experience and multiple publications in qualitative research, including the use of thematic analysis methods. Specifically, the team included professors with clinical experience as medical social workers (eight years and four years, respectively) and a medical social worker currently employed at a specialized hospice institution. This composition provided the team with both research and practical expertise, as well as a deep understanding and theoretical insight into medical social work and hospice care. Additionally, the research team maintained a research journal throughout the entire process, from the research design phase to data collection, analysis, and writing. Regular online and offline meetings were held to share perspectives, address questions, provide mutual feedback, and exchange ideas. To ensure the neutrality of the study, the research team engaged in bracketing to set aside any preconceived notions or biases about hospice care. They thoroughly reviewed related literature, including government guidelines, program manuals, press releases, research reports, academic papers, and materials from the National Hospice Center. Additionally, they visited specialized hospice institutions and attended training courses offered by the Korean Society for Hospice and Palliative Care to gain a balanced and sensitive understanding of the field and the subject matter.

#### 4. Data analysis

The data were analyzed using thematic analysis as described by Braun & Clarke [18]. Thematic analysis is an inductive method that categorizes characteristics of collected data into themes, facilitating rich descriptions and the derivation of

meanings from these themes. This study adhered closely to the six-phase process of thematic analysis. In the first phase, familiarization with the data, the research team individually read through the transcripts and shared their insights during regular meetings. The second phase involved generating initial codes through open coding, focusing on meaningful words and sentences. In the third phase, concepts were categorized, and this categorized content was then used to generate themes. In the fourth phase, the themes were reviewed and refined, with modifications, additions, or deletions made as necessary. The fifth phase involved finalizing the names of the themes and categories, and verifying the appropriateness of the data for each theme. Finally, in the sixth phase, the analyzed content was synthesized and compiled into a report.

## RESULTS

### 1. Participants' general characteristics

The study participants were all women, ranging in age from their 30s to their 50s. Regarding their educational background, six held a bachelor's degree, while four possessed a master's degree. All were certified medical social workers; three were employed at tertiary hospitals, and seven at general hospitals. The hospice services they provided included two inpatient units, one consultative unit, and a combination of inpatient, home-based, and consultative services for the remaining participants. Their experience in specialized hospice institutions varied from 5 years and 5 months to 18 years, averaging 8 years and 9 months. All participants, except for one contract worker, were full-time employees. Six of the institutions were located in the metropolitan area, and four were in other regions (Table 1).

### 2. Results of data analysis

The current study aimed to explore achievements in hospice social work practice and the barriers that hinder these outcomes. Thematic analysis revealed one overarching category, seven subcategories, and 66 concepts associated with the achievements of hospice social work practice. Regarding the barriers, four overarching categories, ten subcategories, and 116 concepts were identified. However, due to space limita-

Table 1. Characteristics of Participants (N=10).

Group	n	Age	Education	Hospital type	Hospice type	Hospice career	Area
1	A	30s	Master	TGH	Inpatient, home	9 yrs 7 mo	Non-metro
	B	50s	Bachelor	GH	Inpatient	5 yrs 10 mo	Metro
	C	50s	Bachelor	TGH	Consultative	7 yrs 8 mo	Non-metro
	D	30s	Master	GH	Inpatient, home, consultative	6 yrs	Metro
	E	40s	Bachelor	GH	Inpatient, home	5 yrs 5 mo	Metro
2	F	30s	Bachelor	GH	Inpatient, home	7 yrs 9 mo	Non-metro
	G	40s	Master	GH	Inpatient	7 yrs 4 mo	Metro
	H	30s	Bachelor	TGH	Inpatient, consultative	10 yrs	Non-metro
	I	40s	Bachelor	GH	Inpatient, home, consultative	10 yrs 1 mo	Metro
	J	50s	Master	GH	Inpatient, home	18yrs	Metro

TGH: Tertiary General Hospital, GH: General Hospital.

tions, only the key concepts are presented.

**1) Achievements in hospice social work practice**

The achievements of hospice social work practice were categorized into one overarching theme, “supporting hospice adaptation and a dignified death through interventions based on the needs of patients and families.” This theme encompassed seven subcategories: (1) supporting patients and families in adjusting to the hospice environment, (2) family care from before death to after bereavement, (3) communication and mediation between patients and families, (4) facilitating communication between patients (and their families) and medical staff, (5) program planning and development, (6) discharge planning and connecting with community resources, and (7) supporting medical staff from a holistic perspective rather than a disease-centered model. These were further broken down into 66 concepts (Table 2).

**(1) Supporting patients and families in adjusting to the hospice environment**

The study participants stated that supporting patients and families in adjusting to hospice care through psychosocial counseling is the most significant achievement in hospice social work practice. Most patients and families entering hospice wards at the end of life face sudden admissions without adequate guidance, resulting in feelings of anxiety, fear, and unfamiliarity with hospice care. Social workers emphasized the importance of providing regular support and counseling to patients and families facing such emotional challenges. Through these efforts, they foster a better understanding of hospice care

and support patients in achieving a dignified death.

*Some patients have endured prolonged treatment before coming to hospice, while others are admitted after receiving a terminal diagnosis. Many patients enter hospice not through a gentle transition but rather feel pushed into it. As a result, they often carry emotional wounds, and their families struggle with how to cope with the situation. Additionally, the emotional changes patients and families experience are significant. Patients are unable to express their feelings, and families often feel unable to voice their frustrations, even toward medical staff. Therefore, we focus heavily on counseling to address these emotional aspects. (Participant A)*

*In the end, the family member or daughter who had been by the patient’s side throughout the caregiving said, “This past month felt like a gift.” When they first received the terminal diagnosis at a large hospital and were told to transition to hospice, it felt utterly devastating. However, after coming here, the patient’s symptoms were managed to some extent, and during that one-month period, they had time to be with their mother and send her off well. They expressed how much support they received during that time. Hearing that made me think, “This is the essence of my role.” (Participant B)*

**(2) Family care from before death to after bereavement**

Social workers focus on both the patient and their family, recognizing the family as a crucial environmental system that influences the patient. They offer family care services to address this dynamic. By supporting and validating the diverse

**Table 2.** Achievements in Hospice Social Work Practice.

Category	Sub-category	Concepts
Supporting hospice adaptation and a dignified death through interventions based on the needs of patient and their families	Supporting patients and families in adjusting to the hospice environment	<ul style="list-style-type: none"> <li>- The most significant outcome is the enhancement of patients' and families' ability to adapt</li> <li>- Interventions help patients and their families develop a positive perspective on hospice care</li> <li>- Providing support through various programs to ensure that patients (and their families) can experience a dignified end of life</li> <li>- The family experiences social welfare services and chooses hospice care again</li> </ul>
	Family care from before death to after bereavement	<ul style="list-style-type: none"> <li>- Supporting families in difficult situations and helping them find stability</li> <li>- Systematic intervention for families from pre-death through the post-bereavement period</li> </ul>
	Communication and mediation between patients and their families	<ul style="list-style-type: none"> <li>- Facilitating communication between end-of-life patients and their families</li> <li>- Mediating the resolution of pre-existing conflicts within the family</li> </ul>
	Facilitating communication between patients (and their families) and medical staff	<ul style="list-style-type: none"> <li>- A communication channel between the medical staff and the family</li> <li>- Advocating for the right to information of patients and their families</li> </ul>
	Program planning and development	<ul style="list-style-type: none"> <li>- Leading the development of care programs tailored to the needs of patients and their families</li> <li>- Possessing the knowledge and information needed for program development</li> </ul>
	Discharge planning and connecting with community resources	<ul style="list-style-type: none"> <li>- Developing a discharge plan for patients transferring to another facility or returning home</li> <li>- Disseminating welfare information through the production of materials such as resource books</li> <li>- Providing social welfare information and connecting resources to meet the needs of patients and their families is a key achievement</li> </ul>
	Supporting medical staff from a holistic perspective rather than a disease-centered model	<ul style="list-style-type: none"> <li>- A social worker who intervenes from a different perspective than the medical team, identifying aspects that the medical team may overlook</li> <li>- Supports the medical team in understanding the patient's situation</li> </ul>

emotional responses families experience—such as grief, confusion, and guilt—social workers help them come to terms with the impending loss of a loved one. Furthermore, social workers continue to provide essential welfare services tailored to the family's needs even after bereavement. Essentially, social workers are committed to systematic interventions that span the entire continuum, from the pre-death phase through to the post-bereavement stage, for families dealing with end-of-life situations.

*Involvement with bereaved families seems to be one of the achievements of social workers. It feels like social workers are likely handling this in every organization. End-of-life and bereavement management, in fact, begins from the time of ad-*

*mission – long before the passing occurs. It extends to making phone calls or sending letters after the bereavement, screening high-risk families, organizing gatherings, or conducting individual counseling sessions. I believe social workers have played a significant role in systematizing these processes, (Participant A)*

*“My younger sibling is passing away, so I feel like I need to follow them to meet my father; otherwise, I might not be about to see him.” In other words, they are signaling that they, too, want to leave. When making bereavement calls, it is quite common to hear spouses, whether wives or husbands, expressing their distress, saying things like, “What do I do? What do I do?”... In this way, we continue providing comprehensive care. This, too, might be considered one of the significant*

achievements. (Participant C)

### (3) Communication and mediation between patients and their families

In hospice care, families facing the death of a terminally ill patient often experience challenges in communicating with the patient. When families find it difficult to directly engage with the patient or when there are pre-existing conflicts within the family, they tend to look to social workers to act as mediators. Social workers actively intervene by providing family counseling.

*Families sometimes face difficulties in directly asking the patient certain questions or hope that someone else will ask on their behalf. Additionally, conflicts within the family, would ideally be resolved among themselves, but they fear it might lead to further disputes. As a result, some request a third party, like a social worker, to mediate from a neutral perspective. (Participant A)*

### (4) Facilitating communication between patients (and their families) and medical staff

Patients and their families often find the hospice environment unfamiliar, which can lead to feelings of anxiety and fear. These emotions make it challenging for them to comfortably engage with medical staff, whether to ask questions or share their feelings. In such circumstances, families tend to feel more at ease with social workers, expressing their thoughts or emotions to them and often expecting the social worker to convey these to the medical staff on their behalf. Patient satisfaction is influenced by the quality of communication with medical staff [19], and one of the roles of hospice social workers is to advocate for patients and their families [20]. From the perspective of patients and families, social workers actively support them to ensure they received the best possible hospice care.

*When speaking with the doctor, many caregivers wonder, “Is it okay to express this?” or worry, “What if bringing up how the doctor’s treatment direction differs from what our family hopes for comes across as confrontational?” They often ask, “How can I convey this without causing misunderstandings?” At the same time, caregivers feel they have the right to know, be involved, and participate in decision-making. In these situ-*

*ations, they often expect social workers to act as mediators to help find a balance.” (Participant G)*

*“I see myself as a bridge between the medical staff and the patients. While I am technically part of the multidisciplinary team and a hospital staff member, patients often perceive social workers not as medical team members but simply as social workers. Because of this, they often express to us the things they wanted to ask but couldn’t, or the feelings they couldn’t voice. For instance, they might say “yes, yes, yes” reluctantly to the medical staff, but deep down, they’re thinking, “I’m struggling so much with this,” or “I really don’t want to do this.” They share these honest feelings with us. I believe one of our achievements as social workers is serving as that bridge, ensuring that patients can fully receive hospice and palliative care services.” (Participant A)*

### (5) Program planning and development

In hospice wards, a range of care programs and annual events are implemented for patients and their families, with social workers primarily responsible for planning and developing these programs. Social workers typically learn program development and evaluation as a mandatory part of their undergraduate curriculum, and they excel at mobilizing resources such as therapists or volunteers needed for program delivery. Therefore, they are considered to play a leading role in the implementation of care programs.

*There are various care programs, and many of them, including those providing hospice services, are often handled by social workers. Social workers frequently take the lead in delivering care programs for patients at the end of life. For example, programs like granting wishes, creating photo albums, or organizing birthday or anniversary celebrations, as well as events for other meaningful days. While patients are in the ward, hospice services differ significantly from those in regular wards, with much more support offered to patients and their families... I believe social workers also have the ability to take the initiative in designing these programs. (Participant B)*

*I believe we play a significant role in supporting care programs that help patients make their remaining time meaning-*

ful and create lasting memories. In addition to providing care programs, we connect patients with therapists and therapy professionals, as well as volunteers who can assist with emotional needs, physical care, such as bathing, and other necessities. I think these contributions are also one of our key achievements. (Participant E)

#### (6) Discharge planning and connecting with community resources

The study participants viewed the identity and uniqueness of social workers in hospice teams as being centered on resource linkage. This function is unique to social workers and not replicated by other professionals within the team. Based on assessments of patients and their families, social workers connect them with public assistance programs such as basic living support, long-term care services, tailored elderly care services, medical expense support, and housing services, as well as various public and private welfare resources in the community. In particular, when patients need to be transferred to another institution or discharged home, social workers refer them to agencies such as community welfare centers, comprehensive social welfare centers, or mental health welfare centers to ensure continuity of care. This is considered to be one of the key achievements of social work practice.

*A recent issue has been discharge planning. According to the Ministry of Health and Welfare guidelines, hospice patients can stay in hospice facility for up to 60 days. While this is grounded in the rationale of necessity for terminal patients, in practice, the average length of stay is often less than a month due to the nature of their conditions. However, when patients do not pass away within the 60-day period, both patients and caregivers often feel like they are being “forced out,” as they describe it. This raises concerns about where to send critically ill patients next. To address these challenges, social workers collaborate with patients and their families to create discharge plans that alleviate their fears and anxieties. These plans are tailored to individual needs, considering factors such as caregiving, housing, and financial circumstances. Developing these personalized discharge plans is one of the critical achievements of hospice social workers. (Participant B)*

*I think the areas that are particularly challenging for other professionals to approach are social welfare resource linkage and program development or planning... I believe one of our key responsibilities is to connect people with resources or provide practical assistance needed by patients and caregivers... For example, when we help with public assistance programs or social information services, patients and families are often very appreciative. Since other professionals often struggle to provide such connections effectively, they tend to turn to social workers in those situations. (Participant F)*

#### (7) Supporting medical staff from a holistic perspective rather than a disease-centered model

Social work practice is grounded in theoretical perspectives such as the person-in-environment approach, the bio-psycho-social model, and family systems theory. It employs a holistic approach that encompasses the multifaceted needs of patients and their families. Rather than focusing solely on the patient’s medical condition and symptoms, this approach focuses on how patients interact with and adapt to their surrounding systems, such as family, neighbors, and the broader community. By identifying and addressing needs that medical staff may overlook, social work practice makes significant contributions through interventions and support for patients and their families.

*Even when conducting the same counseling session or hearing the same story, the way it is interpreted can vary depending on one’s perspective. During initial counseling sessions, we work together as a team, but even when listening to the same conversation, the areas of focus and assessment, as well as the way things are documented, differ greatly. This often leads team members to realize, “This is why we need social workers.” (Participant A)*

*There are aspects that doctors and nurses may not see, such as viewing the patient within their social context and understanding family relationships. When we identify and share these insights, the team members can take them into account, contributing to a more holistic assessment of the patient. I believe we play a role in supporting this comprehensive evaluation. (Participant E)*



**2) Barriers to the achievements of hospice social work practice**

The barriers to the achievements of hospice social work practice can be broadly categorized into two areas: organizational and structural aspects, and social work practice-related aspects.

**(1) Organizational and structural aspects**

In terms of organizational and structural aspects, barriers within and outside the organization were identified within two major categories (structural problems and lack of support within the organization, environmental barriers outside the organization), five subcategories, and 56 concepts (Table 3).

**① Structural problems and lack of support within the organization**

**A. Lack of social work manpower**

All study participants emphasized the shortage of social

workers in hospice settings as a key barrier to achieving the goals of social work practice. In most institutions, hospice social workers work alone as a “one-person social work team,” handling a wide range of responsibilities, including counseling patients and families, resource linkage, program management, and organizing events. In some cases, they are also responsible for budget management and coordinator roles, resulting in an overwhelming workload due to insufficient staffing. Even in facilities with multiple staff members, it is common for only one to be a full-time employee, while contract workers frequently change. This necessitates a significant investment of energy in educating and training new staff whenever they join.

*I’m essentially a one-person team. I’m the only one, with no coordinator. I handle government fund management, resource linkage, counseling, and even outdoor resource management, including selecting vendors and managing those aspects myself. (Participant G)*

**Table 3.** Organizational and Structural Aspects: Internal and External Barriers to the Organization.

Category	Sub-category	Concepts
Structural problems and lack of support within the organization	Lack of social work manpower	<ul style="list-style-type: none"> <li>- There is no place to complain about difficulties due to working alone</li> <li>- Difficulty in advocating for social worker rights when working alone</li> <li>- Taking on a wide range of tasks, including administrative duties</li> <li>- Not being able to handle the given tasks with the current staffing levels</li> <li>- Difficulty in hiring additional social workers under the current guidelines</li> <li>- Difficulty in expanding hospice services due to workforce restrictions</li> <li>- Overwhelmed by the heavy workload, but driven by a sense of duty</li> </ul>
	Work overload due to holding concurrent positions	<ul style="list-style-type: none"> <li>- I’m feeling overwhelmed due to work overload from holding concurrent position</li> <li>- Overburdened with responsibilities due to the concurrent employment system</li> <li>- Struggling to provide home-based hospice care due to the heavy workload</li> <li>- Difficulty in providing high-quality services due to concurrent employment</li> </ul>
	Organizational problems and lack of supervision	<ul style="list-style-type: none"> <li>- Hierarchical organizational structure with a top-down approach</li> <li>- A challenging field of hospice care where it is difficult for new social workers to endure</li> <li>- Being part of the hospice team rather than the social work team, resulting in a lack of supervision</li> <li>- Experiencing difficulties due to a lack of supervision, despite high work demands and expectations</li> <li>- Without receiving supervision, it’s like hitting a brick wall</li> </ul>
Environmental barriers outside the organization	Difficulties in making referrals due to a lack of resources	<ul style="list-style-type: none"> <li>- Lack of community resources and specialized programs for referrals (e.g. bereavement support programs for families)</li> <li>- Referring to the mental health welfare center is ineffective due to their lack of understanding of hospice care</li> <li>- Resources for referrals are even more limited in rural areas</li> </ul>
	Challenges in community-based practice due to responsibilities at a national level	<ul style="list-style-type: none"> <li>- Due to the shortage of hospice wards, inquiries come from all over the country</li> <li>- Patients and families seeking hospice care prefer large hospitals</li> <li>- Need to provide services to patients and families from across the country</li> </ul>

*Most facilities operate with only two types of staff, and hospitals prefer to reduce labor costs by hiring just one social worker.... That's why I often jokingly say, "I have multiple jobs." Some days, I feel like I've started an event planning company; other days, I'm running a photo studio, or even working as if I'm part of a funeral service company. Of course, I have to handle these tasks when needed, along with numerous administrative duties and paperwork. Despite this, whenever counseling is requested, I make sure to provide it as well. (Participant D)*

*I'm the only full-time employee, while the other two social workers are on contract. They change every year or two. By the time they're trained and capable of handling the work, they leave. This cycle repeats over and over. (Participant A)*

### **B. Work overload due to holding concurrent positions**

The shortage of staff has led to work overload due to dual responsibilities, since social workers can handle multiple types of hospice care – such as inpatient, home-based, and consultative hospice – most study participants were responsible for two or more types. This workload, resulting from dual responsibilities, particularly affected home-based hospice care, making tasks such as home visits challenging and negatively impacting the ability to provide active interventions and high-quality services.

*I think the biggest obstacle is the excessive burden of work for social workers and the need to take on multiple roles, which may compromise the quality of care. I, too, am responsible for both inpatient and home-based hospice care, but for home-based care, I can only manage the initial visit. This makes me feel very sorry for the patients and families because there are limits to what I can do. Even when I have the information, I can't respond more proactively, and this leads to significant feelings of burnout and exhaustion for social workers like myself. (Participant F)*

### **C. Organizational problems and lack of supervision**

Although medical social work department exist within hospitals, under the Life-Sustaining Treatment Decisions Act, social workers must be part of the hospice team. Most hospice

teams only employ one social worker, operating under the approval of medical staff and with limited opportunities for promotion. This organizational structure not only risks undermining the autonomy of social workers but also highlights a significant barrier to achieving quality outcomes—namely, the lack of supervision from senior social workers, which is essential for maintaining professional practice standards and quality management.

*Within the organization, while my profession is respected, my managers inevitably nurses and doctors. This means I can only exist as a subordinate team member. Even though I've been in the field for 10 years, it feels disheartening at times knowing that this structure is unlikely to change within the organization in the future. (Participant H)*

*I think the biggest challenge is the inability to receive supervision. There was a time when I was struggling and called [Name] in tears for advice. The reality is that most of us are likely working alone as a "one-person team." Even though I have experience, I still face difficulties and wonder, "Who can I discuss these things with?" (Omitted) Upon reflecting on this, I feel the lack of supervision is largely due to the separation of the hospice team from the social work department, requiring independent staffing within the hospice team. This separation creates significant barriers and makes these challenges even more pronounced. (Participant I)*

## **② Environmental barriers outside the organization**

### **A. Difficulties in making referrals due to a lack of resources**

Study participants identified external environmental barriers, such as resource shortages and imbalances, as significant obstacles to achieving social practice outcomes. These barriers made it difficult to connect with community organizations. For example, welfare resources such as funeral support systems for unaccompanied individuals were primarily concentrated in metropolitan areas, making it challenging for those in other regions to access them. Additionally, community organizations such as mental health welfare centers often lacked understanding of hospice care or related programs (e.g., bereavement family recovery programs), which hindered the smooth

provision of services.

*There was a patient on Medical Aid Type 1 whose family completely abandoned them, so I had to arrange an unclaimed funeral.... There are quite a few support options available in metropolitan areas, but they are far less common in regional areas. When a patient is discharged home, they often feel depressed and struggle emotionally, so I tried connecting them to a mental health welfare center several times. However, the local support systems lack an understanding of hospice care.... But I can't keep pushing them relentlessly, saying, "Do it, do it, do it." (Omitted) These resource issues vary greatly among regions, which is also a significant challenge. (Participant C)*

**B. Challenges in community-based practice due to responsibilities at a national level**

Hospice care is currently concentrated in metropolitan areas. However, there is significant demand from patients and caregivers in other regions, prompting social workers to provide social welfare information online to patients and families in those regions. In such cases, hospice social workers often face difficulties due to a lack of understanding of patients' and

families' specific regional contexts. For example, although resources should be allocated based on the needs of discharged patients or bereaved families, unfamiliarity with local characteristics and available information often complicates the process of linking them to the required services.

*As mentioned earlier, there is a noticeable disparity between metropolitan and regional areas. I work in a setting that experiences a concentration of resources in metropolitan areas. It's similar to how large hospitals dominate. For instance, most tertiary hospitals don't have inpatient hospice wards and only offer consultative hospice care. As a result, patients seek care at general hospitals, and even those from rural areas wish to come here. (Participant B)*

**(2) Aspects of social work practice**

A lack of understanding of the achievements and roles of social work practice, as well as insufficient competencies among social workers, emerged as barriers to achieving effective hospice social work practice. This theme was categorized into two major categories—(1) a reality where it is difficult to show achievements, and (2) lack of understanding and competence

**Table 4.** Aspects of Social Work Practice: Lack of Understanding of the Achievements and Role of Social Work Practice and Lack of Competence.

Category	Sub-category	Concepts
A reality where it is difficult to show achievements	An ambiguous and simplistic evaluation system	<ul style="list-style-type: none"> <li>- The evaluation criteria in the field of social welfare are too ambiguous</li> <li>- Evaluation indicators that fail to capture actual achievement</li> <li>- The simplification of the evaluation system has made it even more difficult to demonstrate achievement</li> <li>- Feeling disheartened by the low scores received despite the amount of work</li> </ul>
	The achievements of social work practice are difficult to quantify	<ul style="list-style-type: none"> <li>- Social work practice is difficult to quantify in terms of achievement</li> <li>- Frustration due to the lack of methods to demonstrate achievement</li> <li>- Unsure of how to present achievements</li> <li>- A reality where demonstrating success is difficult without recognition from the medical team</li> </ul>
	Too busy with tasks to focus on achievements	<ul style="list-style-type: none"> <li>- Overwhelmed by countless tasks, feeling like being stuck in a swamp</li> <li>- Too busy with daily tasks to focus on demonstrating achievement or conducting research</li> <li>- Just doing my job without worrying about achievements</li> </ul>
Lack of understanding and competence in social work practices	A low level of awareness about the role of social workers	<ul style="list-style-type: none"> <li>- A social worker is perceived as an accounting clerk and funeral guide</li> <li>- Challenging and complex tasks fall to social workers</li> <li>- There are no expectations because people don't understand what social workers do</li> </ul>
	Lack of competence among social workers	<ul style="list-style-type: none"> <li>- Unfamiliar hospice work that started without any training</li> <li>- Hospice work that is difficult to manage with just a social worker certificate alone</li> </ul>

in social work practice—and further divided into five subcategories and 60 concepts (Table 4).

### ① A reality where it is difficult to show achievements

#### A. An ambiguous and simplistic evaluation system

Study participants noted that the current evaluation of hospice-specialized institutions has vague or simplistic assessment criteria for the social work domain, failing to adequately capture the outcomes of social work practice. Specifically, the limited number of items and the difficulty in evaluating services unless they involve visible support, such as financial assistance or caregiver connections, were highlighted. They pointed out that the current evaluation system does not effectively reflect the achievements of social workers.

*To be honest, even starting with the evaluation questionnaire, there are very few items for us. On the hospice specialized institution evaluation form, there's a question like, "Did you receive adequate social work services?" and another one... (Omitted). The problem is that when people hear "social work services," they often think it means receiving sponsorship or resource linkage directly. So even if I've coordinated volunteer services tirelessly, people answering the survey don't feel they've truly received social work services unless they've been directly given financial support, such as cancer patient subsidies or caregiving expenses. This makes it difficult for them to give high scores when evaluating social work services. (Omitted) It's disheartening because the scores often don't reflect the effort we've put in. (Participant G)*

#### B. The achievements of social work practice are difficult to quantify

The nature of social work practice, which includes counseling, psychosocial support, family education and care, and providing information about community resources to help patients and families adapt to hospice wards, makes it challenging to quantify and measure service outcomes. Furthermore, relying solely on quantitative indicators such as the number of counseling sessions, volunteers, program operations, or community resource connections often overlooks important aspects.

*As with all areas of social work, the biggest challenge is that our achievements cannot be quantitatively evaluated, mak-*

*ing it difficult to explicitly showcase, "This is how much we've accomplished." The care services we provide could be better assessed qualitatively, as each case could be thoroughly evaluated in that way. However, since our work isn't reflected in measurable outcomes, it may seem ambiguous from an external perspective. (Omitted) Even when counseling resolves an issue, that resolution doesn't appear in the annual reports or program outcome summaries at the end of the year. (Participant H)*

*Honestly, I'm not sure. It feels like my only tangible achievement is hearing people at the hospital say, "If we didn't have you, it would be a big problem." That feels like the extent of my recognized outcomes. (Participant G)*

#### C. Too busy with tasks to focus on achievements

With only one or two social workers employed at each hospital, they are often too preoccupied with daily tasks to focus on achievements in their social work practice. Participants expressed frustration and a sense of defeat as senior social workers, noting that in their busy daily environment, it feels overwhelming to measure outcomes rigorously or conduct research.

*Social workers are incredibly busy, but honestly, there are times when even I'm not entirely sure what I'm doing. Each day, I work through tasks, checking them off and clearing them one by one, but that's about it. (Participant F)*

*As a social worker, I know I should provide counseling and education for patients, but it's very difficult to measure and present these efforts as concrete outcomes. There's so much work to do that I often rush through tasks. Ideally, we'd have data showing that using specific therapeutic theories and interventions leads to positive outcomes, but such resources are lacking. What's really important is evidence that psychosocial counseling and social work interventions have beneficial effects on patients and caregivers, yet the absence of this data is frustrating, leaves me feeling guilty, and saddens me after being in the field for so long. (Omitted) Without proper, in-depth research, it's hard to address these issues. This is a deeply disheartening aspect for me personally. (Participant J)*

## ② Lack of understanding and competence in social work practice

### A. A low level of awareness about the role of social workers

Most patients and families are unaware of the exact roles and responsibilities of hospice social workers. In some cases, they even perceive social workers as funeral directors or insurance agents. This low level of awareness about the role of social workers makes it challenging to build relationships or foster collaboration with patients and families. As a result, more energy is often spent explaining the role of the social worker rather than providing actual services.

*Most people genuinely don't know what social workers do. For instance, after a counseling session, it's common for someone to say, "Um... who was that? Someone from the local community center?" That's why, during rounds, the attending professor always introduces me as the social worker, which facilitates my involvement. (Participant B)*

*I've been asked if I'm a funeral director, and many people expect me to provide guidance in that role or request counseling. I've also had people ask me about the necessary documents for insurance claims, even though I'm not an insurance planner. (Participant G)*

### B. Lack of competence among social workers

Participants expressed that it was challenging to provide services in hospice wards with only a Level 1 social worker certification, without in-depth education or systematic training in hospice care. They noted that the lack of competence among social workers serves as a barrier to high-quality hospice social work practice. To achieve better outcomes in hospice social work, they suggested that it would be more appropriate for certified medical social workers, rather than those with only a Level 1 social worker certification, to be employed in these roles.

*After completing the 60-hour standard education program, I went straight into practice, and honestly, I felt completely lost. Without any prior hospice experience, I found it overwhelming to approach terminal cancer patients and their families, not even knowing how to conduct counseling sessions. Looking*

*back at the current standard education program, while it provides foundational knowledge, I realized that it's insufficient for teachers or practitioners with no prior experience to be immediately deployed into clinical settings. (Participant H)*

*Coming in as a Level 1 social worker and working in the ward while trying to understand medical terminology related to cancer patients felt incredibly challenging. I wonder if one needs to be a medical social worker for this role. (Omitted) I believe that someone who has received professional training as a medical social worker would be better equipped to work as a hospice social worker in a hospice ward. This would allow them to perform more effectively, feel less intimidated, and work with greater confidence, as mentioned earlier. (Participant B)*

## DISCUSSION

As South Korean society enters a super-aged era, there is a growing social demand for ensuring a meaningful end to life. Notably, the hospice utilization rate, which was only 7.3% in 2008, increased to 23.2% in 2021 [21]. The government recently announced plans to increase the utilization rate for eligible hospice patients to 50% by 2028 [15]. Under the Life-Sustaining Treatment Decision Act, hospice care is provided by multidisciplinary teams comprising essential personnel such as physicians, nurses, and social workers. Social workers play a vital role in addressing the complex needs of patients and families by providing a wide range of welfare services. However, despite the meaningful contributions of social workers to end-of-life care for patients and families, research on hospice social work practice remains very limited. This study qualitatively analyzed achievements in hospice social work practice and the barriers to achieving those outcomes by involving senior social workers with over 5 years of experience in hospice institutions as research participants. Based on the key findings, policy recommendations for enhancing the effective role of hospice social workers are presented.

First, the achievements in hospice social work practice, as perceived by the study participants, were identified as "assisting patients and families in adapting to hospice care and achieving a dignified death through needs-based interventions." Specifically, participants recognized achievements in hospice

social work practice as including regular support and counseling to help patients and families adapt to hospice care, family caregiving, facilitating communication between patients and families as well as between patients and medical staff, program planning, resource linkage, and supporting medical staff from a holistic perspective. As the only welfare professionals providing social services in medical settings, hospice social workers require policy support to continue expanding and enhancing these achievements.

Hospice care currently serves as the only specialized system for end-of-life care, primarily delivered through medical institutions [22]. From the point of being diagnosed with a terminal condition or recognizing the need to prepare for death to the end-of-life process, patients and families experience complex needs. These include the need for palliative care support, assistance in maintaining daily life, psychosocial and spiritual support, guidance in making decisions about life-sustaining treatments, and preparation for death (such as funeral arrangements, memorial photographs, burial shrouds, and funeral costs) [22]. Therefore, hospice care must simultaneously provide both medical and social welfare services. Integrating health and welfare services for end-of-life patients and families—currently delivered in a fragmented and sporadic manner—necessitates expansion beyond inpatient and consultation-based services. A strong network among community institutions should be established, and home-based hospice care, which is critical for providing these services in an integrated manner, needs to be actively promoted.

Previous studies have shown that hospice social work practice is associated with reduced hospitalization rates and medical costs, lower frequency of analgesic use, improved patient satisfaction with life, and higher satisfaction among team members, including physicians and nurses [6]. Therefore, efforts to quantify and empirically demonstrate the achievements of hospice social work practice are needed in the future. For example, in the current evaluation of specialized hospice institutions, areas primarily managed by hospice social workers (e.g., bereavement family programs, bereavement family meetings, therapeutic programs) are assessed in terms of their “presence or absence.” However, presenting these outcomes in terms of “frequency of implementation” or “service level” would provide a more concrete representation of the achieve-

ments of hospice social work practice.

Second, the barriers to the achievements of hospice social work practice were categorized into internal and external organizational factors. The most emphasized internal barrier, noted by all participants, was the shortage of social workers. When hospice social workers are required to perform additional roles, such as coordinators or administrative duties (e.g., budget management, supply management), beyond their primary responsibilities, they face challenges in carrying out their core duties. Many social workers who work alone in their roles reported feeling overwhelmed by their workload. According to a self-reported survey by hospice social workers, 39.3% of social workers at hospice institutions reported difficulty fulfilling their roles due to excessive workloads, overlapping responsibilities, and role conflicts. Particularly in institutions operating all three types of hospice services, including inpatient, home-based, and consultation-based care, two social workers are required to manage these services [2]. However, these two social workers are responsible for all three service types, inherently creating a structural shortage of personnel. Previous studies have shown that hospice social workers handle an average of 29 new patients per month and spend approximately 1 hour and 20 minutes per case, including counseling and documentation, indicating a significant workload [23]. These conditions reduce the time available for the regular counseling and support for patients and families, which participants highlighted as a major achievement, thereby diminishing the quality of social work practice. In reality, when hospice social workers are responsible for multiple service types (inpatient, home-based, consultation-based), time-intensive activities such as home visits become practically limited. Despite the many roles social workers could play, such as connecting patients and their family members with community resources and case management, they are unable to dedicate themselves fully to home-based hospice care. Therefore, it is urgently necessary to establish a regulation requiring one social worker per service type to ensure adequate staffing and service quality.

In addition, consultation-based social workers face limitations in both the quantity and quality of services due to their dual responsibility for performing general medical social work duties while also handling roles in clinical departments such as psychiatry. To enable an adequate number of social workers to

focus on hospice duties, changes in the current staffing regulations are required, such as calculating the number of hospice social workers based on the number of beds, similar to the staffing guidelines for physicians and nurses. Budget allocation for increasing the number of social workers is also necessary. Another internal organizational barrier mentioned was the lack of supervision. Hospice care, which involves expressions of empathy and compassion, exposes practitioners to stressful situations, placing them at high risk of burnout [24]. Research has shown that 80.4% of hospice social workers in South Korea experience burnout due to excessive workloads [23]. Burnout acts as a barrier to the effective delivery of hospice care and is associated with low job satisfaction and turnover. Excessive workloads and a lack of support contribute to the burnout and stress of hospice social workers [24], underscoring the need for regular supervision, tailored training by experience level (e.g., for new and senior workers), and specialized training in areas such as spirituality and self-care. Such measures are critical for proactively addressing burnout among hospice social workers. Another finding of this study is that hospice social workers must be part of a hospice team. However, social workers who work alone lack opportunities for supervision, which was identified as another significant barrier. This highlights the practical need for a structured supervision system for hospice social workers. This issue was raised in Western studies over 20 years ago, where concerns were noted regarding supervision by administrators or non-social work professionals in hospice settings. These studies strongly emphasized the need for supervision by social workers to ensure the effective performance of hospice social work roles [6]. A proposed solution is to establish a supervision system in collaboration with medical social work departments.

External organizational barriers to the achievements of social work practice include a lack of community resources for discharged patients and their families, such as caregiving, household support, financial assistance, and bereavement counseling programs. Participants also highlighted the shortage of specialized programs, such as grief counseling for bereaved families, and the challenges of performing community-based roles due to patients coming from across the country. Currently, community welfare services to support a dignified death for end-of-life patients and their families are severely lacking [22].

There are few local resources where bereaved families can receive necessary services, such as grief counseling, limiting hospice social workers' options for referrals. The study revealed that although bereaved families were referred to local mental health welfare centers for counseling, these referrals were often unsuccessful due to a lack of understanding of hospice care. This underscores the need for a nationally structured service delivery system to ensure that families with hospice experience can access ongoing grief counseling in their communities. Additionally, the absolute shortage of hospice providers and beds forces patients from rural areas to seek care in metropolitan regions. In such cases, providing continuous services or referrals for discharged patients and their families becomes difficult. Therefore, expanding hospice institutions nationwide is essential to enable community-based hospice social work practice and ensure accessibility for patients and families in all regions.

Third, the study participants highlighted the difficulty of demonstrating achievements in hospice social work practice as another challenge. Currently, the evaluation guidelines for specialized hospice institutions include only one item directly related to social work practice [25], and its vague wording (e.g., Item 3 on the bereaved family satisfaction survey: "The social worker provided appropriate counseling or services to the patient or family") raises questions about the accuracy and objectivity of the evaluation. Future efforts should focus on diversifying evaluation criteria, developing validated scales, quantifying evaluations using digital records, and establishing measurable indicators. Another notable finding from the study is that due to the shortage of social workers, participants were often too occupied with their immediate duties to prioritize performance evaluations or conduct related research. To address such issues, efforts should be made to expand the workforce and actively promote empirical research on achievements in hospice social work practice through support from the Korean Society for Hospice and Palliative Care, the Korean Association of Medical Social Workers, and partnerships between institutions and universities.

Fourth, a lack of understanding about social workers among medical staff, patients, and families, as well as insufficient competencies among social workers themselves, was identified as another barrier to the achievements of hospice social work practice. Despite the job responsibilities outlined in the hospice

program guidelines, some medical staff perceive social workers as accounting clerks or event coordinators. Participants also reported frustrations about social workers being tasked with the most challenging and complex responsibilities within the team. Role clarity, effective communication, and mutual respect are essential components of multidisciplinary team collaboration, and team communication has been shown to have a direct effect on patient care [26]. Therefore, a clear understanding of the social worker's role within hospice teams is a critical prerequisite for effective collaboration and improved care outcomes.

Hospice social work practice requires a high level of professional knowledge and skills [27]. In South Korea, challenges such as the lack of an education system specifically tailored to hospice social workers, absence of supervisors, insufficient practical training [4], and limited introductory hospice training programs exclusively for social workers [28] have been identified. The need to establish a training process and certification system for specialized hospice social workers has also been emphasized [29]. The current guidelines stipulate that hospice social workers must hold a Level 1 Social Worker certification. However, the findings of this study revealed a predominant opinion that this qualification alone is insufficient for equipping social workers with the competencies required for team-based approaches in medical settings. Unlike physicians and nurses, who have specialized hospice certifications, social workers are deployed to the field after only obtaining a Level 1 certification and completing 60 hours of mandatory training. Consequently, new hospice social workers are often not adequately prepared. To address this, the qualification for hospice social workers should either require a separate national certification, such as that of a medical social worker, or focus on strengthening introductory and continuing education programs for hospice social workers to enhance their competencies. Additionally, it is necessary to develop curricula in undergraduate social work programs that cover topics such as end-of-life care, death and dying, and the roles of hospice social workers. Research indicates that the experience and educational qualifications of social workers positively impact team functioning [6]. Moreover, a study by Tales et al. [30] exploring the prerequisites for effective hospice social work highlighted the importance of enhancing social workers' competencies

and confidence. This study emphasized the need for clearly defined roles, core competencies, and comprehensive training for hospice social workers. Therefore, follow-up research is recommended to develop standardized guidelines, define core competencies, and create a handbook for hospice social work practice.

This study explored the achievements and barriers of hospice social work practice in the context of the growing emphasis on hospice care. The key findings of this research hold significance as they can serve as policy resources for the development of hospice social work practice. However, there are limitations to this study. The participants were primarily female social workers employed in advanced general hospitals and general hospitals; most had experience in inpatient and consultation-based hospice care, but limited exposure to home-based hospice care. Additionally, the study did not include hospice social workers working in smaller hospitals or long-term care hospitals, or those with experience in pediatric and adolescent hospice care. Future research should include male and female social workers from a wider variety of hospice institutions and explore the achievements of hospice social work from the perspectives of other hospice team members, such as physicians and nurses. Furthermore, conducting quantitative studies based on comprehensive surveys is recommended to contribute to evidence-based hospice social work practice.

## CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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Conception or design of the work: all authors. Data collection: all authors. Data analysis and interpretation: SMJ, JWJ. Drafting the article: SMJ, JWJ. Critical revision of the article:



SMJ. Final approval of the version to be published: all authors.

## SUPPLEMENTARY MATERIALS

Supplementary materials can be found via <https://doi.org/10.14475/jhpc.2024.27.4.131>.

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