UNIVERSITY OF GOTHENBURG
DEPARTMENT OF SOCIAL WORK

A Systematic Review of Social Work Education and Training Programs in Palliative and End-of-life Care

Master's Program in Social Work and Human Rights

Degree report 30 higher education credits

Spring 2019

Author: Hang Li

Supervisor: Mikaela Starke

Abstract

Topic:A Systematic Review of Social work education and training programs in palliative and end-of-life care

Background: The advanced modern medicine and people's open-minded attitudes about death call for the development of palliative and end-of-life care. Patients and their family members also promote higher requirement to the professionals and the quality and quantity of the service. Education and training programs in this specific area are the prerequisite for social workers to get basic knowledge, professional competencies, and values and ethics of end-of-life care before they work for clients.

Aim: Reviewing the literature related to social work education and training programs in palliative and end-of-life care globally in terms of participants, goals, modes, teaching and learning strategies, contents, and learning outcomes to get a comprehensive understanding of current programs.

Methodology and Data sources: A systematic review of literature searching social work education and training programs in palliative and end-of-life care from the online databases Social Work Abstracts, Social Services Abstracts, Sociology Abstracts, PsycINFO, and MEDLINE/ PubMed between January 2009 and January 2019. A total of 1376 abstracts were retrieved, and 18 papers were included that met the inclusion and exclusion criteria.

Results: The type of education and training programs were consisted of three components: interprofessional, death and grief, and communication. The majority of them were interprofessional programs with nine papers included. But cultural programs and courses were lacked in the current education programs. Participants highly evaluated these education and training programs that benefited to their personal development and career growth, and enhance their confidence, competency, self-efficacy, and professional knowledge and skills. Real experiences and evidence-based teaching methods, as well as web-based strategies were required by participants.

Discussion and Conclusions: Education and training are necessary to enhance social workers' skills and perceived preparedness in palliative and end-of-life care, but the teaching contents and evaluation methods should be reinforced and completed in the future development.

Key words: social work, education and training programs, palliative and end-of-life care

Acknowledgement

The process writing this thesis has a big impact on me, not only in the academic area to deep the knowledge about palliative and end-of-life care, but also on my own personal development. In writing this degree report, I have received considerable support and assistance from many people. I would like to express my very great appreciation to my supervisor Mikaela Starke. She always gives me valuable and patient advice and help me all the time of research and writing of this report. Without her constructive suggestions and enthusiastic encouragement, the research work will not be successfully completed. Thanks for her. In addition, I should like to thank my interviewees for her insightful views about palliative social work in Sweden.

I would like to offer my special thanks to my parents for understanding and supporting me to study abroad to pursue my dreams. Especially my mom, you always guided and supported me through the most challenging times of my life. Thanks to all of you for being so good to me and thank my family for your understanding and unconditional love.

My special thanks are extended to my best friends here in Gothenburg, Jia Ji. Thanks for her encouragement, standing by my side and willingness to spend time on my sharing. Also, Raquel and Laila, it is really appreciating to have your friendship these past two years.

Last, thanks to myself for insisting on dreams and never giving up.

Hang Li

Gothenburg, Sweden

May,2019

Table of Contents

List of Abbreviation

ACE	Advocation for Clinical Excellence
ACHP-SW	Advanced Certified Hospice and Palliative Social Worker
APCSW	Association of Palliative Care Social Workers
ASSIA	Social Sciences Index & Abstracts (ASSIA)
CASEW	Association of Social Work Education
CESCR	The United Nation Committee on Economic, Social and Cultural Rights
CHPCA	Canadian Hospice Palliative Care Association
CHP-SW	Certified Hospice and Palliative Social Worker
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CNKI	China National Knowledge Infrastructure
EAPC	The European Association for Palliative Care
EPCS	The End-of-Life Professional Caregiver Survey
ERIC	Education Resources Information Center
IAHPC	The International Association for Hospice and Palliative Care
ICESCR	The International Covenant on Economic, Social and Cultural Rights
ICP	Interprofessional Collaborative Practice
IPE	Interprofessional Education
IPCKS	Interdisciplinary palliative care knowledge survey
IPP	Interprofessional practice
HRW	Human Rights Watch
NASW	National Association of Social Workers

NHPCO	National Hospice and Palliative Organization
MMAT	Mixed Methods Appraisal Tool
MSW	Master social work
PDIA	Project on Death in America
PICO	Population, intervention, comparator, and outcome)
PICo	Population, phenomenon of Interest, and the Context
PICOSS	Participants, Intervention, Comparison, Outcomes, Setting and Study Design
SCOPE	Social Work Competencies on Palliative Education
SEIEL	The Self-Efficacy for Interprofessional Experiential Learning Scale
SiP	Association for Medical Social Workers in Palliative Care
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, and Research type
WHO	World Health Organization
WPCA	The Worldwide Palliative Care Alliance

1 Introduction

1.1 The context of the topic

As the increases of global population, life expectancy, and living standards, the death rates decline year-to-year as a general trend (Ritchie & Roser, 2018). The medical advancements today change the experience of dying dramatically, an acute death gradually reduced and transformed into chronic illnesses, such as cancer, dementia, diabetes, and cardiovascular diseases. In 2016, the total death amount was 57 million globally. Noncommunicable death accounted for over 70% of global deaths. Cardiovascular diseases and Cancer were the highest causes of death around 17.65 million deaths and 9 million deaths respectively (World health statistics 2018). These noncommunicable diseases are the majority of deaths prevalent in developed countries, while in developing countries, infectious diseases such as HIV/AIDS, malaria and diarrheal are still remained large percentage. The growing number of aging populations also means that more and more deaths occur in old age and dying process can be interrupted and postponed by the development of modern medicine. By 2050, the aging population worldwide is predicted to increase from 600 million to 2 billion, and the person who diagnosed with cancer will more than double by 2050 globally (Altilio & Otis-Green, 2011).

Generally, death is a sensitive topic that most people find it is difficult to talk openly, which makes the final stage of life more challenge to get support and to fulfill people's final wishes (Association of Palliative Care Social Workers, 2016). Pahor and Rasmussen (2009) noted death and dying still far away from the part of public discourse or excluded in health education. Whilst, a great number of people with life-threatening diseases died with unrelieved pain and psychospiritual suffering in terms of misunderstanding communication with families and the medical teams, and unsatisfied preferences or needs for end-of-life desires (Bern-Klug, Gessert, & Forbes, 2001). Palliative and end-of-life care is an essential form of care for dying patients, it is a highly specialized and generally unified health care service offered in pediatrics, geriatrics, or oncology care. Besides, palliative and end-of-life care is not only a simple medical or nursing care, but also a service including pain management to relieve the pain and other symptoms; psychological and spiritual aspects of care; and social support and bereavement services (World Health Organization, 2018). With the advance of modern medicine, the calls for palliative care will grow in the future and many of terminal ill patients will need palliative care for more extended periods of time in the final year of their life (Altilio & Otis-Green, 2011; Radbrych, De Lima, Lohmann, Gwyther & Payne, 2013; Brennan, 2014). However, according to WHO's report: there are around 20 million people need end-of-care each year, the number is enormous, compare with these unmet needs, there only have a few countries that implemented equitable end-of-life care programs (World Health Organization & Worldwide Palliative Care Alliance, 2014).

Social work as a client-based profession plays a vital role in delivering meaningful end-of-life and bereavement care. Social workers are necessary members of the interprofessional hospice team that are cooperating with doctors, nurses, therapists in hospitals, hospice centers, or at homes for dying patients and their family members (Bern-Klug, Gessert, & Forbes, 2001). They apply professional skills, such as values clarification, crisis intervention, advocacy, bereavement counselling, goal setting, active listening, emotional assessment, and interpersonal communication, to assist patients and their loved ones to gain a meaningful and dignified time during the end of life journey, to understand the natural courses of death, as well as to provide end-of-life services with the new realities of dying (Bern-Klug et al., 2001). From the above, it is crucial for social workers to master different competencies and skills

According to the report from Association for Medical Social Workers in Palliative Care (SiP, 2013), the Swedish Health and Medical Service Act state that palliative and end-of-life care is the most important care in health care and it is necessary to provide comprehensive health care for patient. In 2001, Swedish government published a government report 'Care with Dignity at the End of life' and in 2002, SiP was created and emphasized the palliative care team and the unique roles and qualifications of social workers in this field. With the establishment of the Swedish Council for Palliative Care, more and more palliative care programs are concerned within the regions and countries of Sweden. And the increasing need to recruit expertise medical social workers like educators, consultors, and supervisors in psychosocial issues are taken into consideration (SiP, 2013). The tasks such as symptoms management, bereavement support, teamwork, and communication are clarified and needed for social workers.

1.2 Problem statement

With the improvement of living standards, palliative and end-of-life care are gradually accepted by the public, dying patients and their family members to promote a higher requirement to the quantity and quality of professional care in this area. Many standards for comprehensive evidence-based palliative and end-of-care social workers and the advanced professional certification have been established and developed (Berkman & Stein, 2018). All of these developments claim higher standard and requirement for health professionals and response in creating educational to palliative and end-of-life care. Social workers are expected to equip with advanced knowledge and skills and greater competency to help clients recognize the realities of illness and end-of-life matters. And they are responsible for and should create opportunities to receive further education and training in palliative and end-of-life area to develop themselves, such as taking part in meeting, conferences and university curricula (SiP, 2013). Educators should develop educational curricula and programs that ensure professional preparation of future practitioners to meet the needs of the clients and the needs within current academic structures and curricula norms (Forrest, 2004). Which requires education and training programs tied to professional roles and mediation knowledge.

Although social work education has already access to the curriculum in palliative and end-of-life care, the inadequately educational challenges and insufficient trained social workers is a major barrier to meet the needs of palliative and end-of-life care in the new centuries (Pahor & Rasmussen, 2009). A range of deficiencies of curriculum and practicum training for social workers in medical, interprofessional, cultural education in palliative and end-of-life area, letting many social workers feel that their preparation in assisting life-limited patients and their families are deficient as a consequence (Jones, 2011; McCormick, 2007; Christ & Sormanti, 2000). Some social workers reported that they lack specialized training and continuous education support in end-of-life care, and they recognized that there are few social work experts and educators could function as role models to provide advanced education, training, innovation, and advocacy (Christ & Sormanti, 2000). Many practitioners confront ethical dilemmas, but less professional supervisors can search for help (McCormick, 2007; Bosma et al., 2010). They have not in readiness in both emotional and educational aspects to work with other professionals to care for clients (Pahor & Rasmussen, 2009). The limitation of current research and literature on social workers' education and training in palliative and end-of-life care also indicated that many social workers are not as prepared as they need to be or would like to be in realistic practice (Csikai & Raymer, 2015). The lack of training in skills and competency may leave social workers in an inadequately prepared situation that cannot meet different clients' needs. Also, end-of-life care education relate to social work practitioner's attitude and the level of comfort working with the terminally ill when facing death and grief. Insufficient education may let social workers easier feel a sense of fear, anxiety, depression, and job burnout when compared to other staffs like doctors and nurses (Forrest & Derrick, 2010; McDonough, 2008).

Sufficient education and training are the prerequisite for social workers to get basic knowledge, professional competencies, and values and ethics of end-of-life care before they work for clients. Palliative care social workers work with clients and colleagues from different cultures and backgrounds, it is important for them to equip with interprofessional competency and cultural competency while working. In addition, social workers provide service to dying patients and their family members, the knowledge and skills relate to death, grief and bereavement is also required to master. So, it is important to know the needs of knowledge among social workers that work within palliative and end-of-life care and to explore the current education programs to promote social workers' abilities and competencies in practice.

1.3 Purpose of research

The primary aim of this study is to examine what palliative and end-of-life care education and training programs do social work have globally, and to explore these specific programs in terms of participants, goals, modes, teaching and learning strategies, contents, and learning outcomes to get a comprehensive understanding of current programs. The secondary aim of this study is to evaluate the deficiencies between education needs and realistic programs to promote future development in palliative and end-of-life care.

This paper is guided by the following research questions:

(1) what program types and contents do social workers have in the included literature

of study?

(2) What are the learning outcomes of these education and training program overall?

(3) Which aspects of education and training contents should pay more attention to the future design of education programs? And what ways can improve the education and training programs?

1.4 Overview of the structure

The first section introduces the background information and problem statement to the current challenge, the aim of the purpose and research question central to the study was set out. The second section describes the relevant background and definition to palliative and end-of-life care, why social workers play the unique role in palliative care, and the considering of hospice human rights. Following this background to the topic, next part turns to focus on the current situation and theories relate to social work education in palliative and end-of-life care in terms of education and training needs, death and grief education, and the professional competency and interprofessional education. The fourth section reports the methodology of this study, which contains detailed inclusion and exclusion criteria, data extraction process, and reliability and validity of data synthesis approach. The fifth part states the results and analyses related to the research questions and literature. Finally, the concluding discussion, limitation and implication of further research will be highlight in the last part to conclude and promote the future development of social work education in palliative and end-of-care life area.

2 Palliative and end-of-life care

The purpose of this study was to explore social workers' education and training programs in palliative and end-of-life care. Understanding the difference between hospice, palliative, and end-of-life care may help one to understand the design of the education programs. So, first in this section, the definition of different end-of-life care will be provided along with a description of why social workers are fitted into palliative care. Next section concerns hospice human rights to clarify the aim of the palliative and end-of-life care is to help patients dying well or experience a respectful and dignity death at the last stage of life.

2.1 Definition of Palliative and End-of-life care

2.1.1 End of life care

End-of-life care is a care service for people who are approaching death. During that time, patients always become vulnerable with multiple comorbidities, and may not need extensive medical treatment, but will receive some informal health and social care from family members, communities and hospitals (Reith & Payne, 2009). It is also a process of social change for individuals when they become aware that death is close at hand. (Reith & Payne, 2009). Historically, Zimmerman noted that end-of-life care originated from the roles of families that taking care of their sick and dying relatives, it started to become active in institutional construct after it was introduced into hospitals (as cited in Alvarez, 2007). From 1940 to 1970, the initial studies of end-of-life care sprang up and developed rapidly. The disciplines of hospice, palliative, and bereavement care also came out and the formal network and organizations also developed (Reith & Payne, 2009). With the advanced-technology developed in medications, the awareness of end-of-life care and patient-centered treatment was raised at the same time.

2.1.2 Hospice care

Hospice care originated from the Latin word ‘hospes’ which means ‘host’, ‘guest’, and ‘stranger’ (Lewis, 2000, p.371) implied ‘the sense of warming between host and guest’, then it gradually evolved into ‘hospice’ as a function of church of charity to support and rescue the elderly, refugees and poor people (Su, 2013). The concept of ‘modern hospice’ was formed in the 20th century to provide all-around physical, psychological, and spiritual care for the dying patients, in terms of guaranteeing their rights to die in dignity and worthiness. In 1967, the first hospice, St, Christopher’ s Hospice was established by Dame Cicely Sanders in London, which marked the rise of the modern hospice movement. This hospice model provided an example for others to follow. After that, Hospice facilities began to spring up in more than 60 countries including Africa, Australia, the United States, China, Japan, Finland and so on (McDonough, 2008; Aiken, 2001; Su, 2013). Up till now, hospice care has become a new field care method and widely used in the end-of-life stage.

Hospice care is end-of-life care which emphasize the medical, psychological and spiritual support. It aims to promote peace, comfort and dignity, as well as control pain and other symptoms for those dying patients (WHO and World Palliative Care Alliance, 2014). Hospice care provides services to support family members, which is a highly specialized health care service including counseling and consulting, medical and nursing care, spiritual and social support, death and care education, and the quality of life and death (Su, 2013). And considering the psychological and physiological needs of dying patients and family members as the primary purpose of study (ibid.). According to the National Hospice and Palliative organization (NHPCO, 2017) that hospice focuses on caring rather than curing. Family members as caregivers work with interdisciplinary hospice team (like physician, nurses, social workers, volunteers, and other counselors) at home, hospitals, or hospice centers for the terminally ill patients. The hospice team makes a special plan that meets patients’ individual needs based on social, emotional, and physical level, along with other services for family caregivers by providing coach, counsel and bereavement care at the same time.

2.1.3 Palliative care

The term of ‘palliative’ comes from the Latin word pallium means ‘cloak’ or ‘cover’, palliative care grew out of the modern hospice movement approximately fifty years ago (Abu-Saad, 2001). Cicely Saunders established the ‘St. Christopher's Hospice’ in London, which marked the rise of modern palliative care (Su, 2013). Then, the movement of modern palliative care motivated by Elisabeth Kubler-Ross who came up with the stages of emotional reactions towards to impending death. In 1975, the first palliative care service center set up in Royal Victoria Hospital in Montreal, Canada. The term 'palliative care' was first used to relieve symptoms and other pain of illness without curing it. It provides a thinking to carry out end-of-life care services in medical institutions by using hospital's overall strength and medical facilities to improve quality and increase efficiency (Su, 2013).

Palliative care is provided for those who are diagnosed as chronic and life-threatening diseases and no longer considered curable in the earlier intervention before the final stages to help them manage the symptoms and painful, not only for those who are dying (WHO and World Palliative Care Alliance, 2014; Chochinov, 2006). Palliative care focus on the psychological, social and spiritual issues for the patients who have serious diagnosed illness as well as the emotional alleviation for bereavements. It is a multi-professional practice cooperated by doctors, nurses, social workers, therapist, and caregivers to provide services, which needs to base on the patients' needs rather than prognosis. The delivery of palliative care is not time limit and prognostic limit, and it is not limited to care setting and specialist disciplines and services. The Global Atlas described palliative care into three different levels care: 'palliative care approach' provided by all healthcare professionals, 'general palliative care' for those who are good educated and trained, and 'specialist palliative care' lead by a specialist team (WHO and World Palliative Care Alliance, 2014).

In 1990, the World Health Organization (WHO) reported a significant international policy, which demonstrated that health care services made available trained staff for pain relief and related services and defined palliative care as an active total care for patients rather than curative treatment (Reith & Payne, 2009). Palliative care is a method to care that improves the quality of life of people and their family members who are facing the problem associated with life-limited illness. The primary purpose of palliative care is through early identification, assessment, and treatment to prevent and relieve the suffering of pain, symptoms and other issues in terms of physical, psychosocial, and spiritual. Many aspects of palliative care are applied in the illnesses as well as anti-cancer treatments (WHO, 2004).

The WHO (2004) outlines the principles of palliative care as follow:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Billings illustrated that the definition of WHO was identified palliative care as a family-oriented care approach focusing on symptom control and psychosocial and spiritual care. It practices in the interprofessional team to maximize the quality of life for both dying person and bereavements (as cited in Abu-Saad, 2001). According to Ireland Palliative Care Competency Framework Steering Group (2014) described that palliative care was divided into three levels. The first level is that palliative care should be considered as a core skill to practice by all health care professionals to meet patients' care needs. Level two encourages continuous training and education for health care providers to enhance the quality of palliative care in hospital or community settings, and it should be supported by the authorities. The last level is to strengthen specialist palliative care services to meet more complex care needs. Palliative care can be applied at all stages of end-of-life phases once the cure is no longer possible for dying patients (Chochinov, 2006).

Today, End-of-life care is composed of hospice and palliative care, they are described differently, but both are closely related to models of care in multidisciplinary and a wide range of settings. (National Association of Social Workers, 2010). As Abu-Saad mentioned (2001): "Palliative care differs from hospice care on the grounds of employing physician input, the acceptance of research in terms of quality improvements and scientific advancements." Palliative care focuses more on preventing or relieving pain and symptoms, Patients can receive palliative care at any point throughout the illness no matter the life-limiting illness or chronic illness, but they may also pursue physical care at the same time (NASW, 2010). Hospice care is a form of palliative care, which can be further subdivided into 'palliative sociology', 'palliative psychology', 'palliative medicine' and other relevant branches (Su, 2013). The focus point of hospice care includes support and physical comfort for patients at the end of life and grief counseling for bereavements.

2.2 End-of-life care social work

As National Association of Social Workers (2017) mentioned that the primary mission of social work is to enhance individual's well-being and meet their basic human needs, they pay attention to individuals in the full context of their lives and address problems in living and environmental forces, as well as promote the role and responsibility of organizations (Bosma et al., 2010). Social work is a practice-based profession promoting social change, development, and social integration, it underpins the principle of human rights and social justice and combines multidiscipline theories and knowledge into practice. Social workers consider person-family centered care as the central of social work practice (Sumer et al., 2015). They devote to empower and liberate individuals, families, groups and communities to address life challenges and enhance wellbeing (International Federation of Social Workers, 2014; APCSW, 2016).

There are three reasons mentioned by Small (2001) that why social workers should be included in palliative care. The first reason is that social workers are concerned with loss in many situations, death and critical intervention are grasped by social workers as practice skills. Then, social work emphasizes 'people-in-environment' theory. They work in a whole system with clients, families, communities, social, and cultural perspectives. The third reason is that social workers focus on both physical and social impact of changing in palliative care service. Social workers provide service based on a set of core values, they respect each person's dignity and worthiness and focus on human relationship; they emphasize the improvement of their own competency; and they keep the values of non-judgment and unconditional acceptance that respecting people from different cultural and social background, and respecting their different choice (AWPSW, 2016). Palliative social workers respect and promote the right of patients' self-determination, ensure their autonomy and give them opportunities to identify and clarify their goals and needs, and make decisions of service in end-of-life care and bereavement, unless clients' determination poses potential risks to others or themselves (NASW, 2017). Palliative Social workers also respect and be sensitive to cultural and sexual diversity. Following the principle of inform consent, social workers should use understandable and clear language to tell clients the truth of death and dying in the right time and the purpose of the service, increasing their awareness of death and preparing ahead before death coming (NASW, 2017; APCSW, 2016). Similarly, social workers also need to keep privacy and confidently when they work with dying patients and families.

All social workers, whatever their specialty, may need to help their clients with end-of-life issues. They are obliged to help clients face uncertainties at different times in the sequence events of dying and death and help them pass through these phases (Reith & Payne, 2009). End-of-life social workers use their particular skills and knowledge to help patients and families to strengthen their power, access services and get resources they are entitled to, deal with personal and social problems of illness, relieving loss and grief, out of sorrow, and to have a respectful death (APCSW, 2016; Joseph et al., 2009). They work along with other professionals in a range of settings such as palliative care teams or units in hospital, hospices, emergency rooms, intensive care units, and obstetric, neonatal and pediatric units; community clinics; nursing and care homes; and home and domiciliary settings (Kramer; Paroureke, & Harland-Scafe, 2003). Social workers spend a lot of time with patients in home visiting, official consultation, and inpatient ward. They also make telephone calls to coordinate and search resources for clients and spend some off-hours to report emergency coverage (NASW, 2010). The ward in ICU always faces high-level death anxiety, fear, pressure, and grief. The shortage of communication between families, staffs, and patients are ubiquity there. Social workers who work in the ICU collaborate with doctors in family meeting to guide communication, make decisions, address death anxiety and grief, and reduce pressure for other team members (Joseph, Berzoff, & Dobbie, 2009).

2.3 Hospice human rights

Cicely Saunders once said: “You matter because you are you, and you matter until the last moment of your life” (Saunders, 1976, Brennan, 2014). Dying well or experience a respectful and dignity death is one of the aims for end-of-life care. Dying well includes both physical and spiritual aspects, such as removing or relieving physical symptoms of diseases, reducing mental and social stresses for the dying patients and their families, satisfying various needs of dying patients, and affirming sources of energy and hope (Reith & Payne, 2009, Chochinov, 2006). Dying patients should be guaranteed the rights to access healthcare, basic medications to control symptom and end-of-life care, as well as containing palliative care into national healthcare policies (Connor et al., 2014). Chorchinoy (2006) illustrated that dying is part of the lifespan, but it does not mean dying poorly. A ‘good death’ should be a meaningful process only his or her are satisfied and supported by their families and friends in terms of physical, psychological, spiritual, and emotional.

Humans’ inherent dignity and rights were found in the articles of international human rights including the right to health (Brennan, 2014). Palliative care is one of continuum of health care for all humans, which encourages to respect and protect dying person’s dignity through word and behave (Field & Cassel, 1997; Brennan, 2007). Both palliative care and human rights are based on the principle of the individual and universal’s dignity and non-discrimination (Gwyther, Brennan, & Harding. 2009). In The United Nation Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 (2000) read that “care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.” Human rights could give a voice to the dying patients to express their suffering and end the needless pain, it also needs to focus more on children’s palliative care rights,(Ezer, Lohman, & de Luca, 2018)

The first time regarded pain and suffering as one of the human rights was in 1992 by Margaret Somerville, a scholar of medical law, who argued that patients’ dignity should be respected to relive the pain and suffering, and that should be a human right for life-limiting patients (Somerville, 1992; Somerville, 2001; Brennan, 2007; Brennan, 2014). Gradually, palliative and end-of-life care have been included in many official documents in different countries. In 2000, the Standing Committee of the

Canadian Senate admitted that everyone should enjoy the right of palliative and end-of-life care (Chochinov, 2000). The Council of European (2003) stated that “palliative care is an inalienable element of a citizen’s right to health care.” Follow on, the second Global Summit for National Hospice and Palliative Care Associations held at Korea in 2005 demonstrated that government should consider palliative care as fundamental human rights (The Korea Declaration, 2005). And in 2013, the European Association of Palliative Care published the Prague Charter for Palliative Care as a Human Right was published by the joint declaration from The European Association for Palliative Care (EAPC), the International Association for Hospice and Palliative Care (IAHPC), the Worldwide Palliative Care Alliance (WPCA), and Human Rights Watch (HRW) (Brennan, 2014; Radbrych, De Lima, Lohmann, Gwyther & Payne, 2013).

Recently, there has a growing call to include palliative care into human rights (Gwyther et al., 2009). Many international organizations and bodies recognize end-of-life care is an essential component of healthcare. The UN Declaration of Human Rights and the Article 25.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) claims that: “Everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and necessary social services.” Article 12.1 of ICEESCR read that “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” While the right to death and palliative care is not specifically mentioned in the statements. It is enforceable only the signatory countries are expected to fulfill these articles. The CESER (2000) considered to promote “attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.” The UN Special Rapporteur on torture affirms that denying access to pain relief can be seen as inhuman treatment. WHO Action Programme on Essential Drugs (1999) clarified the minimum key concept of the rights to health is: “Accessing to adequate sanitation facilities, hospitals, and other health-related settings and accessing to essential medicines” (Connor et al., 2014). The essential palliative care drugs have also been defined on the WHO Essential Drug List, likewise, the Montreal Statement that combines international right with the universal access to essential medicines (Brennan, 2007).

Despite governments, nongovernmental organizations, and international bodies are all endeavoring for palliative care and human rights. Government takea the responsibility to promote the right of end-of-life care and the dignity of a patient. In CESCR General Comment No.14 (2000) noted that: “States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons …to preventive, curative and palliative health services.” This emphasizes the obligations of government to link health care rights to human dignity (Brennan, 2014). In the petition of the Prague Charter, governments were urged to ensure the right to palliative and end-of-life care. The contents include: government should ensure and adopt health policies and essential medicines to terminal ill patients and palliative care; governments should promote adequate training and education to health care workers at undergraduate, postgraduate or subsequent levels; and governments should ensure the development of palliative care along with the innovation of education systems (International Association For Hospice And Palliative Care & Worldwide Palliative Care Alliance, 2008; Radbrych et al., 2013).

2.4 Summary

Social workers play unique roles in palliative and end-of-life care to distinguish the different definition among hospice, palliative and end-of-life care, and to grasp the essential knowledge and skills of palliative and end-of-life care. Besides social workers should uphold the professional ethical guidelines to respect patients’ dignity and human rights to promote the quality of service for patients at the end of life stage and to have an empathetic attitude to protect the vulnerable patients and family members.

3 Social work education in end-of-life care

First of all, this section presents a review of the development of palliative and end-of-life care education and training program. Then illustrates the shortage of materials and curricula and multiple barriers relate to education for both students and practitioners. Secondly, Understanding the process of death and dying as well as grief theories from patients and the bereavement's perspectives are of benefit to combine the theoretical framework into education and training program. I will explain the definition of the major theoretical models of death and dying in this part. Thirdly, palliative and end-of-life care is an interprofessional collaboration work, each team member should equip with their unique knowledge and competencies to assist other team members in providing a quality service to clients. So, in the third section, social workers' professional competencies and interprofessional teamwork will be concerned relate to competency education.

3.1 Education and training situation

Education and training in palliative care are not only the needs of social work students, but also of social work professional practitioners. NASW (2017) reported that social workers should provide services and use intervention techniques or approaches only after receiving advanced education and engaging in appropriate training, supervision, mentoring from people who are expert in the field of palliative and end-of-life care, to ensure practitioners are capable enough to protect clients from harm. Social workers promote human rights and social justice to clients, they advocate social changes, deal with human relation problems, empower and liberate vulnerable groups to achieve well-being. All of these required social workers to equip with high-quality knowledge and advanced skills to do the intervention works with clients and promote improvement instead of harm (NASW, 2007, p. 6). The Council of Social Work Education in the United States came up with the accreditation requirements and standards for all school social workers. The standards of accreditation required social worker students to integrate the knowledge, values and ethics, and professional skills into competent practice (Olson, p. 31). The equipment of thanatology and other death-related education will enhance social work professionals' technology, motivation and competency while working with dying patients and families (Hugenbert, 1999).

The milestones and publications of end-of-life education for social workers can be seen from 1992. Duke University put forward the leadership education in end-of-life care (Reith and Payne, 2009), which led to the development of end-of-life education. In 1999, Christ and Sormanti (2000) documented the need for education and training for social workers in end-of-life. From 1994 to 2003, the Project on Death in America (PDIA) of the Open Society Foundation created an important educational development in the United States. This nine-year program contributed to build and shape the end-of-life care field, and to improve understanding of culture and care for dying clients and bereavement. It also promoted organizational changes, encouraged research and education activities, and put dying issues on the public agenda (Clark, 2014). In 2000, New PDIA supported certificate training programs at New York University and Smith College to accept their first social work students (Altilio & Otis-Green, 2011). In 2003, NASW established 'standards for social work practice in palliative and end-of-life care, which designed guidelines to promote the development of practice and education in this field (Reith and Payne, 2009). Social work competencies in palliative care was published in 2004 (Gwyther et al., 2005); In 2005, Second Social Work Leadership Summit on Palliative and End-of-life Care held at NASW, which presented the 'state of the social work field' and published education, practice, research, and policy statement at the same time (Csikai and Raymer, 2005). In the same year, the need for end-of-life social worker's continuous education and skills were published. In 2008, Certified Hospice and Palliative Social Worker (CHP-SW) and Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) were launched by NASW (Altilio & Otis-Green, 2011).

The qualifications of palliative social workers are put forward in the theories and contents in palliative and end-of-life education. Several knowledge areas are meaningful include the knowledge of symptoms in terms of physical, psychological, social and spiritual perspective; crises theory; grief theory; death-related knowledge and the process of illness; family systems; cultural, life philosophy and values; social support measure; ethical, legal and economic questions relevant for patients and families; and survivor support (SiP, 2013). The approach train-the-trainers are mostly used in palliative care education and training as a supplement (Ellen & Mary, 2005). In addition, interdisciplinary teamwork education, collaboration, emotional engagement, and communication such as grief counseling and structured counseling also provided experiential teaching methods to change ideas and to learn from other disciplines (Linder et al., 1999). Cultural and religious as an essential part in end-of-life care education requiring social workers equipped with cultural awareness and social diversity to work with clients in various race, color, sex, age, belief, and religion. They need to honor diversity among different professionals and disciplines (McDonough, 2008). And be prepared with the sensitive to respect and understand various cultural and religion issues in this globalization world (Csikai et al., 2009). Numerous experiential education methods such as videotaping, role-play, storytelling, sharing personal experiences, and case studies are used as an educational instrument in lecture and discussion (Cohen & Iris, 2002; Zelinsky and Thorson, 1983). Experiential methods such as role-play and videotaping are favorite by learners, MacLeod and Nash (as cited in Cohen and Iris, 2003) mentioned that role-play is easier for students to understand palliative care situations from their aspects and enables students to explore self-awareness and solutions to work with clients. But the disadvantage of authenticity of role-plays are criticized by many attendances which may be caused by poor acting talent, less motivation, stronger identification, and inhibition in clients' roles, while this could be enhanced by using simulated patients to portray the roles in a standardized way (Neuderth et al., 2019; Melluish, Crossley, & Tweed, 2007).

3.2 Education and training needs of social workers

End-of-life education is required by social workers who choose to work with dying patients and their families. The need for death education began to recognize since the 1960s and 1970s when researchers have started to pay attention to the study of death (Gwyther et al., 2005). Today, education about palliative and end-of-life care has increased in quality and quantity. According to Zelinsky and Thorson (1983), adequate education is important for social workers to equip with advanced practice skills in palliative and end-of-life care. And further articulate contribution and expertise to different dying patients, families, other professionals, institutions and policymakers (Canadian Hospice Palliative Care Association, n.d.). The improvement of social work education contributes to meaningful and effective palliative and end-of-life care (Bosma et al., 2010).

The World Health Organization have recommended that all countries should carry out a national palliative care policy, and the education and training for health care professionals should be promoted, as well as public awareness (Brennan, 2007). Education for practice must ensure competency-based contents for health and social care professionals (Palliative Care Competency Framework Steering Group, 2014).

McGaghie, Sajid, Miller, and Telder (1978) put forward three types of curriculum models for medical education students as subject-centered curriculum, competency-based curriculum, and integrated curriculum. WHO also mentioned three levels of palliative care education as basic palliative care training, intermediate training for life-threatening illnesses, and specialist training for symptom management needs (World Health Organization & Worldwide Palliative Care Alliance, 2014).

Caring for dying patients expect students and staffs to acquire professional knowledge and skills in terms of cultural and sexual diversity, ethical dilemmas, physical, mental and spiritual needs, and symptom management (Joseph et al., 2009). As the Canadian Association of Social Work Education (CASEW) pointed out that education and training for all level of social workers are positive to their career development (CHPCA, n.d.). However, there still has significant gaps in social work education (Turner, Kuyini, Agustine, & Hunter, 2015). Many social workers reported that they have not been well-prepared to work in palliative and end-of-life care settings (Bosma et al., 2010; Sanders, 2004; Csikai & Raymer, 2005). Sanders (2004) found that undergraduate social work students need more training and preparing for end-of-life issues in practice. Unlike other health care professionals, education and training are underdeveloped and unavailable for medical social workers, most of them only rely on themselves in palliative and end-of-life care. Insufficient education and training have been regarded as a challenge to social work practice and development. Without preparedness to integrate research into practice will increase the learning gaps, especially in need of competency such as cultural differences (Sumer et al., 2015; CHPCA, n.d.; Csikai and Raymer 2004b). Prelock et al. (2017) claimed four primary learning needs for social workers: first one is the confusion and differentiate between hospice care and palliative care. Then most of the social workers sought deeper understanding and continuing education to support clients and bereavement efficiently. They lack real experiences in end-of-life care and desire to enhance therapeutic communication skills to talk with patients and families and even team members.

3.2.1 Social work students

According to Prelock et al. (2017), they made a needs-assessment for students to ensure gaps in knowledge and skill and found four basic learning needs ‘the difference between palliative and hospice care; desired to improve communication skills; deeper understanding of bereavement support process; and lacked real experiences in end-of-life care.' Many undergraduate social work students reported that they are not being prepared to solve death and dying issues among dying patients and their families, their interest in end-of-life care should be paid more attention to promote their career development (Sanders, 2004). Appropriate intervention approach to clients in terms of death prevention, working with dying patients, and working with families and friends to increase the comfort with death and dying were needed by social workers (Cohen & Iris, 2002; Zelinsky & Thorson, 1983). Chow (2013) presented that traumatic losses increase the risk of grief reactions, but social work practitioners and students lack the education of loss and trauma.

Social workers develop numerous education programs for BSW and MSW education as well as professional continuous education and training, which were based on the competencies (Bosma et al., 2010). Social Work Competencies on Palliative Education (SCOPE) conducted a survey in Canada showed the respondents that some practitioners said they are ill-prepared with end-of-life issues; educators said they need more resources into curricula, and students reported that they lack undergraduate programs with grief and loss, death and dying, and caring bereavement (CHPCA, n.d.). Berkman and Stein (2018) conducted a cross-section design to measure the characteristics of courses for palliative care social workers in MSW programs (248 programs in the United States and 32 programs in Canada), it was found that only 10 programs from 105 participating programs dedicated to palliative care, and the majority of them only had 25%, few had 50% palliative content courses. The finding of this research means that a more basic and specialized palliative care education for master social workers is needed. According to Csikai and Raymer (2004a): "Curriculum building is an ongoing process in social work education and is appropriate for such a dynamic profession". Social work curriculum on palliative care should include three education materials: The Human Behavior and the Social environment sequence, social work practice, and social work field placement or internship (Christ and Sormanti, 2000)

But the content in palliative and end-of-life care was only included in elective courses that few Bachelor and Master degree social work students can receive these courses, even some content related to elderly care and the end of the lifespan rather than end-of-life care (Ellen & Mary, 2005). In 2003, the Council on Social Work Education in the United States taught social workers about human behavior across lifetime in the learning manual (Council on Social Work Education, 2003). However, due to the lack of death awareness and death is always considered as a sensitive topic, death-related contents are seldom mentioned in the textbooks and curricula (Olson, 1999). Textbooks as one of important constituent part also insufficient in end-of-life education. As the study researched by Kramer, Pacourek and Hovland-Scafes (2003), they used descriptive study to evaluate 50 textbooks which selected from a list over 700 books, only found 3% of the total text was included ten essential social work competencies in the end-of-life care content. The contents in these 50 textbooks are end-of-life social work perspectives, cultural and gender elements, social work intervention and assessment skills, different diagnosis, communication skills, pain and emotion management, legal, policies, and other issues relate to end-of-life care. But they did not mention which textbook is the best one to use in end-of-life care education for social workers.

Courses in both bachelor and master level are missing vital education on death, end-of-life care and medical knowledge (Walsh-Burke & Csikai, 2005). Some theoretical concepts like crisis intervention and grief counseling are out of touch with practice, and absent from undergraduate and graduate level training programs. Inadequate mentoring and unprofessional supervisors have negative effect on social workers' future careers and development, and insufficient training hindered the improvement of end-of-life care system for clients and their family members (McCormick, 2007; Christ & Sormanti, 2000).

3.2.2 Social work practitioners

Continuing education is important for social workers to stay updates and develop in this changing world to provide advanced services for clients (Weisenfluh & Csikai, 2013). However multiple barriers hinder the development of education, which includes the shortage of internal funds, professional boundaries, various interdisciplinary learning needs; healthcare hierarchy; lack of knowledge and skills of the social worker, outdated and overloaded curricula; limited experienced professionals; and logistical problems such as school location, time scheduling, and space availability (Head et al., 2014). As the survey revealed by Sumer et al. (2015), only 46% of social workers responded that they felt prepared by social work education, about 81% of respondents learned specialist knowledge and skills through interprofessional collaboration and 74% were from social work colleagues. The result indicated that the model of attaining knowledge and skills would not satisfy the increasing needs in the area of palliative and end-of-life care. In the study of Ellen and Mary (2005), they received 391 respondents, only 28% social workers had field placements focus on end-of-life care, 31% social work students thought their program was enough for work immediately after graduation, and only 22% of them considered the courses and contents were adequate. As to continuing education, most social workers had participated in continuing education from seminars, conferences, colleagues, journals, textbook, internet, and job experience. Seminar and conference were the most popular continuous education form about 87% (n=334) for social workers. But the challenges such as lack of time, access, funding, remote distance, and limited support from organizations were hinder the attendance rate.

Weisenfluh and Csikai (2013) did an internet-based quantitative survey and collected data through website for 3 weeks with a total of 1169 social workers responded to this survey. The result of this survey showed three content areas: patients and families' psychological and social needs; psychosocial interventions to ameliorate distress; and family dynamics on dying. These contents were needed by social work leaders and educators for continuing education and other educational programs, and were considered to include in the development of curricula. In addition, the cultural diversity to death experience and financial issues were also important for both beginner or advanced level of palliative care social workers' education programs. In another survey, Csikai and Raymer (2004a, 2004b) found that social workers felt they are most prepared in the area of end-of-life care decisions, and palliative or hospice care systems in social work education and continuous education program. But the content areas such as clients' social and psychological needs, relieve distress and grief, and the influence of dying on family dynamics were most needed in palliative and end-of-life care education.

As for training, Bekkema et al. (2014) mentioned end-of-life care was not covered very well in vocational training, only a few social workers had taken relevant courses in this area. Social work practitioners complained the barriers in the current programs, some programs were too costly without any subsidize, some of that were time-consuming and only had little content relate to social work (Ellen & Mary, 2005). A

Netherlands questionnaire survey investigated 181 nurses and social workers, which found that there had fewer differences between nurses and social workers, but around 70% of respondents felt they need additional training in palliative and end-of-life care, especially social workers. The interested areas are how to support clients facing death and deal with the farewell process, cultural differences, and euthanasia and suicide laws and regulations (Bekkema et al., 2014). Meier and Beresford (2008) identified the training of counseling, understanding and working with family systems and community resources, and crisis intervention should be promoted in the palliative care training program to help the clients better. The aspects of beliefs, death anxiety, denial, and treatment preferences are also important for palliative and end-of-life care social workers (Reese et al. 2005).

3.3 Death and dying

3.3.1 Dying

Dying is a ‘life-limiting’ or ‘life-threatening’ illness period along with the pain and symptoms in the rest of lifespan (Reith & Payne, 2009). In general, the use of ‘dying’ means that a person will die soon (Bern-Klug, 2010). Physicians consider that dying happened when a major of organs (heart, lung, brain, and kidneys) stop to sustain life. Such diseases like Alzheimer, Parkinson, cardiovascular diseases and cancer are considered as a chronic process leading to death (Reith & Payne, 2009). Physicians always take the responsibility to analyze and determine when dying begins, which affect the rest of treatment and care proposed, and how to help patients to prepare for the death (Salkind, 2006). In Pattison’s ‘living dying model’, there has an interval time between the ‘crisis knowledge of death’ and the actual death (as cited in Bern-Klug, 2010). Pattison came up with three phases of dying: the acute crisis phase, the chronic living-dying phase, and the terminal phase (Pattison, 1977, p.55). Beyond that, Reith and Payne (2009) cited Pattison’s dying phases and thought there were several dying stages: the first stage is ‘the potential death’ when people know they are diagnosed a fatal illness. Then ‘the crisis knowledge of death’, people are informed or come to know that their illness might lead to death. The third phase reaches a peak, which is called ‘the acute crises phase’— a subsequent period of anxiety. ‘The chronic living dying phase’ is the fourth phase, after receiving prognosis, patients decline anxiety and start to prepare their impending death. At the final stage, the suffering on physical and social factors limited the quality of life until the last step coming — the point of death.

Through the dying process, patients are easily feeling tired, weak, frailty, and pain. At the final stage of dying, some people even loss conscious about the physical decline, they do not want to leave bed and meet visitors, they have less interested in things happening around them; they start to feel anxious and unrest. Their digestive system becomes less effective, and they may not want to eat or drink and become breathless and disorientation (Furst and Doyle 2004; Salkind, 2006). At the society level of death, death and dying affect social relationships and social networks in various aspects. Social network includes social institutions, such as hospitals, clinics, nursing houses, and funeral homes, as well as crematoria such as social rituals, having funerals, and burials (Reith & Payne, 2009). Dying is a family journey that accompanied by loved ones, a good experience of death for dying patients depends on the support and closeness of families, friends and local communities, rather than hospital and institutions (Reith & Payne, 2009). Corr, Corr, & Bordere (2013, P.143) identified four tasks in the dying process: the first one is physical task, dying patients concern themselves with satisfying body needs and reducing physical distress. Then is psychological task which aims to enhance autonomy, security, and richness, dying patients should free from anxiety and fear and have the right to make decisions. In addition, dying patients only can feel richness and satisfied when they access to activities. In social task area, it emphasizes the interpersonal relationships and the attachment social implications of dying. Finally, spiritual task, patients should develop and reaffirm the meanings of life and hopes.

3.3.2 Death

Death is an inevitable stage in every person's life, but all of people do not know where and when they are going to die. Monaghan have summarized that in many western countries, the confirmation of death determined when blood circulation ceased, breathing stopped and the whole brain or brain stem death, but some countries argued that death only be confirmed when lung and heart ceased (as cited in Reith & Payne, 2009). Death could be a natural and well-prepared experience when people get old and have diseases, it also could be a sudden and unpredicted moment include human-induced death (accidents, violent crimes, suicide, genocide, or war) and nature disaster (such as earthquakes, tsunami, and flood) (Reith & Payne, 2009).

Death is hard to predict, it is not always occurred in accurate time and it is difficult for physicians to diagnose which terminal ill patient will die in six months. Most contemporary death occurred in an institution rather than at home, and many patients died with pain and suffering (Bern-Klug et al., 2001). Death is a unique and individual process, not everyone will experience all the stages one by one. The stages can be revisited or jumped according to the real situation (McDonough, 2008; Zastrow & Kirst-Ashman 2007). But the attitude towards death is like Becker noted that "The fear of death is natural and presents in everyone's life, it is the basic fear that influences all others, no one can be immune no matter how disguised it may be." (Becker, 1973, p.14). Death is a painful and horror experience, some people have experienced the process of death, and some are closed to death due to the death of their loved ones. Therefore, death can be seen as the most challenging crises that everyone has to face in their lives (Reith & Payne, 2009).

3.3.3 Grief theories

Grief is a natural human response to significant death, trauma, and loss, it is a common and important element in human life and always connect with mourning and bereavement (Ryan, 2007; Buglass, 2010). Stroebe et al. (2001) defined grief as: "a primarily emotional (affective) reaction to the loss of a loved one through death". Grief is a process along with the period of losing in terms of physical, psychological, social, and spiritual aspects. And mourning is an active expression of grief which be of benefit to address grief (Buglass, 2010). Everyone will experience the death of parents, friends, siblings, and other loved ones through their lives. Stroebe, Hansson, Strobbe, and Schut (2001) defined bereavement as: "an objective situation that losing someone significant, which regards as a distressful time for most people" (p.6). Parkes put forward that the loss can be regarded as a personal help or reminder to bereaved people, and a number of behaviors in response to loss is natural and significant (as cited in Riller, 2015). Experiencing loss and grief leads to the change of psychological and physical for the bereavements, people may experience fatigue, insomnia, loss of appetite, and other relative infections at the physical aspect. The psychological changes may include emotional, cognitive, and behavioral changes. People feel fear, anxiety, guilt, sadness, depression, poor concentration, loneliness, helpless and lack of help (Reith & Payne, 2009).

When it comes to the education of grief and loss. It provides a framework to support the practice. There are various grief-related theories available to social workers. Freud formed his study of mourning based on his clinical experience, and he thought grief is a solitary and detachment process (Buglass, 2010). After Freud, many researchers started to explore grief models and theories (Webster, 2015). Elisabeth Kubler-Ross theorized five stages of grief in her book *On Death and Dying* in 1969. These five emotional states 'denial, anger, bargaining, depression, and acceptance (DABDA)' are used as the fundamental paradigm in terms of the stages of death and dying, to reflect how people deal with illness and dying when they received diagnosed. (Kubler-Ross, 1969; Alvarez, 2007; Broom, 2004). According to Kubler-Ross (1969): the first stage of emotion is denial. Patients and families do not believe the diagnose and refused to receive the truth of their impending death. Following denial is anger, after patients received the truth, in this stage, they become anger, frustrated, and resentment with the responses like "How could this happen to me! Why? It is unfair". At the 'bargaining' stage, people make their mind to change the way of life, they fill their heart with the hope to negotiate with God to bargain more time to live or a life extension. The fourth stage is 'depression'. People start to realize that they are going to die soon due to increased symptoms and treatments, the sense of grief, disappointing, lonely and losing overwhelm them, they refused to meet visitors, even their family members, but despair with their mortality. The final stage is acceptance, people acknowledge and embrace this inevitable truth, they may use their rest of time to prepare or bid farewell to their loves. This stage is characterized by calmness and silent only waiting for the point of death (Kubler-Ross, 1969, p.44; Alvarez, 2007; Kübler-Ross & Kessler, 2014). Even though Kubler-Ross's model were criticized as the lake of empirical research and support (Corr, 1993), the stage of grief theory is commonly used by professionals to help people understand their own emotions in the process of death and dying, and it paves the way to the further theories.

Westberg (1971) outlined ten stages of grief model in his book *Good Grief* including "shock, expression of feelings, depression, and isolation, physical symptoms, panic, guilt, anger and resentment, hope, and acceptance". A most recent advance was in 1999, Stroebe and Schut (1999) provided a dual process model, which is more flexible to manage grief and more sensitive to cultural diversity. This dual process model is a dynamic process, which emphasizes the loss-oriented and restoration-oriented domains between the move and back forward process. The bereaved individual should cope with grief and try to come to terms with loss at the same time, but this process is necessary for future adjustment (Stroebe & Schut, 1999; Buglass, 2010; Webster, 2015).

3.3.4 Death and grief theory in social work education

Grief and death issues often present in social workers' daily work when working with clients, regardless of the settings they are practicing in. According to APCSW (2016), social workers help families recognize the impact of loss, grief, death and dying in order to support dying person; building a therapeutic relationship between clients and medical staffs instead of conflict, anger and frustration relationship. Bruce and Schultz (2001) mentioned three principles for end-of-life care social workers who work with bereavements: it is important to help bereavements control their social situation and their life; help them preserve their personal identity; and find the significance of loss from what they have experienced. Grief is a complicated process. Helping people address loss is one of social workers' agenda. They need to help bereavements get back to the track of life. The bereavement also needs times to out of grief and go back to the normal life. All of these grief stages and models have many similarities and can be reflected in different person's losing experiences, but it also needs to consider different cultures and backgrounds when applied them into practice.

The basic level of education in palliative and end-of-life care should include the content about death and dying and grief theories. Dying and death as the core part in palliative and end-of-life care services are initially denied and feared by patients and families, but after few processes, the acceptance of death will be the ultimate goal. Death and grief theories offer a clear description of the dying process and explain different reactions of patients when they face the impending death. This theory, in turn, encourages healthcare professionals to equip with an awareness and knowledge of different dying and grieving process to provide effective support to dying patients and bereavement (Buglass, 2010). Social workers will eventually encounter death in their careers, no matter it is the death of a client or a client be in the stage of grief that related to death (Sanders, 2004). The education of death is originated emerged in the United States in the 1960s and developed to other countries (Clark, 2001). Moore (1984) described a course about how to train social workers to work with life-limited patients in the US. Kramer (1998) reported a multi-method grief course for graduate social work students by using a pre and post evaluation about students' level of death acceptance and sense of preparation, and it showed a greater improvement in their knowledge, skills and attitudes towards death and grieving issues. However, death and dying or loss and grief content are lacked in the curricula, they always combine with other subjects and textbooks such as 'Human Behavior in the Social Environment' or 'development across the lifecycle', offered in the first or second year of bachelor education. The specialist courses about death and dying are only provided in the third or fourth year in few schools as an elective subject, usually, few than 25 percent of students select these subjects. The lower enrollments and the lack of advanced training indicate many students unprepared to work effectively in death and dying related issues (Kramer, 1998; Ryan, 2007).

It is challengeable and complicated to prepare social workers with death and grief knowledge (Kramer, 1998; Worden, 1991, p.134). Even though death is a normal and expectable event in palliative care settings, few social workers have prepared for these circumstances (Iris, 2002). Working with dying patients require professionals to equip with self-awareness, empathy, compassion, knowledge of one's attitudes towards death, and the courage to overcome the fears (Iris, 2002). Irwin and MelbinHelberg (1992, p. 74) demonstrated students should equip with loss and grief knowledge and skills when working with the bereaved, such as the theories of grief stages, the mourning process, the range of losses throughout life cycle. Death acceptance is "a high degree of self-awareness and knowledge of one's own fears and feelings about death, and most fundamentally, an acceptance of death that enables the greatest possible integration of professional knowledge with personal feelings in this domain" (Irwin and MelbinHelberg, 1992). Social workers require to be trained in self-awareness and bereavement training programs to let themselves feel prepared to cope with losses in their personal life, to make use of various resources, and to better aware of their own limitations for practicing (Worden, 1991).

The level of death and dying comfort including death acceptance, death anxiety, and death attitudes (Iris, 2002). Death anxiety is a mode of emotion related to death attitudes and reactions when working in death-related scenarios (Neimeyer, Moser, & Wittkowski, 2003). Social workers were found experienced higher levels of stress and death anxiety than other professionals due to the sense of helplessness and traumatization, which affected the comfort level, empathetic response, and burnout rate while working with dying patients and grieving family members (Holland and Neimeyer, 2005; Chow, 2013). Death attitudes are related to the effectiveness of death education. But there were few articles about death and dying education and training for social workers and evaluate educational effectiveness (Kramer, 1998; Dane & Miller, 1990; Moore, 1984). Irwin & Melbin-Helberg (1992) noted that death anxiety might be an unreliable index impact the death education, and the inherent uncertainty increases the sense of discomfort to health care professionals (Quill, 2001). Carr and Merriman (1995) noted that receiving more formal education about death and dying would improve the level of comfort for health care professionals, the practitioners who learned bachelor or master in relevant areas felt more comfortable than others, as well as attending one or more relative seminars. Which means that earlier specific education about death and dying would benefit later comfort while working with dying patients and their families. The primary purpose of death education is to promote social workers' acceptance of death and understand death as a natural factor of life.

Chow (2013) reported three domains relate to emotional competency education to address death anxiety, traumatization and the sense of loose. The first one is effective supervision, communication or continuing education. Then is the change of the personal system, such as improving sleep quality, cultivating new hobbies, developing good habits, exercising, and keeping a healthy lifestyle. The third one is to find a space to release stress and to reflect the experience of death. Emotional competency education is necessary for social workers. According to Chow (2013) and Pereira, Fonseca and Carvalho (2011), the negative professional quality of life will affect social worker's job satisfaction and the quality of service in this specific field. However, education and training related to death and grief is underdeveloped and unavailable to use in practice, so, the need to develop emotional competency programs to help social workers deal with past unresolved losses, anticipated losses and projected self-mortality are claimed by social workers (Chow, 2013). Death-related education help professionals feel more comfortable and improve students' competency to support and communicate with dying patients and their families (Kramer, 1998). Leaning theories and knowledge can give a guideline for social workers to understand different emotional process and be aware of different cultural and sexual factors of clients that hind behind the emotion (Irwin & Melbin-Helberg, 1992). These theoretical frameworks also could be used to guide the study in terms of palliative and end-of-life care education and training, as well as social work competency to improve their confidence and crisis intervention skills while working.

3.4 Professional competencies and interprofessional teamwork

Profession is a sense of duty for professionals to ensure the quality and well-being of clients (Reeves et al., 2002). Professional education can give students a view to think about professional values, attitudes, methods in a particular way, which will determine how they use knowledge of theories and practice and how they develop their careers to achieve professional goals (Iris, 2002). This section will illustrate the profession theories and the unique roles of social workers in the interprofessional team, then presenting the communication competency and interprofessional competency education and describing why competency-based education is important to social workers.

3.4.1 Profession theories

The changing role of states and organizations, and the influence of markets, managerialism and consumerism leading influence the education and training of professional practitioners (Evetts, 2012). Many professional education and training in health care are undertaken in a certain way that integrating with professional skill, judgment and experience in the contextual and cultural factors. Education and training play an important role in fostering professionalism to promote health professionals' competency (Richardson, 1999). Popkewitz (1994) defined profession as the term that used for those well-trained, competent and specialized professional groups which are highly effective and efficient to serve the public trust. While the label 'professional' is not just a declaration of public trust, but a social category to imputes status and privilege to the professional group (P.3).

Profession is a socially constructed term that has been described as self-regulating occupations, connecting to social environment with extensive training and specialized knowledge, and usually has profession ethics and values and certification or license (Evetts, 2012; Henrik, n.d.). Profession involves different ways to organize work, workers, and work relations. The discourse and ideology of professionalism emphasize knowledge and competency of professionals, and the values of professionals emphasize that the shared identity produced by education, training, and experience are fundamental requirements of specialist competencies and licenses. This could reduce the imposed rules governing work but increase the exercise of discretion and judgment, especially in complex situations. Professional relations are characterized as supportive and trust interactions between practitioner-client and practitioner-employer (Evetts, Muzio & Kirkpatrick, 2011). The tasks of professionals are defining and solving the problems, meeting the needs of the public, and promoting knowledge-based work and social progress (Schon, 1991; Richardson, 1999). In 1996, Quinn, Anderson, and Finkelstein pointed out four levels of professional intellect as the primary tool of knowledge workers: Cognitive Knowledge of knowing what to do, advanced skills about knowing how to do, systems understanding why it must be down (know-why), and the last but not least one, self-motivating creativity, caring about why to do it (Quinn et al., 1996, p.72; Richardson, 1999; Duffy, 2017). These four levels are used to encourage the motivation and adaptability of workers to be more confident and well-prepared in their professional areas. For students, advanced education and training from educators and good interaction between supervisors and other students are benefit for their ability enhancement, as Richardson (1999) noted: “learn to act as professionals is determined by their experiences of being a student of a profession” (p.9).

Evetts (2003) noted: “The development of professionals could change professionalism. Professional development is a key process within the wider agenda of raising standards and increasing societal growth capacity by improving policy and practice in all areas of public service provision, not least education.” In addition, understanding different meanings and concepts of professionalism and professionalization are necessary to promote professional socialization in education programs. Professionalism is part of professionalization but not the sufficient cause leading to professionalization (Vollmer and Mills, 1966). Professionalism is a term requiring specialized knowledge and practice preparation to conduct and organize work. According to Southon and Braithwaite (1998), professionalism is different from profession which focusing on particular tasks. professionalism encourages health professionals to possess an ability by using sophisticated skills to address unpredictable and uncertainty crisis and meet the need of clients (as cited in Richardson, 1999). On the contrary, professionalization is a sequence of developmental stages, a social and dynamic process related to professional action, it existed in professionals’ attitude, values, behaviors, and other formal and informal advance competency and skills to achieve goals of professionalism, and it is a self-development to life-long learning (Sjöström, 2013; Houle, 1980). Professionalization promotes professional practitioners' occupational self-interest in salary, status, power, and occupational jurisdiction, and it claims to specific competency and the quality of service and its benefits to society (Evetts, Muzio & Kirkpatrick, 2011). Precisely, the efforts to establish professional authority and monopoly are considered as the main driving force behind professionalization (Sjöström, 2013). According to Leighninger (1978), social work's knowledge-based education can be taught in light of a general movement toward professionalism. Using knowledge-based standards to design the professional curricula and applies special knowledge for practice. Social work professionalization has two main concerns: producing effective services to clients and gaining autonomy to control the practice of one's work. These two goals connect and conflict with each other to promote the development of knowledge-based expansion and undergraduate social work education, which is useful in social work educational and organizational growth.

As for professional socialization, Vollmer and Mills defined professional socialization is a process that individuals learn the values, attitudes, and beliefs to improve their professional ability and to develop their professional career (as cited by Richardson, 1999). It is not only a process to equip with professional competency, but a prerequisite to prepare for professional efficiency practice through internalizing profession knowledge, skills, and theories with the profession values, ethics, attitudes, and beliefs (Richardson, 1999). Professional socialization occurs through the observation of socializing agents' performances to learn profession values and norms (Shuval & Adler, 1980). It is a dynamic and continuous process that relies on interaction encountered. Goffinan (1959) had mentioned symbolic interaction theory as the main content of professional socialization indicates team members to bring their unique roles but cooperate in staging a performance. When team members work together, understanding other professionals' roles and frames of reference can increase work efficiency and may lead to fewer role conflicts in a team (Lister, 1982). The professional occupations including physician, nurse, social workers, and clergy have different specialisms and sections. The hierarchy and different layers are concerned with different tasks and job responsibilities in the multidisciplinary teams and cooperating work process. It may have conflicts and inequalities within groups, and some gender inequality access to professional position and training and education (Evetts, 2012). So, early interaction with other professionals plays an important influence on later professional socialization efficiency (Iris, 2002). Clark (1997) noted that interdisciplinary education is a dual socialization between individual and colleagues' professions. These two processes complement each other that "Students only learn who they are and define their professional focus in the context of others. While others may overlap or be complementary with them in some areas, sharing common identity or supplement in other dimensions of clinical practice" (p.449). This shows that professional socialization has dual benefit of helping students and health care works to identify their professional role to improve collaboration between multidisciplinary team (Iris, 2002).

3.4.2 Interprofessional teamwork and social work roles

Palliative care is client-centered rather than disease-oriented services based on multidisciplinary and interdisciplinary teamwork (Richardson, 1999). It adopts a team cooperation approach, focusing on individuals' physical, social, spiritual and psychological aspects and address health problems through a process of problem-solving (Fort Cowles, 2001). Ducanis and Golin defined interdisciplinary team as a functioning unit that staffs bring various and specialized knowledge to work together to provide services to clients (as cited in Iris, 2002). The original interprofessional team, include psychiatrists, psychologist, social workers, and caregivers, appeared in 1960s in a community mental health movement. The focus area of this team was physical health initially, then developed into focusing on the social dimensions of their clients rather than simply on physical symptoms (Parry, 2001). Interprofessional collaborate requires "coordinated effort" to promote the efficiency and effectivity for end-of-life care and the clients in terms of client outcomes, cost containment, and team member satisfaction (Marmo, 2016; Kobayshi & McCallister, 2013). The use of interprofessional team has been supported and recommended by many research literature, palliative care handbooks, and public policies, even the World Health Organization have valued the function of interprofessional team (Marmo, 2016). Today, the interprofessional team in palliative settings consists of physicians, nurses, social workers, physiotherapists, Chaplains, psychologists and some specially trained volunteers (Alvarez, 2007). Each professional has their specialist knowledge and unique set of values, they cooperate and complement each other to share different understanding and technological skills to achieve the goal of promoting quality and comprehensive services to patients and families (Alvarez, 2007).

Interdisciplinary emphasize interaction and collaboration by multiple professions, while the multiple roles among different professions sometimes become confused and blurred that having a negative effect on the contribution of social workers, leading to some social workers felt less connected to other team members (Marmo, 2016; Brandsen (2005). Different disciplinary, cultural, and individual perspectives let the decision-making process more difficult and complicated to process (Howe, Hyer, Mellor, Lindeman, & Luptak, 2001). These have a negative effect not only on social workers' involvement in practice compared with other professionals, but also on how to educate social workers in palliative and end-of-life care. In a study researched by Reese (2011) which based on the previous analysis of Kulys and Davis (1986) founded that social workers did not work as a unique role in hospice settings, nurses can take the same tasks to provide crisis intervention, advocacy, and communication as social workers, which regarded nurses are more qualified than social workers. In addition, Blacker, Head, Jones, Remke, and Supiano (2016) demonstrated that the unclear responsibilities and different scopes of knowledge and skills are hard to determine which disciplines contribute to the desired outcome of care. Barriers and conflicts occur in multiple levels during the serving process, such as power differentials, overlapping roles, and misunderstanding. Physicians are always considered as the team leaders and authoritative experts in health care services, they take great power in decision-making and resources allocation than other professionals (Blacker et al., 2016).

Social workers work with patients and their loved ones in the early and late palliative stages make contributions to support clients' social, psychosocial and emotional aspects. Social workers also play significant roles in end-of-life care team as administrator, policy maker, educator, researcher, propaganda, and advocator (NASW, 2017). These various roles show that social workers are greatly needed in end-of-life care. According to Parry (2001, ch.2). Social workers who contribute to providing end-of-life care and palliative care helps patients and their family members react to the diagnose, make self-decisions, and support them in terms of emotion, finance, and practice. Numerous activities such as resource connection and referral, mental health intervention, counseling, and complex case management also need social workers' contributions (Blacker et al., 2016). A further study researched by Canadian Hospice Palliative Care Association (n.d.) noted that social workers play important roles in lowering hospice costs, enhancing team function, reduce unless medical services, and decrease the severity of cases. Parry (2001) pointed out that social workers as one of the professionals in interprofessional team always supplementary to support nurses, so they should learn nurses' orientation and roles to patients in palliative care settings.

Palliative and end-of-life care social workers assess and diagnose problems quickly from all levels of the patients' system to help them plan and solve these problems (Gwyther et al., 2005, McDonough, 2008). They encourage families to recognize that their loved one is facing death, also encouraging clients to consider how to prepare for the death and where they prefer the death take place (Bern-Klug et al., 2001). The preparation and planning regarding the psychosocial needs for both patients and families could enhance clients' satisfaction and cooperation rather than increase the need of crisis intervention (CHPCA, n.d.). Social workers play the role as "context interpreters" in helping dying patients and their families understand the natural process of dying, the positive and negative consequences of medical interventions, the misunderstanding jargons, and the medical decisions which they are likely to face (Bern-Klug et al., 2001). Social workers interpret the information based on the medical and social contexts and deal with the emotions that provoked at the same time. Similarly, they also express clients' hopes, desires and needs to other professionals of the end-of-life care team. Social workers act as a liaison or a broker between clients and professionals, searching sources of professional or community support and making referrals to link clients to their needed resources and capacities (Abu-Saad, 2001). Social workers also take responsibility to connect the whole system and put individual experience into border context to bring a special knowledge of community resources (Parry, 2001). In addition, fiscal management and cost reduction as one of key parts in health care system affect the health care decisions and policies and the treatment for patients. Social workers need to help clients and health care setting reduce the conflicts about costs, and expect to identify, assess, and demonstrate the values and meanings in cost avoidance to enhance the quality of service and care (Blacker et al., 2016).

Social workers work as counselors encouraging clients to express their needs, it is significant to comprehensively assess and satisfy dying patients' needs before they died. Social workers need to clarify clients' problems, intervene crisis and manage negative emotions in order to affirm dying patients and families' personal strengths and capacities to face impending death through providing resources, sharing information, and facilitating communication (Alvarez, 2007). Relieving other team members' pressures and dealing with their feelings related to death experience is also an important task for social workers as counselors. As advocators, social workers also need to consider different cultural backgrounds, individual needs and fight for the rights of clients to acquire needed sources by using appropriate legislation, before advocating self-determination and reinforcing autonomy to assist patient to make decisions and negotiate between clients and health professionals (Alvarez, 2007; McDonough, 2008; Bern-Klug et al., 2001; APCSW, 2016).

3.4.3 Social work competency

Manzanera-Ruiz and Marín-Sanchez (2018) presented that professional competency is the ability to use professional knowledge, accomplishments and expertise while working. Social work is a subject in which social workers engage in professional activities to know how to apply their creative and technical competency through involvement. The professional competencies education is promoted by focusing on "know-how" and knowledge and technical innovations to educate students as future professionals in the current context of globalization, international cooperation and competition (Manzanera-Ruiz & Marín-Sanchez, 2018). Competency-based training is considered as the link between social work education and the professional requirement, and the principle to increase social workers' competitiveness, efficiency and effectiveness in the palliative and end-of-life care settings. Social workers bring a unique perspective holistic philosophy and play an important role in palliative and end-of-life care. But their roles and functions are ambiguous and undefined, increasing the confusion and misunderstanding among other professionals (Bosma et al., 2010). According to the Core of Ethics of NASW (2007): "Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience." It is crucial for social workers to identify that competency is related to practitioners' job performance and career progression, they should take into account their roles and competencies before they work in palliative and end-of-life care.

In 2002, a national Social Work Leadership Summit held at Duke University, this meeting reviewed the literature and constructed the description of the knowledge, skills, values, and the role of social workers. Additionally, they determined and formed a list of knowledge and skills competency for end-of-life care social workers (Gwyther et al., 2005). A group of Canadian social work educators and practitioners used Delphi technique to do a survey nationally for the front-line social workers, synthesizing a range of expert opinions and reaching consensus about eleven core competencies that essential to social work practice in palliative and end-of-life care, as well as the required attitudes, knowledge and skills (Bosma et al., 2010). The eleven competencies were identified as ‘advocacy, care delivery, community capacity building, confirmation, evaluation, care planning, decision making, education and research, information sharing, interdisciplinary team, and self-reflective practice.’ Another six competencies were put forward by the participant, but it is unsure whether these competencies should be included in or not, especially the cultural competency took up 50%, much higher than the others (Bosma et al., 2010).

Similarly, multidisciplinary palliative and end-of-life care professionals in Korea identified domains and subdomains competencies for social workers by using a two-round Delphi survey and a final consensus meeting. They came up with an interesting result that different disciplines have different core competency, social workers should have 5 domains and 15 subdomains, nurse and physicians should have 11 domains competencies, and spiritual care workers have 3 domains. The most important domains are also different, physicians are specialized in physical care and treatment, nurses for pain and symptom management, social workers need to focus on bereavement care and supervise volunteers, and communication skill is the main competency for spiritual care professionals (Kang et al., 2013). Sumer, Remke, Leimena, Altilio, and Otis-Green (2015) did two surveys for social workers, one for educators and the other for students and practitioners in terms of investigating preparation, training, and self-assessed competency. The result of this survey found that collaboration with team (94%) is the highest competency recognized by most of health social workers, then followed by dealing with family and caregiver distress, addressing cultural and ethnical diversity, and promoting family conference with 87%, 82%, and 80% respectively. Legacy work was the lowest needed competency accounted for 38% in the total. The data also showed that self-assessed competency is important in psychosocial intervention for social workers to enhance safe, high-quality and effective palliative care.

According to the report of Palliative Care Competency Framework Steering Group’s (2014), which supported by National Clinical Program in Irish. The group members analyzed and evaluated exist competency frameworks and came up with six core competencies for palliative care including palliative care principles, effective communication in life-limiting condition, decision-making and inter-professional teamwork, improving comfort and quality of life, care planning and collaboration, dealing with loss, grief and bereavement, and ethical practice. Furthermore, standardized competency can be integrated into palliative and end-of-life care training and education programs and evaluation criterion to improve practitioners and students' capacity (Kang et al., 2013; Bosma et al., 2010). Along with enhancing the care of dying patients and families and interprofessional corporation in palliative care area (Palliative Care Competency Framework Steering Group, 2014).

3.4.3.1 Communication competency education

Communication includes verbal and nonverbal language and active listening is the fundamental skills of social workers, it is significant to affect the relationship with clients. Good communication is crucial when patients are facing serious, life-threatening illness and it is vital to convey the caring and empathy to dying patients and promote the quality of end-of-life care. Communication is not only conveying information from a communicator to a receiver, but listing and understanding patients and families' concerns and demands especially when patients are facing life-limiting illness (Bunting & Cagle, 2016). Effective delivery the information of disease and emotional issues is important to meet the spiritual and emotional needs of dying patients and caregivers, and help them understand risks and benefits, prepare the impending death, and decision-making (Bunting & Cagle, 2016), while poor communication can mislead patients' preferences and physicians' directions for treatment and goals of care. Truth and hope as two importance aspects of communication in end-of-life care encourage social workers to console and counsel patients and families during the process of being hopeful, maintaining hope, and losing hope, and encourage clients to express and share their feelings which they have been concealed in ordinary conversation (Reith & Payne, 2009). Day-to-day communication and conflict management within the team and with clients were explored (Gordon, Ridley, Boston, & Dahl, 2012). Effective team collaboration requires shared language and communication strategies. But similar terms lead to various meanings, let alone specialized terminology may make it hard to understand for other professionals (Blacker et al., 2016). The professionals without sufficiently training in communication skills are much easier to feel burnout, anxiety and stress while working (Brighton et al., 2017).

Lane and Rollnick (2007) reviewed studies about which area taught communication skills and summarized as sexual health, breaking bad news, behavior change, domestic violence, and cancer. And they also found that role-play and simulated patients were commonly used as the teaching strategies in communication training. Delivering bad news or breaking bad news is occurred daily in the hospital settings, it is one of component of communication skills. Many social workers who have not received formal training before, shown to lack confidence and skills in the clinical work. Bor, Miller, Goldman, and Scher (1993) defined bad news as a situation: "where there is neither a feeling of hope, a threat to a person's mental or physical well-being, a risk of upsetting an established lifestyle, nor a message is given to an individual with fewer choices in his or her life." Therefore, training the skills for delivering bad news can reduce the feelings of discomfort and participants will learn how to break bad news effectively. Similarly, training communication skills could improve self-efficacy and decline fears of communication about death and dying.

Palliative and end-of-life care social workers play the role in maintaining communication between physicians and clients. Cagle and Williams (2016) noted well-educated school learning and continued education on more advanced training are important for social workers to handle complex situations and grasp communication competency such as dealing with conflict, facilitating relationships, preserving hope, and improving family dynamics. However, there have many studies research on the need to provide communication training to physicians and nurses rather than social workers. And the communication skills training for social workers is often regarded as 'too theoretical' for practice (Neuderth et al., 2019). So, it is important to review the communication education and training programs to impact the effectiveness of palliative care served by social workers (Bunting & Cagle, 2016).

3.4.3.2 Interprofessional competency education

Interprofessional education is necessary to prepare students in palliative and end-of-life education in terms of collaboration, communication, leadership, and the new trends of team-based care (Blacker et al., 2016; Head et al., 2014). Palliative care needs the expertise interprofessional team-based care that encouraging the education opportunities for students to learn how to work in the team practice settings and how to provide quality client-centered care (Head et al., 2014). In 2010, WHO defined interprofessional education (IPE) is "from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (p. 7). WHO also defined Interprofessional Collaborative Practice (ICP) as "the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/families/communities to enable optimal health outcomes" (p.8). Interprofessional team composed the IPE education, the goal of these efforts is to develop knowledge and skills to promote the staffs' behaviors, attitudes and competency in palliative care (Blacker et al., 2016).

Although each profession educates its professions separately, in the palliative care team, interaction and backstage familiarity as central components of teams encourage professionals to work together to learn about applying for their different roles. Educating the knowledge about personal roles and team roles early in professionals' careers is beneficial for team function (Lister, 1982). Training in interprofessional word would benefit from the interprofessional education model. As Association of Palliative Care Social Workers (2016) mentioned: Good palliative, end-of-life, and bereavement care is founded on professional skills and knowledge and values which can decline the suffering among physical, psychological, social and cultural (Berkman & Stein, 2018). Palliative care team as a multidisciplinary team calls for a fresh look at the professional socialization process and professionalism and professionalization. In the cooperation with multidisciplinary team, providing quality of palliative care and services and good cooperation are pursued by health care professionals. Professionals should clearly understand their roles before they can contribute effectively to teamwork and break barriers between professions (Hall et al., 2006). Lynn, Schuster, and Kabcenell (2000) demonstrated that good end-of-life care requires different disciplines collaborate with each other on patient care, it requires an interprofessional approach that each professional has a defined role and take their responsibilities in the team, they should feel confidence and understand their abilities and roles in the team and respect other colleagues' roles as well.

Therefore, the interaction and socialization process between professional members and multidisciplinary team should be included in the educational structure for different disciplines. Palliative and end-of-life care education and training program focused on teaching interdisciplinary content cannot only encourage both students and workers to grasp other professions' knowledge and values, but also can prepare them for the future collaboration practice (Berkman & Stein, 2018). The vital role of social workers on palliative and end-of-life care teams is well-recognized, social work has a different professional socialization processes in their education when compared with other professionals in the area of palliative and end-of-life care. Better educational preparation is necessary to ensure social workers are educated and trained with the essential interprofessional competencies for high-quality palliative care (Csikai & Raymer, 2005; Gwyther et al., 2005). But the existing materials and curriculum for social workers are insufficient to improve interprofessional competency, and the advances and researches on social work education are limited and how do social workers perform in interprofessional team is poorly understood (Supiano & Berry, 2013; Howe et al., 2001). Learning how to work together requires experiential learning methods that focus on specific patient-central goals are more practical than simple interprofessional lectures (Hall et al., 2006)

3.5 Summary

The above review illustrated the gaps and barriers among current education and training programs and clarified the important competency-based education of social workers in palliative care. Interprofessional teamwork is a necessary prerequisite and cornerstones of palliative care, social workers as one part of team members should strive to collaborate with other professionals. The deeper understanding of theoretical framework of death and dying, interprofessional teamwork as well as profession theories, and the identifying of the barriers and demands of both students and practitioners in the field of palliative and end-of-life can better understand and describe the theories, in order to combine them with current education programs and to promote social workers’ confidence, self-efficacy and career growth.

4 Research Method

At first, I intended to interview social workers who work in the hospice center in Gothenburg. While after taking an interview with one palliative care social worker, she told me there only have four palliative social workers work in the Sahlgrenska university hospital, that I realized the small simples may give a poor result. According to my interviewee, they received palliative care knowledge almost from colleagues, seminars, and conferences rather than from the course or school education programs. Which shows the shortage of professional education and training for end-of-life social workers. Then I searched the bachelor and master courses and programs related to palliative and end-of-life care through the department of social work in the University of Gothenburg, Stockholm, Umeå, Lund, and Uppsala, but the education programs were deficient in this area. In these schools, there have some courses relate to elderly, such as in the University of Gothenburg, it has a course relate to elderly and aging. But only the master course in Umeå university, which named 'social work with elderly' mentioned the content relate to end-of-life care, death and bereavement. I perceived the growing number of aging populations means more and more deaths occur in old age that lead to the palliative education are almost connected with gerontic.

I also considered to interview Chinese social workers and use the database such as CNKI (China National Knowledge Infrastructure) in the systematic review, but there have less papers relate to social work education programs in China, and the translation of the papers will be a challenge in this limited time. Therefore, I selected to use systematic review to get a generalized overview instead of interviewing to find and synthesize the current studies on palliative and end-of-life social work education program. In this section, I will present and discuss the choice of research methods, the process of data collection and extraction, data analysis and synthesis method, the issues of validity, reliability and generalizability as well as the ethical considerations. The table of data extraction and quality assessment can be found in Appendix.

4.1 Systematic review

Systematic review is a type of literature review and an aggregate summary approach focusing on a single topic and based on clear and transparent methods (Drisko and Grady, 2012). It is considered as the gold standard approach to synthesis research findings in the field of medical, healthcare, education and another discipline by doing a meta-analysis or meta-synthesis approach. Sackett et al. (1996) identifies "integrating individual clinical expertise with the best available external evidence from systematic research." Evidence-based study generates research studies and evidence that comprehensively explore the research in detail. Littell et al. (2008)

advised: systematic review is based on particular questions to comprehensively collect and synthesize literature, by using organized, transparent, and replicable methods at each step in the whole processes. Snilstveit (2012, p.17) defined systematic review methodology as “a powerful tool for bringing together evidence from a range of different studies in a transparent and systematic manner”.

Systematic review is a crucial and rigorous method in evidence-based practice. Traditionally, systematic reviews use an objective and primarily qualitative approach to synthesize and assimilate statistical analysis. This comprehensive search process has been considered as a key factor in preventing bias, reducing disparities and providing a true representation of all relevant researches. On the other hand, comprehensive search also emphasizes the qualitative or narrative reviews to answer health service research questions, which is widely used as qualitative evidence syntheses in systematic review (Methley et al., 2014). Systematic review methodology is applied to answer different types of research questions and synthesis different types of evidence including quantitative evidence or qualitative evidence (Snilstveit, Oliver & Vojtkova, 2012; Gough, Oliver & Thomas, 2012). It focuses on both qualitative and quantitative research on theories, methods, and outcomes of effects which can provide an excellent learning opportunity to explore the data in great depth (Boland, Cherry and Dickson, 2017). Systematic review follows a well-structured protocol with previously specifies objectives, concepts, and methods (Littell et al., 2008). Each step of review processes is carefully documented in detail and has significant implications when applying into a broader range of evidence, which provides a guidance on all of these aspects from designing research questions to defining inclusion and exclusion criteria, searching and screening, synthesizing, and presenting results (Snilstveit et al., 2012). It is easier for readers to follow and evaluate at the same time.

To do the systematic review, this research followed the ten key stages guided by Boland et al. (2017, p.197) and the models from Cooper’s (1998, p.22-23) as: ‘plan-review; performing scoping searches; identifying review question, inclusion and exclusion criteria, and writing protocol; searching literature; screening titles and abstracts; obtaining papers; selecting full-text papers; theoretical standpoint and synthesis plan; data extraction and quality assessment; qualitative analysis and synthesis; and writing up, editing and disseminating.’

The consideration of my research process can be illustrated clearly as follow:

1. First of all, I formulated a clear and structured plan-review previously with specific objectives and research questions.
2. Then I considered explicit inclusion and exclusion criteria (such as conditions, populations, interventions, comparisons, outcomes, and study designs) to determine which data will and will not be included in the following steps. In this step, specialist experts in relevant studies might be contacted and asked for help to ensure the research questions are relevant and to get some unpublished studies and information (Cooper, 1998).
3. Following this, a well-thought-out review protocol about the current evidence base, later processes and methods was written to support the research.
4. Next step is screening and searching. After scoping searches about the relevant references relate to research topics. I screened titles, abstracts, and full-text papers to select and remove irrelevant references based on inclusion and exclusion criteria.
5. Data extract process can make sense of data descriptively and analytically. It is essential to identify which data is relevant to the research questions, build data extract forms or tables, and present data in it (Boland et al., 2017). I used the table of matrix method to extract and collect data.
6. Next, in the quality assessment steps, it needs to select appropriate tools to assess included studies' quality critically. This step is used to minimize bias and ensure transparency of the reviewing process (Drisko and Grady, 2012). Due to there have different research methods in my selected papers, Mixed Methods Appraisal Tool (MMAT) is more suitable to evaluate the quality of each papers.
7. Finally, it is important to choose an appropriate method to analysis and synthesis data in a narrative or statistic way, then presenting the results into research. So, I used the narrative synthesis to describe, compare and contrast findings across studies.

4.2 Data collection

4.2.1 Inclusion and exclusion criteria

Inclusion and exclusion criteria are important to guide the data searching process and other critical decisions (Littell et al., 2008). They depend on review questions and contain sufficient characters and details and give a clearly and accurately structure to find which studies are fit for the review. Inclusion and exclusion criteria complement each other, but sometimes they are mutually exclusive. (Boland et al., 2017). Inclusion criteria, which known as eligibility criteria, describe the necessary and specific conditions that a study must include in review. And exclusion criteria describe the specific attributes that disqualify the review. Eligibility criteria specify the population, interventions, comparisons, and outcome measures. These criteria will determine what kinds of data should be included or excluded in the review, and it helps researchers stay clear-mind to eliminate omitted and irrelevant studies included. In addition, explicit inclusion and exclusion criteria have clear boundaries that easier for other researchers to replicated or extended (Littell et al., 2008).

According to Boland et al. (2017, p.199) There are many ways to define inclusion and exclusion criteria, such as PICO (Population, intervention, comparator, and outcome), PICo (Population, phenomenon of Interest, and the Context), PICOSS (Participants, Intervention, Comparison, Outcomes, Setting and Study Design), and SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, and Research type) tables, that can make systematic review effectiveness. In this study, PICo framework, which stands for population or problem, interest, and context is more suitable for the research design and can specify the characteristics in this study.

P	**I**	**Co**
Population	**Interest**	**Context**
Social workers include undergraduate or graduate students and hospice social workers.	Different kinds of education types such as classroom-based education, online program, curricula, mentoring or training.	The field of palliative, hospice or end-of-life care.

Using the inclusion and exclusion criteria will make it easy to screen and select potentially relevant full-text papers which are relevant to my research questions (Boland et al., 2017). I wished to select papers that focused on specific education and training contents related to palliative and end-of-life care, targeting at social work students and practitioners with the aim to enhance their competencies and skills. Also, I focus on studies that had formal methodologies of how they evaluate participants' learning results and programs' efficiency by either qualitative or quantitative methods. The review of each programs' results and implications can make up the deficiency and provide a new insight for future development. This research limited to literature on end-of-life social workers populations that published in English from 2009 January to 2019 January as peer-reviewed journals. Unpublished dissertations and grey literature such as Google scholar were excluded due to the huge workload, time and quality. But all of the relevant studies which satisfied all the criteria will be included, especially those descriptive studies. The results were imported into Zotero software to remove duplicates and monitor selection process. The full strategy including search terms used for each database is available and may be requested to contact the corresponding author. The summary of all inclusion and exclusion criteria was concluded in Table 1.

Table 1. Inclusion an Exclusion Criteria.

Inclusion:
Written in English The latest published, from 2009 January to 2019 January Target at the palliative, hospice, and end-of-life care social workers Focus on specific education, training, curricula, or mentoring methods Describe specific educational approach to promote social workers' practice abilities Peer-reviewed articles with methodology
Exclusion:
Studies focus on other professionals without social workers Studies describe education for patients and other family caregivers. Studies that do not describe research data or learning results.

4.2.2 Search Strategy

Systematic review depends on bibliography databases as primary data sources. It requires a comprehensive summary of the literature and emphasizes the importance of using different databases to do the search strategy (Littell et al., 2008; Boland et al., 2017). Different databases have its special focusing area. Social work researchers widely use databases such as Social Work Abstracts, Social Services Abstracts, Sociology Abstracts, PsycINFO, and MEDLINE/ PubMed. Other databases, such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed for physicians, and the Education Resources Information Center (ERIC) for educators also could be used as references while searching.

A comprehensive and advances search process includes specific keywords, search strings, and Boolean operators in various electronic bibliographic databases. Keywords are the essential component of the searching process, they often come from the framework of populations, interventions, comparisons, and outcomes of interests. Search strings such as (?), (*), or ($) and Boolean operators as ‘AND’, ‘OR’, or ‘NOT’ are also used with keywords to expand and precise search areas in the online databases.

After several scoping searches, articles published in the latest 10 years in various countries in English and indexed in the following databases will be searched: Sociology collection (Social Sciences Index & Abstracts (ASSIA), Sociological Abstracts, Sociology Database, Social Services Abstracts are already included in this database, but I will search them separately as supplement), and Scopus. The initial resources and key words in this research were (social work*) AND ((hospice care) or (palliative care) or (end-of-life care)) AND ((educat*) or (stud*) or (curricul*) or (co*rse) or (train*) or (mentor*)). The overall search strategy process was followed by the PRISMA flow program and summarized in Figure 1.

4.2.3 Screening and selecting strategy

Boland et al. (2017, p.62) explained: “Searching is an umbrella term that is used to describe the many methods by which you can identify evidence of relevance to your review questions” Potential sources can be searched from bibliographic database, journals, reference lists, and some grey literature such as government databases, conference reports, and newspapers. In addition, some software packages such as EndNote, Zotero, and RefWorks can be used to identify and screen duplicate records, extract data, synthesize and write up findings.

The key steps for selecting and screening the papers are based on the recommendation by Boland et al. (2017): De-duplicate reference is the first step to delete repeated sources. Then screening all titles and abstract to remove those against inclusion and exclusion criteria. After that obtaining full-text and reading them carefully and noting the reasons which paper should be excluded is important to identify the potential papers for systematic review.

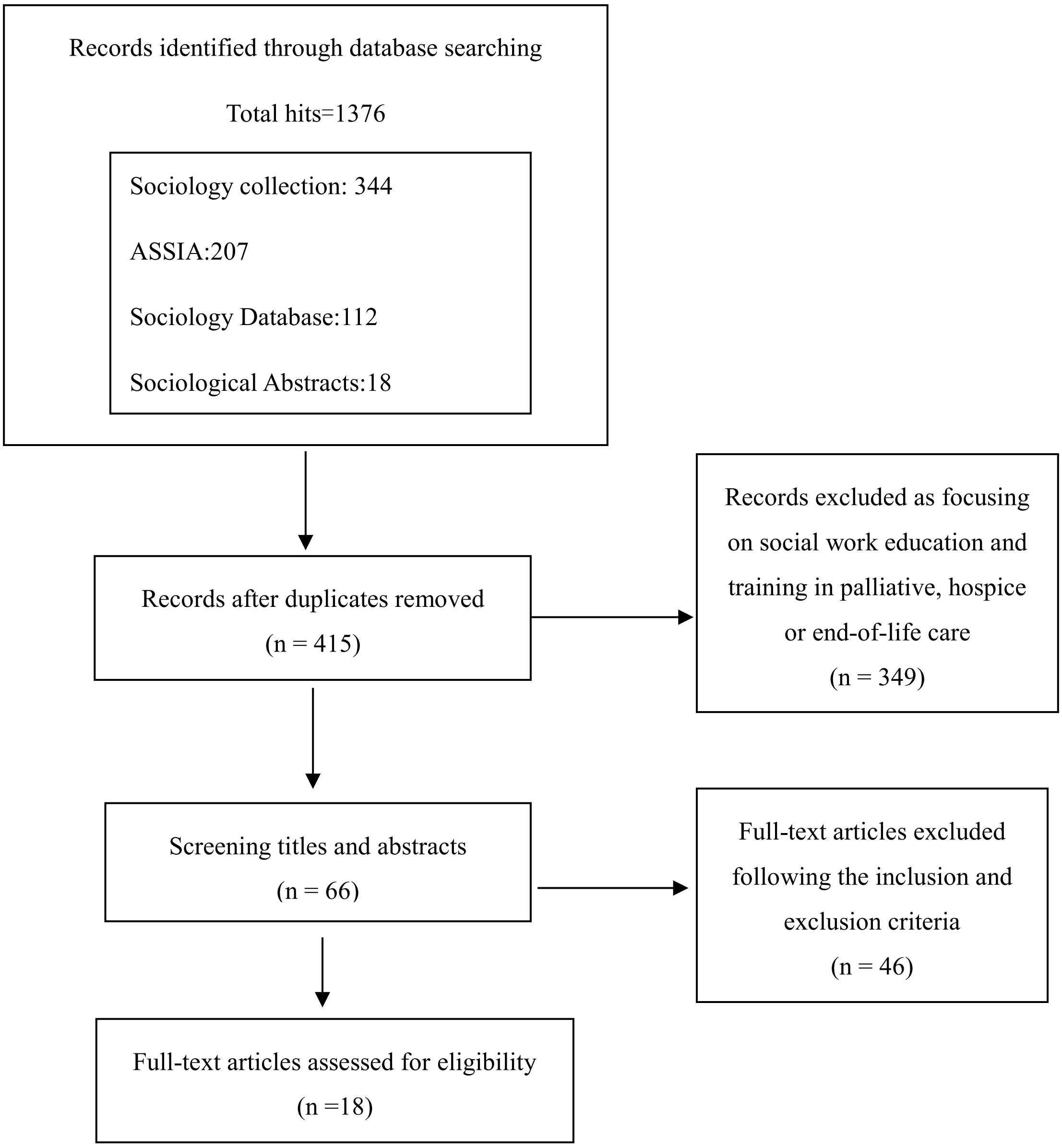


Figure 1. Selection process of this systematic review.

In my screening and searching process, online database search identified a total of 1376 ‘hits’ based on the highlight words as social work, palliative care, hospice care, end-of-life care, education, training, and mentor. After using Zotero to remove duplicates, left only 415 ‘hits’ to be screened for inclusion figure 1. Examining the title or abstract of papers led to exclude those papers focus on other professionals without social workers, describe education for patients and family members rather than social workers in the field of end-of-life care, resulting in 66 potential papers being retained. Those papers which I have any doubts whether they should be included at this stage are all included to ensure no important paper had been omitted. Then the full-text papers of all these potential papers were obtained. Using the inclusion and exclusion criteria set out in the (table 1), excluding those without methodology and results, 18 papers were identified for the next step. All of these selection processes were summarized in Figure 1 and Table 1.

4.2.4 Data extraction

After screening and selecting eligible papers, in this stage of reviewing process, data extraction is needed to sort and identify relevant data from included paper and clarified them in a data extraction table. This extracting and presenting process could make sense of data, both descriptively and analytically (Boland et al., 2017). When extracting data, there are two types of data: analytical data and descriptive data, and there also have some irrelevant data. So, it is important to keep clear mind and reread inclusion and exclusion criteria all the time (ibid.). Once decided which data should be extracted, the next step is to develop data extraction forms or tables. Reviewers should first assess various of systematic reviews' forms to choose which one is more tailored or fitted to the particular purposes, questions, and results that want to address from the review (Littell et al., 2008). Higgins and Green (2006) suggest the data forms provide a bridge to connect primary research studies with research synthesis that giving reviewers a historical record. The forms could be completed by an old-fashion paper or using a software package to extract the data. Software package is convenient and easier to get the final data tables, and may decline the mistakes while entering the data, but paper forms are more comfortable to set up and modify for coding procedures and pilot-tested (Littell et al., 2008).

A well-designed data forms will save time and energy and avoid returning to the papers back and forth. The data form structures should include the descriptions of interventions, populations, research methods, outcome measure, and maybe some statistical and evaluation information. And it is better to use pilot-test to evaluate whether the data fit the purpose of a particular review or need to adjust before producing the final tables (Littell et al., 2008). After completing the data, the final task is to report and make sense of data and compare the differences and similarities in each included study.

In this step, I chose the matrix method to extract and collect data. Matrix method has a standard structure which is useful to organize information and enhance efficiency, and it can work further on the explanatory theory, conceptual or interpretative framework (Nolfi, 2018). Matrix method allows to sort and categorize different contents and outcomes focused on the same topic by using a box or table with rows and columns. As Garrard (2014) mentioned, using matrix method needs to follow two rules, one is the 'Rule of Rows' for abstract paper, another one is the 'Rule of Columns' for preparing a synthesis. Matrix review can quickly compare and contrast articles to determine the scope of research across time, and it is easier to find differences and similarities between different articles (Nolfi, 2018). The reason for using the Matrix Method is to structure and categories the data in the publications (Garrard, 2014).

After screening the articles, I created a folder and arranged documents chronologically following the year of publication from the oldest to the most recent to extract data. The first step is to search and identify key descriptive information from each paper. I reviewed my research questions and designed column topics which allowed me to track the details of studies clearly. The rows are for documents and the columns are for the topics which I used to summarize the key terms only describes the most important points about the topics. The column topics were followed the same format as the Cochrane review's characteristics include participants, interventions, outcomes, and notes (Popay et al., 2006). But it was modified and added further information including author(s), nationality, year of publication, participants, goals of program, modes of program, teaching and learning strategies, contents, evaluation methods, and conclusions. After that, the next step is to category and summarize the key characteristics into columns, I extract and collect sources one by one under each of column topics which make the characteristics in each paper clearly at a glance and easier to synthesize and compare. The table can be seen in Appendix A.

4.3 Data synthesis

Data synthesis is a critical step to analysis and to review numerous literatures on a specific topic, examining the gaps in both the content and methodology. Synthesis based on the same sets of paper and themes to summary the similarities and differences in terms of purpose, content, methodology, and conclusions, in order to put the disparities into a logical and coherent whole (Garrard, 2014). Selecting an approach to synthesis and analysis data is very important before starting to extract data, assess quality and produce tables. A range of factors such as research questions, purposes of synthesis, the nature of the evidence, resources and time will determine the choice of synthesis method (Noyes & Lewin, 2011).

Qualitative research as one of valuable component of systematic review is a scientific process which emphasizes 'trustworthy' and 'rigorous' as core principles (Hannes, 2011). The synthesis of empirical evidence as credible studies was sometimes very complicated due to the influence of different research designs, participants, measures, and inconsistent results (Littell et al. 2008). Qualitative evidence synthesis is known as qualitative synthesis review that can respond types of questions. Saini (2002) noted that qualitative evidence syntheses can answer or complement different set of questions, and can improve effectiveness from quantitative syntheses (as cited in Snilstveit, 2012). The aim of qualitative evidence synthesis is to illumination and interpretation, which identified the gaps in the literature base and develop themes, theories, explanations, insights and/or conclusions in the research. It also collects findings and constructs the meaning from the results of primary qualitative researches (M. Bern-Klug, Gessert, & Forbes, 2001).

There are kinds of methods of qualitative evidence synthesis, Snilstveit (2012) mentioned three types of synthesis: translating themes across studies (reciprocal translation); identify, characterize and explain contradictory findings (refutational synthesis); and the last one, using findings to create a broad interpretation (lines-of-argument synthesis). According to Boland et al. (2017), the synthesis methods can be broadly categorized into integrative approaches and interpretative approaches. Integrative synthesis is a 'deductive' approach, its concepts and themes have been clearly defined in advance, data which extracted from multiple primary studies are comparable and suitable for summarizing. Therefore, we only need to use these existing concepts and categories to extract, describe and summarize data without developing a new concept. Broome (1993) defined integrative approach as "a review method that aggregate past empirical or theoretical literature to deduce a more comprehensive understanding of a particular phenomenon or healthcare problem" (as cited in Whittemore and knafl, 2005). Another one is interpretative synthesis, it takes an inductive approach to interpret existing findings. In an interpretative synthesis, concepts and theories are not categorized in advance, so this approach aims to develop concepts and theories from the results of included qualitative studies to explain evidence base (Boland et al., 2017). Aggregative methods are more appropriate to describe and test a hypothesis or theory, while configurative/interpretive methods are used to explore and define the research questions with wide data (Noyes & Lewin, 2011).

After extracted data and form the data tables, the next step was to synthesis and report the data. The synthesis process in systematic review brings together the findings from selected papers and draw a conclusion based on the evidence (Popay et al., 2006). In this study, after comparing various options according to the *Choice of Synthesis* from Noyes and Lewin published in 2011, statistical meta-analysis and another form of synthesis are not feasible in this study, so narrative synthesis was much suitable to describe the process and synthesize ideas and theories. Popay et al. (2006, p.5) defined narrative synthesis as an approach synthesis the findings from multiple studies that rely on the studies by using words and texts to summaries and explain, while the defining characteristic use textual approach to synthesize and 'tell the story' of the findings from the included studies. Narrative synthesis involves the manipulation of statistical data and it can be used to synthesize a wide range of questions including but not restricted to the effectiveness of a particular intervention. Narrative synthesis uses several tools and techniques to implement syntheses including textual descriptions, tabulation, groupings and clusterings, constructing a common rubric, thematic analysis, content analysis, and vote counting (Popay et al., 2006).

In this paper, textual descriptions and tabulation were selected to synthesis the findings. Tabulation is a common approach used in systematic review to present both quantitative and/or qualitative data, it is useful to develop the initial description of extract data and identify patterns across studies (Popay et al. 2006). This study followed the columns and rows in the form of matrix methods to synthesis the findings. After narrating the interpretation of tabulated data, textual description was used to describe, compare and contrast findings across studies, which can complement the findings given in the tables by explanatory summary text.

4.4 Validity and Reliability

There is no standard way to assess and report reliability, but there are various options to choose (Higgins & Green, 2006). Initial coding forms is essential to initial reliability to reflect consensus ratings while solving discrepancies. Coding discrepancies arise if there are some presentation differences among the included studies. Some authors suggested the extract coding process requires training. It is better to have two different reviewers screen or extract data independently and compare the results with each other, or double-code or screen the studies in different times or two separate occasions (Littell et al., 2008).

In this study, I only screen and extract data by myself. So, in order to increase t reliability and validity of the study, I searched help and advice from my supervisor and librarian to make the database, research questions, and inclusion and exclusion criteria more clearly. Then I designed my search strategies and kept records in detail to update and accurate the data I achieved at different stages of the review, and reviewed the decisions I have made to defend and justify my decision-making. These records included the data that each search carried out, the version and interface of each bibliographic database, different search filters or keywords, and complementary search activities. I compiled a list of all of the data to help myself summarize, describe, and interpret the data and examine the result iteratively. I also use PRISMA flow program and bibliographic software like Zotero to store and manage the results of research. In addition, no matter when I screened the papers or finished data extraction. I put the results to one side and repeated the process a few days later to reflect and resolve the discrepancies to make sure the validity.

In addition, quality assessment captures and analyzes variations in included studies in terms of their credibility and bias (Littell et al., 2008) to assess the quality of the systematic review and minimize the bias and errors in order to increase the validity and reliability in the design, analysis and results. Bias exists in many stages of systematic review, especially in the screening and coding process. Quality assessment focuses on the bias in terms of selection, performance, attrition, and detection features. It can develop a great understanding of the study and benefit to get a meaningful conclusion from the data, making the study more trustworthy and generalizable (Boland et al., 2017). In order to check the validity and reliability of selected papers, I used the checklist of the Mixed Methods Appraisal Tool (MMAT) to do the quality assessment. MMAT is a critical appraisal tool for systematic mixed studies reviews (SMSRs) to assessment empirical studies using different methods, which allows for a comprehensive understanding of the issues and solutions (Hong, 2018). The MMAT checklist includes two screening questions and 19 items to assess the quality of studies in five different types: qualitative research, quantitative descriptive studies, randomized controlled trials, non-randomized studies, and mixed methods studies (Pluye et al., 2011). The quality assessment process of MMAT in this study was followed by the steps demonstrated by Pluye et al. (2011). Using screening questions to assess all of selected papers; then, determining the type of methodologies and using corresponding criteria to evaluate each study's quality; and finally scoring the quality of each study (if needed) and dividing the number of criteria. In this study, according to the different evaluation methods in my selected papers, I selected three types include qualitative research, quantitative descriptive studies, and mixed methods studies for the assessment. The table of quality assessment were used the latest version of the MMAT that updated in 2018 and the results were provided in Appendix B.

4.5 Ethical considerations

According to Seale (1998) that researchers should consider the ethical issues when developing a proposal, the amount of attention about ethical issues relies on the sensitivity of your proposed study. The main reason to consider ethics in the checklist of systematic review is to increase awareness and ethical standards in research (Weingarten, Paul, & Leibovici, 2004). Since palliative and end-of-life care is a sensitive topic, without using interview or questionnaire to collect data from dying patients, families and practitioners, this paper does not need to consider the anonymous, confidentiality, privacy, informed consent, voluntary and other ethic issues in the study. Instead, I have to investigate the selected articles' reliability and validity and strive to correct my reproduction of information and sources when I extract and analyze the results of studies.

5 Findings and Analyses

The present systematic review included eighteen papers that met the inclusion and exclusion criteria were put in the reference, and the data extraction table can be seen in Appendix A. This section will synthesis and describe each education and training program's participants, goals, type of modes, teaching and learning strategies, contents, and learning outcomes along with the analysis of outcome data. The results and analyses will connect to the theories and research questions to guide the study. The first research questions can be found in 5.1 to synthesis the findings of each programs. Then second and third research question will be analyzed in 5.2.

5.1 Synthesis of programs

First of all, this part relates to the first research questions to answer what program types and contents do social workers have in the included literature of study? The findings were syntheses as following:

5.1.1 Countries

There have 18 papers been selected, 13 of them were from the United States, one corporation program from Sweden and Slovenia, and another four papers were from the United Kingdom, Canada, Australia, and Germany respectively. The articles included in this research show a geographical spread that highlights the needs of advanced education and current social work education and training program in palliative and end-of-life care globally.

5.1.2 Participants in the reviewed studies.

In the selected papers, there are seven papers focus on palliative care practitioners; one is in the ICU setting ((Gordon, Ridley, Boston, & Dahl, 2012). Eleven of them were about students in bachelor and master's degree. Thirteen papers related to multidisciplinary education include social work, nurse, medicine, spiritual care, occupational therapy, psychology, physiotherapy, clergy, counselor, pastoral care, genetic counseling, pharmacy, speech-language pathology, physical therapy, and nutrition. The majority of participants in these were nurses, social workers, and clergies. The other five papers were only related to social work students and staffs. One interesting finding is that over 80% of participants were females and whites in these 18 papers.

5.1.3 Goals of programs

The goal of programs reflected the needs and motivations of practitioners and educators to promote the development of palliative and end-of-life care. There had various similarities and differences among these 18 papers. The purposes of these programs were eager to enhance the learning opportunists and experiences for practitioners to grasp advanced knowledge and skills of palliative and end-of-life care, to increase knowledge-to-skill-building (Doorenbos et al., 2010; Agnew & Duffy, 2010; Forrest & Derrick, 2010). And to enhance the attitude and application of skills in clinical practice settings (Supiano & Berry, 2013). For those interprofessional programs, they intended to decline feelings of isolation and build interprofessional relationships to understand other professions and to promote team functions and interprofessional communication (Prelock et al., 2017; Supiano & Berry, 2013; Gordon et al., 2012). According to Otis-Green et al. (2009), the goals of Advocating for Clinical Excellence (ACE) project paid 35% attention to palliative care education, 32% on clinical care, and 21% on organizational change. The innovation, effective, efficient, patient-centric interdisciplinary curricula and leadership were also thought as primary purpose to design (Head et al., 2014). In addition, the object such as addressing the differences among professionals and cultures in palliative care (Pahor & Rasmussen, 2009); declining the fears of death and dying and personal death anxiety, distress and non-empathetic responses (Chow, 2013; Bunting & Cagle, 2016); and enhancing attitudes and awareness about grief and loss and end-of-life challenge was mentioned to encourage students to use their own experience while dealing with grieving suffering for clients (Supiano& Vaughn-Cole, 2011).

These end-of-life programs aimed to increase the capacity of self-reflection, critical thinking, empathic compassion, the ability of solution and conclusion, and the core competencies in practice in terms of values and ethics, professional roles and responsibilities, emotional competency, and communication skills (Prelock et al., 2017; Bunting & Cagle, 2016; Doorenbos et al., 2010) to increase practitioners' confidence and self-efficacy (Turner et al., 2015). The methods to evaluating practitioners' needs and the effectiveness of curriculum and different methods (Hamilton et al., 2014; Head et al., 2014; Matthieu & Swense, 2014) was also the purpose of these programs, to provide high quality, practice-relevant research, and person- and family-centered services for dying patients and their families (Gardner, Gerbino, Walls, Chachkes & Doherty, 2015).

5.1.4 Type of programs

Nine papers related to interprofessional education and training programs, one of them was a cooperation program collaborated by Sweden and Slovenia about how does culture show in an international and interprofessional course (Pahor & Rasmussen, 2009). There were three communication training programs, including a web-based education program to improve cross-cultural communication (Doorenbos et al., 2010); a comparative test with in-person, second life, and phone role-playing communication skills laboratory (Hamilton et al., 2014); and a communication training for social workers (Bunting & Cagle, 2016). Four programs were delivered as end-of-life care, grief, and bereavement, and emotional competencies programs (Turner et al., 2015; Chow, 2013; Supiano & Vaughn-Cole, 2011), but one focused on end-of-life education by using innovation approaches (Agnew & Duffy, 2010). Apart from these, two special programs were included in the search results. One is a suicide prevention training for frontline workers in a community hospice setting (Matthieu & Swense, 2014), the other one is a mentoring program for next-generation social workers (Gardner et al., 2015).

5.1.5 Modes of delivery and duration of education programs

There were many differences in the modes of delivery and duration of different education programs. The length of programs ranged from 1 day to five years, a series of learning days spread over a period of time throughout the project. Short term programs were around 60 minutes of scenarios role-play (Hamilton et al., 2014) and

90 of minutes teaching sessions in two or three times about the same or different topics. Long term programs were around four academic years for undergraduate and postgraduate students. There also had some three-day or eight-day workshops over a few weeks for participants (Chow, 2013). As for the modes of delivery, LEARN model include listening, explaining, acknowledging, recommending, and negotiating were used to deliver the courses (Doorenbos et al., 2010). Except the typical classroom-based education and training courses, three programs combined distance or web-based learning with traditional method (Pahor & Rasmussen, 2009; Doorenbos et al., 2010; Head et al., 2016), one program had a follow-up reunion conference (Otis-Green et al., 2009) and another one had eight seminars over the academic year (Forrest & Derrick, 2010). There also had support groups, research colloquium, field placement visits, and practice integrate with teaching sessions.

5.1.6 Teaching and learning strategies

How to design class sessions and teaching and learning strategies is vital to the efficiency and effectiveness of learning outcomes. In these papers, the teaching methods used both innovative and traditional educational modality that can be classified into three parts: classroom-based strategies, computer-based strategies, and practice-based strategies.

Table 2. Teaching and learning strategies
Classroom-based learning strategies[1,2,4,5,6,7,8,9,10,11,12,13,14,15,17,18] lecture or course, didactic instruction, role play, literature, case studies, problem-based learning, participant scenarios, sharing stories, drawing, presentation, hands-on activities, referral cards, mentoring, critical reflective writing, interactive discussion, panel discussion, workshop, interactive small group work, interdisciplinary teamwork, seminar, meeting or conference, interdisciplinary case management experience (Face-to-Face), question and answer period, and a behavioral rehearsal component test.
Practice-based strategies[1,5,11,13,16,18] on-site employee education, experiential exercises, field placements supervision and experiences, clinical rotation, one-to-one mentorship, and interprofessional teaching and

learning in practice.
IT-supported strategies[1,3,4,7,12,14,15,16,17] Audio-visual materials, including video vignettes and clips, slides, music, DVD excerpts of patients' narratives, live facilitated interviews, case studies include photos and audio recording, visual simulation and observation, didactic online modules, and in-person film/discussion format.

5.1.7 Contents of programs

The 18 papers all reported the specific contents of palliative and end-of-life care program with actual titles of courses. After removing repeated terms and synthesis all of contents in these papers, the contents included in these programs were presented in Appendix A. The following specific contents of palliative and end-of-life care were those that often mentioned in these studies: palliative and end-of-life care knowledge; death and dying and grief, loss and bereavement, this related to reduce personal death anxiety, distress and enhance emotional competency (Chow, 2013); Ethical, cultural, legal and spiritual perspective; interprofessional team cooperation; communication skills; pain and symptom management; cultural competency include cultural diversity, cultural awareness, cultural sensitivity, and cultural competency (Doorenbos et al., 2010). Overall contents of each curriculum were included in the extraction table of studies (Table 3)

Table 3. Synthesis of curriculum content
· Palliative and end-of-life care knowledge [1,3,14,16] · Oncology[13,16] · Death and dying[2,14] · Grief, loss & bereavement[2,6,9,10,13,14] · Reduce death anxiety distress[6,8,18] · Sigh of moral distress[7] · Family support & care[10,15,17] · family dynamics[9] · Quality end-of-life care[7] · Value-based training[1] · Futile treatment & Clinical experience[5,16]

- advance care planning[5]
- Ethical, legal, cultural, physical, psychological, and spiritual issues[9,10,11,13]
- Advocacy[1]
- Pain and symptom management skills [1,9,10,13]
- Leadership[1,13]
- Team collaboration &Team boundaries[1,2,5,9,10,11,13,15,16,17,18]
- Group support process[6]
- Cultural competency[2,4,6,9,10,11]
- Personal identity competencies[5]
- Communicate skills[3,5,7,11,15,16,17,18]
- Breaking bad news and information[3,15]
- Emotional competency[8,13]
- principles of self-care[6]
- ICU issues[7]
- Practice standards and expectation[10]
- role responsibilities[10]
- suicide detection[12]
- Question, Persuade, Refer (QPR) training[12]
- "Evidence-Based and Promising Practice" Risk assessment[12]
- evidence-informed interventions[13]
- self-reflective behavior[18]

5.2 Synthesis of the evaluation

This part based on the evaluation of selected papers to answer the second and third research question: What are the learning outcomes of these education and training program overall? Which aspects of education and training contents should pay more attention to the future design of education programs? And what ways can improve the education and training programs? The third research questions also can be found in the next chapter in implication of this studies.

5.2.1 Evaluation methods

Knowing the research methods in the studies is helpful to evaluate the practicality and validity of the teaching methods in terms of positive and negative areas that are contributing to promoting future education programs. The evaluation methods were different in each paper by using qualitative and quantitative methods; some papers used both of them to evaluate and analyze the feedbacks. Questionnaire and interview were two conventional used methods. 14 papers used questionnaires to collect rating scales and demographic data, four of them used 4-point Likert-type scale or 5-point Likert-type scale questionnaires (Agnew & Duffy, 2010; Matthieu & Swense, 2014; Prelock et al., 2017; Neuderth et al., 2019). The others were used self-administered questionnaires. There were 12 papers used qualitative methods to evaluate the programs through interviews, open-ended questions, focus groups, and telephone interviews. Among these papers, the use of repeated-measures like 'pretest-posttest' was popular to assess the course evaluations and learning outcomes of participants. Three studies used follow-up evaluation methods ranging from 1 months to 1 year after the end of programs by using telephone interview or questionnaires (Head et al, 2016; Bunting & Cagle, 2016; Matthieu & Swense, 2014; Head et al., 2014; Chow, 2013; Supiano& Vaughn-Cole, 2011; Agnew & Duffy, 2010; Forrest & Derrick, 2010; Otis-Green et al., 2009).

Many studies evaluate the learning content, process, outcomes, and logistical considerations after role-playing session, video, discussion, documentary depicting, or responding to scenarios (Neuderth et al., 2019; Prelock et al., 2017; Head et al., 2014). It is noteworthy that Head et al. (2014 & 2016) noted three validated instruments to evaluate the learning outcomings: 'The End-of-Life Professional Caregiver Survey (EPCS); The Self-Efficacy for Interprofessional Experiential Learning Scale (SEIEL); and Interdisciplinary palliative care knowledge survey (IPCKS)'. EPCS is a 28-item survey supported by Yale University School of Nursing and used to evaluate the specific educational needs of palliative care. SEIEL is a 16-item scale developed in Canada to evaluate student's self-efficacy and perceptions in interprofessional teamwork. IPCKS is a pre- and post-test instrument to evaluate the outcomes at the last two semesters of the project.

5.2.2 The evaluation of teaching methods

In all of these papers, participants reflected that they prefer real experienced teaching methods. Students commented the experiential learning such as interdisciplinary case simulation exercises and role plays were significant for them to know the actual clinical settings. And they also mentioned that they prefer out-of-class learning, taking elective courses outside their discipline department. But some students reported they have less opportunity to apply the skills into clinical settings (Forrest & Derrick, 2010). One-third of attendees considered the behavioral practice and role play was worthful and provided an opportunity to try the new skills (Matthieu & Swense, 2014). Hamilton et al. (2014) also mentioned the scene to scene method was very useful and easier to replicate, especially by using remote methods (phone and second life). Comparing to in-person role plays, participants felt anxiety and embarrassment while performing, remote methods like phone and computer can be more familiar, realistic and unthreatening to use. Turner et al. (2015) noted that participants would like to have more real experience materials such as "storytelling" as teaching methods about palliative care (Turner et al., 2015). From the students' feedback revealed that the actual hands-on experiences teaching methods, such as clinical rotations and interprofessional collaboration practice rather than lectures and course content, this face-to-face interactive learning methods can let students focused and engaged effectively (Head et al., 2016).

In addition, the writing assignment and small group sharing were highly commented by students, as well as the reflection feedback from faculty. Both medical students and social work students emphasize the efficiency of realistic setting and case-scenarios, which combined the practice with knowledge and connected different professionals. However, the online didactic modules were reported as useless and waste too much time to complete with many redundancies (Head et al., 2016). According to Neuderth et al. (2019), students were satisfied with the repeated role-plays and write a reflection work on one of the cases; these methods can subjectively and steadily promote communication skills, competency, and learning curve effects. But the compulsory attendance was also criticized by participants and social work students want more cases to guide their consultations (Neuderth et al., 2019).

Participants also emphasized innovative teaching methods: The interprofessional course was considered as useful and enjoyable. A well-structured curriculum is helpful for students to practice and meet the needs of patients and their family members. However, the heavy course loads and time-consuming online discussions hindered the participation rate for students in other faculty in both countries (Pahor & Rasmussen, 2009). The web-based design training provided an innovative approach to deal with the time and cost-efficient problems in cross-cultural communication education. Participants reported that they want more examples of communication errors and how to deal with these errors when communicating with patients and families from other countries (Doorenbos et al., 2010). Pictures, audios, and feedbacks can avoid boring during the presentation, and the use of bullet point can make the presentation easier to read, but text boxes could be deleted because they are not helpful (Doorenbos et al., 2010). Similarly, according to the feedback in Agnew and Duffy's survey (2010), DVD was regarded as an effective and useful teaching material to provide meaningful user involvement, but these digital technologies should combine with practice and real life rather than using it in isolation. Head et al. (2014) reported the feedback of the format of the curriculum from student evaluation and focus groups: Online didactic modules were too long with too many contents in medical knowledge and information for social work students. Three face-to-face activities in three different days were burdensome for students, and students felt disappointed when faculty did not write feedback to their reflective writing exercise. Curricula should balance both content and structure and avoid overlap to create a more efficient and sustainable curriculum (Head et al., 2014). Prelock et al. (2017) also mentioned that participants were appreciated innovative teaching methods rather than traditional classroom courses and unidisciplinary clinical experiences. After-class discussion can provide students opportunities to consider how best to deal with the death of a client as a professional. In addition, participants highlighted the advantage of transdisciplinary collaboration by using small-group interaction and participant networking (Otis-Green et., 2009). Also, considering financial support, the change of physical space, lunch, and refreshments providing, and provide more serials of workshops would increase the opportunities for staffs to take part in the program (Gordon et al., 2012)

5.2.3 The evaluation of learning outcomes

In all of these papers, there was a greater variety of educational preparedness. The learning outcomes of these studies show the improvement of participants' ability in education curricula and clinical training program of palliative and end-of-life care. Although different papers used different teaching and learning strategies and evaluation methods, the results were consistent. Participants at all levels show positive results, no matter what they were taught or evaluated. The most common learning outcomes were the knowledge of end-of-life care; attitudes towards death and dying; professional confidence and competency; and communication skills that promote participants' personal development and career growth.

5.2.3.1 Interprofessional education

There were nine papers focused on interprofessional education, almost all of them received high satisfaction from participants. The similarities of the learning outcomes were increasing the confidence, self-efficacy, advocacy, communication, and leadership competency to work in a team. And improved the interdisciplinary team collaboration, problem-solving and dealing with conflicts and ethical dilemmas.

Otis-Green et al. (2009) reported a transdisciplinary palliative care education named Advocating for Clinical Excellence (ACE Project). Participants were asked to rate their proficiency on 32 palliative care competencies; most people felt they were good at family care, team collaboration, decision-making at end-of-life, and bereavement education and support. But they feel shortage in the competencies of communication, combine research with practice, psychosocial pain assessment, basic knowledge of pain and symptom management, and advocacy at the institutional level. Participants responded the interprofessional program met their objectives and they rated high satisfaction about the course and syllabus. The three types of course contents include value-based training, palliative care knowledge, and advocacy were most meaningful to represent the useful topics include personal growth, goal refinement, ethical issues, and team collaboration. This program increased their confidence and had a positive effect on leadership and interprofessional palliative care skills and the increase of confidence especially the leadership and palliative care skills. The follow-up reflections showed participants' achievement and development from this effectiveness and meaningfulness project (Otis-Green et al., 2009).

Pahor and Rasmussen (2009) reviewed an international and interprofessional program between Sweden and Slovenian. Result found that context-dependent is vital to develop and implement the course, different educational system and learning experiences would influence the attitude towards the course. For example, the educational system in Slovenian is more rigid, so that they were more positive to the course than Swedish participants, and the students in Slovenia were interested in innovative classes. Students commented teamwork as the most important content that benefit know other professions and others' competencies. Students could find an opportunity to express themselves and exchange opinions, and they also could work and solve conflicts together. However, this program lacked initiative and evidence-based knowledge about dying and grief that posted a challenge for the education. In addition, Pahor and Rasmussen emphasized the cultural influences in this interprofessional program. National boundaries and cultural difference let students aware the relationships between culture and experiences. Sensitive competency relates to cultural diversity and cultural norms, values, expectations, and religious beliefs need to pay more attention in this multicultural world.

The interprofessional program surveyed by Forrest & Derrick (2010) used pre- and post-test to evaluate the learning process. It reported that the evaluation of the level of satisfaction with the program reached a high level. Most of the participants considered this program met their expectations and should continue. This program impact students' future career plans that some of them planned to find a job in palliative and end-of-life care. And this program influenced their job performance and they learned how to bring interprofessional skills more effectively into their work. This interprofessional programs also helped students prepare for working with dying patients and increased the levels of knowledge competencies. Identifying clear professional boundaries in terms of responsibilities and personal beliefs and enhancing professional competency and interdisciplinary ethical strategies. The interprofessional program in ICU settings researched by Gordon et al. (2012) also got a high satisfaction rating, 92% of participants agreed or strongly agreed the program enhance their ability on end-of-life care in ICU, and 96% of participants responded that they would use these techniques and strategies into work. Staffs considered the useful contents were: the knowledge of end-of-life care, listen and learn from other professions; recognize signs of moral distress, and communication skills (Gordon et al., 2012). Another program reported by Supiano & Berry (2013) showed the learning outcomes included the acquisition of palliative and end-of-life care knowledge and skills, understanding the value of role-blending, and scope of practice. The learning also increased social workers' confidence, self-representation and competency to work in a team and enhanced the development of high-quality care for dying patients and families. Head et al. (2016) reviewed an interdisciplinary curriculum about team-based palliative care in oncology. This experiential interdisciplinary palliative and oncology care curriculum had significant improvement in teaching palliative care knowledge and skills, raising the comfort level, self-efficacy, and confidence of palliative care skills and interdisciplinary learning, and influencing their attitudes and abilities on team-based palliative care practices in oncology. To successfully integrate palliative care and interdisciplinary practices into cancer treatment, health students must participate in these programs as part of their clinical practice preparation.

When different dominant and subordinate professions come and work together in a multi-professional team, the challenges derive from different professional cultures, values, attributes, and beliefs. Also, hierarchies and various professional status post barriers in work task allocation and problem-solving (Sjöström, 2013). Overlapping roles, misunderstanding, and unclear responsibilities demonstrated that interprofessional collaboration and interaction are important in palliative and end-of-life settings for social workers to clarify their roles, responsibilities and self-identify. Interprofessional education is the main component in palliative and end-of-life education include team collaboration, communication, and leadership competencies. It prepares participants to know how to work in a team and how to provide quality client-centered care with other professionals (Head et al., 2014). It is important for social workers to equip with the interprofessional competency to improve their ongoing development and career growth. According to the current education programs, interprofessional education and training is the most widely used type of programs compare to other special end-of-life education programs. The interprofessional programs are offered to different disciplinary practitioners from social work, nurse, medicine, spiritual care, occupational therapy, psychology, physiotherapy, clergy, counselor, pastoral care, genetic counseling, pharmacy, speech-language pathology, physical therapy, to nutrition. But in some interprofessional programs, social workers only accounted for a small part of attendances, nurses and physicians tended to be dominated. These programs aim to reduce the feeling of isolation, increase understanding of other disciplinary, build interprofessional relationships in the team, and improve participants' professional competency to provide quality services to clients. Compared to the single education models of death and grief, the content of interprofessional education programs also contain death, grief and bereavement knowledge and the definition of palliative and end-of-life care, but it emphasizes the team collaboration and the content of pain and symptom management, family dynamics, and professional competencies such as leadership, advocacy, and communication.

Participants highly commented on these interprofessional programs that meet their expectations. According to Sjöström (2013) and Bolin (2011): "professional' s self-identity is important to interprofessional interaction, with team-related identity moderating the effects evolving from the interaction between diverse professions in healthcare teams." These programs help participants identify professional boundaries and understand the value of role-blending. Participants learned how to bring interprofessional skills into work and enhanced their professional and leadership competency. The development of professional identity contributes to strengthen the effectiveness of the work performance in interprofessional team and promote their confidence, self-representation and self-efficacy. Furthermore, as Abbott (1988) noted that professionals also regard as performers of cultural work to legitimate cultural values and knowledge in daily practice. Therefore, cultural awareness and sensitivity competency were required by social workers (Pahor & Rasmussen, 2009). However, cultural education still needs to pay more attention, and various challenges such as recruiting participants and selecting a cohesive and balanced education model were controversial issues in these interprofessional programs. Interprofessional education needs to be reinforced by practice experience and greater involvement of different disciplinary participants to promote curriculum development and delivery, and the participants should understand other disciplines, learn ‘with’, ‘from’ and ‘about’ each other to promote inter-unit initiatives in a team (Gordon et al., 2012).

5.2.3.2 Communication education

According to Prelock et al. (2017), an augmentative communication class and self-reflection assignment were provided in the interprofessional education (IPE) and Interprofessional practice (IPP). It demonstrated that there were few significant differences between disciplines and self-assessments in the interprofessional education training and practice; students highly value this team-based learning; the competency has been increased. Results revealed strong positive agreement among the disciplines regarding the value of the learning opportunities provided during this IPE simulation activity. 92% of students agreed that they should respect unique contribution from other disciplines; cooperate with other professionals to provide better service for clients, communicate with group members effectively about their roles and responsibilities, recognize the limitation in providing care, feel more comfortable to combine expertise and experience to provide care to dying patients. 84% of students agree that the format and discussion time of this speech-language pathology (SLP) training program was well-designed (Prelock et al., 2017). The latest education program reported by Neuderth et al. (2019) showed that the evaluation after each role-playing had a high satisfaction of the standard client training. This program strongly agreed the combination of role-playing with SC method, encouraging students to apply their competencies and to increase their self-efficacy.

The three communication training programs used different teaching approaches with variety contents which were efficient and effective, but there also have some limitations need to modify. According to Doorenbos et al. (2010), many social workers found the Web-based training was helpful and convenient and the interactive format was valuable to use, it was realistic to education, but not for nurses. This program discussed core information about hospice services and focus cultural diversity settings that can improve the communication quality of cross-cultural patients and reduce the disparities in end-of-life care. The concerned about using interpreters in clinical settings and the content of this program could be strengthened for decision making. A few participants thought this program should be more user-friendly and include less medical jargon for social workers (Doorenbos et al., 2010). Hamilton et al. (2014) demonstrated a communication skills laboratory program in three scenes of in-person, second life and phone-role. 85% of participants rated the effectiveness of the program as excellent or very good and it was an excellent opportunity to improve communication skills. The 94% of participants rated that the role-play in the laboratory was very helpful to prepare them to discuss end-of-life decisions with patients and families. There were no significant differences between disciplines for social workers and nurses, but there were significant improvements from different scene to scene. The disparities between in-person and second life and in-person and the phone were significant, but no between second life and phone. Participants reported that using the phone and second life were equally effective, and the feedback from the mentors were constructive and excellent. In addition, one interesting finding was that the participants who rated poorly were those who performed poorly. Bunting and Cagle, (2016) reported a communication training for hospital social workers, the result showed that the training of communication skills in breaking bad news was effective, efficient, and feasible. 67% of participants rated that they were good at breaking bad news, while 34% of the remainders rated as fair, 10% of participants plan to break the bad news to patients. It was low-burden for staffs to participate in, and the effectiveness can be sustained a long-term. They also found a brief, evidence-informed communication training can improve social workers' communication self-efficacy and decrease the fears of death and dying.

End-of-life communication was the most challenging competency for health professionals (Wittenberg-Lyles, Goldsmith, Ferrell, and Burchett, 2014). Communication as the core competency is important for social workers to communicate with other team members and support patients and families. Finding from these current programs support the efficiency and practicality of online communication training in palliative care and suggest that the virtual training methods such as phone and second life role play are more successful and comfortable than in-person communication training (Hamilton et al., 2014). The need to continue communication training is notably founded in the feedback of participants in both special communication programs and other education and training programs. Results from these current communication programs can provide direction for the development of future communication competency training and education. In the included papers it showed that the specific communication training could increase participants' confidence and communication skills, it should focus more on breaking bad news and use more evidence-informed methods such as scene-to-scene role-play to improve social workers' self-efficacy. As communication skill is not only important for social workers but the entire care trams. So, future communication training could be expanded in the interprofessional team to assess the effectiveness and compare outcomes for different professionals. Also, it can be evaluated while intervening with clients before and after the training with clients. Another content required to be added in the future training is to work with interpreters (Doorenbos et al., 2010) and many participants suggest the communication programs should include some knowledge and practice about cultural and religion consideration in order to work with cross-cultural patients.

5.2.3.3 Dying and grief education

As for the end-of-life and bereavement care program. Supiano and Vaughn-Cole (2011) found that the previous experience with grief highly existed in students and the construction of the meaning of loss can relieve this feel and benefit to future development. Students expressed that the emotional guidance provided by teachers or counselors can promote professional and personal growth in caring for suffering persons. Many students highly commented on this educational experience that enhancing their ability for compassionate care and understanding grief and loss knowledge. The group work experience and clinical rotation also highly valued by students that benefited to their preparation sessions. The emotional competency program researched by Chow (2013) reported three content relating to death anxiety: the past-related regrets, the future-related regrets and meaningfulness, and death anxiety can influence the level of comfort and competency. The feedback showed that this program was effective, and it increased the emotional competency and comfort level of working with dying patients and bereaved and reduce the death anxiety and fear. There had an unexpected result that the awareness of regrets increased and the future-related regrets were reduced after the reflective exercises. Another study about palliative care resources concluded six themes: ‘emotional demands, sensitivity and flexibility among educators, developing social work perspective, exploring spirituality and cultural-sensitive practice, protect vulnerable students, and study privately or in class’. There had some improvement after class, but some student participants still felt awkward and discomfort when communicating about death (Turner et al., 2015). Another end-of-life care program reported by Agnew and Duffy (2010) showed that, the program improved students’ confidence, comfort, self-awareness, and the knowledge and skill of palliative and end-of-life care. A majority of students identifies that the incorporation with service users was valuable since it brought theory to practice, and they also highlighted the importance of real experiences and communication skills.

Social workers who work in palliative and end-of-life settings are easily confronted with uncertainties and exceptional emotional challenges with dying and bereaved persons. The knowledge of death and grief theory is fundamental but essential for social workers that changes not only social workers’ attitude and comfort level, but also provides advanced services to dying patients and bereavements in the face of impending death. Death anxiety is common in palliative care social workers. The education and training programs can increase their awareness and prepare them with death anxiety, denial, and views of end-of-life care (Buglass, 2010). According to the current end-of-life and bereavement care education programs, they all aimed to develop a theory-driven training program to increase the knowledge and competency of grief and loss, breaking bad news, enhance participants’ emotional competency (empathy and compassion), comfort level, and attitudes to reduce personal death anxiety and distress. These programs aimed to prepare social workers to become more confidently and compassionately to cope with the sense of loss and grief for dying people and their families. The effectiveness of death education revealed that the programs have a positive influence on participants’ attitudes and values towards to death and grief, and the result indicated significant improvement for participants to increase role understanding, confidence in practice, and other personal behaviors. But one needs were identified that social workers should improve cultural awareness of death attitudes to respect and build the trust relationship with clients in practice.

Using materials such as DVD, online materials and real experience storytelling are creative and meaningful to promote users' involvement and it is beneficial to yield positive learning outcomes. Support groups and workshops are helpful for participants to express and share their experience and feelings without imposing that experience as an expectation on others. Participants transformed their roles from observers to participants, they feel more comfortable with respecting and understanding the uniqueness of grief and death and identify their professional and personal identity (Agnew & Duffy, 2010). In addition, the clinical setting and experience bring participants' own loss experiences into the clinical task, reconstruct their feelings of loss and build the empathic connection to suffering clients. The attention to the development of emotional competency in end-of-life training programs can increase the sense of comfort and competency of social workers in working with dying patients and bereaved.

To sum up, the fear of death and avoidance of death have a negative effect on comfort level when social workers working in palliative and end-of-life care. Death, dying, and bereavement-specific education should be discussed openly in the class and it is important to create a non-threatening teaching environment and safe boundaries. Programs should include more contents about the definition of palliative care and end-of-life care, emotional competency, grief and loss, cultural and spiritual considerations, and principles of self-care, in order to prepare social workers to respect diversity among different professionals and clients. And to educate social workers how to work with bereavement and how to deal with grief emotion in terms of personal identity, beliefs, death attitudes, and treatment preferences in end-of-life care education (Reese, Chan, Perry, Wiersgalla, & Schlinger, 2005).

5.2.3.4 Other education types

End-of-life care programs showed the improvement in end-of-life care knowledge and skills and enhanced the emotional competency and comfort level towards death. Another two programs focus on mentoring and suicide prevention education showed that the specific mentoring and training had a positive effect of promoting social workers' professional growth and career development which enhanced participants' competencies, confidence, and self-efficacy in palliative and end-of-life care.

The Zelda Foster Studies Program demonstrated by Gardner et al. (2015) found that the mentors and fellows were highly valued and regarded as an important component of education in the early- and mid-career stage of social work palliative and end-of-life care. This program provided positive support to MSW fellows. The emotional mentoring could reduce anxiety and increase confidence and professional career growth, which was helpful for them to organize and manage the work and strength and identify their leadership and advocacy opportunities. The suicide program demonstrated by Matthieu and Swense (2014) providing on-the-job training to enhance gatekeepers' competencies and confidence and the specific knowledge and skills relate to suicide prevention. Nearly all workers have experienced a potentially suicide person. The suicide prevention training in community hospice settings has a significant effect on participants' self-efficacy. 84% of participants reported the training was valuable, around 75% of participants felt satisfied with the training, and 85% of them thought they would recommend this training.

5.3 Summary

According to the synthesis of this systematic review, it shows that these palliative and end-of-life care programs are well-structured and well-developed in America than other countries. Both students and practitioners have been considered in the education and training programs, but there has a significant inequality in terms of gender and color among the participants. Interprofessional education and training program is the often-used type as well as communication and death and grief programs. Traditional classroom-based methods and materials are commonly used in end-of-life programs, while the innovative teaching methods such as online didactic and real experience methods include role-play and clinical rotation are more effective and accessible by participants. Furthermore, the goal of programs almost intends to improve the knowledge-to-skill-building and enhance participants' attitude, confidence, self-efficacy, and professional competency. Which were realized and highly evaluated in the learning outcomes, and participants reported that these programs were helpful for their career growth and contribute to providing quality services to dying patients and families.

6 Conclusion

The purpose of this study was to better understand and present the current social work education and training programs in palliative and end-of-life care. This section provides a discussion of the findings and a conclusion of the research. Further, the study's limitations and the limitation in selected papers are noted, as well as the implications of future research and development of education and training programs in palliative and end-of-life care.

6.1 Concluding discussion

According to Zelinsky and Thorson (1983), adequate education is important for social workers to equip with advanced practice skills in palliative and end-of-life care and contribute to quality services for dying patients, families, other professionals, institutions and policymakers (CHPCA, n.d.). Relating to the literature, many social workers reported that they have not been well-prepared into practice (Bosma et al., 2010; Sanders, 2004; Csikai & Raymer, 2005). They feel the shortage of end-of-life care knowledge, real experiences in end-of-life care, and competencies such as communication skills (Prelock et al., 2017). According to the synthesis of 18 papers in the latest ten years found that social work educators and trainers widely use interprofessional education and training program. Communication, end-of-life care and bereavement are also the important component in palliative and end-of-life care education. Which meet the education needs of participants to enhance their professional confidence and competency in terms of death and dying and end-of-life care. However, there has a growing demand for cultural related education. Social workers are required to become sensitive and compassion to respect and understand various cultural and religious background. In these selected papers, there were two cultural related programs, but they were combined with interprofessional and communication programs rather than a specific cultural program, one was the cross-cultural communication program included cultural contents in terms of cultural diversity, cultural awareness, cultural sensitivity, and cultural competency (Doorenbos et al., 2010). Another one was the Sweden and Slovenia program: "how does culture show in an international and interprofessional course in palliative care" (Pahor & Rasmussen, 2009)? Other cultural contents were only mentioned as ethical, cultural and spiritual considerations in the courses.

Some interesting areas such as euthanasia and suicide prevention are also needed in palliative and end-of-life education (Bekkema et al., 2014), but they are rarely found in the programs. Only one study in these extracted papers related to suicide, this program made guidelines and policies for suicide risk and prepared social work staffs who work in community hospice settings with the knowledge of suicide prevention (Matthieu & Swense, 2014).

These type of education and training programs are very similar for both students and staffs, but the primary education and practice experiences, as well as well-designed textbooks are more important for students to understand various cases they will meet in the future careers, and to prepare professional attitude, confidence and self-efficacy in terms of palliative and end-of-life care. As mentioned before, social work students in bachelor and master level have reported the lack of education on death, bereavement, loss and trauma, end-of-life care, and medical knowledge (Chow, 2013; Walsh-Burke & Csikai, 2005). While the 11 papers relate to students show that there have many contents include 'the knowledge of palliative and end-of-life care, oncology, death and dying, grief and loss, death anxiety, moral distress, family support and family dynamics, quality end-of-life care, pain and symptom management.' The interprofessional education and training program cooperated with other department students, such as physicals, nurses and clergies, which can improve interprofessional collaboration and leadership competency in a team. But the education contents may include too many medical jargons and only have little related to social work. Which post challenges to interprofessional education that it is hard to establish a cohesive education model and find the optimal balance for all disciplines due to the 'sophistication' of different occupational roles, skills, and settings. Different professions have different goals to address policy issues and service contents (Otis-Green et al., 2009). Working with other disciplines in clinical and face-to-face learning may lead to chaotic curricula, and it was a challenge to choose an adequate and equal number of student representations from different disciplines (Head et al., 2016) and different countries (Pahor & Rasmussen, 2009). Offering extra credit to encourage students to take part in interprofessional education activities also considered as a challenge while recruiting students (Prelock et al., 2017).

As to practitioners, continuous education and specialist mentoring are needed for social workers to stay updated and develop their competency and careers (Weisenfluh & Csikai, 2013). However, the main barriers hinder practitioners in continuous education and training are the shortage of funds, outdated and overloaded curricula, limited experienced professional, and logistic problems such as location, time, and space availability (Head et al., 2014). Therefore, on-the-job training becomes one of the feasible and acceptable ways to provide education and training in the workforce. According to these 18 papers, many innovative teaching methods could use to solve this problem, such as using web-based design training to deal with the time- and cost-efficient issues for participants in different countries and states (Doorenbos et al., 2010). Search financial support, change physical space, provide lunch and refreshments, increase the number of workshops and learning opportunities also can improve the participation rates of staffs (Gordon et al., 2012). But the online didactics need to be well-structured to avoid overlap, time-consuming and burdensome course loads. One challenge relates to online teaching method is that technology and internet would influence the quality of sound and avatars during teaching process (Hamilton et al., 2014) and may not able to use in rural hospice settings (Doorenbos et al., 2010).

Both students and practitioners' professional and personal capacity got improved after education and it could be found in the knowledge and skills of palliative and end-of-life issues to deal with loss and grief for clients, the change of attitude on death anxiety and discomfort, and the skills of communication and advocacy to better work with clients. However, they all demand the use of real experiences in palliative care education. It can be reflected in experiential teaching methods from these selected education programs, such as interdisciplinary case simulation exercises, interprofessional collaboration, role plays, clinical rotation, out-of-class learning, "storytelling", case-scenarios, and writing assignment. These methods can increase the rate of the participant and the efficiency of learning outcomes. However, the process of creating roles, recruiting actors, implementing feedback-trainings (Neuderth et al., 2019), and balancing 'realistic' and 'hopeful' brought unprecedented challenges to educators (Turner et al., 2015). Additionally, Evidence-based education and practice are also needed by practitioners, which can improve social work educational reform in structural and pedagogical changes in the social work curriculum (Jenson & Howard, 2008). There are two levels of evidence-based education, one is to apply comprehensive evidence research and literature into education and associated curricula. The other one is to establish sound evidence if it is lack, uncertain, or questionable. The goal of these two levels is to ensure future education can meet the high-quality criteria on educational activities, processes, and outcomes (Davies, 1999). Evidence-based education and practices can change the way people think about education and educational policy and practice, and it is necessary to assure social workers can provide high-quality palliative care services. It encourages social workers to develop their professional judgments and expertise, and require social work practitioners to implement problem-solving, information retrieval and methodological skills to further social work education and in turn social work practice (Gambrill, 2006; Jenson & Howard, 2008; Teater & Chonody, 2018). This needs can be reflected in some programs such as 'Evidence-Based and Promising Practice' Risk assessment, suicide detection, Question, Persuade, Refer (QPR) training program (Matthieu & Swensen, 2014), developing theory-driven and evidence-based training program to enhance emotional competency ((Chow, 2013), and using evidence-informed communication training to improve communication self-efficacy (Bunting & Cagle, 2016).

In addition, many educators claim that palliative and end-of-life social work education should base on the competency-based curriculum. According to Gervais (2016): "competency-based education is an outcome-based approach to education that incorporates modes of instructional delivery and assessment efforts designed to evaluate mastery of learning by students through their demonstration of the knowledge, attitudes, values, skills, and behaviors required for the degree sought." Competency-based education links theory to practice that clarifies and evaluates professional's roles and activities in the interprofessional care teams to promote the development of practice (Bosma et al., 2010). Sjöström (2013) noted three unique and specialized social work competencies in interprofessional healthcare settings. First one is counseling, which includes social rights counseling and psychosocial counseling to support and guide the clients. Then is case management competency which understands as the case-related efficient and effective systematic management. The third one is clinical skills such as discretionary competency and specific inference competency. Apart from this, as mentioned before, social workers' competencies in the area of palliative and end-life care include: advocacy, care delivery, supervise volunteers, community capacity building, confirmation, evaluation, decision making, education and research, information sharing, self-reflective, self-assessment, cultural competency, team collaboration, family and caregiver distress, loss, grief and bereavement, addressing cultural and ethnical diversity, promoting family conference, and communication skill (Sumer et al., 2015; Kang et al., 2013; Bosma et al., 2010). While in the current education and training programs, the often-mentioned competencies are the knowledge of end-of-life care, grief, loss and bereavement, death and dying attitudes, emotional competency, cultural competency, communication skills, leadership, advocacy, self-efficacy, team collaboration, personal-identity, problem-solving, dealing with conflicts and ethical dilemmas. It could be found that the conversation competency for crisis intervention, solving conflicts, needs assessment, adaption-centered counseling is important for social workers in practice.

6.2 Limitation of this study

This study used systematic review as the research method, since working alone, there might have some bias in the screening and extracting process, the process of coding and sorting also varied due to personal views and ideas. In addition, this study was limited to English language and excluded unpublished papers and grey literature, as well as the limited bibliography databased. Thus, some relevant studies did not meet the inclusion criteria may have been missed, and there may exist bias and limit the generalizability in the results and discussions.

One limitation in these selecting papers is the small sizes of samples, dropout participants and low rated respondents that might cause biases and lack rigorous in sampling and data analysis (Neuderth et al., 2019; Bunting & Cagle, 2016; Turner et al., 2015; Matthieu & Swense, 2014; Chow, 2013; Supiano & Berry, 2013; Doorenbos et al., 2010; Agnew & Duffy, 2010). As well as the inequality of gender and color and the number of recruitments from different disciplines are not equal in the interprofessional education programs. Another common limitation was that many programs did not use long-term and follow up evaluation, and without the comparison or control group to guarantee reliability and validity of data. By using short-term evaluation is hard to know ongoing impact on those participants, and it would be repeated and inefficient if using the same content as pretest (Neuderth et al., 2019; Head et al., 2016; Bunting & Cagle, 2016; Matthieu & Swense, 2014; Agnew & Audrey, 2010). For those programs which did not use pre- and post-test, it is not clear if participants' prior experiences may influence their evaluation result of the curriculum and topics. In addition, some programs only focused on students' subjective statements in terms of satisfaction and development needs but ignored objective gains of competencies (Neuderth et al., 2019) and course materials (Turner et al., 2015). It is difficult to evaluate which program is the most efficient due to these studies use various research methodologies in both qualitative and quantitative approach, and the unequal number of selected papers from different countries is also brought disadvantages to compare and understand different countries' education situation in detail.

6.3Implication of this study

Education plays an important role to promote the development of social workers and change practice environment in palliative and end-of-life care. Based on the findings, it calls for extra attention on competency- and evidence-based education and clinical practice by using real experience teaching methods and updated knowledge and practical techniques to increase the sense of comfort of social workers in working with dying patients and bereavement.

The future design of courses should have a more explicit structure and comprehend multi-disciplinary knowledge and skills to apply knowledge and theories into practice. Future content should base on the needs of participants, dying patients and families, and focus on their everyday challenges. The teaching materials should include the roles and responsibilities of social workers within interprofessional resources and add more content to cultural and traditional therapies. The teaching methods should embrace not only the traditional learning strategies, such as lecture-based training, didactic instruction, but also the interactive and innovative teaching methods, such as online learning resources, hands-on kits, role play, case studies, and clinical rotation to promote the quality learning and the sense of participation. Also, it calls for the need to focus more on social work ethics and values including self-determination and put decision-making in the teaching content. Emotional competency relates to the attitude of death anxiety, stresses, burnout, and compassion fatigue also worth to consider in the future education to help social workers feel more comfortable and improve their job competency. It is important to consider different cultures and religious and the growing needs of cultural related education to equip social workers with cultural sensitivity, cultural awareness and cultural competency.

These findings are a significant milestone to promote the evidence-based, theory-driven, and nonprescriptive palliative and end-of-life care training. Synthesizing these education and training programs and effectiveness studies shed light on the current education for social workers, and it also highlights an international need for specific education in palliative and end-of-life area. There still have many countries without special end-of-life care education in the under- or post-graduate level or continue education. It hoped that the gaps in the education could be identified, scrutinized and addressed in the future programs and the policies and laws in health care education could be developed, in order to promote social workers to fit in the real practice. Only then can we improve the quality of care for patients and caregivers in the future end-of-life care areas.

As for the implication to the future studies, control groups and randomization of assignment with a larger sample in pre- and post-test trial design could be used to improve rigors, reliability and validity, and it is better to include a long-term and follow-up test to evaluate the learning outcomes and effects. The effect of learning materials and tools also needs to be measured more accurately. Furthermore, future studies should listen to service users' voice, so that it can evaluate the intervention outcomes, and the training changes relate to clients and clinical practice, as well as the costs of care before and after the training.

6.4 Conclusion

When people are facing end-of-life care situations as a time of great vulnerability, it is important for social workers to provide psychosocial and crisis intervention for dying patients and their families to receive the truth and prepare for death. It is crucial for social workers to identify and outline their roles and competency. This important task can only be fulfilled after receiving sufficient education and training preparation to equip social workers with professional confidence and competency. This study used the systematic review to review and synthesize different education curriculum's goals, contents and feedbacks to highlight the current education programs' weakness and areas for improvement, which is significant for the future social work education and practice in the field of palliative and end-of-life care. Future research and knowledge will hopefully expand on current findings and it should focus more on cultural competency and use the pre- and post-test to evaluate which course is the most efficiency and beneficial to use in palliative care education.

Papers included in the systematic review

1. Pahor, M., & Rasmussen, B. (2009). How does culture show? A case study of an international and interprofessional course in palliative care. *Journal of Interprofessional Care, 23*(5), 474-485.

2. Otis-Green, S., Ferrell, B., Spolum, M., Uman, G., Mullan, P., Baird, R., & Grant, P. (2009). An overview of the ACE project—Advocating for Clinical Excellence: Transdisciplinary palliative care education. *Journal of Cancer Education, 24*(2), 120-126.

3. Agnew, A., & Duffy, J. (2010). Innovative Approaches to Involving Service Users in Palliative Care Social Work Education. *Social Work Education, 29*(7), 744-759.

4. Doorenbos, A., Lindhorst, T., Schim, S., Van Schaik, E., Demiris, G., Wechkin, H., & Curtis, J. (2010). Development of a Web-Based Educational Intervention to Improve Cross-Cultural Communication Among Hospice Providers. *Journal of Social Work in End-Of-Life & Palliative Care, 6*(3-4), 236-255.

5. Forrest, C., & Derrick, C. (2010). Interdisciplinary Education in End-of-Life Care: Creating New Opportunities for Social Work, Nursing, and Clinical Pastoral Education Students. *Journal of Social Work in End-of-Life & Palliative Care*, 6(1–2), 91–116. http://dx.doi.org.ezproxy.ub.gu.se/10.1080/15524256.2010.489224

6. Supiano, K.P., & Vaughn-Cole, B. (2011). The impact of personal loss on the experience of health professions: Graduate students in end-of-life and bereavement care. *Death Studies,* 35(1), 73–89. https://doi.org/10.1080/07481187.2010.507321

7. Gordon, E., Ridley, B., Boston, J., & Dahl, E. (2012). The building bridges initiative: learning with, from and about to create an interprofessional end-of-life program. *Dynamics (Pembroke, Ont.)*, 23(4), 37–41. Retrieved from Scopus.

8. Chow, A. (2013). Developing Emotional Competency of Social Workers of End-of-Life and Bereavement Care. *British Journal of Social Work,* 43(2), 373-393.

9. Supiano, Katherine P., & Berry, P. H. (2013). Developing Interdisciplinary Skills and Professional Confidence in Palliative Care Social Work Students. *Journal of Social Work Education;* Washington, 49(3), 387–396. http://dx.doi.org.ezproxy.ub.gu.se/10.1080/10437797.2013.796851

10. Hamilton, G., Ortega, R., Hochstetler, V., Pierson, K., Lin, P., & Lowes, S. (2014). Teaching communication skills to hospice teams: Comparing the effectiveness of a communication skills laboratory with in-person, second life, and phone role-playing. *American Journal of Hospice and Palliative Medicine,* 31(6), 611–618. https://doi.org/10.1177/1049909113504481

11. Head, B. A., Schapmire, T., Hermann, C., Earnshaw, L., Faul, A., Jones, C., … Pfeifer, M. (2014). The Interdisciplinary Curriculum for Oncology Palliative Care Education (iCOPE): meeting the challenge of interprofessional education. *Journal of Palliative Medicine,* 17(10), 1107–1114. https://doi.org/10.1089/jpm.2014.0070

12. Matthieu, M. M., & Swensen, A. B. (2014). Suicide Prevention Training Program for Gatekeepers Working in Community Hospice Settings. *Journal of Social Work in End-of-Life & Palliative Care,* 10(1), 95–105. http://dx.doi.org.ezproxy.ub.gu.se/10.1080/15524256.2013.877865

13. Gardner, D. S., Gerbino, S., Walls, J. W., Chachkes, E., & Doherty, M. J. (2015). Mentoring the Next Generation of Social Workers in Palliative and End-of-Life Care: The Zelda Foster Studies Program. *Journal of Social Work in End-of-Life*

and Palliative Care, 11(2), 107–131. https://doi.org/10.1080/15524256.2015.1074142

14. Turner, L., Kuyini, A. B., Agustine, S. S., & Hunter, S. (2015). Social Work Student Views on Palliative Care Learning Resources. *Australian Social Work,* 68(2), 259–270. https://doi.org/10.1080/0312407X.2014.995683

15. Bunting, M., & Cagle, J. G. (2016). Impact of brief communication training among hospital social workers. *Social Work in Health Care*; New York, 55(10), 794–805. http://dx.doi.org.ezproxy.ub.gu.se/10.1080/00981389.2016.1231743

16. Head, B., Schapmire, A., Earnshaw, T., Faul, L., Hermann, A., Jones, C., . . . Pfeiffer, F. (2016). Evaluation of an Interdisciplinary Curriculum Teaching Team-Based Palliative Care Integration in Oncology. *Journal of Cancer Education,31*(2), 358-365.

17. Prelock, P. A., Melvin, C., Lemieux, N., Melekis, K., Velleman, S., & Favro, M. A. (2017). One Team-Patient, Family, and Health Care Providers: An Interprofessional Education Activity Providing Collaborative and Palliative Care. *Seminars in Speech and Language*, 38(5), 350–359. https://doi.org/10.1055/s-0037-1607071

18. Neuderth, S., Lukasczik, M., Thierolf, A., Wolf, H.-D., van Oorschot, B., König, S., … Henking, T. (2019). Use of standardized client simulations in an interprofessional teaching concept for social work and medical students: first results of a pilot study. *Social Work Education,* 38(1), 75–88. https://doi.org/10.1080/02615479.2018.1524455

Reference

Abbott, A (1988). *The System of Professions – An Essay on the Division of Expert Labour.* Chicago: The University of Chicago Press.

Abu-Saad, H. (2001). Evidence-based palliative care: Across the life span. Oxford: Blackwell Science.

Aiken, L. R. (2001). *Dying, death, and bereavement. Hillsdale,* NJ: Lawrence Erlbaum.

Altilio, T., & Otis-Green, S. (2011). *Oxford textbook of palliative social work*. New York: Oxford University Press. Available at:http://public.eblib.com/choice/publicfullrecord.aspx?p=679392 [Accessed 2019/02/27]

Alvarez, E. (2007). *Palliative Care in Multicultural Communities: A Phenomenological Study Exploring the Lived Experiences of Nursing Staff,* ProQuest Dissertations and Theses.

Association for Medical Social Workers in Palliative Care (SiP). (2013). Quality Assurance Criteria for Medical Social Workers in Palliative Care. Available at: https://fsip.se/fsipdoc/Quality%20Criteria%20in%20Palliative%20Care.pdf [Accessed 2019/04/24]

Association of Palliative Care Social Workers (APCSW). (2016). *The role of social workers in palliative, end of life and bereavement care.* [Report]. Available at: http://www.apcsw.org.uk/resources/social-work-role-eol.pdf [2019/01/29]

Baur, N. (2018, February 26). A new world map of palliative care development. Available at: http://endoflifestudies.academicblogs.co.uk/a-new-world-map-of-palliative-care-development/ [Accessed 2019/02/07]

Becker, E. (1973). *The denial of death*. New York, NY, US: Free Press.

Bekkema, N., de Veer, A. J. E., Albers, G., Hertogh, C. M. P. M., Onwuteaka-Philipsen, B. D., & Francke, A. L. (2014). Training needs of nurses and social workers in the end-of-life care for people with intellectual disabilities: A national survey. *Nurse Education Today*, *34*(4), 494–500. https://doi.org/10.1016/j.nedt.2013.07.018

Berkman, C., & Stein, G. (2018). *Palliative and end-of-life care in the masters of social work curriculum*. *16*(2), 180-188.

Bern-Klug, M., Gessert, C, & Forbes, S. (2001). The need to revise assumptions about the end of life: Implications for social work practice. *Health and Social Work*, 26,38-48.

Bern-Klug, M. (Ed.). (2010). *Transforming palliative care in nursing homes: the* *social work role*. New York: Columbia University Press.

Birkenmaier, J., Dewees, M., Berg-Weger, M. and Dewees, M. (2014). *The practice of generalist social work*. 3rd ed. New York: Routledge, pp.205-207, 300, 303-304, 383.

Blacker, S. (2004). Palliative care & social work. In J. Berzoff, & P. R. Silverman (Eds.), *Living with dying (pp. 409–423)*. New York: Columbia University Press Blacker, S., Head, B. A., Jones, B. L., Remke, S. S., & Supiano, K. (2016). Advancing Hospice and Palliative Care Social Work Leadership in Interprofessional Education and Practice. *Journal of Social Work in End-of-Life and Palliative Care*, *12*(4), 316–330. https://doi.org/10.1080/15524256.2016.1247771

Boland, A., Cherry, M., & Dickson, R. (2017). *Doing a systematic review: A student's guide (2nd ed.).*

Bolin, A. (2011) *Shifting Subordination: Co-located interprofessional collaboration between teachers and social workers*. Gothenburg: Gothenburg University. PHD

Bor, R., Miller, R., Goldman, E., & Scher, I. (1993). The meaning of bad news in HIV disease: Counselling about dreaded issues revisited. *Counselling Psychology Quarterly, 6*(1), 69-80.

Bosma, H., Johnston, M., Cadell, S., Wainwright, W., Abernethy, N., Feron, A., … Nelson, F. (2010). Creating social work competencies for practice in hospice palliative care. *Palliative Medicine; London*, *24*(1), 79–87.

Bowlby, J. (1961). Processes of mourning. International journal of psychoanalysis. 1961; 42:317-39.

Brandsen, C. (2005). Social work and end-of-life care: Reviewing the past and moving forward. *Journal of Social Work in End-of-Life & Palliative Care,* 1(2), 45-70

Brennan, F. (2007). Palliative Care as an International Human Right. *Journal of Pain and Symptom Management, 33*(5), 494-499.

Brennan, F. (2014). Dignity: A unifying concept for Palliative Care and human rights. *Progress in Palliative Care, 22*(2), 88-96.

Brighton, Koffman, Hawkins, Mcdonald, O'Brien, Robinson, . . . Selman. (2017). A Systematic Review of End-of-Life Care Communication Skills Training for Generalist Palliative Care Providers: Research Quality and Reporting

Guidance. *Journal of Pain and Symptom Management, 54*(3), 417-425.

Broom, M. S. (August 30, 2004). "Milestones". TIME. Available at: http://content.time.com/time/magazine/article/0,9171,689491,00.html[Accessed 2019/03/06]

Broome M.E. (1993) Integrative literature reviews for the development of concepts. In *Concept Development in Nursing*, 2nd edn (Rodgers B.L. & Knafl K.A., eds), W.B. Saunders Co., Philadelphia, PA, pp. 231–250.

Bruce, E. J., & Schultz, C. L. (2001). *Nonfinite loss and grief: A psychoeducational approach*. Baltimore: Brookes.

Buglass, E. (2010) Grief and bereavement theories. *Nursing Standard*. 24, 41, 44-47.

Bunting, M., & Cagle, J. G. (2016). Impact of brief communication training among hospital social workers. *Social Work in Health Care; New York*, *55*(10), 794–805. http://dx.doi.org.ezproxy.ub.gu.se/10.1080/00981389.2016.1231743

Cagle, J. G., & Williams, K. (2016). Communication education for social workers. In E. Wittenberg-Lyles, B. Ferrell, J. Goldsmith, T. Smith, S. Ragan, M. Glajchen, & G. Handzo (Eds.), *Textbook of palliative care communication.* New York, NY: Oxford University Press.

Canadian Hospice Palliative Care Association (CHPCA). (n.d.). Social Work Competencies on Palliative Education – SCOPE. Available at: http://www.chpca.net/projects-and-advocacy/projects/scope.aspx [Accessed 2019/03/03]

Carr, M., & Merriman, M. P. (1995-96). Comparison of death attitudes among hospice workers and health care professionals in other settings. Omega. 32. 287-301.

Chochinov, H. (2000). Address to Standing Committee on Social Affairs, Science and Technology. Quality end-of-life care: The rights of every Canadian. Final report of the subcommittee to update of life and death. Ottawa, ON: Senate of Canada, 2000. Available at: https://sencanada.ca/content/sen/committee/362/upda/rep/repfinjun00part1-e.htm [Accessed 2019/03/05]

Chochinov, H. (2006). Dying, Dignity, and New Horizons in Palliative End‐of‐Life Care1. *CA: A Cancer Journal for Clinicians,56*(2), 84-103.

Chow, A. (2013). Developing Emotional Competency of Social Workers of End-of-Life and Bereavement Care. *British Journal of Social Work, 43*(2), 373-393.

Christ, G., & Sormanti, M. (2000). Advancing Social Work Practice in End-of-Life Care. *Social Work in Health Care, 30*(2), 81-99.

Clark, P. G. (1997). Values in health care professional socialization: Implications for geriatric education in interdisciplinary teamwork. *The Gerontologist* 37. 441-451.

Cohen, Iris (2002) *Early professional socialization: Evaluation of multidisciplinary palliative care education for social work and medical students (UMI No. 3043281).* Dissertation Abstracts International, 63 (02). pp. 1-754.

Connor, S. R., Sepulveda Bermedo, M. C. (2014). *Global atlas of palliative care at the end of life*. Available at: http://www.thewhpca.org/resources/global-atlas-on-end-of-life-care [Accessed 2019/02/07]

Committee on Economic, Social and Cultural Rights (CESCR) (2000, August 11). General comment no.14: The Right to the Highest Attainable Standard of Health (Art. 12). Twenty-second session. Geneva. Available at: https://www.refworld.org/pdfid/4538838d0.pdf [Accessed 2019/03/04]

Committee on Economic, Social and Cultural Rights (CESCR). (2000, August 11). General Comment 14, para. 25. Available at: https://www.refworld.org/pdfid/4538838d0.pdf [Accessed 2019/04/25]

Committee on Economic, Social and Cultural Rights (CESCR). (2000, August 11). General Comment 14, para. 12. Available at: https://www.refworld.org/pdfid/4538838d0.pdf [Accessed 2019/04/25]

Corr, C. A. (1993). Coping with dying: lessons that we should and should not learn from the work of Elisabeth Kübler-Ross. *Death Studies.* 17, 1, 69-83

Corr, C. A., Corr, D. M., & Bordere, T. C. (2013). *Death & dying, life & living* (7th ed). Belmont, CA: Wadsworth, Cengage Learning.

Council of Europe. (2003, November 12). Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organisation of palliative care Available at: https://www.coe.int/t/dg3/health/Source/Rec(2003)24_en.pdf [Accessed 2019/03/04].

Council on Social Work Education (CSWE). (2001). Educational policy and accreditation standards. Alexandria, VA: Author.

Council on Social Work Education (CSWE). (2004). Educational policy and accreditation standards. Alexandria, VA: Author

Council on Social Work Education (CSWE). (2008). Educational policy and accreditation standards. Alexandria, VA: Author

Council on Social Work Education (CSWE). (2015). 2015 Educational policy and accreditation standards for baccalaureate and master's social work programs. Available at: https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx [Accessed 2019/03/19]Csikai, E. L., & Raymer, M. (2004a). Evaluation of a Social Work Continuing Education Curriculum in End-of-the-Life Care. *Professional Development: The International Journal of Continuing Social Work.* Vol. 7 No. 2.

Csikai, E. L., & Raymer, M. (2004b). An assessment of social workers' educational needs in end-of-life care. Unpublished manuscript.

Csikai, E. L., & Raymer, M. (2005) Social Workers' Educational Needs in End-of-Life Care, *Social Work in Health Care,* 41:1, 53-72, DOI: 10.1300/J010v41n01_04

Damaskos, P., & Gardner, D. S. (2015). Cultivating a Culture of Mentorship in Palliative Social Work. *Journal of Social Work in End-of-Life and Palliative Care*, *11*(2), 101–106. https://doi.org/10.1080/15524256.2015.1074138Field, M & Cassel C. K. (1997). Approaching death: improving care at the end of life. *Washington, DC: National Academy Press; 1997.*

Dane, B. O., & Miller, S. 0. (1990). AIDS and dying: The teaching challenge. *Journal of Teaching in Social Work,* 4,85-100.

Davies, P. (1999). What is Evidence-based Education? *British Journal of Educational Studies, 47*(2), 108-121.

Drisko, J., & Grady, M. (2012). *Evidence-Based Practice in Clinical Social Work* (Essential Clinical Social Work Series). Boston, MA: Springer US.

Duffy, F. M. (2017). *Reimagining Instructional Supervision: Supervising Knowledge Work*. Rowman & Littlefield.

Evetts, J. (2003). The Sociological Analysis of Professionalism: Occupational Change in the Modern World. *International Sociology, 18*(2), 395-415.

Evetts, J., Muzio, D., & Kirkpatrick, I. (2011). A new professionalism? Challenges and opportunities. *Current Sociology, 59*(4), 406-422.

Evetts, J. (2012). Similarities in Contexts and Theorizing: Professionalism and

Inequality. *Professions and Professionalism, 2*(2), Professions and Professionalism, 12/04/2012, Vol.2(2).

Fischer, J. (1973). Is casework effective: A review. Social Work, January, 5-30.

Fischer, J. (1990). Problems and issues in meta-analysis. In L. Videka-Sherman & W. J. Reid (Eds.), *Advances in clinical social work research* (pp. 297-325). Silver Spring, MD: National Association of Social Workers.

Forrest, C. (2004). *Social Work Education about End-of-life Care: Assessment of One Approach for Action* (Doctoral dissertation, University of South Carolina).

Fort Cowles, L.A. (2001). *Social work in the health field.* New York: Haworth Press.

Furst, C. J., & Doyle, D. (2004). The terminal phase. In D. Doyle, G. Hanks, N. Cherny, & K. Calman(Eds.), *Oxford textbook of palliative medicine* (pp.1119-1133). Oxford University Press.

Garrard, J. (2014). *Health sciences literature review made easy: the matrix method* (4th ed). Burlington, MA: Jones & Bartlett Learning.

Gambrill, E. (2006). Evidence-based practice and policy: Choices ahead. *Research on Social Work Practice*, 16, 338–357.

Gambrill, E. (2007). To be or not to be: Will five-step be used by clincians? *Research on Social Work Practice*, 17, 428–434. A review of J. C. Norcross, L. E. Beutler & R. F. Levant (Eds.), Evidence-based practices in mental health: Debate and dialogue on the fundamental questions. Washington, DC: American Psychological Association.

Gervais, J. (2016). The operational definition of competency ‐ based education. *Journal of Competency ‐ Based Education,1*(2), 98-106.

Gibbs, L., & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice, 12*, 452–476.

Goffman, E. (1959). *The presentation of self in everyday life.* New York: Doubleday Anchor Books.

Gray, J. A. M. (2001). *Evidence-based health care: How to make health policy and management decisions* (2nd ed.). New York: Churchill Livingstone.

Gough, D., Oliver, S., and Thomas, J., eds., 2012. Introducing systematic reviews. In: *An introduction to systematic reviews*. London: Sage, 1–16.

Gwyther, L. P., Altilio, T., Blacker, S., Christ, G., Csikai, E. L., & Hooyman, N., et al. (2005). Social work competencies in palliative and end-of-life care. *Journal of Social Work in End-of-Life & Palliative Care,* 1,87-120.

Gwyther, Brennan, & Harding. (2009). Advancing Palliative Care as a Human Right. *Journal of Pain and Symptom Management, 38*(5), 767-774.

Hall, Weaver, Fothergill-Bourbonnais, Amos, Whiting, Barnes, & Legault. (2006). Interprofessional education in palliative care: A pilot project using popular literature. *Journal of Interprofessional Care, 20*(1), 51-59.

Hannes, K., (2011). Critical appraisal of qualitative research. The Cochrane Collaboration Qualitative Methods Group. Available at: http://cqrmg.cochrane.org/supplemental-handbook-guidance [Accessed 2019/03/13]

Henrik, N. (n.d.). "Professionalism, Lecture 5, What is a Profession?". University of Nottingham. Available at https://web.archive.org/web/20070926100028/http://www.cs.nott.ac.uk/~nhn/G52GRP/LectureNotes/lecture05-4up.pdf [Accessed 2019/03/08]

Higgins, J. P. T., & Green, S. (Eds.) (2006). *Cochrane handbook for systematic reviews of interventions*. Chichester, UK: John Wiley & Sons.

Holland, J., & Neimeyer, R. (2005). Reducing the risk of burnout in end-of-life care settings: The role of daily spiritual experiences and training. *Palliative Supportive Care, 3*(3), 173-181.

Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.

Houle, C. O. (1980). Continuing Learning in the Professions, Jossey-Bass, San Francisco.

Howe, J., Hyer, K., Mellor, J., Lindeman, D., & Luptak, M. (2001). Educational Approaches for Preparing Social Work Students for Interdisciplinary Teamwork on Geriatric Health Care Teams. *Social Work in Health Care, 32* (4), 19-42.

International Association for Hospice Palliative Care, & Worldwide Palliative Care Alliance. (2008). Joint Declaration and Statement of Commitment on Palliative Care and Pain Treatment as Human Rights. *Journal of Pain and Palliative Care*

Pharmacotherapy, 2008, Vol.22(4), P.300-302, 22(4), 300-302.

International covenant on economic, social and cultural rights (ICESCR) (1966), article 12. Geneva, Switzerland: Office of the High Commissioner for Human Rights. Available at: https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx[Accessed 2019/03/04]

International Federation of Social Workers. (2014). Global Definition of Social Work. Available at: https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/ [Accessed 2019/02/01]

Iris, C. (2002). *Early professional socialization: Evaluation of multidisciplinary palliative care education for social work and medical students (UMI No. 3043281).* Dissertation Abstracts International, 63 (02). pp. 1-754.

Irwin, H. J., & Melbin-Helberg, E. B. (1992). Enhancement of death acceptance by a grief counseling course. Omega, 25, 73-86.

Jenson, J. M., & Howard, M. O. (2008). *Evidence-Based Practice.* NASW Press and Oxford University Press. https://doi.org/10.1093/acrefore/9780199975839.013.137

Jenson, J., & Howard, M. (2013, June 11). Evidence-Based Practice. *Encyclopedia of Social Work.* Ed. Available at: http://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-137 [Accessed 2019/03/19]

Jones, B. L. (2005) Pediatric palliative and end-of-life care: the role of social work in pediatric oncology. *J Soc Work End Life Palliat Care* 2005; 1: 35–61.

Jones, E. K. (2011). A cultural and mental health competency training program on end-of-life care for new social workers. ProQuest Dissertations and Theses.Kramer, B. (1998). Preparing Social Workers for the Inevitable. *Journal of Social Work Education, 34*(2), 211-227.

Joseph, O., Berzoff, J., & Dobbie, K. (2009). Successfully Increasing Palliative Care Social Work ICU Referrals. *Journal of Social Work in End-of-Life & Palliative Care*, *5*(3–4), 201–215. http://dx.doi.org.ezproxy.ub.gu.se/10.1080

Kang, J., Kim, Y., Yoo, Y. S., Choi, J. Y., Koh, S. J., Jho, H. J., … Jones, D. (2013). Developing competencies for multidisciplinary hospice and palliative care professionals in Korea. *Supportive Care in Cancer; Heidelberg*, *21*(10), 2707–

2717. http://dx.doi.org.ezproxy.ub.gu.se/10.1007/s00520-013-1850-3

Kobayashi, R. & McAllister, C. A. (2013). Similarities and differences in perspectives on interdisciplinary collaboration among hospice team members. American Journal of Hospice and Palliative Medicine, 31(8), 825-832

Kramer, B. J., Parourek, L., & Hoveland-Scafe, C. (2003). Analysis of end-of-life content in social work textbooks. *Journal of Social Work Education,* 39 (2),299-320.

Kubler-Ross, E. (1969). *On death and dying.* New York: Macmillan.

Kulys, R., & Davis, M. (1986). *An analysis of social services in hospice.* Social Work, 11(6), 448–454.

Kübler-Ross, E., & Kessler, D. (2014). *On grief and grieving: finding the meaning of grief through the five stages of loss*. New York: Scribner.

Lane, & Rollnick. (2007). The use of simulated patients and role-play in communication skills training: A review of the literature to August 2005. *Patient Education and Counseling,67*(1), 13-20.

Leighninger, L. (1978). Professionalism and Social Work Education: Substance and Structure. *Journal of Sociology and Social Welfare, 5*(2), 188-213.

Lewis, C. (2000). *Elementary Latin Dictionary*. Oxford Univ. Press. p. 371.

Lister, L. (1982). Role training for interdisciplinary health teams. *Health & Social Work.* 7 (11. 19-25).

Littell, J., Corcoran, J., & Pillai, V. (2008). *Systematic Reviews and Meta-Analysis* (Vol. 9780195326543). New York: Oxford University Press USA - OSO.

Lynn, J., Schuster, J. L., &Kabcenell, A. (2000). *Improving care for the end of life: A sourcebook for health care managers and clinicians*. New York, NY: Oxford University Press.

Linder, J. F., Blais, J., Enders, S. R., Melberg, S. E., & Meyers, F. J. (1999). Palliative education: A didactic and experiential approach to teaching end-of-life care. *Journal of Cancer Education.* 14. 154-160

Luptak, M. (2004). Social work and end-of-life care for older people: A historical perspective. Health & Social Work, 29(1), 7-15.

Manzanera-Ruiz, R., & Marín-Sanchez, I. (2018). Professional competencies in social work education for the third sector in southern Spain. *Social Work Education, 37*(1), 92-107.

MacLeod, R. D., & Nash, A. (1991). Teaching palliative care in general practice: A survey of educational needs and preferences. *Journal of Palliative Care.* 7(41. 9-12.

Marmo, S. (2016). Sustaining the Role of Social Work in Hospice Care: Social Workers' Perceptions of Job Satisfaction, Interdisciplinary Collaboration and Organizational Leadership. *ETD Collection for Fordham University*. AAI10189596. Available at: https://fordham.bepress.com/dissertations/AAI10189596 [Accessed 2019/03/01]

McNeece, C. A., & Thyer, B. A. (2004). Evidence-based practice and social work. *Journal of Evidence Based Social Work,* 1(1), 7–25.

McCormick, A. (2007). *Training Social Workers in Palliative Care: Evaluation of a Self-Efficacy Model.* Portland State University.

McDonough, P. T. (2008). *Undergraduate social work student attitudes about death and end-of-life care* (Order No. 1452549). Available from ProQuest Dissertations & Theses Global. (304841693). Retrieved from https://search-proquest-com.ezproxy.ub.gu.se/docview/304841693?accountid=11162

McGaghie, W. C., Sajid, A. W., Miller, G. E., Telder, T. V., Lipson, L., et al. (1978). Competency-based curriculum development in medical education : an introduction / William C. McGaghie ... [et al.] ; with the assistance of Laurette Lipson. Geneva: World Health Organization.

http://www.who.int/iris/handle/10665/39703

Meier, D. E., & Beresford, L. (2008). Social workers advocate for a seat at the palliative care table. *Journal of Palliative Medicine,* 11 (1), 10-14.

Melluish, S., Crossley, J., & Tweed, A. (2007). An evaluation of the use of a simulated patient role-plays in the teaching and assessment of clinical consultation skills in clinical psychologists’ training. *Psychology Learning and Teaching,* 6, 104–113.

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. BMC health services research, 14, 579. doi:10.1186/s12913-014-0579-0

Monaghan, P. (2002). The unsettled question of brain death. *Chronicle of Higher Education,* February 22, 2002, 14-16.

Moore, K (1984). Training social workers to work with the terminally ill. Health and Social Work, 9(4), 268-273.

Morrow, A. (2018, December 6). The Four Phases and Tasks of Grief. Available at: https://www.verywellhealth.com/the-four-phases-and-tasks-of-grief-1132550 [Accessed 2019/03/06]

National Association of Social Workers. (2004). NASW Standards for Palliative & End-of-Life Care. Washington, DC: National Association of Social Workers. Available at:https://www.socialworkers.org/LinkClick.aspx?fileticket=xBMd58VwEhk%3D&portalid=0 [Accessed 2019/02/02].

National Association of Social Workers. (2007). Code of ethics. Available at: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English [Accessed 2019/04/25]

National Association of Social Workers (NASW), 2010. Social Workers in Hospice and Palliative care-occupational profile. Available at: https://www.socialworkers.org/LinkClick.aspx?fileticket=rq8DPC0g-AM%3D&portalid=0 [Accessed 2019/1/28]

National Association of Social Workers (2015). Advanced Certified Hospice and Palliative Social Worker (ACHP –SW). Washington, DC: National Association of Social Workers. Available at:https://www.socialworkers.org/LinkClick.aspx?fileticket=HDxgi7l_Zb4%3D&portalid=0 [Accessed 2019/02/02].

National Association of Social Workers (NASW) (2017). Code of Ethics. (Rev. ed) Washington DC: NASW Press. Available at: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English [Accessed 2019/02/28]

National Association of Social Workers (NASW) (n.d.). Evidence-based practice. Available at: https://www.socialworkers.org/News/Research-Data/Social-Work-Policy-Research/Evidence-Based-Practice [Accessed 2019/03/18]

National Hospice and Palliative Care Organization. (Rev. ed. April 2018), NHPCO

Facts and Figures: Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, Available at: https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf [Accessed 2018/10/26]

Neimeyer, R., Moser, R., & Wittkowski, J. (2003). Assessing Attitudes Toward Dying and Death: Psychometric Considerations. *OMEGA — Journal of Death and Dying, 47*(1), 45-76.

Nolfi, D. (n.d.). LibGuides: Matrix Method for Literature Review: The Review Matrix. Available at: http://guides.library.duq.edu/c.php?g=232914&p=1546140 [Accessed 2019/02/08]

Noyes, J. and Lewin, S. (2011). Supplemental guidance on selecting a method of qualitative evidence synthesis, and integrating qualitative evidence with Cochrane intervention reviews. In J. Noyes, A. Booth, K. Hannes, A. Harden, J. Harris, S. Lewin and C. Lockwood. (2011). *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Available at http://methods.cochrane.org/qi/supplemental-handbook-guidance [Accessed 2019/02/08]

Olson, R. (1999). Education of social workers in issues of death and dying. Unpublished thesis, California State University, Long Beach. Thorson.

Palliative Care Competency Framework Steering Group. (2014). *Palliative Care Competency Framework.* Dublin, Ireland: Health Service Executive.

Parkes, C. M. (1972). *Bereavement: studies in grief in adult life*. London: Tavistock.

Parry, J. K. (2001). *Social work theory and practice with the terminally ill (2nd ed.).* Binghampton, New York: Haworth Press.

Pattison, E. M. (1977). *The experience of dying.* Englewood Cliffs, NJ: Prentice Hall.

Petticrew, M. and Roberts, H., (2006). Systematic reviews in the social sciences – a practical guide. Oxford: Blackwell PublishingPereira, S. M., Fonseca, A. M. and Carvalho, A. S. (2011) ‘Burnout in palliative care: A systematic review’, Nursing Ethics, 18(3), pp. 317 – 26.

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O’Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. (2011). Proposal: A mixed methods appraisal tool for systematic mixed studies reviews. Retrieved from http://mixedmethodsappraisaltoolpublic.pbworks.com. Archived by WebCite® at http://www.webcitation.org/5tTRTc9yJ

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., … Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews:* A product from the ESRC Methods Programme. https://doi.org/10.13140/2.1.1018.4643

Popkewitz, T. (1994). Professionalization in teaching and teacher education: Some notes on its history, ideology, and potential. *Teaching and Teacher Education, 10*(1), 1-14.

Prelock, P., Melvin, C., Lemieux, N., Melekis, K., Velleman, S., & Favro, M. (2017). One Team–Patient, Family, and Health Care Providers: An Interprofessional Education Activity Providing Collaborative and Palliative Care. *38*(05), 350-359.

Quill, T. E. (2001). *Caring for patients at the end of life: Facing an uncertain future together*. New York: Oxford University Press.

Quinn, J. B., Anderson, P., & Finkelstein, S. (1996). *'Managing professional intellect: Making the most of the best',* Harvard Business Review, 74, 2, 71-80.

Radbruch, L., De Lima, L., Lohmann, D., Gwyther, E., & Payne, S. (2013). The Prague Charter: Urging governments to relieve suffering and ensure the right to palliative care. *Palliative Medicine, 27*(2), 101-102.

Radbruch L, Payne S, Bercovitch M, et al. White paper on standards and norms for hospice and palliative care in Europe part 1—recommendations from the European Association for Palliative Care. Eur J Palliat Care 2009; 16: 278–289 Ritchie, H., & Roser, M. (2018). Causes of Death. *Our World in Data*. Available at: https://ourworldindata.org/causes-of-death [Accessed 2019/03/11]

Rapp-Paglicci, L. (2007). To be or not to be: Will evidence-based practice be used by clinicians? *Research on Social Work Practice*, 17, 427–428. A review of A. R. Roberts & K. R. Yeager (Eds.), Evidence-based practice manual: Research and outcome measures in health and human services. New York: Oxford University Press and A. R. Roberts & K. R. Yeager (Eds.), Foundations of evidence-based social work practice. New York: Oxford University Press.

Reese, D. (2011). Interdisciplinary perceptions of the social work role in hospice: Building upon the classic Kulys and Davis study. *Journal of Social Work in End-of-Life & Palliative Care*, 7(4), 383-406.

Reese, D. J., Chan, C. L., Perry, D. C, Wiersgalla, D., & Schlinger, J. M. (2005). Beliefs, death anxiety, denial, and treatment preferences, in end-of-life care: A comparison of social work students, community residents, and medical students. *Journal of Social Work in End-of-Life & Palliative Care*, 1, 23-47.

Reeves, J., Smith, P., O'Brien, J., Tomlinson, H., & Forde, C. (2002). *Performance Management in Education: Improving Practice.* London: SAGE Publications. Retrieved from http://public.eblib.com/choice

Reith, M., & Payne, M. (2009). *Social work in end-of-life and palliative care*. Chicago, Ill. : Bristol: Lyceum Books ; Policy Press.

Richardson, B. (1999). Professional Development: 1. Professional socialisation and professionalisation. *Physiotherapy, 85*(9), 461-467.

Riller, D. (2015, May 18). Life Experiences – loss -Colin Murray Parkes Available at: https://humandevelopmentandbehaviour.wordpress.com/2015/05/18/loss-transition/ [Accessed 2019/01/28]

Rosenbaum, M., Ferguson, K., & Lobas, J. (2004). Teaching medical students and residents skills for delivering bad news: A review of strategies. *Academic Medicine : Journal of the Association of American Medical Colleges, 79*(2), 107-17.

Rubin, A., & Parrish, D. (2007). Views of evidence-based practice among faculty in Master of Social Work programs: A national survey. *Research on Social Work Practice*, 17, 110–122.

Rubin, A. (2008). Practitioner's guide to using research for evidence-based practice. Hoboken, NJ: Wiley.

Ryan, M. (2007). Teaching loss and grief to social work students: Some reflections. Advances in Social Work and Welfare Education, 9(1), 69-81.

Ryan K, Connolly M, Charnley K, Ainscough A, Crinion J, Hayden C, Keegan O, Larkin P, Lynch M, McEvoy D, McQuillan R, O'Donoghue L, O'Hanlon M, Reaper-Reynolds S, Regan J, Rowe D, Wynne M; Palliative Care Competency Framework Steering Group. (2014). *Palliative Care Competency Framework. Dublin:* Health Service Executive.

Sackett, D. L., Rosenberg, W. M., Gray, J. A. M., Haynes, R. B., Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. BMJ 1996; 312:71-72. Doi: https://doi.org/10.1136/bmj.312.7023.71

Sackett, D. L., Rosenberg, W., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1997). Evidence-based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71–72.

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach EBM (*2nd ed.). New York: Churchill Livingstone.

Saini, M. (2012). Qualitative synthesis to help explore complex interventions: an evolving approach within systematic reviews, presented at the Campbell Colloquium, Copenhagen, 29–31 May 2012. Available at: http://www.sfi.dk/Default.aspx?ID=11043 [Accessed 2019/03/18].

Sanders, S. (2004). Death and dying content in undergraduate social work education: Student views of their preparation for end-of-life practice. *The Journal of Baccalaureate Social Work,* 10,136-146.

Seale, C. (Ed.). (2012). *Researching society and culture* (3rd ed). Thousand Oaks, CA: SAGE Publications.

Schaefer, J. A., & Moos, R. H. (2001). Bereavement experiences and personal growth. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.)*, Handbook of bereavement research consequences, coping, and care (pp. 145-168).* Washington, DC: American Psychological Association.

Schofield, R. F., & Amodeo, M. (1999). Interdisciplinary teams in health care and human services settings: Are they effective? *Health & Social Work.* 24(3). 210-219.

Shuval, J. T., & Adler, I. (1980). The role of models in professional socialization. Social Science & Medicine. 14A. 5-14

Sjöström, M., & Göteborgs universitet. Institutionen för socialt arbete. (2013). *To blend in or stand out? hospital social workers' jurisdictional work in Sweden and Germany* (Skriftserien / Göteborgs universitet, Institutionen för socialt arbete, 2013:2). Göteborg: University of Gothenburg, Dept. of Social Work.Supiano, Katherine P. (2013). Weaving Interdisciplinary and Discipline-Specific Content into Palliative Care Education: One Successful Model for Teaching End-of-Life Care. *Omega - Journal of Death and Dying,* 67(1–2), 201–206. http://dx.doi.org.ezproxy.ub.gu.se/10.2190/OM.67.1-2.x

Small, N. (2001). Social work and palliative care. *British Journal of Social Work*, 32 (6), 961-971.

Snilstveit, B., Oliver, S., & Vojtkova, M. (2012). Narrative approaches to systematic review and synthesis of evidence for international development policy and practice. *Journal of Development Effectiveness, 4*(3), 409-429.

Somerville M. (1992). Human rights and medicine: the relief of suffering. In: Cotler I, Eliadis F, eds. *International human rights law: Theory and practice.* Montreal: Canadian Human Rights Foundation.

Somerville M. (2001). *Death talk.* Montreal: McGill-Queen's University Press; 2001. p. 205–6.

Southon, G., & Braithwaite, J. (1998). 'The end of professionalism?' *Social Science Medicine,* 46, 1, 23-28.

Stroebe, M. & Schut, H. (1999). The dual process model of coping with bereavement: rationale and description. *Death Studies.* 23, 3, 197-224.

Stroebe, M. S., Hansson, R. 0., Stroebe, W., & Schut, H. (2001). Introduction: Concepts and issues in contemporary research on bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research consequences, coping, and care (pp. 3-22).* Washington, DC: American Psychological Association.

Su, YG. (2013, April 26). A Comparative Study on the Hospice Care between U.K. and China [in Chinese]. Jinan: Shandong University, 2013: 31, 40.

Sumser, B., Remke, S., Leimena, M., Altilio, T., & Otis-Green, S. (2015). The Serendipitous Survey: A Look at Primary and Specialist Palliative Social Work Practice, Preparation, and Competency. *Journal of Palliative Medicine, 18*(10), 881-883.

Teater, B., & Chonody, J. (2018). Identifying as an evidence-based social worker: The influence of attitudes, access, confidence, and education. *Social Work Education,* 37(4), 442-457.

The Korea Declaration (2005). Report of the Second Global Summit of National Hospice and Palliative Care Associations. Seoul, Korea: National Hospice and Palliative Care Associations.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*(1), 45.

Thomas, J., Harden, A., and Newman, M. (2012). Synthesis: combining results systematically and appropriately. In: D. Gough, S. Oliver, and J. Thomas, eds.

An introduction to systematic reviews. London: Sage, 179–226.

Visser, C., Hadley, G., & Wee, B. (2015). Reality of evidence-based practice in palliative care. *Cancer biology & medicine*, *12*(3), 193-200.

Vollmer, H. M., & Mills, D. L. (eds) (1966). Professionalisation, Prentice-Hall, Englewood Cliffs, New Jersey.

Walsh-Burke, K. (2004). Assessing mental health risk in end-of life care. In J. Berzoff, & P. R. Silverman (Eds.), *Living with dying (pp. 360–379)*. New York: Columbia University Press.

Walsh-Burke, K., & Csikai, E. L. (2005). Professional social work education in endof-life care: Contributions of the Project on Death in America's Leadership Development Program. *Journal of Social Work in End-of-Life & Palliative Car*e, 1(2), 11-24

Webster, B. (2015, April 11). Theories of Grief. Available at https://griefjourney.com/startjourney/for-professionals-and-caregivers/articles-for-professionals-and-caregivers/theories-of-grief/ [Accessed 2019/03/06]

Webb, S. (2001). Some considerations on the validity of evidence-based practice in social work. *British Journal of Social Work*, 31, 57–79.

Weingarten, M. A., Paul, M., & Leibovici, L. (2004). Assessing ethics of trials in systematic reviews. *BMJ (Clinical research ed.)*, *328*(7446), 1013–1014. doi:10.1136/bmj.328.7446.1013

Weisenfluh, S., Murphy, M., & Black, P. (2006). End-of-Life Care and Social Work Education: What Do Students Need to Know? *Journal of Gerontological Social Work, 48*(1/2), 219-231.

Weisenfluh, S., & Csikai, E. (2013). Professional and Educational Needs of Hospice and Palliative Care Social Workers. *Journal of Social Work in End-Of-Life & Palliative Care, 9*(1), 58-73.

Westberg, G. E. (1971). *Good grief: a constructive approach to the problem of loss. Philadelphia,* Pa: Fortress Press.

Wittenberg-Lyles, E., Goldsmith, J., Ferrell, B., & Burchett, M. (2014). Assessment of an Interprofessional Online Curriculum for Palliative Care Communication Training. *Journal of Palliative Medicine, 17*(4), 4-406.

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553.

Worden, J. W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (2nd ed.). New York: Springer.

World health statistics 2018: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO

WHO and World Palliative Care Alliance. (2014). Global atlas of palliative care at the end of life. Available at: http://www.thewpca.org/resources/global-atlas-of-palliative-care/ [Accessed 2019/02/27]

WHO Model List of Essential Drugs. (1999 December). WHO Drug Information, vol. 13, No. 4, 1999. Available at: https://apps.who.int/medicinedocs/en/d/Jh1461e/ [Accessed 2019/04/25]

Worden, J. W. (2009). *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*, 4 edition. (New York, NY: Springer Publishing Company, 2009), 17.

World Health Organization. (2004). Definition of Palliative Care. Available at: www.who.int/cancer/palliative/definition/en [Accessed 2019/02/27]

World Health Organization (WHO). (2010). Framework for action on interprofessional education and collaborative practice. Geneva, Switzerland: World Health Organization Department of Human Resources for Health. Available at: https://www.who.int/hrh/resources/framework_action/en/ [Accessed 2019/02/27]

World Health Organization. (2019). WHO Definition of Palliative Care. Available at: http://www.who.int/cancer/palliative/definition/en/ [Accessed 2019-01-18]

Zastrow, C, & Kirst-Ashman, K. K. (2007). *Understanding human behavior and the social environment (7 ed.).* Los Angeles, CA: Thomas Brooks/Cole.

Zelinsky, L. F., & Thorson, J. A. (1983). Educational approaches to preparing social work students for practice related to death and dying. *Death Education*. 6. 313-322.

Zimmerman JM (1981) *Hospice—complete care for the terminally ill.* Urban and Schwarbenberg, Baltimore.

APPENDIX A. Data Extraction Form

(Adapted from Health Sciences Literature Review Made Easy: The Matrix Method by Judith Garrard)

Ref	Authors, nationality, year pub	Participants	Goals of program	Modes of program	Teaching and learning strategies	Content	Evaluate Method	Conclusion
1	(Otis-Green et al., 2009). USA	148 psychologists, social workers, and spiritual care professional. female (80%)	Improve the delivery of palliative care through an intensive advocacy and leadership training program	A 5-year, NCI-funded ACE project for 300 professionals; transdisciplinary PC curriculum include 4 training	Role play, discussion, experiential exercises, case studies, multiple resources including	Palliative care delivery, leadership and advocacy skills, team collaboration, pain and	the application, course evaluations, and 6- and 12-month postcourse evaluations, during and	Increased confidence in defined palliative care skills. Improved personal development. group interaction and goal refinement.
2	(Pahor & Rasmussen, 2009) Sweden and Slovenia	Out of 44 undergraduate students of six departments (nursing, medicine, occupational therapy, psychology, physiotherapy and social work) in two countries. From 20 to 48 years old 40 were women	Address differences in professional and national cultures relevant to quality in palliative care.	International, interprofessional and IT-supported undergraduate course in Sweden and Slovenia. Using virtual classes in Year one; course for 10 pilot students from each country in Year two, adjusted course in year three.	Case study: international and interprofessional course; problem-based learning; discussion; workshop. Literature, web addresses and interprofessional staff members	Four topics include patients; significant others; professionals; and social construction of death and dying. learn to work in interprofessional teams; be sensitive to cultural issues.	Interview and questionnaires and analyzed quantitatively and qualitatively.	The development and implementation of the course have been very much context-dependent; Interprofessional education is necessary in health care education, and enable students understand globalization issues. Communication and collaborate skills are crucial to make students more sensitive and considerate. A clear structured program will be needed, and IT tools could be used.
3	(Agnew & Duffy, 2010) UK	Undergraduate (n=12) and post qualifying social work students (n=12) seven female (58%) participants in group 1, 12 females (100%) in group 2	Students can avail themselves of learning opportunities and experiences, address gaps in their learning opportunities.	90-minute Innovative Approaches teaching session	Observation and discussion of DVD excerpts of cancer patients' narratives; Observation of a live facilitated interview	Define palliative care; present key messages and challenges; communicate bad news and information; Create a non-threatening teaching environment and safe boundaries.	Compare two methods of user involvement; Three phases four-point Likert scales questionnaires	Have some or fully understand palliative care; bring theory to life; improved confidence; importance of communication skills; Enhance Service user involvement and digital technology.

4	(Doorenbos et al., 2010) USA	Hospice providers (social work, nurse and clergy)	Provide realistic case studies to recognize situations hospice social workers are likely to encounter; maximize active learning through self-reflection, critical thinking, and application of new knowledge, with feedback confirming or expanding the social worker solution or conclusions.	A 3 hours web-based, cross-cultural communication training education in three dimensional model: provider-level, cross cultural communication skills and patient/family-level constructs	Six Case study (The cases are enriched with photos and audio recordings). video vignettes, LEARN model (listen, explain, acknowledge, recommend, negotiate)	Cultural diversity, cultural awareness, cultural sensitivity, and cultural competence.	90 minutes focus group	Training is useful and appropriate, web-based education is valuable. Improving the quality of cross-cultural communication can contribute to reduce disparities at end-of-life
5	(Forrest & Derrick, 2010). USA	Up to 16 students per academic year for social work, nurse, and chaplaincy.	Knowledge-to-skill-building in four program objectives: education curriculum; field and clinical experiences; policies and procedures; and develop college-university-agency;	Curricula, eight seminars over the academic year and divided into discipline-specific and interdisciplinary, out-of-department elective.	Interactive small group work, didactic instruction, case simulations, role plays, cross-discipline course exposure, and field experiences. Two distinct components support the program's work: the seminar and the out-of-department elective.	Knowledge, skills and personal identity competencies; communication, advance care planning, futile treatment, and interdisciplinary care.	Pre and post program self-assessments; post-seminar self-assessment; Focus groups; and Post-completion evaluation. Follow-up Telephone interviews; online questionnaires.	Promote professional competencies and confidence.
6	(Supiano& Vaughn-Cole, 2011) USA	Graduate students in nursing, social work, counseling, pastoral care, and genetic counseling	Enhance the students' knowledge, attitudes, and skills about grief and loss; foster empathic compassion; and prepare students to appropriately use their selves and life experiences as they address suffering in grieving persons.	Grief support groups field practicum. 8-week support groups; Medical students' observation session;	Check-in meeting, cofacilitators, didactic, interactive discussion,	Grief and loss, cultural and spiritual considerations, group support process, and principles of self-care.	Pre-assessed and posttest by using a brief 15-item True/false questionnaire and open-ended questions	Understand grief and construct the meaning of their loss can mediate students' developing sense. Professional and personal growth can be enhanced by teacher Become more confidence in their developing skills.

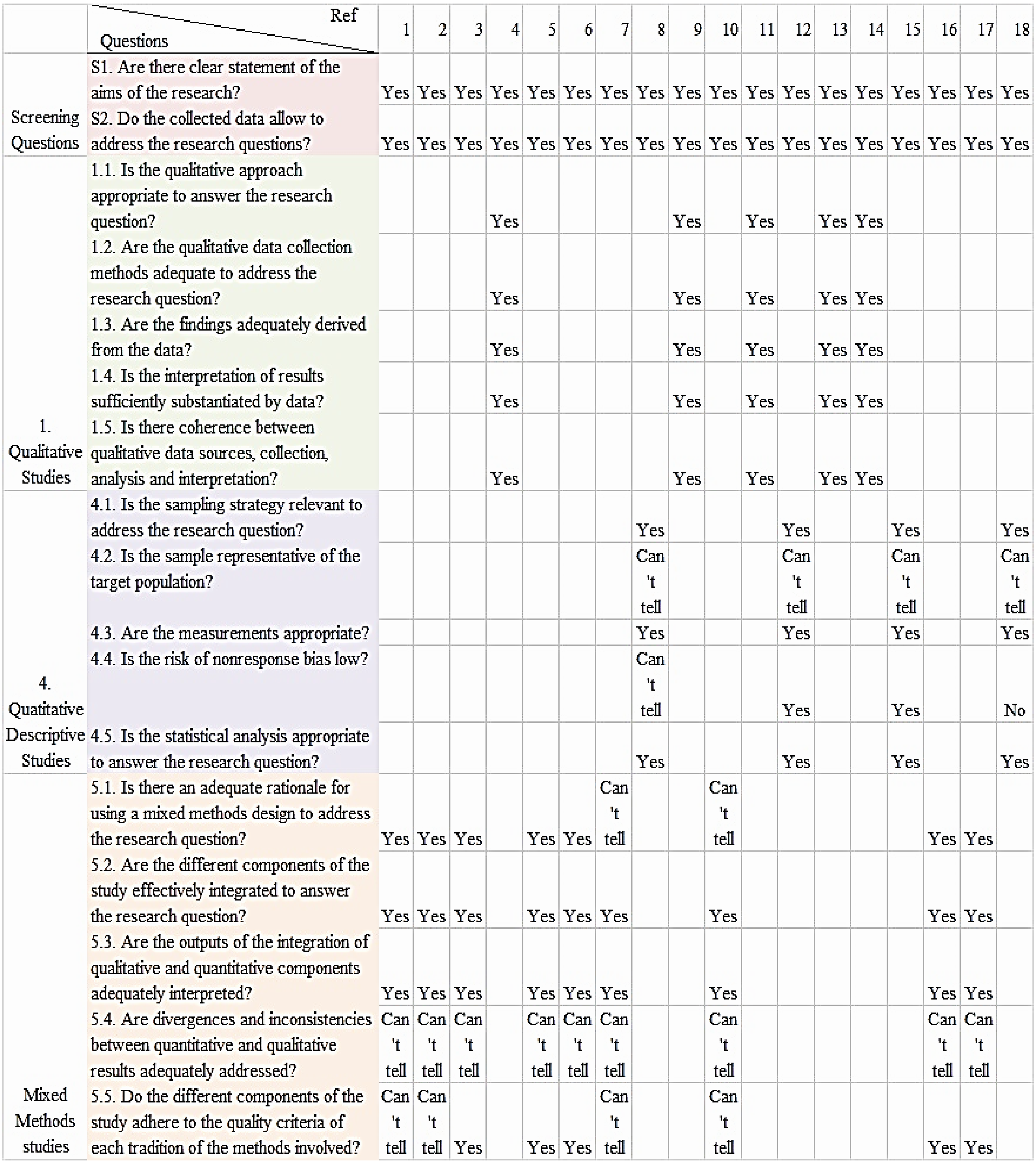
7	(Gordon, Ridley, Boston, & Dahl, 2012) Canada.	200 ICU staff (nursing, social work, medicine, physiotherapy, etc.) in three Toronto General Hospital	1. Raise awareness of moral distress and end-of-life challenges 2. minimize feelings of isolation and increase understanding among professions within the ICU community. 3. Increase awareness of UHN resources 4. Build interprofessional relationships ICU teams.	An interprofessional end-of-life program offered in eight-hour education day by 12 times over 6 months in 2010.	Varied teaching strategies and interprofessional teaching. Role-play, panel discussion, hands-on activities, case studies, and participant scenarios.	ICU work, moral distress, staff wellness, team communication, and quality end-of-life care.	Qualitative reflection, program evaluation and an individual learning assessment.	92% participant have increased the ability to discuss end-of-life issues in ICU. 96% participants felt they could use these techniques and strategies in the work place. listen and learn from colleagues in other professions; Recognizing signs of moral distress • A better understanding of quality end of life from all disciplines • all of the different interprofessional practices involved and testimonials • Communicate with each other
8	(Chow, 2013). Hong Kong	Fifteen groups composed of 385 social workers. females (86.1 per cent)	Enhancing the emotional competence of social workers in Hong Kong; reducing personal death anxiety, distress and non-empathetic responses	Two molds of death anxiety education programmed. Ten groups for grief, and three groups for bereavement join the camp in a three-day workshop over three weeks. Another two groups on complicated grief join the camp in an eight-day workshop over eight weeks.	Amplifying death salience by sharing stories, drawing, visual simulation; examination of past-related regrets; anticipation of future-related regrets; reflection the meaningfulness.	Reduce personal death anxiety, distress and enhance emotional competence	Pre, post and follow-up self-administered questionnaires.	Comfort and competence are related to death anxiety and meaningfulness. Work comfort and competence level were increased and death anxiety was decreased after the workshop. Develop theory-driven and evidence-based training program; Develop emotional competence; promote other positive areas in the field of death and dying.
9	(Supiano & Berry, 2013) USA	87 students in nursing, pharmacy, social work, and gerontology, 23 of them were MSW students (21 were female).	Increased knowledge in palliative care, enhanced attitudes in practice, and application of skills to their clinical practice settings.	A graduate-level interdisciplinary course in palliative care for students in nursing, social work and pharmacy.	Classroom group lecture, discussion, discipline-specific learning groups and interdisciplinary team.	Interdisciplinary collaboration, pain and symptom management, ethical, cultural, and spiritual issues, grief and bereavement and family dynamics.	Post semester focus group sessions	Conclude two themes: Social work students' relationships with other disciplines and self-representation. Social work students' competence and confident and self-assessment was enhanced.

10	(Hamilton et al., 2014) USA	279 Nurses and social workers	The purpose of this study was to compare the effectiveness of the 3 methods of role-playing: in-person, Second Life, and phone for communication skills training。	Three common hospice scenarios role-play in 60 minutes: in-person, phone, and Second Life.	10 minutes Role-play, 10 minutes feedback and mentoring. Use common complaints to create 3 scenes for nurses and 3 sciences for social workers.	Communication skill training.	Repeated-measures analysis; Learners were scored on four communication aspects and finished post-CSL survey and feedback.	Results support the effectiveness of this communication skills laboratory while using different teaching modalities and show phone and Second Life role-plays were more effective than an in-person role-play. Scene to scene is a useful method for learning; The simulated performance would be ideal than the actual performance in the hospice setting.
11	(Head et al., 2014) USA	Medical, nursing and social work students and chaplains in a public metropolitan university.	(1) Design and implement an innovative interdisciplinary oncology palliative care curriculum that would be effective, efficient, accepted, sustainable, and patient-centric and (2) Develop an evaluation system to measure the effectiveness of the curriculum and learner outcomes.	A mandatory interdisciplinary curriculum for oncology palliative care Education (iCOPE)	Use both innovative a traditional educational modality; curricular components, case-based modules, didactic online modules, clinical rotation and critical reflective writing, interdisciplinary case management experience (Face-to-Face)	Interdisciplinary communication; collaboration; physical care; psychosocial, spiritual and cultural care; ethical/legal	Pretest/posttest design (EPCS and SEIEL) focus groups.	Curricular components were redesigned followed the feedback. Interdisciplinary palliative education can be improved by focusing on feedbacks and learners' outcomes, The curricula also need to balance content and structure and to avoid overlap. To create a more efficient, sustainable and feasible curriculum.
12	(Matthieu & Swense, 2014) USA	39 Gatekeepers (frontline staff include social workers) Nearly 90% of attendees are women	(a) Evaluating a brief suicide prevention education program in community hospice settings; and (b) To assess the educational needs of hospice gatekeepers for future suicide prevention education opportunities.	1–2 hour on-site employee education program of suicide prevention	Lecture, role play, seminar, conference, 10-minute video, a question and answer period, referral cards, and a behavioral rehearsal component test.	"Evidence-Based and Promising Practice" Risk assessment, suicide detection, Question, Persuade, Refer (QPR) training.	Pre- and post-, one group design, 5-point Likert scale.	Emerging guidelines and policies for suicide risk. enhance knowledge and skills specific to suicide prevention Providing on-the-job training to enhance the competencies of gatekeepers working in community hospice settings.

13	(Gardner et al. 2015) USA	Social work students	A mentorship program designed to promote social work capacity and provide leadership in direct, organizational, policy, and research practice.	Zelda Foster Studies Program in palliative and end-of-life care. Career trajectory (a) a 4-year MSW Fellowship (b) a two-years post-master's certificate program (c) an 18-month leadership fellowship	PELC seminar, curricula, field placements supervision, one-to-one mentorship	Bio-psychosocial and spiritual assessment, pain management, evidence-informed interventions, interdisciplinary teamwork, ethical issues and dilemmas, leadership, grief, loss and bereavement theories, emotional-support.	Self-report forms and open-ended surveys, one-to-one interviews, and focus groups	Improve social workers' competencies and leadership; mentor the trajectory of careers. The mentoring and being mentored process were highly values and regarded as important component.
14	(Turner, Kuyini, Agustine, & Hunter, 2015) Australia	Social work students	To prepare professionals who are capable of responding to and acting confidently and compassionately with dying people	Palliative care curriculum for undergraduate students (PCC4U) project	Online materials, video clips, reading and class discussion, reflective writing, 90-minute compulsory class	Death, dying, hospices and palliative care.	Three open-ended questionnaire and one-hour focus group discussion.	Conclude six themes: emotional demands, sensitivity and flexibility among educators, expanding social work philosophy in curriculum materials, developing a social work perspective, exploring spirituality and cultural-informed practice. using high quality accessible materials to teach death and dying.
15	(Bunting & Cagle, 2016), USA	Twenty-nine university-based hospital social workers. (96% female)	This study aims to understand the impact of a brief training for hospital social workers. The training is designed to improve communication skills and self-efficacy, as well as lessen fears of death and dying.	A 90 minutes communication training program	Traditional didactics, group discussion, case vignettes, presentation slides, and handouts.	Team communication; braking bad news; care goals conversation using case scenarios.	Pre-test, immediate post-test, and one month after test.	Communication self-efficacy improved after training and sustained one month. the fears of death and dying were decreased. Evidence-informed communication training can improve communication self-efficacy, and integrative training approach seems to be effective and feasible for social workers.

16	(Head et al, 2016). USA	Fouth-year Medical and nursing students, master social work students, and chaplaincy students. Female accounts the main participants.	The goal is to report the outcomes of one university's effort to educate interdisciplinary students via a mandatory palliative-focused oncology curriculum.	Interprofessional Psychosocial Oncology Distance Education (IPODE) Project. Interdisciplinary Curriculum for Oncology Palliative Education (iCOPE) curriculum five semesters beginning in fall 2012.	Online case-based didactics; Interdisciplinary Case Management Experience (ICME); clinical rotations; and critical reflection writing exercises.	Palliative care and oncology; team-based care; Communication skills; team-based skills; clinical experience.	pre- and post-measure (EPCS; SEIEL; IPCKS); open-ended questions; focus groups to provide feedback on overall content, process, outcomes, and logistical considerations	Improve significantly in palliative care knowledge and skills and self-efficacy. Impact students' attitudes and abilities related to the practice of team-based palliative care in oncology.
17	(Prelock et al., 2017) USA	Undergraduate students (from medicine, speech-language pathology, social work, physical therapy, and nutrition) and graduate nursing students. 86.4% are females	(1) Engaging in effective interprofessional communication and teamwork, (2) Discussing therapeutic patient/family communication, (3) Employing supportive holistic care with patients and families at end of life, and (4) Relating the patient's physiological assessment findings to the dying process.	Interprofessional education (IPE) and practice (IPP).	Six videotaped scenes, in-person film/discussion format, team-based discussion, preparatory reading.	Interprofessional communication and teamwork; therapeutic patient/family communication; supportive holistic care; physiological assessment.	14 Likert scale questions and four open-ended questions; four open-ended questions about the value of the video and discussion. Demographic Data.	There were few significant differences between disciplines; students highly value this team-based learning; the competence has been increased. Results revealed strong positive agreement among the disciplines regarding the value of the learning opportunities provided during this IPE simulation activity.
18	(Neuderth et al., 2019) Germany	Medical and social work students	Both groups should gain knowledge about the other professions tasks and learn to handle clients' emotional reactions.	An innovative teaching concept with different learning goals: 2 × 90 min interprofessional lectures; 10 × 90 min training sessions; 90 min (only SW) visit. palliative care ward and a 3 × 90 min research colloquium.	Role-play; observation; case-vignettes; lecture; Interprofessional teaching and learning in practice	Interprofessional teamwork, self-reflective behavior, dealing with anxiety and despair, and communicative competencies training.	Questionnaire after each role-play session and evaluate the (standard client) SC-concept by rating 5-point Likert scale at the end of the course.	High satisfaction with this teaching concept, role-plays and the standardized clients/patients methods. The standardized clients/patients method and interprofessional application is a practicable and motivating way to enhance conversational skills for both teachers and students.

APPENDIX B. Mixed Methods Appraisal Tool (MMAT) VERSION 2018



	Ref Questions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Screening Questions	S1. Are there clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	S2. Do the collected data allow to address the research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1. Qualitative Studies	1.1. Is the qualitative approach appropriate to answer the research question?				Yes					Yes		Yes		Yes	Yes				
	1.2. Are the qualitative data collection methods adequate to address the research question?				Yes					Yes		Yes		Yes	Yes				
	1.3. Are the findings adequately derived from the data?				Yes					Yes		Yes		Yes	Yes				
	1.4. Is the interpretation of results sufficiently substantiated by data?				Yes					Yes		Yes		Yes	Yes				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				Yes					Yes		Yes		Yes	Yes				
4. Quatitative Descriptive Studies	4.1. Is the sampling strategy relevant to address the research question?								Yes				Yes			Yes			Yes
	4.2. Is the sample representative of the target population?								Can't tell				Can't tell			Can't tell			Can't tell
	4.3. Are the measurements appropriate?								Yes				Yes			Yes			Yes
	4.4. Is the risk of nonresponse bias low?								Can't tell				Yes			Yes			No
	4.5. Is the statistical analysis appropriate to answer the research question?								Yes				Yes			Yes			Yes
Mixed Methods studies	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	Yes	Yes	Yes		Yes	Yes	Can't tell			Can't tell						Yes	Yes	
	5.2. Are the different components of the study effectively integrated to answer the research question?	Yes	Yes	Yes		Yes	Yes	Yes			Yes						Yes	Yes	
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes	Yes	Yes		Yes	Yes	Yes			Yes						Yes	Yes	
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Can't tell	Can't tell	Can't tell		Can't tell	Can't tell	Can't tell			Can't tell						Can't tell	Can't tell	
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Can't tell	Can't tell	Yes		Yes	Yes	Can't tell			Can't tell						Yes	Yes	