Implementing audit in palliative care: an action research approach

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Introduction

Palliative care has been defined as the ‘active total care of patients whose disease is not responsive to curative treatment’ (World Health Organization 1990). It is a relatively new clinical discipline and there has been a marked growth in this type of service provision during the last 25 years (Higginson & McCarthy 1989). However this expansion is not reflected in the amount of research that has been conducted, particularly in relation to quality. The purpose of this paper is to report on an investigation of the implementation of a system of clinical audit in a palliative care setting, using an action research approach.

It has been suggested that quality is embodied in the ideals, structure and delivery of palliative care (Tierney et al. 1994, National Council for Hospice and Specialist Palliative Care Services [NCHPCS] 1997, 2000). However, this belief can result in reluctance to use quality assurance methods (Higginson 1993a). Yet the requirement for systematic measurements of care, such as clinical audit, to be integrated into practice is clear (Higginson 1993a, 1998, NCHPCS 1994, 2000, Tierney et al. 1994, Department of Health...
Given this situation, this study was designed to examine how clinical audit could be successfully implemented in a palliative care unit.

Quality assurance

Quality assurance in health care is concerned with ensuring that people work together and use available resources to provide the best possible care for patients (Schofield 1990). One of the main approaches to managing quality assurance in health care is the use of audit. In practice this can involve the application of a range of methods. However, Shaw (1989) suggests that essentially it is accomplished through the definition of standards, measurement of their achievement and implementing mechanisms to improve performance if they are not met.

In palliative care in the United Kingdom (UK) the need for audit became more pressing following the White Paper Working for Patients (DOH 1989) and the resulting creation of a quasi-market structure in the National Health Service (NHS), based on a purchaser/provider model (Bassett & McSherry 1996). The ensuing contracting of services had an impact on quality assurance in health care as contracts contained quality specifications that had to be met (Weston & Bruster 1995). This was also evident in palliative care as many of the independent units contracted with local health trusts to provide specialist palliative care services (Clark 1993, NCHPCS 1994, Tierney et al. 1994, Clark et al. 1995). The publication of A First Class Service – Quality in the New NHS (DOH 1998) and the NHS Plan (DOH 2000) indicate that the need for quality systems in all specialities will be a persistent theme in health policy for the foreseeable future.

Literature review

Clinical audit in palliative care

The foundations of palliative care lie within the modern hospice movement, which holds a unique position in current health care for the following reasons:

- a significant proportion of service provision is in the independent sector;
- many units have charitable status;
- service provision often relies on high levels of volunteer support;
- it has developed and expanded outside of NHS provision and therefore practitioners have experienced a greater degree of autonomy than colleagues in NHS settings (Clark 1993).

This assessment provides some information to explain why audit has not been widely implemented in palliative care services. However there are other more specific difficulties that were examined to inform the design of the research reported here.

Implementing clinical audit in palliative care

Palliative care has developed in an unplanned way and there is a diversity of provision within the speciality which leads to conceptual and technical difficulties when implementing standard measures of quality assurance (Higginson & McCarthy 1989, Tierney et al. 1994, Robbins 1998). This has led to quality measurement being focused on individual components of care such as pain control. However, information concerning these elements in isolation is not an evidence of effective palliative care.

Measurement is also difficult because of the multidisciplinary approach adopted in many palliative care services. It has been suggested that the essence of hospice care is teamwork delivered by a range of professionals (Clark & Seymour 1999) and this approach is a characteristic of specialist palliative care (NCHPCS 2001). This may enhance holistic care but renders the measurement of effectiveness problematic because there are difficulties in selecting suitable multidisciplinary measurement tools and getting all team members together at the same time to complete joint assessments (NCHPCS 1992).

There are also ethical dilemmas when implementing certain methods of quality measurement. For example, in comparative studies of hospice and acute care it would be unethical to ask patients in the last stages of their lives to agree to random allocation between a hospice and acute service provision for the purpose of achieving a robust study design (Higginson & McCarthy 1989, Mino 1999). These difficulties go some way in explaining the lack of research in the speciality in the past. In recent years however, quality tools that can be used in palliative care settings have been developed. The one used in the study reported here is examined below.

Audit tools in palliative care

In selecting a suitable outcome measure to audit palliative care delivery it was important to choose a tool that measured aspects of care that reflected the specific aims of palliative care provision, for example, pain and symptom management, improving quality of life before death and support of the family/carers (Hearn & Higginson 1997). Following a review of possible tools the Support Team Assessment Scale (STAS)
(Higginson 1993b) was deemed to be the most appropriate clinical audit tool for this study for the following reasons:
- measurement items were developed by cancer support teams to reflect the goals of palliative care;
- it is widely used in palliative care and community settings;
- it is reliable;
- ease of use (quick completion time, approximately 2 minutes) (Hearn & Higginson 1997);
- it is a validated measure of the effectiveness of palliative care (Higginson & McCarthy 1993).

See Figure 1 for the elements of the scale and an example of one of the scale items.

The study

Despite audit being a familiar concept there appears to be little written about the views of staff participating in it (Hayes 1993) and the use of action research to implement clinical audit does not appear to have been examined in the past. This study was designed to address this deficit and a key component of the research was the combination of an action research approach and the audit cycle to facilitate a change in nursing practice. There are similarities between the audit cycle and the action research approach (Nolan & Grant 1993, Birkett 1995, Allcock 1996) as illustrated in Figures 2 and 3. Both processes are cyclical in nature and include the elements of planning, review and feedback. Because of these similarities and the common origin of action research and Lewin’s (1951) change theory, the study of a change in practice, using an action research/audit framework, was felt to be worthwhile and to offer the prospect of generating insights relevant to palliative care. Therefore the research set out to identify the factors that determine the successful outcome of clinical audit programmes in the speciality of palliative care.

Methodology

The term action research originates in the pioneering work of the social psychologist Lewin (1946). The main aim of his approach was to combine the systematic approach of social science with action that responded to the social problems of the day (Hart & Bond 1995). A crucial element in this process is collaborative action to bring about change in a situation and an increase in knowledge about that change. Lewin’s (1946) method is cyclical in nature and is illustrated in Figure 2.

Action research is a naturalistic form of enquiry, and has been successfully employed in a range of settings. It focuses on a local issue and the problem is solved in its context (McGarvey 1993). This requires the participation of those involved in the change, and democratic collaboration between researcher and subjects (Wallace 1987, Sheehan 1990, Holter & Schwartz-Barcott 1993, Webb 1996).

The stages of the action research process identified by (McGarvey 1993, p. 375) are listed below:
- the problem to be studied is identified;
- problem concepts are investigated and related literature is studied;
- the plan of action to solve the problem is designed;
- the plan is put into action and its workings observed and monitored;
- a reflective stage follows where changes and modifications to the solution can be made.

This cycle of events is repeated until practical considerations, such as time or resources, terminate the study (see Figure 2).

Action research is a useful research technique in nursing (Greenwood 1984, Webb 1989, Gibbings 1993, Hart & Bond 1995). It has been widely used to effect change in a variety of settings (Birkett 1995) because it is flexible (Smith 1979, Hunt 1981), and has the potential to bridge the gap between theory, research, and nursing practice (Holter & Schwartz-Barcott 1993). It also encourages reflective practice (Webb 1990, Wallis 1999) and nurses involved in action research programmes report increasing levels of control over change and practice (Hendry & Farley 1996, Edwards & Talbot 1999, Wallis 1999).

Background

The research was carried out in a well established unit which began as a specialist palliative home care team and over a 14-year period has been developed to provide the following services:
- home support;
- day care;
- bereavement support;
- advice and education;
- pain and symptom control;
- emotional and psychological support for patients, families, carers and friends;
- spiritual support;
- social support (equipment, grant applications, volunteer support);
- help with communication problems (patients, families and professional carers).

The research was conducted in partnership with members of the home support team and day unit staff, and with the agreement of the hospice management. The research
## Measurement items within STAS

<table>
<thead>
<tr>
<th>Core items</th>
<th>Additional items</th>
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<tr>
<td>• Pain control</td>
<td>• Planning</td>
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<tr>
<td>• Other symptom control</td>
<td>• Practical aid</td>
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<tr>
<td>• Patient anxiety</td>
<td>• Financial</td>
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<td>• Family anxiety</td>
<td>• Wasted time</td>
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<td>• Patient insight</td>
<td>• Spiritual</td>
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<tr>
<td>• Family insight</td>
<td>• Professional anxiety</td>
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<tr>
<td>• Communication between patient and family</td>
<td>• Advising professionals</td>
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<td>• Communication between professionals</td>
<td></td>
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<td>• Communication professional to patient and family</td>
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The Support Team Assessment Schedule (STAS) consists of 16 objectives measured on a 5-point scale (0–4), with high scores indicating high levels of need and low scores indicating low levels. The objectives relate to physical, psychological, spiritual and practical elements of care and thus can be used to evaluate the holistic approach promoted within the speciality. The gradings were developed by reviewing care delivered to patients using multidisciplinary, rather than individual scores and the definitions of each item and grading allow for standardisation of recordings and reduce the subjectivity of measurements (Mc Carthy & Higginson 1991).

Below is an example of an objective and gradings.

### PAIN CONTROL

**Definition**

Effect of his/her pain on the patient

**Scoring system**

0 = None  
1 = Occasional or grumbling single pain. Patient is not bothered to be rid of symptoms.  
2 = Moderate distress, occasional bad days, pain limits some activity possible within the extent of the disease.  
3 = Severe pain present often. Activities and concentration markedly affected by pain.  
4 = Severe and continuous overwhelming pain. Unable to think of other matters.

**If it is not possible to measure an objective an alternative score can be utilised as specified below.**

7 = For all items for weeks when there was no contact with the patient or family.
8 = If the item is not applicable e.g. When scoring family anxiety and insight if there is no carer.
9 = If you are unable to assess an item to indicate a missing score.

![Figure 1](STAS items and example of scoring system. Reproduced with the permission of Higginson (1993b).)
sample consisted of all those involved in the setting namely:
- Patient services manager ($n = 1$)
- Clinical medical officer ($n = 1$)
- Social worker/Counsellor ($n = 1$)
- Clinical nurse specialists – community ($n = 5$)
- Clinical nurse specialists – day hospice ($n = 2$).

Methods

Data collection

Action research is cyclical in nature and the methods evolve as the research progresses, in response to feedback from participants, an approach advocated by Hart and Bond (1995).

The four methods of data collection used in this study were:

Focus group to discuss previous implementation of audit and STAS

This initial 2-hour meeting focused on the team’s previous experience of clinical audit and STAS. A collaborative approach was introduced during this early stage of the research by encouraging participants to express their views. An analysis of strengths, weaknesses, opportunities and threats (SWOT) was used to structure the discussion.

Preimplementation questionnaire ($n = 10$)

A detailed questionnaire consisting of six open items which encouraged ‘richer and fuller information’ (Polit et al. 2001, p. 267) was administered. This was designed to assess staff readiness for the implementation of STAS.

Five review meetings

Detailed notes were made of five review meetings, each lasting approximately 90 minutes. The meetings aimed to draw on participants’ experiences of implementing audit and STAS, and discussion was stimulated by the use of a short, flexible agenda. Action points were agreed and notes of the meetings were compiled and circulated to all participants before the next meeting, where their accuracy was confirmed. This ensured that the notes were cross-checked for content validity.

Postimplementation focus group

This group met for 90 minutes to evaluate the clinical audit programme 2 months after completion of the trial. Participants had previously decided to incorporate audit into their clinical practice and during the time that had elapsed since this decision they had reflected on this change. Data were collected through a discussion and SWOT analysis.

The results from each method of data collection will now be presented.

Findings

Summary of the focus group discussion of the previous implementation of audit and STAS

It was found that the previous implementation had been unsuccessful because the tool was modified and misused. This in turn resulted in inconsistent evaluations of care being conducted. Also participants were apprehensive about the need for audit and how the results would be used. It was difficult to record measurements in collaboration with members of the multidisciplinary team and a 4-month delay before the results were shared with the team were factors in the lack of success with the previous attempt. Participants reported that they found it helpful to review why the previous implementation was unsuccessful stating that it ‘tidied up some ends’ and that it was ‘very constructive and noncritical’.

Results of preimplementation questionnaire

Six out of 10 questionnaires were returned. The detailed responses from each question were transcribed onto cards as described by Dey (1993), and content analysis of the data was undertaken (Polit et al. 2001). The data were then organized into themes under headings which reflected the broad categories of responses given, as follows:
Understanding of the term clinical audit
In general there was a good general level of knowledge regarding the term clinical audit.

Perceived difficulties of implementing an audit tool in palliative care
The difficulty of auditing, because of the nature of the speciality, arising from concerns about ethical issues and the different variables involved in patient care was evident.

Mixed feelings about the proposed implementation of audit
Some felt enthusiastic and others expressed anxiety.

Apprehension about the programme
This centred mainly on the time commitment and how the audit results would be used.

Variable understanding of the Support Team Assessment Scale (STAS)
Some participants demonstrated more awareness than others, despite the fact that they had all received the same information about the tool.

Results from review meetings
Content analysis of these notes identified the following themes:

Clarification of the audit tool
This was a continuous theme throughout the trial and when the change had been incorporated into practice. Issues requiring clarification included the terminology used in the tool, for example ‘family’, ‘carer’, ‘communication between professionals’, ‘wasted time’ and the scoring system, with the explanation and discussion of scores 7, 8 and 9 occurring at several of the meetings.

Implementation of the change
Participants identified ways of administering the tool that were relevant to the way the team functioned. This was illustrated by notes concerning who should conduct the assessment, how frequently patients should be assessed, devising appropriate documentation and reducing subjectivity of measurements by adhering to the STAS definitions.

Problem identification
Participants identified problems with the audit tool and agreed on ways to address these. This is illustrated in records of discussions regarding confidentiality, patient selection, time issues and ensuring that assessments related to the part of the service being measured.

Collaboration between researcher and participants
This theme is evident throughout the notes and is illustrated through co-operation between participants and researcher in accessing relevant information and implementation of the tool. Examples of this were liaison between the researcher, STAS office and participants, and continuous evaluation of the change.

Ownership of the innovation
This element emerged in later meetings focusing on documentation and frequency of assessments. Ownership of the innovation became evident at a meeting when participants suggested and agreed ways of incorporating the change into their clinical practice.

Post-implementation focus group
Content analysis of these notes identified two main themes, these were:

Factors instrumental to the success of the implementation of audit
These were reported as the hospice philosophy of teamwork and supporting one another, which was enhanced by the small size of the team. Good relationships with management and the input from an external facilitator were also regarded as crucial to success. This was largely the result of the facilitator’s good working relationship with the team and her clinical experience and expertise in the area of care being measured. Prompt and tangible feedback of results early on in the process was also regarded as a positive aspect of the audit.

Evaluation of the audit
The exercise although time-consuming was felt to be worthwhile. Participants increased their degree of multidisciplinary teamwork, mainly because communication between professionals is a measured item. It also encouraged reflective practice and was helpful, to the team, in illustrating their value to outside agencies.

The results show that participants’ feelings and attitudes changed during the time the research was undertaken. Prior to the reintroduction of audit there was reticence amongst team members regarding the extra workload that would be generated and how the results of the audit would be used. However, as the trial implementation progressed participants reported more positive aspects of audit on an individual and organizational level. This was also helped by the
improvements in care that were identified through the use of the audit. For example STAS scores improved for seven items and were consistent at 0 for eight items. Whilst problems and difficulties were still identified, such as no improvement in the score for ‘other symptom control’, team members worked towards resolving these. The factors that led to these changes and the difficulties encountered in the research process will now be discussed.

**Discussion**

The results generated during action research are inextricably linked to the process that produces them. Therefore, in order to consider the results and research process together, the stages of action research, as identified by McGarvey (1993), are used to provide a framework for the discussion.

**The problem to be studied is identified**

The need to integrate clinical audit into clinical practice was identified by the hospice management. However team members also recognized this need because of their previous experience and their awareness of government and the local community trust’s policies. This change in practice had to take place in response to the contracting for services and, as the previous implementation had failed, it was important to study the problem and learn from this process.

**Problem concepts are investigated and related literature is studied**

The lack of success in the previous attempt to introduce STAS was a result of mistakes that were made. There was no structured plan for the change, and insufficient preparation and training of staff. These activities are crucial to the success of the audit process (Andrews 1993, Higginson 1993c). The previous implementation was management driven and the strategy for the initiative was 'top down' whereas a key factor in quality assurance programmes is the nurturing of a 'bottom up' approach (Ingleton & Faulkner 1995, Johnston et al. 2000) in order to encourage feelings of ownership and control. This issue was not managed effectively in the previous attempt and led to feelings of mistrust and suspicion. Finally, early feedback of audit results is recommended (Higginson 1993d) but in this case a delay of 4 months occurred, which was viewed negatively by participants. It was at this point that the audit was terminated, which is not uncommon in audit programmes (Higginson 1993d). However, despite these previous difficulties, the participants were still able to see the benefits of audit and STAS.

Through the process of identifying why the previous implementation had been unsuccessful, a valuable insight was gained into the reasons for participants’ current feelings towards audit. This opportunity to express their feelings and views also laid the foundations for later collaborative working as it 'tidied up some ends' and was constructive.

**Plan of action to solve the problem is identified**

The plan of action was proposed by the researcher and modified in the light of suggestions/feedback from participants and therefore was a joint initiative. Opportunities for the expression of views about the implementation plan were provided and the data collected at this point show that participants had mixed feelings about reintroducing audit. Key concerns centred on the level of commitment required by participants, illustrated in comments regarding workload and time involvement. This indicates an awareness of what was involved in the initiative because personal investment in quality assurance mechanisms is considerable (Ingleton & Faulkner 1995), and it was essential that this issue was acknowledged by all those involved in the study. Anxiety regarding how the results of the audit would be used was expressed and this was also noted by Lorentzon (1987) and Morrell (1996) who suggest that many health professionals view audit as a punitive measure to identify 'poor practitioners'. Conversely, positive feelings were also expressed. Audit was seen as a means to evaluate and improve the service provided, which is one of its aims yet even when positive feelings are expressed, change is commonly resisted (Dowding & Barr 2002, Mullins 2002) because it is likely to challenge, or even overturn, firmly held assumptions and can be a potentially painful process (Sheehan 1990, Lamb & Cox 1999). Consequently, the pace of change needed to be steady and with the opportunity to review the audit as it was in the process of being implemented, participants were able to adapt to the change gradually. This was enhanced by the positive results achieved for most of the STAS items.

By their engagement in planning the initiative participants were also defining goals and expectations and thus completing a stage of the audit cycle (see Figure 3). What also appeared to be occurring at this stage was that participants were moving through the first two stages of the process of change outlined by Lewin (1951). By identifying the problem and discussing possible solutions, they were ‘unfreezing’ the current situation and creating the motivation to change it. Through collaborative working and discussion between those suggesting the change and those implementing it, participants were ‘moving’ and agreeing that the status quo was no longer
acceptable. Lewin (1951) also discusses the notion of driving forces that facilitate and restraining forces which hinder the process of change. By discussing the problem and plan of action participants were able to identify these, which is an important process when planning change (Andrews 1993). These activities were in direct contrast to the previous unsuccessful implementation of audit, and their inclusion in this study and its eventual successful outcome suggests that they are important features in the successful implementation of clinical audit.

The plan is put into action and its workings observed and monitored

During the implementation and monitoring stage of the research it was clear that participants were gaining an understanding of the audit tool and how to implement it effectively in their clinical practice. Interpretation of the definitions in STAS was a problem, as found by McKee (1993), and participants expressed concern regarding the scoring system. This was addressed by adhering closely to the STAS definitions when making an assessment, in order to reduce subjectivity.

An issue that continued to be problematic was the use of the ‘missing’ STAS scores (i.e. scores 7, 8 and 9). This item also proved to be difficult in McKee’s (1993) project, although she states that this problem was quickly resolved. This was not the case in this study as the differences between these scores and issues concerning when they should be used were discussed on several occasions and remained a source of anxiety. This may indicate a problem with STAS as a tool in that the definitions for scores 8 and 9 are very similar and perhaps need to be refined.

A key issue that emerged throughout the implementation of this initiative was the importance of collaboration between researcher and participants as advocated by Holter and Schwartz-Barcott (1993), Bowling (1997) and Kelly and Simpson (2001). The success of audit programmes is dependent on staff involvement (Ingleton & Faulkner 1995), and this was a crucial factor in the successful outcome of this project. Action research encouraged a ‘bottom-up’ approach, which is vital in the development of quality assurance mechanisms (Harvey 1991, Ingleton & Faulkner 1995, Johnston et al. 2000).

Yet collaboration was difficult at times, as the aim was to empower participants to make their own decisions and take control of the initiative. Initially they exhibited over-reliance on the facilitator for advice about audit and solutions to problems. However as the study progressed, they were encouraged to find solutions themselves and to work towards decisions based on group consensus. This was important because if the change was to last and become integrated into practice, participants needed to become less dependent on external guidance and more self-directing (Haffer 1986). This did occur eventually and the notes of meetings reflect the increasing amount of control that participants took in the implementation as they started to take ‘ownership’ of the change. This behavioural shift can be attributed to the increasing levels of confidence developed in terms of knowledge and practice of clinical audit. Through this process participants started to feel that the change was their responsibility (Wright 1989). ‘Ownership’ is an essential component in the adoption of new behaviours (Evans & Corrigan 1990, Kitson 1990), and its emergence in this study was a major factor in its successful outcome.

A reflective stage follows where changes and modifications to the solution can be made

In this stage of the study participants reflected on two issues: clinical audit itself, and the factors affecting this particular implementation. With regard to clinical audit this was generally viewed positively with participants reporting how it had enhanced their clinical practice. The audit encouraged reflexivity amongst participants, which is an important aspect of current nursing practice (Bailey & Cassidy 1996). Taking ‘time out’ encouraged the team to think about their care and the action research process incorporates this activity (Webb 1990). Participants’ early fears that the results of the audit would be used to spot ‘poor practitioners’ were not realized and instead they viewed audit as a tool to evaluate their care, highlight any deficits, identify good practice, and illustrate how much time was being spent on different aspects of care. Also, although they identified that the audit was time consuming (as they did prior to its implementation) this view was now counterbalanced with feelings that it was worthwhile rather than the ‘burden’ and source of anxiety it had been. This result was also found by Hayes (1993) and McKee (1993).

A finding that does not seem to have been reported before but was central to this study, was that clinical audit improves teamwork. This was identified several times by participants during the postimplementation focus group and was not a finding that had been anticipated. The reason for this is not entirely clear, however, it appears to have resulted from a combination of factors. First, communication with other professionals (in this case members of the primary health care team) is reported to have improved because this item is measured by STAS. Presumably, by auditing this item, participants reviewed and evaluated their practice and addressed actual or potential problems. Secondly, the
reported improvement in teamwork within the hospice team could be attributed to the fact that the audit encouraged the team to examine its practice as a whole and this illustrates its worth to other agencies. As the results of the trial implementation were positive, this raised participants’ feelings of self-esteem and provided evidence to support a belief that the team was providing an effective service.

Current situation
Since January 1997 the home care and day care teams have fully integrated STAS into their clinical practice. During 1997–1999 they conducted assessments on first contact with patients bi-monthly and at the final contact prior to discharge or death. The audit was then suspended for 6 months to allow for reflection on the process and the results, and restarted in January 2000. Currently the care of all new patients is audited on a weekly basis for a 3-month period as it is felt that this provides a more comprehensive evaluation of the care delivered.

Team members have developed the scope of the audit further by adopting the more comprehensive STAS scores for individual symptoms devised by McKee (1993). By auditing symptoms that are commonly experienced by patients receiving palliative care, for example, nausea, constipation, anorexia and dysphagia, it is hoped that a more comprehensive evaluation of this important component will be measured objectively. The team has also developed definitions and scores in the STAS format to measure bereavement care within the service. Lastly, participants have recognized that they could not complete the audit cycle as they did not have standards of care that related to items measured by STAS. They have now developed these and incorporated acceptable STAS scores for items in each standard.

Thus, as a result of the introduction of clinical audit, participants are now engaging in all stages of the audit cycle, and are continually monitoring and evaluating their care. This practice has persisted despite the many staff changes that have occurred. It would appear that when audit programmes are introduced in a planned, collaborative way the effects are enduring. Clearly this innovation has provided the impetus for the team to review and change its practice and in doing so, to improve the quality of patient care.

Conclusion
The delivery of a quality service is important in all areas of health care, and palliative care is no exception. However there are particular circumstances specific to this specialty which require a particular type of approach. The collabor-


