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THE INFLUENCE OF ORGANIZATIONAL STRUCTURE ON HOSPITAL SOCIAL WORK PRACTICE AND PROFESSIONAL IDENTITY

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by

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Abstract of the Dissertation

The Influence of Organizational Structure on
Hospital Social Work Practice and Professional Identity

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This qualitative study examined the variability of hospital social work practice and how social workers experience these differences in their day-to-day work. Through the analysis of semi-structured interviews, the findings explore factors influencing the experiences of hospital social workers and how such factors impact professional identity. Participants were forty Masters level social workers from thirteen different hospital settings across Long Island and New York City.

Three major interdependent themes emerged: control of role, role clarity and practice value. Control of role is influenced by organizational transitions, non-social work management and interdisciplinary relationships and perceptions. The dynamics of who controls the definition of social work and who shapes social work practice varied from setting to setting; most broadly within merged and restructured departments. Social work autonomy was experienced along a

continuum of models. Role clarity is functionally linked to how roles are defined and controlled. Fragmentation and interchangeability of practice roles between disciplined; how one's professional identity is individually perceived and projected to others; and varying intra professional perceptions regarding practice roles impact role clarity.

Participants more likely characterized their experience as positive when they had control and clarity of their role and felt valued. When patient cases were first assessed by case managers and then referred, their practice role became task driven and was often perceived to be inconsistent with an understanding of social work. Overall experiences were more generally negative. Reporting to a non-social work manager increased perceptions of powerlessness and competition with non-social work colleagues. Professional identity is compromised as non-social workers are increasingly defining social work practice and professional supervision is lacking. The recognition of a clear and unique social work professional contribution to hospital settings is challenged as these themes intersect.

The implications of the study findings emphasize the need for educational curriculum and evidence based research to clarify social work definition and effective scope of professional practice. Policies are needed to incorporate the specific expertise of hospital social work into the language of professional licensing and health care accreditation bodies to ensure a continued professional role for social work in hospitals.

DEDICATION

This dissertation is dedicated first and foremost to my husband Howard. Without his unwavering support, encouragement and sacrifice, this achievement would not have been possible. Howard, your faith in me and your love allowed me to persevere even during those times that my journey seemed endless and impossible.

This dissertation is also dedicated to my children, Rachel and David. Along with your father, your own sacrifices, your patience and endless humor have sustained me and balanced me. You have become incredible adults during my long dissertation journey and for that I am forever grateful and proud.

Lastly I wish to dedicate this dissertation to my mother, Claire. Your personal strength and wisdom has been an inspiration throughout my life and your belief in me has always helped me reach my goals. Mom, thank you for seeing me to this day and for repeatedly encouraging me through these years to "go do my homework".

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CHAPTER 1: INTRODUCTION

Stanley L. Witkin, 1999, writes:

> How do we know what to do, how to do it, and who to do it with,
> unless we have some clarity about who we are...Social work may
> be many things, but it cannot be everything. It must have
> boundaries. Part of our identity is deciding the location of these
> boundaries and their permeability. (p.293)

Statement of the Problem

Witkin's editorial titled "Identities and Contexts" introduced a Special
Centennial issue of the journal Social Work, and discussed the current status of
the social work profession.   What makes this statement most relevant to the
present study is the following: if the "role of social work" within the profession
at large, after a century, is unclear, defining hospital social work is even more
difficult. Professional identity and role clarity for hospital social workers can
become increasingly elusive, with changing organizational structures,
transformation or elimination of social work departments and different health care
professionals assuming many if not all of traditional social work roles. As
hospitals have reorganized, in response to political and economic forces, the mere
survival of social workers in these health care institutions is continually
threatened (Neuman, 2000).

The present qualitative study is an in depth look at the experiences of social
workers providing direct care in hospital settings within the context of this
changing environment.   The driving assumption is that the experiences and
meaning of their experiences may vary within different organizational and

administrative structures. In particular, how professional identity and role clarity is perceived by workers within such environments and what factors might influence these perceptions will be explored.

Study Background

To date, social work writers have reported on the evolution of hospital social work, often through the eyes of administrators examining social work roles in different models of restructuring, or exploring a specific function such as "discharge planning" which included the perspectives of different disciplines (Berger, Caynor, Mizrahi, Scesney & Trachtenberg, 1996; Berger & Mizrahi, 2001; Berger, Robbins, Lewis, Mizrahi & Fleit, 2003; Holliman, Dziegielewski & Datta, 2001, Neumann, 2003). As internal administrative structures have changed, supervision at times is provided by non-social work administrators (Berger & Mizrachi, 2001; Neuman, 2000), adding to the challenges new or even seasoned hospital social work clinicians face as they develop or expand their professional identities and expertise. How hospital social workers are experiencing or adjusting to organizational changes is further reflected in studies looking at personal attitudes such as job satisfaction, stress, burnout, and overall "staying power", proposing what characteristics allow a social worker to continue working in such an uncertain setting (Pockett, 2003).

Gibelman (1999) perhaps best sets the stage for the present study, describing how throughout the history of the social work profession, employment niches, professional boundaries and scope of practice have been redefined based on socioeconomic fluctuations and political priorities of the general society at any given time. It is the finding that social work professional definitions continue to fluctuate in response in part to factors external to the profession is what makes

studying practice within a continually changing practice environment interesting and significant.

The best way to understand the broad context of this study is to envision a number of rotating and evolving systems intersecting at the point of hospital social work practice and professional identity. One overarching system would be the health care environment, the other the social work profession itself. Within each, political and economic factors have accounted for continual flux and adaptations. The subsystem shared by both is hospital social work which has changed over the century in response to both external factors, those driven by new realities of health care delivery and by internal factors, those emanating from the teaching and mentoring influences of the profession. The following study will start with an examination of the larger spheres of influence, continue with a look at how hospital social work has evolved within that context; and conclude with the theoretical perspective on professional identity and what factors within the hospital social work environment may be critical to identity formation and practice.

The Hospital System

The main objective of a hospital is to provide quality health care to patients. Historically, hospitals functioned with little accountability to oversight bodies, with physicians being the dominant profession and in most cases, making all relevant decisions about health care. Cost-based, retrospective reimbursement systems enabled hospital stays to be extended without negative financial consequences as long as the treating physician felt it was justified. In 1972, Professional Standards Review Organization (PSRO) was mandated to both set standards of practice and to monitor costs of health care provided (Schreiber, 1981). As health care costs continued to escalate, and with the government being

the single largest payer, federal legislators looked at Medicare expenditures for hospital care and implicated unnecessary length of stays as a primary reason for escalating costs. Schreiber (1981) stated that two billion dollars per year could be saved if merely one day on an average seven day hospital admission could be eliminated.

The American Hospital Association had already defined discharge planning as a primary administrative function in their 1974 manual (Davison, 1978); however, its fiscal significance was now being subject to external mandates. Length of hospital stays continued to be a focus of financial viability with the advent in 1983 of prospective payment systems such as Diagnostic Related Groups (DRGs). Care for Medicare patients would be reimbursed based on previously determined rates according to specified diagnoses and procedural codes, no matter the length of the actual inpatient stay (Kadushin & Kulys, 1993; Marcus, 1987). Physicians and their medical judgment were no longer the sole standard upon which extent of hospital care was determined (Blumenfield & Rosenberg, 1988).

Reports of reduced length of stays followed the implementation of DRGs (Abramson, 1990), highlighting the significance to the organization of all activities related to transitioning a patient out of the hospital (Iglehart, 1990; Kadushin & Kulys, 1993). The Omnibus Budget Reconciliation Act of 1986 mandated the delivery of discharge planning services to all hospitalized Medicare patients (Iglehart, 1990). Oversight bodies, accreditation agencies and federal legislation legitimized discharge planning as a key hospital function impacting both quality of care and fiscal responsibility, but which professional discipline should have control over this critical and powerful function was never specified.

Despite who initiates discharge planning within a facility, this responsibility is now linked via external mandates to revenue which becomes available to the hospital operating budget. The challenge this creates is that patients and diagnoses do not fall neatly into predetermined standardized categories. The

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realities of costs associated with hospital admissions are subject to broad complexities of both diagnoses and individual responses to treatment. Patient care strategies have to adjust to new financial uncertainties.

Increasingly the emphasis of care is shifting from inpatient care to more structured outpatient services, with 98% of all medical encounters occurring in non-hospital settings (Berkman, 1996). Between 1980 and 2003, total outpatient visits in community hospitals increased from 200 million to approximately 550 million (American Hospital Association, Trendwatch Chartbook, 2005). Patients that are admitted to hospitals for care do so because their needs are too complex to be managed in an outpatient setting and/or their fragile health requires close and sophisticated monitoring. The quality of care challenge therefore becomes one in which the patient enters the system "sicker" and is subject to forces requiring the shortest stay possible. So while the increase in outpatient care might make income and costs more predictable on one end, the financial uncertainties of providing more extensive care to inpatients, with limited reimbursements, may create a greater burden as overall budgets are assessed.

Skyrocketing national health expenditures and rapidly changing reimbursement systems within both the federal arena and private insurance sectors additionally create great challenges to organizational budgets. Government mandated cost-containment efforts, particularly moving from cost-based reimbursement to prospective and capitated payment streams, increased infiltration and control by managed care plans, and reduced length of stays have contributed to greater financial deficits (Lee & Alexander, 1999). In fact, by 2003, hospitals reported a financial shortfall of $14 billion for governmental reimbursements, with an average of 60% of hospitals serving Medicare and Medicaid patients describing losing money, thus potentially risking the survival of their organizations (American Hospital Association Trendwatch Chartbook, 2005).

The hospital organization has had to continue to adapt to survive with less predictable income streams. Borrowing from corporate sector strategies, more controllable and tangible cost containment efforts involving reorganization and reengineering have been ongoing over recent decades (Berger, et al 1996, 2003, Lee & Alexander, 1999). The American Hospital Association (AHA) reported that by 1996, 40% of all community hospitals were part of a health care system and 26% were members of networks (Dranove, Simon & White, 2002). For the period 1998 through 2003, the AHA (Trendwatch Chartbook, 2005) reports that there were 514 completed hospital merger and acquisition deals involving 869 hospitals in this country. Through an analysis of data from AHA statistics and governmental censuses, it is the local prevalence of managed care payers which has driven these consolidations as efficiency and market strength are sought to ameliorate financial challenges (Dranove, Simon & White, 2002).

Reorganization can take many forms resulting in full control by a single owner at one end of the spectrum to network affiliations or joint ventures. These latter structures typically lack a centralized locus of control and may only focus on consolidation of certain administrative functions or particular patient care pathways (Bazzoli, LoSasso, Arnould & Shalowitz, 2002). Strengthening financial position and increasing efficiency is cited as the most frequent reason for consolidation processes.

A number of authors have examined in more detail how externally imposed financial challenges for health care settings have driven internal adaptations and impacted service delivery and staffing (Bazzoli,et al, 2002; Berger et al, 2003, 1996; Gregorian, 2005; Lee & Alexander, 1999; Neuman, 2000). Specific facility-level changes were explored in a survey of 214 healthcare systems which included 190 full hospital mergers and 24 other types of affiliation formats (Bazzoli, et al, 2002). These authors described that the event of the merger was used as a catalyst to "reduce service duplication, consolidate departments and

programs, restructure/downsize patient care and support staff and restructure/downsize administrative staff" (p. 19). Lee and Alexander (1999) described how when institutional reorganization occurs, internal allocation of resources shift, lines of communication are altered, and disruptions of power distributions among professional groups and departmental units inevitably follow.

Berger, et al (1996, 2003) in longitudinal studies conducted over 3 timeframes covering 1992-1998, described the changing environment for hospital service delivery while focusing in on how social work practice has been impacted. Using a stratified random sample of 750 hospitals, administrators were asked in a mailed survey to describe current status and what changes have occurred during the prior two years. Increasing use of cost-containment strategies were employed to improve efficiency, with flattening of bureaucratic hierarchies, use of care maps to standardize patterns of care, matrix management (i.e. dual reporting arrangements), decentralization involving elimination of departments, and use of care management models to maximize care efficiency. Similarly, when social work services were the focus, erosion of the traditional centralized social work departmental structure was reported over time, in favor of matrix or decentralized service delivery models. A steady increase in the number of departments functioning without a social work director with a concurrent increase in leadership by professionals with non-social work degrees was reported. An increase in the use of nurses within social work departments was also described. These findings represented small but significant changes over recent times with significant directional trending mirroring the larger organizational restructuring described above.

For social work services, different reengineered approaches have emerged. At one extreme, professionals providing overlapping services are combined into one multi-skilled professional who can be a member from each of the previously distinct disciplines. These newly defined professionals are expected to assume all

aspects of discharge planning, data collection, analysis, and insurance review and in some instances responsibilities include addressing the psychosocial needs of patients. An alternative model separates psychosocial counseling and behavioral management from continuity of care tasks and limits social workers to these former designated functions (Neuman, 2003a).

Reengineering is the approach increasingly being implemented in health care settings, representing a cost saving strategy across financial, organizational and structural functions. Often this encompasses a move to a more patient focused practice. As described by Neumann (2000), reengineering seeks to create a workforce that is multidimensional and flexible with regards to roles, with effectiveness assessed using results oriented performance measures. Towards this goal, redundant staff and bureaucratic layers are reduced; generalization is favored over specialization; and the skill mix of professionals is altered as new roles and responsibilities are defined. Employees in this model are empowered as reporting bureaucracies are collapsed and more generalized skills permit practice over broader areas or responsibilities.

Various authors describe the modified integrative organizational model as a predominant format for change (Berkman, 1996; Globerman & Bogo, 1995). These hospitals are patient-focused, organized around programs and services and not discipline specific departments. Centralized departments are disbanded with professionals reporting, for example, to patient "problem" focused teams. Professionals are cross-trained, and required to function autonomously. Lacking upper level supervisory structures, decision making is made at the point of service. Without a formal department to report to, workers have to learn to seek consultation as needed, similar to how physicians routinely function. (Globerman & Bogo, 1995; Neuman, 2000).

Neumann (2003a) described an example of reengineering in which social work, case management and utilization review departments were merged into one

division called Outcome Management. This restructured department combined overlapping patient focused tasks related to continuity of care. Each professional, social worker, nurse or case manager, now known as "Outcome Management Consultant" functioned interchangeably. Overall effectiveness of the interdisciplinary team was measurable as length of stays decreased, insurance authorization denials decreased, and cross training of professionals provided better staff coverage.

Neuman (2003b) additionally looked at the effect of reengineering involving four other hospitals, three that had utilized the combined role model described above and one in which the alternate merged department allocated distinct functions to social workers and other responsibilities to nurse case managers. A fifth hospital which had not reengineered was used as a comparison for her study. Surveys and informal focus groups were used to collect data focusing on attitudes toward their job comparing their experiences before and after reengineering, specifically with regards to morale, job satisfaction, extent new roles and responsibilities were consistent with their professional identity and educational preparedness, and satisfaction with supervisory experiences. Forty four respondents were included and were comprised of 23% nurse/case managers, 57% MSW's, one held a BSW degree, and two were discharge planning or social work technicians. The remaining six were identified as utilization review coordinators. Though the sample was small, preliminary findings indicated that the reengineering process negatively impacted job satisfaction, and this sentiment was worse when roles were realigned in ways workers did not perceive as consistent with their professional identity and training. Social workers who retained more traditional roles of discharge planning and counseling were most satisfied with their employment. Social workers, who were reengineered, but specifically assigned counseling only roles, expressed higher levels of job satisfaction when

compared to colleagues reengineered into combined roles shared with other disciplines.

As health care systems continue to evolve, measures of efficiency and effectiveness have become the critical mantra for all service delivery and practice models. Work settings have been experiencing financial pressures to cut staff. The health care industry specifically reports that thousands of hospital employees lost their jobs in 1995 and tens of thousands have experienced drastic changes in their working conditions (Citrome, 1997). Citrome refers to Maslow's hierarchy of needs to propose that safety or in this case, job security, is the primary need to be met before any aspect of satisfaction or productivity can be considered. Change and the uncertainty that accompanies organizational restructuring are associated with increased stress even for those who remain after downsizing (Berger, et al., 1993; Gladstone & Reynolds, 1997). Employees collectively and individually are affected across all roles and responsibilities.

The Effects of Reorganization on Social Workers

A number of authors have looked at how social workers in hospitals have been affected by and/or adapted to the day to day realities of organizational changes. Different reorganization and reengineering strategies are likely to have a range of anticipated to unexpected consequences for hospital social workers. In some cases, efforts towards proactive planning was hoped to minimize the impact. For example, in the model of reengineering described by Neuman (2003), as social work, case management and utilization review departments were merged, disciplines were sensitive to potential role blending that might result and attempted strategies to avoid this. However, after the six month trial, these roles had blurred more than expected, with social workers performing less psychosocial counseling and discharge planning and spending more time on insurance related

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issues. This outcome is not a new concern as changing responsibilities and social work role ambiguity in hospitals have been ongoing for decades (Cowles & Lefcowitz, 1992, 1995; Davison, 1990; Egan & Kadushin, 1995, 1997; Donnelly, 1992; Gregorian, 2005; Pockett, 2003). Burnout and decreased job satisfaction are well documented consequences of role ambiguity and overlapping job responsibilities (Jayartne & Chess, 1984; Siefert, Jayartne & Chess, 1991).

In the integrative hospital model, without distinct department involvement and oversight, social workers are challenged to maintain strategies for continued education, practice standards and teaching responsibilities. The social work "voice" is not formally structured, and with the loss of social work leadership, decision making and professional role definition are not under social work's control. Hospital social workers, fewer in sheer numbers than other disciplines such as nursing, become isolated from peers in their daily work. More purposeful and proactive efforts to connect and provide meaningful and unique professionally related activities become critical.

A number of authors have outlined these concerns and presented strategies to ameliorate their potentially negative impact (Globerman & Bogo, 1995; Sulman et al, 2004). In one setting, a Social Work Professional Standards Group organizes and maintains the professional interests of social work in education, research and teaching for settings with decentralized departments (Globerman & Bogo, 1995). Such self-governing structures, designed to sustain professional activities, can provide forums for journal clubs and social work "rounds" to enhance knowledge and practice. Peer/collegial consultation and student training are other potential programs that can be developed. Though lacking administrative responsibilities, the coordinator of such a group would represent social work issues to hospital administrators and maintain a professional role within overall organizational functioning (Globerman & Bogo, 1995). Success of these strategies is often dependent on receptive organizational support and

requires the commitment of individual participants to champion the goals and needs of the discipline.

Sulman et al. (2004) offers the "social work group" as a similar strategy within an integrative hospital setting to foster collegial support and unified advocacy. The model described has collective decision making and shared leadership, meets along program lines for more specific problem solving (i.e. perinatology might be one, psychiatry along with surgery and emergency might be another "peer management group"); but also convenes as a whole discipline for broader organizational issues and standards maintenance. Facilitators are fully functioning peers with identical caseloads. Groups provide support in many forms including social, emotional, clinical, administrative and political. Peer groups maintain accountability to practice standards and are responsible for peer performance appraisals. When indicated, peer group members act to address any uncovered or reported practice concerns of individuals, intervening to both improve their colleague's work and more broadly to maintain the positive image of social work as a whole within the organization. In assessing effectiveness of the model, the authors report less isolation and workers express feeling emboldened by peer support to be stronger advocates on behalf of patients. Other disciplines have commented on social work's strength and visibility within the organization despite their comparatively small numbers.

A case study of a hospital in Canada that was undergoing reorganization to a fully integrative, patient focus setting was examined using interviews of staff at different time points (Michalski, Creighton & Jackson, 1999). In this setting, Professional Practice Leaders and Professional Councils were created to replace disbanded formal departments. These leaders and councils were charged with maintaining professional standards and adherence to the principles of patient focused care standards. Workers approached this initial transition to program management with enthusiasm, looking forward to increased autonomy and

enhanced decision making. Later views became more negative as isolation grew and less attention to education and research was reported. Decreased job satisfaction was linked to perceived loss of recognition and support from their assigned programs. Over time, the Councils and Social Work Practice Leaders lost significant influence, resulting in suspension of social work rounds and greatly diminished student internship efforts.

Social workers have reported feelings of disempowerment as departments move away from centralized structures.   They describe increasing challenges in remaining connected to social work colleagues and a shift away from allegiance and identification with the profession itself. A commensurate decline in their motivation to provide student education, participate in research and publications and reduced morale and enthusiasm for social work practice in health care are additional outcomes resulting from a restructuring to decentralized structures (Globerman, White & McDonald, 2002; Michalskiet al., 1999).   Hospital social workers' capacity to manage the emotional stress associated with their work is compromised when peer support is not available (Nelson & Merighi, 2003).

 Globerman, White, Mullings & Davies (2003) looked at the issue of disempowerment by interviewing 22 social workers from 22 hospital sites, over an eight year period. Sixteen workers were still available to be included in the longitudinal study. Participants had access to questions prior to the interview and were instructed to obtain and include perspectives from colleagues. Not surprisingly, the "happiest" and most productive social workers described settings in which a clear and consistent mission was evident and workers were actively engaged on committees. They perceived their involvement was valued within their systems. Workers who could proactively define their roles and solidify their position and voice believed they were best understood among other disciplines. One strategy reported was to market themselves as "specialists", with defined practice responsibilities such as discharge planning or case management, while

retaining and protecting their title of social worker. This accomplished two primary functions: with carved out roles, other disciplines valued their distinct contributions, and secondly, by associating the title with the specific roles, other professionals could not as easily assume these tasks. When social workers in this study perceived their setting as unstable, more discontent was undoubtedly reported, and descriptions such as "toxic" were applied to their work environment and "victim" was attached to themselves. Workers who were more positive felt they had control over their environment and were more likely to be flexible; those less positive conversely expressed feeling others defined their roles, they were less respected within their teams and in general experienced more anxiety regarding their jobs. This supports earlier findings among psychiatric social workers that job satisfaction was linked to role definition, organizational requirements, job prestige and autonomy (Marriot, Sexton & Staley, 1994).

Reorganization of departments and staffing patterns can impact whether or not supervision is available to social workers. Studies suggest that social workers are directly impacted by how supervision is provided, which becomes significant as reorganization continues. Consequences such as a decrease in worker satisfaction and professional identity were reported when changes in supervision modalities, especially in structures with non-social work administration, occurred (Berger & Mizrahi, 2001; Neuman, 2003). In addition, the content of supervision, which logically could be linked to the background of the supervisor, becomes most meaningful for new workers who report a strong need to enrich and improve their basic social work skills for their work in health care settings. More senior social workers, though confident with their expertise, express a need to learn advanced interventions to enhance their practice (Cohen & Gagin, 2005).

Cohen and Gagin (2005) specifically explored using skill development as an intervention to alleviate the experience of burnout in hospital social workers. They designed skill development training that incorporated educational and

supportive components, based on Kadushin's concept of supervision (Kadushin & Harkness, 2002). Education designed to be specific to the professional's development level and provided by other social workers was most significant. The benefits of both skill enhancement and perceived peer support resulted in a decrease of burnout scores when pre- and post-training levels were compared. A greater decrease in emotional exhaustion was found among the newer workers and was attributed to their increased experience of collegial support.

Supervision provided to workers in other settings has been studied as well. Egan & Kadushin (2004) explored the experiences of home health social workers, traditionally supervised by nurses. Professional development and mentoring was reportedly absent because non-social work supervisors were not trained specifically in social work ethics, values and practice knowledge. Gimble, Lehrman, Strosberg, Ziac, Freeman, Savicki & Tackley (2002), found that among HIV/AIDS community workers, supervision was a significant predictor of job satisfaction. This is consistent with Kadushin's (1992) finding that supportive supervision provides the psychological and interpersonal resources for workers to cope with job-related stress and promotes effective job performance. The quality of one's manager has been shown to be linked to job satisfaction, an employee's capacity to adapt to change and overall staff retention (Globerman et al., 2002; Pockett, 2003). Even initial interest in employment in a hospital setting has been linked to a student's satisfaction with their supervisory relationship (Pockett, 2003).

But perhaps one of the more telling trends in social work research thus far are a series of articles that acknowledges the cumulative challenges faced by hospital social workers and focuses on what characteristics, personal and organizational, are needed to remain in such a tumultuous employment setting. Pockett (2003) summarizes existing findings such as retention and turnover and their relationship to job satisfaction and burnout, along with role clarity and poor organizational

environment as predictors of burnout. Using in depth interviews, Pockett found that job satisfaction was dependent on a successful interrelationship between an individual's professional aspirations and that of the hospital. Perceived value of the work and the extent of available professional support and autonomy were key components of job satisfaction. Professional leadership was seen as necessary in developing and maintaining the profile of social work services in a hospital setting; its leader critical to integrating departmental services into the overall hospital organization.

Similarly, specific personal and professional attributes are being increasingly linked to "survival" in the throes of evolving hospital organizational structures (Gregorian, 2005). Social workers must continually educate other professionals regarding their roles and value. This is especially challenging in settings in which "others" continually redefine the work. The difficulty is compounded by frequent changes in lines of authority; and the need to "prove" one's worth by taking on challenging situations. Personal characteristics that are needed to "make it" include a good sense of professional self-worth and self-esteem along with clear personal and professional boundaries (Gregorian, 2005). A willingness and openness to learning and change are especially needed as adaptation to new professional and organizational systems are increasingly guiding the practice of social workers (Pocket, 2003).

A number of authors have commented on how social workers have the specific educational training and professional practice skill set to adapt to environmental and organizational changes and in turn promote and secure their place in most practice systems (Globerman, et al, 2002; Gibelman, 1999; Kitchen & Brock, 2005). Kitchen & Brock (2005) most recently piloted a practice model in which hospital social workers, tapping into their collaboration skills, secured a role as the central and pivotal member of the medical team. Social workers were recognized as the most proficient in coordinating all aspects of a patient's care

from admission to discharge.   All patients and families were assessed and potential obstacles to care and discharge identified early on. Only 30% of patients and families outside the project received similar proactive planning. The team experienced the process of service delivery and discharge as more orderly, insurance coordinators benefited from more advance knowledge of pending discharge issues and administration staff reported more accurate and timely documentation. Physicians described having more complete social information about patients and families and medical residents admitted that they were not previously aware the many ways social workers could be of assistance.

More broadly, as experts in systems theory and change strategies, social workers are poised to identify and strategically negotiate between stakeholders and decision makers, as well as tap into their own and their colleagues' professional capabilities through strengths and empowerment perspectives. This knowledge and skill should enable social workers to turn seemingly chaotic opportunities into positive experiences.   However, use of empowerment language and advocacy strategies is not always easy for social workers when addressing their own concerns, especially with regards to carving out their place within their organizations. The use of power by social workers for their own benefit presents two issues. First, the concept of power is traditionally viewed negatively and secondly, to use "power" one has to believe that he or she has something of tangible value to offer (Globerman, et al, 2003; Berger, 1991). The concepts of organizational power and value, to be discussed in more detail later on, are particularly challenging in a host agency such as a hospital. Additionally, struggles and realities within the social work profession have created and perhaps amplified some of the obstacles now faced by hospital social workers as they confront an evolving health care system.

The Social Work Professional System

The social work profession can be described as the second fluctuating system informing the background for this study.   When one considers members of other professions, for example, a lawyer, an accountant, a teacher, a nurse, one has a fairly clear picture of what each individual does when working. This is not necessarily the case with regards to a social worker. Over the last century and surprisingly recently, the social work literature is replete with descriptive phrases which speak to the challenges of defining social work and clarifying the work of social work. For example, in her article titled <u>The Search for Identity: Defining Social Work – Past, Present, Future</u>, Gibelman (1999) provides concepts such as "the quest for status and identity has occupied center stage since social work's inception" (Gibelman,, p. 293); "professional roles and relationships underwent substantial transformation during the 1980s (p. 303), and "boundaries of the social work profession will continue to broaden and change" (pg. 305). When professionally based practice is discussed, Rosenfeld (1983) reports on the profession's failure to present a coherent view of the domain of social work and the core of expertise relating to it; Gorden (1983) offers that "there is a slow but documentable evolution and not a revolution, taking place in social work" (p. 183) when describing how the focus of the work of the profession has changed over time, that it is "searching for a frame of reference different from that of other disciplines"(pg. 183) and similarly, Shulman (1993) writes "social work is in the early stages of building an empirically based holistic practice theory" (p. 91).   These action oriented words found in the literature, from the writings of social workers, such as - searching, quest, transformation, boundaries that broaden and change, evolution, early stages of building, –from as recent as 1999, highlight the perpetual motion of the profession from within the profession.

In 1956, the newly formed National Association of Social Workers (NASW), provided a "temporary and tentative" working definition of social work practice,

describing the goals of social work, as it was understood that the definition would be continually revised and refined as knowledge and extent of social work practice interventions expanded (Gibelman, 1999).   By 1970, the NASW Board of Directors, described social work as "the professional activity of helping individuals, groups and communities enhance or restore their capacity for social functioning and creating societal conditions favorable to this goal" (Gibelman, p. 300). This definition has been amended and adjusted throughout the last 50 years and in a more recent version, social work practice is defined as "the use of social work knowledge and social work skills to implement society's mandate to provide social services in ways that are consistent with social work values." (Barker, 1999, p. 456).

Besides NASW, social work writers have concurrently presented alternative working definitions of social work. Crouch (1979) approached the issue differently, not focusing on the widely varied tasks and activities of social workers, but instead developing an inclusive but concise definition that would encompass the profession's diverse fields and specialty practices. He suggested "Social work is the attempt to assist those who do not command the means to human subsistence in acquiring them and in attaining the highest possible degree of independence."(p. 46)   In this definition "human subsistence", contains the complex components of physical, economic, political and social survival. Rosenfeld (1983) speaks to the need to "demystify" the profession and make it "more comprehensible" both within the profession and to others. He described the domain of social work practice as that which reduces the gaps and discrepancies between the current and anticipated needs of people and the resources available to ensure their well-being. Consensus is needed to describe a common expertise that would be global enough to embrace the broad political, social and economic spheres of practice at any given time. In his view, social work expertise can be summarized as the creativity and effectiveness with which

workers are able to adapt existing resources to the needs of individuals or populations, throughout micro and macro practice. Barker (1999) in the social work dictionary offers simply that social work is the "applied science of helping people achieve an effective level of psychosocial functioning and effecting societal changes to enhance the well-being of all people (p.455)".

A number of authors expand on this discussion. Social work definitions and identities are more often described through the contexts which influence the work, where the work is occurring and within what social context the work is taking place (Gibelman, 1999; Witkin, 1999). Gibelman (1999) proposes that social work is defined by its place in the larger societal environment at any given time, not surprisingly analogous to the profession's guiding practice framework of looking at the interaction of the individual and his or her environment. She argues that external forces have been more influential in defining the boundaries of social work and shaping the nature of its practice than intra-professional forces and choices. Historically, the profession has continuously reexamined its definition, varying in response to different segments of the profession.   From the profession's beginning, boundaries and professional identities have been further challenged by its dual focus of addressing the concerns of individuals, families and groups on one hand and social reform and social justice on the other hand. Practice domains, functions and roles of professional social workers are more expansive than most other professionals, which limits efforts to define what social workers do, where they do it, who they serve and what methods are used. Fluidity of boundaries, confusion within the profession and continual interpretation to the public about its role and function are understandable consequences (Gibelman, 1999).

Germain (1980) suggests that a reliable sense of professional identity leads to increased competence and autonomy. The acquisition of a professional social work identity involves a growing self-awareness coupled with an emerging

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identification with the role of a social worker and the values and ethics of the social work profession (Carpenter & Platt, 1997). To this end, professional identity can be better fostered through a clearer definition of the unique nature, social commitment and purpose of the profession, a definition that would be sufficiently broad to encompass the distinguishing features in all fields of practice. Without such clarity, controversy has existed as to whether social work even meets the proffered standards of what the literature describes as a true profession.

Social work has been described as a semi-profession or an "occupational category by authors such as Etzioni (1969) who in particular cites its tremendous diversity in training, activities and settings as one reason for its low status on the continuum of defined professions. For example persons involved in basic social work tasks can have a high school diploma at one end and a PhD at the other extreme conducting research on new practice interventions.   An evolving knowledge base, observed to be continually upgrading, mostly founded on skills and experience and not theory have been criticisms contributing to a tenuous classification of social work as a profession (Toren, 1969). And while these authors commented almost 40 years ago, the internal challenges faced by the social work profession persist.

Finally, it has been proposed that in times of uncertainty and rapid change, identity cannot be viewed as a fixed thing. Identity is instead viewed as open, negotiated, shifting, ambiguous, and the result of culturally available meanings and these meanings as subject to the power laden influences in everyday situations (Sachs, 1999). With this in mind, perceptions of role and professional identity have been explored among social workers in hospital settings in this present study. Hospitals represent a particularly intriguing study site having experienced rapid organizational change over the past several decades and as host settings to practice in, social workers become particularly vulnerable to the

consequences of power shifts and institutional changes. As will be described below, the evolution of hospital social work can be directly linked to such forces. It is within the context of these two continually evolving and intersecting systems, health care and the social work profession that the following background is also provided, specifically how hospital social work has evolved within itself, over the course of a century.

History and Evolution of Hospital Social Work

Social workers have been working in hospital settings for over a century. They were first invited in by physicians who identified that the success of medical treatment involves more than science. The medical-social needs of patients and families during the infection epidemics of 1918 and the devastating consequences of World War I created an unmet need and a professional niche for social workers in the health care arena. Securing concrete resources, assisting families' transitioning back to homes and employment following illness or injury became key functions of medical social work (Davidson, 1978; Holliman, Dziegielewski & Datta, 2001; Kershon, 1979). Social workers were recognized as having the skills to put in place an appropriate discharge plan to dovetail with medically recommended processes, and a secure professional niche was established.

Over the century, however, the roles and responsibilities of hospital social workers have evolved, in response partly to changes in the profession itself and more recently in response to economic challenges driving health care organizational changes.   The timely influence of Freud provided a mechanism by which social workers could identify themselves as mental health professionals. As hospital social workers joined their mental health peers in adopting psychodynamic theory as a practice framework, they re-defined themselves as experts in psychosocial assessment and treatment. This re-definition would

hopefully lead to more autonomy within the hospital setting (Davidson, 1978). Planning for discharge became a secondary focus for hospital social workers as their therapeutic role evolved. The concrete services component of discharge planning was viewed as a distinct and non-professional function and perhaps not worthy of their diagnostic and therapeutic skills (Holliman, et al, 2001).

Growing ambivalence towards the very role that had previously characterized their unique domain, created an opening for differently trained staff and other disciplines to assume part or all of their tasks. In a recent study, Holliman, et al, 2001, surveying 178 professionals responsible for discharge planning from 58 different hospitals and found that 62% were social workers, 30% were nurses, 1.1% were respiratory therapists and 13% had varied backgrounds that included sociology, psychology, human services and history. Twenty five percent of the social workers in this study were at the BSW level.

By the 1980's, timely discharge planning and the push to eliminate non-essential professional staff had a significant impact on social workers.   Shortened hospital stays made psychodynamic functions and approaches less significant to economic survival. Competition among disciplines to provide visible, critical functions within the hospital setting, such as discharge planning, was seen as leading to more job security (Holliman, et al., 2001). Practitioners including social workers began to compete for control of discharge planning activities. This led to conflict, duplication of services, and political unrest.

The resulting erosion of social work role clarity is further documented by authors who describe how different disciplines view their roles and the roles of social workers (Davison, 1990; Cowles & Lefcowitz, 1992, 1995; Egan & Kadushin, 1995, 1997; Donnelly, 1992). There seems to be a consensus among most studies that nurses and physicians see networking for concrete resources and clarification of financial issues as clear social work functions (Cowles & Lefcowitz, 1992, 1995; Davison, 1990; Egan & Kadushin, 1995, 1997). Nurses

and physicians also viewed psychosocial assessment as functions shared between social work and nursing consistent with their perspective that a client's medical needs were inclusive of both physical and emotional concerns (Cowles & Lefcowitz, 1992). Social workers were less willing to concede that counseling and psychosocial issues were not more exclusively social work functions (Carrigan, 1978; Egan & Kadushin, 1995; Cowles & Lefcowitz, 1995). When discharge planners comprised of both social workers and nurses were surveyed across 58 hospital settings, both disciplines performed the following tasks consistently: coordination of services, assessment, supportive counseling, documentation, and treatment team participation. Interestingly, social workers were most often employed at larger hospitals, those with greater than 250 beds and nurse discharge planners conversely were more prevalent in smaller settings. Social workers were more likely to specialize in working with challenging psychiatric patients or more complex cases such as those patients with HIV/AIDS, in efforts to maintain a distinct place in the organization (Holliman, Dziegielewski & Teare, 2003).

Perhaps compounding disparities and varied role perceptions is the observations made by Katz (1984) as he offers his assessment of the "elusive vision" of social work in health care: that social workers as a profession are better at reacting to a given set of societal gaps or needs than proactively looking inward at their expertise and carving out niches where their skills are best needed. He provides two examples, rehabilitation counseling during the post-World War II period and in the 1960's and early 70s, with the advent of genetic counseling. In both instances, social workers failed to identify how their skills could be applied and other disciplines moved in to provide the necessary services. Where one would perceive a social worker would "fit", another discipline instead took on that role, again potentially confusing onlookers.

To summarize the key points thus far, social workers in hospitals continue to be challenged by both internal and external factors impacting their professional identity and their practice and these forces seem to be increasing in complexity and consequence. To preserve a professional place in hospitals, to offset financial threats to survival, hospital social workers have to be individually clear about their professional identity, their practice roles and their value to the organization. Others in the setting have to share their view. This study explores the current perspectives of hospital social workers with regard to these issues.

CHAPTER II: THEORETICAL PERSPECTIVES

This chapter is an overview of the relevant theories that underpin this research and will include a discussion of both organizations and professional identity in organizations. Since the basic research question asks how different organizational structures might influence hospital social work, the literature regarding how organizations work and factors that impact their structures and functioning will be presented first.

Organizations

Organizations are more than concrete physical buildings with employees. They are complex systems of structured components, authority lines and interrelated networks that are designed to work together towards fulfilling its overall mission. Organizational theories examine in different ways how these parts and relationships maximize institutional goals and survival, what factors outside the organization influence and impact its functioning and how organizations respond to internal and external forces.

Structural theories provide a formal perspective to help understand organizations. Organizations by necessity have a rational structure which enables tasks, decision making and accountability to have a reliable flow. The more complex an organization is, the more subunits or departments are in place and the greater the potential administrative distance there is between the top executive and the workers most "hands on" and involved with production. Hierarchies exist to represent the lines of command as well as the relationships between subunits that have been logically established to allocate work and coordinate different

roles. Differentiation and division of labor are key characteristics of formal organizations. Accountability for the activities of large numbers of employees can be preserved through these structures. Subunits have their own internal structures that facilitate the designated work of the particular component of the hierarchy (Blau & Scott, 2005; Jaques, 1990/2005; Bolman & Deal, 1997).

Bolman and Deal (1997) outline six basic assumptions that summarize the structural frame perspective (p. 40):

1. Organizations exist to achieve established goals and objectives
2. Organizations work best when rationality prevails over personal preferences and external pressures
3. Structures must be designed to fit an organization's circumstances
4. Organizations increase efficiency and enhance performance through specialization and division of labor
5. Appropriate forms of coordination and control are essential to ensuring that individuals and units work together in the service of organizational goals
6. Problems and performance gaps arise from structural difficulties and can be remedied through restructuring

Within this perspective, the distribution of authority and employee positions, roles and duties are assigned in an objective and logical manner determined to be the most efficient way to accomplish the organization's goals (Hasenfeld, 1992). Actions and behaviors are prescribed and predicted by the established structure. Coordination of these different roles and organizational subunits becomes the challenge as complexity increases and added layering within hierarchical structures is needed to accommodate such expansion. Information now has to pass through many individuals and decisions through many levels. When managers and subordinates share the same experience and expertise, subunits can

become insulated from the overall mission. A manager's leadership abilities and vision may be compromised and unable to see beyond the functioning of his or her particular subunit (Jaques, 1990/2005).

When one envisions a formal hierarchical structure, an organizational chart comes to mind. While there is usually a rational design to the lines of authority and subunits depicted, how distinct subunits are interdependent is not always evident. Mintzberg (1979/2005) provides a model that outlines how the interaction of different structural components of an organization can be envisioned to understand overall coordination and functioning. In his model, the operating core, viewed as the "heart of the organization" is where the basic work of production is carried out. These tasks would include securing needed inputs and resources for production of products or services, transformation of inputs and resources and the distribution of outputs and services. The strategic apex would be made up of the organization's leaders and visionaries, for example the CEO, board president or superintendent, those individuals and their support staff, who ensure that the organization serves its mission effectively and also is responsive to those who might have power over the organization. Some tasks might be decisions about resource allocation; design of the organizational structure itself – who reports and is accountable to whom, and what they are accountable for; contact with influential persons in the outside community; and strategy formation to manage and adjust to the organization's interactions with the environment and make internal decisions to account for these influences and relationships. It is this aspect of the organization which provides the most abstract and forward thinking perspective of the organization.

Continuing with this model, the middle line management component joins the strategic apex to the operating core. This would be represented by the middle of an organizational chart where department directors or managers responsible for a number of operations would form a basic organizational unit; another manager

would then oversee a number of these organizational units and so on until all are under one manager at the strategic apex. It is within the middle line that information and decision making flows up and down the hierarchy. A manager collects feedback from within his or her unit, passes it up to the managers above, who then collect and process the information from all the units he or she is accountable for. Different concerns are dealt with at different levels; resources flow down to address identified needs. Middle line managers also manage influences from the environment outside the particular subunit or organizational components related horizontally within the larger organizational structure. Middle line managers maintain contact with other managers, analysts, and supports to develop strategies specific for the functioning of their own subunit. As one moves down the hierarchy, the jobs of the subunits become less abstract and more detailed involving specific tasks.

Mintzberg describes two additional components in his model, technostructure and support staff. Technostructure is made up of the analysts and their clerical support staff who provide the techniques to make the work of others, in all aspects of the organization, more effective using studies of work flow, standardization processes, long range planning, etc. The support staff are those individuals and services needed at all levels of the hierarchy to maintain overall day to day functioning.

Mintzberg's perspective expands our understanding of formal organizational structure as it enlivens the lines and boxes one sees on an organizational chart. The influence of the environment upon organizational functioning is introduced, not evident in classical structural theories, but included by theorists moving to more comprehensive and dynamic perspectives (Shafritz, Ott & Jang, 2005). A formal structure works best when either insulated from the environment or functioning within a very stable and predictable environment, but does not account for times of turmoil emanating from external forces (Hasenfeld, 1992).

Perspectives viewing organizations through Open Systems Theory look at the environment as an integral component of organizational functioning, as influences and activities from both within and outside the organization continually interact and are interdependent. Organizations are not static but are instead continually shifting and adapting to changes in the environment and similarly, activities from within the organization impact on relevant aspects of the environment outside the institution. Survival of an organization can be linked to how these relationships are managed (Shafritz, Ott & Jang, 2005).

The concept of open systems when applied to organizations builds on the work of von Bertalanffy who introduced general systems theory to explore the dynamic properties found in the natural and social sciences (Katz & Kahn, 1966/2005). Open systems, as first described by Betalanffy, accounts for energy going into a system (input), the processes involved in the transformation of energies within the system (through put) and the energy leaving the system (output) (Katz & Kahn, 1966/2005). Organizations must continually import resources, which could be in the form of information, money, regulatory structures and/or people, for example, whatever is necessary to accomplish its mission. The energy or resources going into the organization are then subjected to the internal processes or specific work of the institution to produce a product or service. Products or services are then introduced back into the environment.

Systems are cyclical. The energy put back into the environment renews the energy available to be reintroduced into the system. With regards to organizations, more energy - operating funds, for example - should be going into the system than flowing out. This ensures a margin of safety needed for organizational survival in the event of unpredictable influences (Katz & Kahn, 1966). In addition, systems have to be able to accept as input any negative feedback from the environment and have mechanisms in place to process and make any necessary functional corrections. As organizations grow, subsystems

multiply to attempt to gain more reliable control of known and anticipated environmental influences. Systems strive to maintain a steady state or homeostasis as their internal structures evolve (Katz & Kahn, 1966/2005; Thompson, 1967/2005). As organizations respond and expand, subsystems move towards differentiation and elaboration; specialization within the organization increases.

The principle of equifinality describes how systems may follow a variety of pathways of development to reach its most effective functional state (Katz & Kahn, 1966/2005). A distinguishing characteristic of open system theory is that organizational survival depends on being structured in such a way to ensure adaptability to a range of external and internal forces. Too much control or rigidity within its design or any attempts to operate without being fully permeable to the environment would create threats to organizational functioning (Katz & Kahn, 1966/2005; Thompson, 1967/2005). It is significant to note here that how an organization responds to the environment is greatly influenced by the organization itself and how internal systems have been designed to permit, interpret and process information received. Internal "filters", constructed by persons or groups of influence, can be responsible for an organization's perceptions of reality (Pfeffer & Salanick, 1978/2005)

Relevant to the focus of this research, and outlined in the previous chapter, hospitals are highly dependent on their environment for financial reimbursement which in turn is impacted legislatively, and of course a hospital needs patients. Outputs for a hospital would be represented by discharging medically stable and satisfied patients back to the community in a financially efficient and marketable manner, and in a way that is consistent with regulatory bodies that legitimate the hospital's existence. Patients, and financial resources to serve patients, have to be continually renewed in order for the hospital to survive. When the environment changes as seen over the last few decades, internal structures have to be

responsive and be able to adapt to newly regulated or restricted inputs, change its throughput processes and adjust its outputs to conform to what is now being required from the environment. The restructuring of hospitals described in the previous chapter represents a systems response to its ongoing environmental challenges.

As stated earlier, organizations can utilize different strategies and varied structural designs to reach its goals. Decision makers face a series of choices as to how to create work units. Bolman & Deal (1997) describe a number of options once employee positions and roles are determined, and these include: functional groupings based on knowledge or skill; units based on a timeframe such as a shift; based on a product; established around customer types such as pediatrics, maternity; work delineations based on regions; and work subunits designed by process, incorporating a complete flow of work from initiation to completion. An example cited, relevant to this study would be - should specialists in a particular function be grouped under a common manager even if they are involved in different aspects of the organization or should the various specialists working as part of team on a common task be grouped together under one supervisor (Walker & Lorsch, 1969/2005).

Decisions regarding how these subunits are assigned and coordinated can be examined using theories that explore the distribution and control of power within the organizational system. The acquisition of power and the ability to effectively use one's power is tied to structural, political and economic influences from both inside and outside the organization and these will be explored below.

Hasenfeld (1992), in his book, *Human Services as Complex Organizations,* discusses some of the key aspects of the political-economic theory as follows;

> The focus on the interactions between the organization and its environment and their effect on its internal dynamics is the cornerstone of the political-economy perspective. It recognizes

that for the organization to survive and produce its services it must garner two fundamental types of resources: (a) legitimacy and power (i.e., political); and (b) production resources (i.e., economic). (p.31)

The greater the dependence of the organization on resources controlled by an external element, the greater the influence of that element on the organization. Power and economic relations both internal and external to the organization determine how services are implemented, how resources are controlled and how decision-making authority is determined (Hasenfeld, 1992; Ross, 1993). The importance of the environment is therefore highlighted for its direct role in shaping in this case the health care service delivery system. Ross (1993) describes the existing constrained and uncertain economic environment as one in which hospital administrators are scrutinizing all expenditures for cost, effectiveness and value. Using this perspective, employees who create no measurable revenue and whose role is not readily apparent would be valued the least. Similarly, employees who are closely identified with critical tasks that directly relate to the economic functioning of the institution would be greatly valued.

Discharge planning in a hospital is a function that impacts the flow of revenue into and out of the setting as new admissions can only occur if patients vacate beds; and increasingly, the extent of reimbursement for services provided is closely linked to a patient's length of stay in the hospital often irrespective of medical need. It then follows that one gains recognition and power within the hospital by impacting the discharge planning process in a positive way. As one gains power, one acquires the ability to influence decision making and goal prioritizing (Berger, 1991). In organizations in which there are multiple goals and objectives and many actors are involved, the operation or output will be a product of their relative power. Those with the greatest influences are able to protect their

own interest and that of their constituencies (Marcus, 1987). Those groups who achieve the greatest power and influence in setting rules, distributing resources and determining roles are in a key negotiating position to affect priorities in ways to support their mission or agenda (Marcus, 1987, Shafritz, Ott & Jang, 2005). Power conflicts can result from choice of methods or approaches, and/or "turf" and not necessarily about outcomes. If viewed as a structural phenomenon, power can emanate from the division of labor and specialization within the organization and competing coalitions can form around professions vying for status and control of resources (Shafritz, et al., 2005).

Pfeffer (1981/2005) offers a useful description of power in organizations as follows:

> Power characterizes relationships among social actors. A given social actor, by which we mean an individual, subunit or organization, has more power with respect to some social actors and less power with respect to others. This power is context or relationship specific. A person is not "powerful" or "powerless" in general, but only with respect to other social actors in a specific social relationship. (p. 290)

Pfeffer distinguishes power from politics as follows: "power is a property of the system at rest; politics is the study of power in action" (Shafritz, et al., 2005; p. 292). Political activity within organizations is intentional, used as a method to overcome obstacles or resistance, and as a way to acquire power and influence to enhance or protect the self interest of individuals and groups (Pfeffer, 1981/2005).

Power theory looks at how power is attained. Power is obtained through a variety of mechanisms, one being through one's position based on an organization's hierarchical structure which delineates lines of authority amongst positions and organizational components. Modern structural theorists would consider power in this case as synonymous with authority (Shafritz, Ott & Jang,

2005). This form of power is not specific to the person, as once the position is vacated, someone else enters with the same authority or power (Berger, 1991). In a hospital setting, physicians have traditionally enjoyed having power through authority based on their critical medical knowledge and their influence as the only professional with the right to admit and discharge patients (Berger, 1991).

Power and political theorists consider authority delineated through a vertical hierarchy as only one of a number of routes to attain organizational power (Mintzberg, 1983/2005; Pfeffer, 1981/2005).   Mintzberg (1983/2005) describes five bases of power: "resource… technical skill…a body of knowledge…legal prerogatives which sanctions exclusive rights and privileges to impose choices…and access to those who rely on the previous four mentioned" (p. 335).

Resource control is an example of a component of influence that is not dependent on organizational hierarchies. Two perspectives are important to consider when looking at this source of power – dependency and essentiality of function (Berger, 1991; Ezell et al, 1997). This speaks to intraorganizational relationships and how necessary their interactions are for task accomplishment. Power emanates from whether or not the particular task is essential to meet the objectives of the organization and whether a substitute individual or group could be utilized to accomplish the task. The division of labor within an organization then represents a significant component of intraorganizational power (Berger, 1991). Work of an organization is usually dependent on interconnecting relationships among both vertically differentiated and horizontally related subunits and departments. These interconnecting relationships form a stable network within an organization relative to the flow of work (Berger, 1991). Those individuals or groups located in the most central positions in the network, or in the "hub", gain the most power as the workflow stops without their contributions to the overall process needed for task completion. Power attached to the position in a network is differentiated from power derived from the control

of resources (Berger, 1991). Power relationships relative to critical functions such as discharge planning can be assessed using the concepts of network centrality as it is in most instances a multidisciplinary function involving both internal and external interactions and interdependencies.

On a broader level, power to influence internal objectives and functional strategies is additionally impacted by the organization's dependence on external resources such as money and clients. As discussed in the previous chapter, external forces such as legislative actions and regulatory bodies can restrict access to necessary operating funds and in the case of hospitals, private insurers can not only control reimbursement but also restrict patient admissions. What employees can and cannot do are not only a function of who has the authority within the organization to make those decisions, but is often determined by outside accreditation agencies and professional licensing boards. Consumer satisfaction and community perceptions can also influence the success of the organization and impact how goals and objectives evolve.

In summary, looking through the lens of organizational theories such as systems and political-economic theories, the role one plays in an organization has not only to be understood, but has to be recognized as being of value to the organizations goals and objectives. The discussion in the next section highlights how professional identity is experienced as both an internal process and significantly reinforced through interactions. It is these mechanisms that influence how one's professional role in an organization is acknowledged, cultivated and ultimately understood and valued.

Professional Identity

Brott and Kajs (2002), in exploring the development of the professional identity of first-year teachers, offers the following relevant summary of the subject:

> Becoming a professional incorporates both external requirements and internal self-conceptualizations. An individual's self-conceptualization associated with a career role can be viewed as one's professional identity. Professional identity issues deal with professional socialization and development, person-in-environment fit, and a developmental process of maturation. (p. 4)

How professional identity is developed and understood is found among the theories describing identity and role formation and in the literature exploring the sociology of professions. These concepts will be outlined below.

Identity Theory

Each of us assumes many "identities" during the course of our daily personal, social and professional lives. We can simultaneously be spouses, parents, children, students, workers, supervisors. Identities at the same time can be attained through gender, race, religion and ethnicity. Professional roles realized through unique skill development, education, employment status and peer group membership offers an additional layer of identity for each of us. In our daily lives, we take these identities for granted, when in fact our "identities" are the result of self perceptions continually informed and confirmed through complex social interactions occurring within our environment.

How we perceive our identities can be understood through the study of identity theories. Identities are social products, formed and maintained through processes of self-identification and through exchange with others. Identities have

self-meaning, clarified directly from these interactions (Burke & Reitzes, 1981; Sachs, 1999; Stets & Burke, 2000). Social identity becomes the sense of ourselves that we perceive from the positions we occupy and the adequacy with which we and others assess our role and its efficacy or "fit". It is precisely these reciprocal interactions and repeated negotiated experiences between individuals and/or groups that inform us who we are and cultivate and allow us to internalize our identities (Sachs, 1999).

Contemporary versions of symbolic interactionism as offered by Stryker (2002) for example can be utilized to understand identity and the reciprocal relationship between the social self and social processes and incorporates the contributions of sociologists such as George Mead, Ralph Linton, George Simmel and Max Weber. On the most basic level, the environment is made up of objects and symbols that have shared meaning that is understood between actors and is the foundation for communication through interaction. Symbols or gestures become mutually relevant through ongoing social processes in which behavior and responses within the interaction become anticipated. According to Mead, "self" emerges from social interactions and social experiences and is the product of social roles, or what would be the organized attitudes and expectations of others that one responds to (Stryker, 2002).   Mead further describes that each "self" or social actor, is continually reacting to a society that is not static and thereby he or she is reshaping themselves through ongoing reciprocal interactions. Simmel adds that social structures occur when social processes represent stable forms of interactions and expectations (Stryker, 2002). Role-identities, formed out of social structures and the individual, combine to form the person, whose actions can then impact the structure of society through affecting the behaviors of others (Callero, 1985).

Looking at social relationships, Weber offers that as individuals are involved in an interaction, each orients him or herself to the other and directs their actions

accordingly. This activity is reciprocal and is supported by shared customs and habits (Stryker, 2002). According to Linton (Stryker, 2002) patterns of behaviors and the eventual organization of individuals into categories of actors represent how the labor of society is divided. He further offers that the assumption of a position in society represents a "role" that has duties and rights ascribed to it. It is the multiple positions and roles in a society and their unique relationships that determine what persons do for society and what individuals can expect from society (Stryker & Burke, 2000; Stryker, 2002). According to Stryker and Burke (2000), "social roles are expectations attached to positions occupied in networks of relationships; identities are internalized role expectations" (p. 286).

Within the concept of role-identities, authors describe that there is a hierarchy of identities in which some roles are more dominant to one's self-concept than others (Stryker & Burke, 2000; Callero, 1985). An example of this would be how one's work role identity may take precedent over one's family role identity and how this might be reversed for another individual. The concept of "role-identity salience" implies that those role identities that are most representative of one's self-concept are placed closer to the top of the hierarchy (Callero, 1985). Self-definitions are an outgrowth of role-identity salience in that one's most salient role-identity, highest on the hierarchy of role-identities, should be the most meaningful and reflective of one's overall self (Callero, 1985). This is illustrated in the following example provided by Callero:

> …suppose one has the role-identities of steel worker, union member and Catholic. If being Catholic is salient and union member and steel worker are only   peripherally important, then one's self-identity should reflect the Catholic role- identity,   and the meaning associated with being Catholic should more closely correspond to the meaning associated with the general self. Steel workers and   union member, while also represented in self-definition, should be less important   to   one's   overall   self-definition.   (p. 204)

These concepts are significant for a number of reasons. One's self-esteem becomes linked to how one self-assesses how successful he or she is relevant to salient role-identities, or in other words, those identities of most significance to his or her self-definition (Callero, 1985). Similarly, one's satisfaction is also tied to how closely others assess their role performance as being consistent with their own self-image (Riley & Burke, 1995). Motivation to activate a particular role-identity and commit to that role follows how one's self-esteem is implicated in doing so (Stets & Burke, 2000). In addition, it is through our salient role-identities that we construct our view of the world and how we interpret the actions of others, and thereby impacts how we form our relationships (Callero, 1985). And lastly, the most salient role-identity through which we define ourselves becomes how we present who we are to others and we then become defined by that identity. One's anticipated behaviors and actions with respect to others should again reflect and be predictable based on one's role-identity salience (Stryker & Burke, 2000; Callero, 1985).

A key point relevant to this study is that identity confirmation may or may not occur in a given situation or within an interaction with others. One's own internalized meaning of that role identity might then be altered, influencing its salience or significance (Stryker & Burke, 2000). An extension of this concept is that those with more power within a specific relationship or social structure can reflect their own interests and behave in ways that control the meaning of the relationship for those with less power (Cast, 2003). Commitment to a specific role-identity is impacted by how well the perceived inputs from the social situation and inherent relationships are in agreement with one's own role perceptions (Burke & Reitzes, 1991). One continually then chooses whether or not it is beneficial to alter one's behaviors towards a better "fit" with regards to the feedback received from others or to relinquish these relationships in favor of a more congruent situation.

To summarize the discussion thus far, identity is dependent on both internal perceptions of self and externally how these self constructs share meaning with others. Identities are confirmed and reinforced in social interactions and social situations and dependent on how they are anticipated within the context of established social structures. It is the activity of self-reflection and self-categorizing in relation to others that forms identity. It is through ongoing and reciprocated feedback that the significance and the commitment one has for a particular identity in a particular situation is activated and potentially challenged (Stets & Burke, 2000).

Identity within Organizations

Within organizations, identities occur as individuals classify themselves and others into social categories and further categorize themselves within groups (Ashforth & Mael, 1989; Stets & Burke, 2000). Groups are differentiated from each other through sets of attributes and values, often imposed externally through outsiders or professional societies in the case of professional identities (Sachs, 1999). Within groups, individuals struggle to reduce any discrepancies that might present between their own perceived identity and subsequent performance and the collective identity of the group and its goals (Riley & Burke, 1995). Employees new to an organization might be unclear as to their roles and status and must learn the norms and role expectations of the particular setting. As part of this process, a self-definition within the organization is developed which combines one's self-concept with how one is socialized and interprets the responses of others to them (Ashforth & Mael, 1989). Simply described by Ashforth & Mael, "A developing sense of who one is complements a sense of where one is and what is expected" (p. 27).

Social workers, as employees of hospitals occupy both an organizational role and a professional role. Each contributes to their perceived identity and at times can be in conflict (Ashforth & Mael, 1989). Closer identification with one's department and/or professional group can result in a less salient organizational identity and discord over roles and values. For example, social workers as part of their practice code hold highest their client's welfare, above the benefits for the worker or the organization, and this may at times be inconsistent with the goals of the institution (Stryker & Macke, 1978). In the instance of hospitals, pressures exerted to ensure the shortest length of stay might create tremendous personal and professional strain for social workers. Hospital social workers are often caught between being an organizational representative and a patient advocate as they struggle to first meet the needs of the organization that employs them and what they see as the needs of the patient that may extent their inpatient stay (Auerbach, Mason & Laporte, 2007). Such persistent role incongruence can result in tensions and job dissatisfaction on an individual basis, and eventually lower productivity, promote poor working relationships, lower organizational commitment and create high staff turnover for the organization (Biddle, 1986; Stryker & Macke, 1978).

For institutions in which roles are not clearly defined or in flux, more identity conflict can occur if an anticipated role is not available or a highly valued role is lost (Stryker & Macke, 1978). The extent and meaning of the emotional stress such conflicts generate is dependent on the significance or salience that role-identity represents to an individual's perceived self-concept (Simon, 1997). One can imagine that even among members of a particular professional group, how one experiences a conflict or stressor would vary depending on each person's cluster and hierarchy of identities that is brought into the work setting.

Professional Identity Formation

Looking more specifically at professional identity formation, King and Ross (2003) view professional identity as constructed through interactions and relationships between people. People recreate and negotiate role performance with each interpersonal interaction. Professionals are constrained by historically and culturally embedded values and expectations related to their professions. These values and expectations are adopted through professional socialization and reinforced through interactions with colleagues from their own and other professions and with the general public.

Adams and Kowalski (1980), in exploring professional self-identification among art students, provide the following broad definition of a professional:

> …the professional is a person who performs a special type of service, has mastered a prescribed body of theoretical knowledge and or utilitarian skill, is part of a community of like-oriented professionals and receives a rather uniform response from the public. (p. 31)

Formation of professional identity involves professional socialization and development through social learning as specific knowledge and skills are acquired within the context of a new professional role, new values, attitudes and self-identity components. Formation of a professional identity can be viewed as a maturation process as mentors or supervisors are frequently used to move emerging professionals along the continuum from student to seasoned professional, to socialize the mentee/supervisee into the profession and to encourage them to develop a sense of "belonging" as a member of an organizational group (Alutto & Hrebiniak, 1971). In looking at social work in particular, professional identity continues to be challenging. Abraham Flexner's writings in 1915 disputed that social work met the standards for being considered a profession, citing criteria such as the need for a clear and unambiguous

autonomous practice and a learned, intellectual and scientific foundation for practice (Flexner 1915, reprinted 2001).

Social work is not unique in its quest to move from "semi-professional" status to be considered "professional", a challenge that has been faced by others such as nursing and teaching. However while much is written about the sociology of professions, with discussions of boundaries and identities, social work is relatively underrepresented in the literature with regards to clarification of its identity in a changing societal context (Gibelman, 1999).

What actually is a "professional" is outlined in the literature about professions and occupations. From its earliest conceptualizations, professionals were those individuals who possessed special knowledge that would benefit others and not their own self-interest. Professionals believed that because of the altruistic focus for their skills they should be permitted to define what tasks made up their roles and who could perform them (Torstendahl & Burrage, 1990; Trice, 1993). Some of the special traits that initially described a professional (Trice, 1993):

1. a systematic body of academic knowledge known only to others in that profession
2. autonomy to provide and define quality services without outside influences
3. putting the interests of the community above their own
4. autonomy over clients in which clients do not question the ability of the professional to meet their needs
5. specific associations and training schools in which the norms of the profession are reinforced

As capitalism grew, the distinct stratification of the Middle Ages, between "the learned and the common" disappeared and the professionals, no longer part of the elite, now competed with the rest of the populace for the title of

professional. Professionals developed mechanisms to standardize their services so that what they offered was distinct from what others offered and recognizable as such by the public (Trice, 1993). Members of a particular profession claimed superior knowledge, maintained control over their work and retained the authority to train new members to that profession. Associations and guilds specific to a profession served to maintain and perpetuate the cultures and unique nature of the profession (Trice, 1993). Medicine and law are examples of occupations that very early on held distinctive and unchallenged status as licensed professionals and by virtue of their body of knowledge and regulated scope of practice can routinely be self-employed, independent of organizational controls and influences (Friedson, 1994).

State licensing was the ultimate goal for a profession as it conferred the rights to work in that profession, enabled the professionals to set practice standards and excluded others from occupying those roles defined in the license (Trice, 1993). Medicine and law are examples of occupations that very early on held distinctive and unchallenged status as licensed professionals and by virtue of their body of knowledge and regulated scope of practice can routinely be self-employed, independent of organizational controls and influences (Friedson, 1994). While having a license ensures a certain level of practice standard for many occupational categories, it does not guarantee the specific role expectations and terms of employment in an organization, particularly if the license does not restrict a scope of practice (Trice, 1993). Professionals working in organizations are, in contrast, subjected in varying ways to the influences of their work environment. How well understood and valued the work of a particular professional is to an organization, the more control or power one has to determine the specifics and boundaries of their tasks as different occupational groups negotiate their place within organizational structures (Friedson, 1994).

One's self-concept as a professional is cultivated initially through professional schools where students learn specific knowledge, skills, perspectives and professional expectations. Studies have shown however that while schools provide basic qualifications and standards for their work, organizational settings contribute to the socialization, commitment and behavior of professionals as relationships and roles are negotiated (Friedson, 1994). Occupational socialization is the process in which an "outsider" becomes an "insider" (Trice, 1993). Trice compared the process of socialization and commitment among different professions and argues that social workers in particular come into the work place with fewer "rites of passage" than for example physicians who have their work assessed by superiors or mentors at numerous steps from students to licensed professionals. He offers that the education of social workers involves professional practicums that vary greatly between students, often using different language and potentially devoid of common identities. Trice adds that graduates, some with only bachelor degrees, then enter settings with fewer proven and confirmed skills to rely on in perfecting their roles and performances. Social workers usually work alone and their initiation into their professional experience is to "sink or swim". Trice argues that this makes social work professional roles and boundaries more vulnerable to being defined along the way within the organization (Trice, 1993).

Deprofessionalization presents an additional challenge to one's professional status within organizations. Information networking has been expanding and the once exclusive knowledge of the professional is increasingly accessible to the public. Consumers are now able to question and assess what services they are receiving and there are expanding mechanisms in place for scrutiny and governmental sanctions. Specializations within professions have served to separate members into smaller and less powerful advocacy units. Allied occupations have embraced the more available general tasks or techniques

vacated by professionals choosing to limit their practice focus to the use of specialized knowledge (Macdonald, 1995; Trice, 1993). Relevant to hospital social workers would be the finding discussed earlier that nurses in many instances are performing discharge planning activities once the exclusive domain of social work. Additionally, the advent of case management in health care has further blurred professional lines. Case management had its root within the practice of social work however, in the mid-1980's the contribution of nursing to the case management field expanded. The emphasis in health care was shifting to the community and nursing practice now needed to broaden their expertise and incorporate interventions beyond medical needs and inclusive of psychosocial needs (Robbins & Birmingham, 2005).

Since licensing is the most effective mechanism to ensure that professional practice is standardized and publicly understood, a lack of a clear consensus regarding roles and tasks among social workers has been a tremendous obstacle for this critical sanction (Trice, 1993). Delays in licensure have been the result of disagreement regarding degree requirements and scope of practice and in fact led to different standards for state licensing, adding to professional ambiguity (Trice, 1993). In New York State, Education Law created two professional titles for social work in September 2004 (National Association of Social Workers, www.naswnys.org). Prior to that date, the title of "social work" was used by individuals working in a range of social services capacities but not necessarily having the BSW or MSW professional education. The new titles, LMSW and LCSW, each have standards and scopes of practice legally delineated; the LCSW license allows for autonomous practice of clinical social work involving diagnosis, psychotherapy and assessment-based treatment planning. Those with LMSW licenses are required to be supervised when providing clinical social work.

Gregory and Holloway (2005) provide relevant insight into the challenges of social work professional identity, returning to the basic tenets of identity. Similar to how Gibelman (1999) discussed the way social work roles and identities have fluctuated with economic and political influences, Gregory and Holloway examined within that framework, the specific language utilized by practitioners over time to describe themselves, their clients and professional interventions. For these authors, the significance of language was summarized as follows:

> …language is significant as the embodiment of both concepts and values. The power of language is widely recognized: language is used to establish membership of a group and conversely to restrict access to outsiders; to indicate allegiance to a cause; to establish, and sometimes coerce into a position; to restrict communication and the type of communication; to influence the construction of a situation. (pg. 38)

For a timeframe of barely over 50 years, not only have social workers continued to shift their professional emphases but how they communicate amongst themselves and with the public about their work keep fluctuating. This compounds any confusion that may have already existed about the social work profession to an extent not usually considered when other professional groups are discussed. To briefly illustrate some of the changes Gregory and Holloway uncovered in language used in social work textbooks over different time periods, the following is offered:

At the very beginning stages of the social work profession, social workers were "helpers", viewed clients as "morally weak", "defective"; interventions used casework methods to reform those who had failed in some way to achieve what was in their view "normal"; and social workers shared the government philosophy that if clients received relief support to a level that offered comfort, that would be a disincentive to become personally responsible. The professional emphasis greatly shifted as social workers strove to secure a place amongst other mental

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health professionals and incorporated psychoanalytic treatment principles to mobilize a person's resources and capabilities to improve his or her adjustment concerns. It was during this period that social work incorporated sociological and psychological theories into their practice, and began exploring the person-in-the-environment and the social and political forces that helped shape an individual's problems.

The impact of economic turmoil that followed again shifted the profession away from its clinical focus, and social workers were more defined by the tasks they were undertaking to try to meet the growing challenges persons encountered to survive. The 1980's saw efforts to reconstruct the identity of social workers by adoption of language reflecting work with specific values such as "anti-oppressive practice." The 1990's saw social workers as "social entrepreneurs" as the profession incorporated outcome management, consumerism and market terminology into its language. Care is viewed as a commodity and recipients as consumers of products. Gregory and Holloway found during this period and to the present that the social work literature had become almost indistinguishable from the care management literature, with "claims of professionalism once derived from 'special' knowledge, skill and application turning into claims of 'special know-how' as social work stakes its claim to be the profession pre-eminently suited to delivering care management" (p. 48-49)

What identity theorists tell us is that identity is constructed from how we perceive ourselves and how others interpret meaning from what we do and how we do it. What the discussion above illustrates is that even through our own language, the most basic conveyor of meaning to others, we have not been consistent amongst ourselves in the profession and most significantly with those we interact with. This is not to say that a profession that adapts to the needs of the times is good or bad, but it does speak to the issue of professional identity ambiguity and the challenges defining our profession which will be explored in

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this study.   Towards this end, hospital social workers will be asked how they view their work, their relationships with others and how they describe how others perceive their roles. It is precisely this window into how professional social work identities are influenced and challenged within their organizational structures that is the focus for this study.

CHAPTER III: METHODOLOGY

Research Design

Qualitative research employs strategies to answer questions about "social settings and the individuals who inhabit these settings" (Berg, 2007) and represents an appropriate methodology for this study. Individual face-to-face interviews formed the data collection strategy. This study is part of a larger collaborative effort which will focus more specifically on supervision.

The research questions being asked requires that subjects, in this case hospital social workers, provide their own descriptions of what they do and how they experience their roles and their interactions with other professionals. It is these individual perspectives that form the basis for one's sense of identity and professional role within the context of their work setting. Qualitative research allows the investigator to obtain a window through which to view how an individual experiences his or her world and how meaning is created from the context of that experience and interactions with others. It is the individual perspectives that unfolds and creates an understanding of each experience in the setting of interest (Berg, 2007; Marshall & Rossman, 1995; Padgett, 1998). The investigator obtains a distinct picture of what is occurring through individual descriptions and perceptions and then is able to explore how different subjects' perspectives and realities compare across the study sample and work settings. Qualitative research allows the investigator to probe for depth and clarity to best understand how subjects themselves describe their particular world, as each reality is constructed uniquely. This is an aspect of research design not available using quantitative methods (Berg, 2007; Charmaz, 2006; Padgett, 1998).

Sample

The study is comprised of a purposive, self-selected and snowball sample. Professionals with specific experience in the desired information were targetted; it is their experience that is being sought. It is reaching those participants who are available and interested in volunteering. Since participation is totally voluntary, the study sample is biased to include only those social workers who had self-selected as interested and willing to share their views, a number reached as a result of snowballing outreach efforts of both participants and colleagues.

To be included in the study, a participant needed to be currently employed by a hospital and hold at minimum an MSW degree. In addition, the target population for this study was to include staff workers only providing direct services, therefore excluding social workers with any supervisory or administrative responsibilities. Prior work histories and previous work responsibilities were not considered in the eligibility criteria. Recruitment efforts were designed to recruit from hospitals with different organizational structures, to broadly include:

1. Hospitals with traditional centralized social work departments
2. Hospitals with social work departments merged or restructured with other professional departments
3. Hospitals in which social workers are decentralized throughout the setting

As discussed in the introduction, the settings targeted as outlined above are examples of structures described in previous research and are known to include different organizational restructuring strategies for social work services in hospitals. It is the experiences of social workers from within different organizational structures that inform the study research question.

Committee on Research Involving Human Subjects

The research design, developed consent form and all recruitment materials were submitted as required to the institutional CORIHS review committee as an exempt application. As designed, the study met the criteria for an exempt application as it involved interviews only, with professionals, with no anticipated risks. In addition, to most fully protect participant anonymity, a component of the research design, a request to waive signed consent was included in the CORIHS application packet. The application was approved as requested on January 5, 2007 (See Appendix A).

Recruitment Strategies

Volunteers were recruited from New York City and Long Island. Restriction of the geographic area as such ensured that all participants would be subject to the same New York State professional licensing criteria, and also provided a realistic distance for investigator to travel to for interviews. A number of different recruitment strategies were utilized to reach a broad range of potential volunteers, and included networking through peers and colleagues; presentations at meetings, distribution of recruitment flyers, recruitment advertisement placement in professional newsletters, and snowballing contacts from participants themselves. Each of these strategies will be discussed in detail below.

Recruitment in Hospitals: Directors and/or supervisors of hospital social workers known to me and names of administrators obtained through collegial contacts and/or published directories were contacted by e-mail followed by a phone contact if needed. Discussions with administrators served two functions: the first was to clarify the organizational structure within which the social workers perform their tasks to ensure that the setting meets the inclusion criteria; the

second was to determine willingness and feasibility to allow the researcher to solicit volunteers to participate in the study.   Each setting contacted was unique in that in order to proceed, each requested different study support documents and in turn followed their institutional approval processes.   Study prospectus and consent forms were forwarded for review, in some instances by the department director who then agreed to allow us access; in others, study design documents were reviewed by hospitals' legal departments. In one setting, a facility's Institutional Review Board additionally required both Stony Brook University CORIHS approved application and completion of their own Research with Human Subjects application for their internal committee before issuing a commitment to participate.   Methods to disseminate study information were discussed directly with these administrators.   In some settings, a brief presentation about the study was conducted at a staff meeting and recruitment and consent information distributed. When this was permitted, a letter from the setting was submitted to CORHIS to indicate the formal relationship in which the institution has allowed the researcher access to staff. Where a presentation could not be readily accommodated, administrators distributed study recruitment information via staff e-mail and in one setting, where e-mail for staff was not available, recruitment flyers were placed in worker mailboxes (See Appendix B).

Recruitment in Non-hospital Settings: To reach potential volunteers outside of work settings, conferences and professional meetings were identified at which eligible social workers might be in attendance. Coordinators were contacted and permission to attend and distribute recruitment flyers was granted. I attended conferences sponsored by the Suffolk Chapter of NASW and the Suffolk Chapter of the Society for Social Work Leadership in Health Care.   Through additional networking, contact was made with the 1199SEIU United Healthcare Workers East union who fortuitously had a conference focusing on the status of hospital

social workers already scheduled. I was an invited guest and recruitment flyers were distributed to membership in attendance.

Recruitment Advertisement Placement: Professional organizations were contacted to purchase advertising space in their chapter newsletters. The Suffolk County Chapter of NASW and the Nassau Chapter of NASW agreed to publish our recruitment advertisement, appearing in March and May respectively. Interested volunteers were again able to contact this researcher through provided contact information in advertisement (See Appendix C).

Snowballing Contact: Potential participants were identified as well through all contacts made in above efforts. Study volunteers were encouraged to publicize the study to anyone they believed met the eligibility criteria. Those interested contacted me directly and information about the study and how to participate was provided to them for consideration either via e-mail or phone.

Recruitment Summary

It is difficult to accurately break down how many participants were included in the study from each strategy. Initially, from the hospitals in which formal presentations occurred, approximately nine volunteers came forward. Follow-up e-mails from administrators combined with e-mails from colleagues already interviewed, possibly resulted in an additional 15 participants. Snowballing continued, making precise numbers difficult. At least one volunteer entered the study after reading a newsletter advertisement, which then added an additional social worker through snowballing. A colleague who read the advertisement was not eligible but reached out to four other eligible workers who agreed to participate, which then expanded to three more volunteers. At least four

participants volunteered after obtaining a recruitment flyer at the 1199SEIU conference and/or through other union initiated outreach efforts on behalf of this study. These four volunteers are known to have recruited five others. During the recruitment process, it was found that forwarded e-mails that contained investigator's direct e-mail link, whether from institutional administrators, colleagues or interviewed subjects, best facilitated participation. The most significant marketing "tool" however occurred when after a few interviews, potential participants could be told that the interviews have averaged 30 minutes and that the experience reported by subjects was positive.

Limitations of Recruitment Strategies

A number of significant obstacles to recruitment occurred. As originally designed, it was anticipated that hospitals with different organizational structures would be readily identified and access to staff made available. The reality of this process proved to be far more complex and prolonged, with recruitment to obtain forty participants lasting six months. At hospitals in which a centralized social work department existed in the organizational structure, the directors were easily identified and contacted. Social work department directors, upon review of the study objectives, either formally authorized participation on their own or advocated through their administrative processes to allow investigator access to the institution to promote study recruitment. What became rapidly evident however was that institutions in which social workers were working under different organizational structures, where the traditional centralized social work department no longer was in place, were not as accessible, and access to actively recruit for participants was often denied. Anecdotally, institutional legal departments were implicated as unwilling to allow me to formally recruit at a particular setting; in one hospital, a supervisor stated that after informally

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canvassing staff, the consensus reported was that individuals were not interested since the interview was being audio taped. No direct contact with staff social workers to clarify study parameters was permitted.

Without a collegial familiarity or professional referral, gatekeepers in hospitals often intercepted cold calling or e-mail outreach efforts. This effort was further complicated in instances in which it was not known under which administrative department social workers reported. Recruitment efforts to reach hospital social workers became dependent on the other more global recruitment strategies (e.g. advertisements and flyers at professional venues), no longer focusing on individual institutions.

Perhaps the greatest obstacle to recruitment related to the nature of hospital social work itself. Even when a presentation about the study was enthusiastically received, volunteering to participate was not forthcoming. Social workers report time constraints and an unpredictable work day as their own obstacles; volunteers who received reminders from their administrators that recruitment was still ongoing, appreciated the outreach stating that they were "carrying around the flyer", but did not seem to be able to stop long enough to make the call. The study sample is comprised of the first 40 volunteers to contact me.

Use of Individual Interviews as Data Collection Strategy

Semi- structured face-to-face interviews represent the chosen research strategy as it enabled individual perspectives to be expressed in response to a broad set of queries generated by the research topic. It is through the process of personal interactions, reflective listening and probing for deeper meaning that pictures of individual experiences were created. Interviews can be viewed as directed or guided conversations that allow the perspective of the respondent with regards to the topic of interest to be described as they see and understand it, and not as the

interviewer might expect it to be (Chamaz, 2006; Lofland &Lofland, 1995; Marshall & Rossman, 1995). Once rapport has been established, the strength of individual interviews is the depth and breadth of the data that can be obtained during the interaction. The trustworthiness of the information obtained is enhanced as a result of this interpersonal relationship (Padgett, 1998).

Interviews provide benefits as a research data collection strategy. Since this study targets how professionals view aspects of their work, discussions may contain potentially sensitive topics which are best shared in the most confidential manner. While focus group formats allow for content to surface through the group dynamics, individual interviews without the presence of colleagues allowed for more openness and honesty. One-to one interviews provided greater flexibility in scheduling and this maximized recruitment potential. Interviews were ultimately scheduled at the day, time and place of the volunteer's choice and convenience, being sensitive to the constraints a workday often presents. Confidentiality could be best maximized through interviews that occurred in as private a setting as the participant felt was needed. This eliminated all reasonable risk of collegial or supervisory identification, again facilitating the decision to volunteer and engage in a more open discussion. Fictitious names were used during the interview and assurances that all references to place of employment would be omitted in the transcripts encouraged openness in the interview process.

There are a number of limitations in the use of interviews as a data collection methodology. The quality of the data can be compromised as respondents bring certain biases to the interview which can filter what they present, perhaps withholding information they may feel is negative or describing what they may believe is what interviewer wants to hear (Chamaz, 2006; Padgett, 1998). The skills of the interviewer also impact greatly on the data collection process, as the flow of the conversation has to be non-judgmental and neutral, lines of inquiry should not be leading the respondent in any specific direction. The efficacy of the

interviewing strategy additionally depends on the depth of probing engaged in and the biases that the interviewer brings to the interaction. These need to be acknowledged as opportunities for clarity can be lost through such actions and filters (Chamaz, 2006; Padgett, 1998).

Data Collection

Willing study volunteers contacted study investigators either via telephone or e-mail and a mutually agreed upon date, time and place for the interview was established. By design to encourage participation, one interview was conducted per participant and the interview only contained the subject's fictitious name. No list was maintained linking the subject to the fictitious name and all identifying information on the subject was destroyed once the interview was completed. These strategies to ensure anonymity and participation made any follow up contacts for clarity not possible.

Sites for interviews included offices, cafeteria, coffee shops, patios and private homes; interviews occurred in the middle of the work day, at the end of the work day or on a non-work day. Participants were provided CORIHS approved consent forms and any questions or concerns addressed prior to initiating the interviews (See Appendix D). No volunteer failed to complete the interview. The interview was audio recorded using an Olympus Digital Recorder. The interview included the fictitious name chosen by the participant and the length of the interview ranged from 20 minutes to one hour.

Interview Guide

An interview guide was developed based on the literature review and research questions. The guide included a predetermined set of broad queries covering the

topics of interest for the study to ensure relative comparability for analysis (See Appendix E). In order to facilitate participation, the interview guide was limited in length to keep the interviews to one hour. Potential probes to maximize depth and clarity were conceived of ahead of time and included on the interview guide for use by the interviewer if needed.

The research question guiding this study was whether social workers within different organizational structure would have varying experiences related to their professional practice and professional identity. The interview guide was generated from a review of organizational and professional identity theories and reflective of potential organizational restructuring outcomes evident from prior research. Specifically, questions were designed to elicit perspectives regarding parameters and influences of daily practice between different settings; and of influences impacting professional identity formation such as the experiences of respondents with professional socialization, supervision and leadership. As identity formation is interactive, questions and how respondents perceive their professional role and how they understand how others perceive their roles.

Three basic groups of questions were designed to elicit information and perspectives from study subjects. The first set of questions asked about the background and experience of the social worker in order to better understand the composition of the sample and to be able to explore possible relationships with themes that might later emerge. These questions were fixed response and open-ended questions that gathered factual demographic data such as when MSW obtained, any specific health care education, training and/or prior professional experience, and a description of administrative reporting structures, management and department composition. The second format for questions were more open ended to generate discussion of roles and responsibilities; perceptions and relationships with other social workers and other professionals; the experience of

supervision; the structure and influence of their administrative systems; and more global perspectives on how hospital social work is viewed and described.

The last type of questions were fixed response in the form of a Likert scale in which respondents were asked to self assess the significance of a series of activities that could contribute to their own professional development and professional identity; one would indicate no significance and a five would represent a most significant influence for the worker. An analysis of responses to this last set of questions was not included in this study.

Impact of Interviewer Background and Bias

My first professional experience after receiving my MSW degree was as a hospital social worker and all subsequent professional roles have been in health care, either in community or institutional settings. As a new social worker, my identification with the social work profession, and its place in hospitals, was invariably shaped by my earliest exposures and influences.   As I remained in the health care field in other capacities, I continued to be sensitive to some of the changes that were occurring in hospitals and the curiosity driving this study grew.

All the interviews were conducted by me and care was taken to be as objective as possible given my familiarity with the subject matter. There is no question however that deeper meaning or clarity in some instances may have been sacrificed during the interview as a consequence of the perspectives and filters I brought to the interaction. Self-reflection following each interview was used to minimize this limitation as the process of interviewing subjects continued. Regular discussions with study sponsor were also used to address any process concerns. The most positive aspect however of my experience was that rapport was easily and quickly established with participants as they immediately sensed

the sincerity with which I was sensitive to and appreciative of the challenges faced by offering their time.

Impact of Interview Environment

The setting and conditions under which the interview occurred at times impacted the data collection process. Although the time and place of the interview was selected by the participant, the environment was not as predictable as assumed. Some participants chose what they believed to be the "end of the work day' to meet in their offices, however telephone and beepers sometimes went off and/or patients, families and staff knocked on their door. The interview continued after these interruptions; however these breaks in continuity created distractions for both the participant and the investigator. Not only did it interrupt the flow of information and reflection but it also represented to the social worker that this chosen time was not "the end of their day". As soon as the interview would be over, more work would have to be done before their day could truly end. While this awareness was not acknowledged at the time, it may have unintentionally limited the extent of both the responses and potential probing by I engaged in. At least three interviews had to be rescheduled at the last minute due to unanticipated work chaos which did not allow for even a 30 minute timeframe to be carved out.

Other chosen sites included fewer work related interruptions however were more public such as cafeteria and coffee shops, where occasional noise and potential eavesdropping opportunities were present. During an interview in a hospital cafeteria, one volunteer interrupted the interview so we could relocate away from interdisciplinary team members for more privacy.

Data Management

Recorded interviews were saved as individual files to a database using Windows Media Player. Verbatim transcription was facilitated using Express Scribe designed by NHC Swift Sound. Express Scribe is an audio player software program downloaded for free from the NCH Swift Sound website, through which saved audio interview files were played. By using associated purchased foot pedal, playback could be controlled for speed and played forward and backwards for transcription accuracy. Transcribed interviews were saved as Word documents. A doctoral student and I transcribed all recorded interviews in this study; I personally transcribed 75%, and reviewed the transcripts completed by the student for accuracy. Copies of recorded interviews were maintained until transcripts were checked for accuracy, and then deleted. During transcription, any use of participant actual names were replaced with the chosen fictitious names and any information that would identify the particular work setting was substituted with a more general reference such as "the patient" or "the hospital". MAXqda qualitative analysis software was utilized for the data management and stages of analysis. Training in use of this software and qualitative analysis strategies was obtained through Research Talk, Inc.

Analysis

Consistent with the principles of grounded theory, data contained in interviews was analyzed in a stepwise fashion, coding for themes and concepts (Chamaz, 2006). As themes emerged, relationships were identified. Coding was active and content continually re-analyzed as new codes and categories emerged. Memo writing was an ongoing function associated with coding process as

thoughts and ideas that surfaced as data was "picked through" were saved to assist with the themes that were later developed.

Three initial reviews of the data took place before any formal coding. Since I conducted all interviews, initial analysis began immediately. Notes were generated following each contact for initial impressions of the participant, setting and overall tone of the interview. Investigator self assessments and reactions were recorded as well to screen for potential bias and to inform the process of subsequent interviews. The second stage of initial analysis occurred during the transcription or review of transcriptions when notes of initial interest from the data were generated. The interviews were then read a third time from which an initial set of codes was created (See Appendix F).

The transcribed interviews were uploaded as text documents into MAXqda to begin the process of formal coding. Interviews were reviewed again line by line and codes from a predetermined list were attached to small segments of text. New codes were generated when needed. Memos continued to be written as well during this stage of analysis. Demographic variables were managed through the *attribute* function of MAXqda software. Information about the volunteers such as organizational structures they worked in, practice assignments, years of post-MSW experience and professional discipline of department directors and supervisors. Coded segments could then be sorted using these attributes for later stages of analysis. MAXqda was used to look for instances in which different codes clustered within text segments.

In addition to the use of the software, I processed the data manually. As coded segments were sorted and reviewed using the software, groupings of codes occurred and themes emerged. I returned to the interviews to look for these larger themes. This process was performed by hand as the story of each interview was explored. For each interview an individual story was created that reflected the themes that had previously emerged. Paper coding and sorting was then

performed using each individual story. Graphic displays of findings were used to condense the data into related themes and sort findings through variables.

I had not undertaken a qualitative study before this one. This stepping back from the software and a return to the data was necessary for me to ensure that the software was not guiding the analysis and in this manner verified the findings. MAXqda was again used to generate the data consistent with the relevant themes for the analysis that follows.

Analysis Decisions

The initial phase of analysis looked at organizational structures driving differences in experiences. Since this was the anticipated relationship, it was surprising to find that this did not tell the entire story of each participant's experiences. Following strategies outlined in Miles and Huberman (1994), it was the process of looking for the intervening variables, what was happening within the experiences of participants that were different than most others that deepened the analysis and guided later analysis stages. Examples of some of these findings include: having a social work manager in a traditional social work department did not always provide a secure and positive experience; having a nurse as a manager was not always linked to a negative experience; and having control of one's practice role did not always provide for a secure and positive experience.

> Any given finding has exceptions. The temptation is to smooth them over, ignore them, or explain them away. *But the outlier is your friend.* A good look at the exceptions, or the ends of the distribution, can test and strengthen the basic finding. It not only tests the generality of the finding but also protects you against self-selecting biases, and may help you build a better explanation.
> (Miles & Huberman, p.268).

This process was most helpful for me since data collection was through the use of a semi-structured guide which predetermined categories of data. By looking beyond the obvious and for what did not fit together, new findings and relationships emerged that became significant and are presented in the chapters that follow. Chapter IV contains a descriptive overview of study settings and sample; Chapter V discussed the major themes that emerged relevant to the influences of Organizational Context; and Chapter VI discussed the themes of Roles and Value that shaped the experiences of study participants.

CHAPTER IV: DESCRIPTION OF THE SAMPLE

Introduction

This study explored the current status of social workers, challenged within their hospital settings as a result of both external and internal forces. The hospital social workers interviewed expanded on their experiences with departmental membership, professional practice and collegial interactions. Participants described how their work and practice experiences have been influenced by their changing organizational environments. The perceptions of their role and identity and valued contributions to the organization were explored.

The study findings are presented in the following three chapters. The themes discussed are provided through the lens of how the professional identity of hospital social workers is impacted as a consequence of evolving practice environments. Professional identity emerges from one's initial expert education; how one is socialized into one's profession and organizational setting through supervision and collegial interactions; and lastly how one's roles are consistent with one's training and confirmed through interactions with others within the organization. The spectrum of organizational responses to environmental challenges represents the backdrop for the analysis.

Chapter 4 begins the discussion, providing an overview of the sample and settings where participants were employed. Among the 13 hospitals represented in this study, different organizations have responded in unique ways to address their external environment, and these differences will be highlighted. The demographics of the study sample are summarized in Table 1.

Descriptive Overview of Sample Participants and Settings

Social workers employed by 13 different hospitals were interviewed. This purposive sample was comprised of the first 40 volunteers who contacted this researcher and met the inclusion criteria. Both the sample and the settings represented in the study provide a rich spectrum of post-MSW professional experience, practice diversity and administrative reporting structures. These variations are detailed in the findings described below.

The 13 hospitals represented by participants in this study have diverse characteristics, ranging in size, affiliations and locations. Seven of the hospitals are from urban settings and six are located in suburban communities. The sizes of these hospitals greatly vary from the smallest with 120 beds to the largest, with 1171 beds, including others with 190, 293, 321, 336, 371, 452, 530, 530, 652, 727 and 780 beds rounding out the represented sites (median size = 452 beds). Seven hospitals are considered tertiary care centers; nine settings are described as academic centers or teaching sites; at least four had direct affiliations with medical schools. A number of health care systems are represented in the study, one large hospital as the anchor for a 15 regional hospital health system; three hospitals in the study are part of a different 12 hospital health system. One specialty hospital that merged with a large teaching hospital is represented along with a hospital that is the largest in a Catholic Health services system. Lastly, a number of participants are employed by a federally run hospital center under the auspices of the Veterans Administration.

The numbers of participants from each of these settings also varied, with twelve subjects from one large setting with a department of over 200 social workers, down to one subject who is the only social worker employed at a small community hospital. One social worker from each of two larger settings participated with the other nine hospitals having two to four participants. To

address one of the major focus areas of this study, the organizational structure of the hospitals that social workers report to were examined. Of the 40 participants, 18 were part of a traditional centralized social work department; 17 were part of a department that has been merged or restructured to include other disciplines; and five social workers in the sample reported through unit based departments specific to an area of patient care such as mental health. The practice assignments of the participants again greatly varied with 24 working on inpatient medical units (represented by oncology, pediatrics, neurology, orthopedics, general medical/surgical, traumatic brain injury, rehabilitation, cardiology, cardiothoracic surgery, transplant, and dialysis); three on inpatient psychiatric units, five assigned to medical outpatient clinics (such as metabolic, oncology, dialysis, speech and language); one worker had a combined inpatient and outpatient assignment for the gynecological oncology service; two worked in free standing mental health centers, three primarily assigned to their hospital emergency rooms, one in an outpatient clinic for children with developmental disabilities and one social worker worked as part of a caregiver resource center.

Demographically, the range of years that social workers had their MSW degrees went from barely one year to as many as 47 years (mean = 11.0 years) and report working in the health care field again from just under one year to 33 years (mean = 10.0 years). Prior professional experience in health care settings included other hospitals, skilled nursing facilities, inpatient and outpatient mental health settings, outpatient care clinics and/or home care agencies. At the time of the interviews, social workers report having job tenure at their current setting ranging from one month through 33 years (mean = 6.8 yrs.) and 28 have only worked in their present hospital since obtaining their MSW degrees. Thirty six of the social workers in the study are female, four are male.

Descriptive Overview of Organizational Structures

For the broadest overview the following organizational structure categories within this study are used and can be briefly described as follows:

Centralized Departments (3 hospitals) include settings in which all social workers report to a single department. These are the more traditional structures in hospitals for social workers and the director and supervisors of these departments are social workers. The department is inclusive of all social workers regardless of their assignments, including both medical and psychiatric services and inpatient and ambulatory care units. No other professional discipline was structurally part of the department.

Merged/Restructured Departments (8 hospitals) represent departments that include social workers and at least one other professional discipline. The director and supervisors may or may not be social workers. Among these settings, two have social workers as departmental directors and six are directed by nurses. In all but two hospitals, social work supervisors are available to social workers although two social workers interviewed specifically stated that their particular supervisors were nurses while social work supervisors were assigned to other workers. Within these structures, the configurations of staffing also vary, most having social workers and nurse case managers but in one, social work case managers are present in addition to the social workers and nurses, and in another, both social workers and nurses share the title and identical responsibilities of case managers. In one hospital there had not been a social worker presence until the hire of the one social worker interviewed for this study. Bachelor level social work or discharge planning assistants are reported in two of these settings categorized this way.

Unit Based Structures (5 examples) describes instances in which social workers employed by a hospital report to a department that is organized to provide a specific service. Within this study, that includes social workers assigned to a Behavioral Health Department for both inpatient and outpatient psychiatric services; free standing outpatient mental health clinics and one rehabilitation clinic for children with developmental disabilities. Among these settings, the directors are not social workers. Within the two settings in which the social workers are part of the hospital-based Behavioral Health Department, social work supervisors are available. These structures are organizationally part of four different hospitals, two of which are hospitals represented elsewhere in this study.

Descriptive Overview of Hospital Social Work Practice

As different organizational structures were targeted for this study, a surprising finding was that not only did hospital social work practice vary between broadly defined organizational structures - Centralized, Merged and Unit based - but it was found to be different within the settings themselves. The following section provides an overview of primary hospital social work responsibilities delineated through organizational structures and primary work assignments. Themes and concepts within these findings will be explored in later sections and chapters.

Inpatient medical and/or surgical assignments – represents social workers involved in oncology, gynecology oncology, pediatrics, neurology, orthopedics, medical/surgical, traumatic brain injury, rehabilitation, cardiology, cardiothoracic surgery, transplant, and dialysis.

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Centralized Department (10 social workers); includes one worker with both an inpatient and an outpatient assignment.

Ten social workers categorized in this manner described discharge planning as their primary function and reported performing and controlling most if not all aspects of the discharge planning process. If case managers were part of the team, their primary functions have been described in more tangible terms, doing clinical reviews for insurance coverage and in some instances, the nurse case managers obtain insurance authorizations for home care, equipment; sub-acute rehabilitation or long term care. In one setting, the case manager completes applications for sub-acute and long term care.

One social worker reported that a case manager has been present on her team for just over a month and now "helps" her with skilled nursing facility applications which she had been completing on her own for the three years she has been in her current assignment.

A social worker interviewed in another setting reported that there are formal delineated responsibilities between social work and case management in relation to discharge planning processes: case managers do the assessment and implementation for equipment and referrals for Visiting Nurse Services, but only if there is no need for home health aides or the aides are already in place. Social work is responsible for interventions involving other facilities such as for rehabilitation, psychiatric care, adult home placements; and all home care cases involving new home health aide placement.

Merged/Restructured Departments (15 social workers):

Similar to the experiences of social workers in traditional centralized social work departments, discharge planning was reported as their primary function by workers within departments currently merged with other disciplines. It was among and within these settings that the most variation in social work practice

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was experienced. Contributing to this practice diversity can in part be attributed to the increasing involvement of case managers and to what extent they participate in the discharge planning process. Eleven social workers reported being primarily responsible for discharge planning within their setting with at least four of these workers, from two different sites, adding that on other units in their particular hospitals, nurse case managers perform specific parts of the discharge.

For example, a traumatic brain injury unit and a maternity unit in one hospital, has no nurse case manager so the social worker puts in place the entire discharge. But on more general medical units within this same hospital, the duties are shared, with the case manager referring for home care and being responsible for the more technical aspects of needed care, such as intravenous antibiotics or feeding tubes. The social workers on the medical surgical units in the same hospital are responsible for skilled nursing home placements, adult home referrals, substance abuse and psychiatric transfers, but hospice and assisted living referrals are the responsibility of the nurse care coordinators. Case managers or in this case "care coordinators" on the medical surgical units review all patients charts and determine what cases will be referred to social work. Additionally, when social workers from this hospital cover on weekends, they are the discipline responsible for all aspects of a discharge even if during the week, it was not their responsibility.

In other hospitals all cases are first reviewed by nurse case managers and only those patients assessed to need social worker interventions are referred. In one of these merged settings, case managers utilize a brief questionnaire to assess a patient's needs and supports and plans accordingly. This merged department is also interesting in that it includes social workers, case managers and discharge planning assistants. The discharge planning assistants are responsible for contacting facilities for transfer to different levels of care; the case managers are

mostly nurses but include two who are social workers and "have completed some additional credentialing" to be considered "case managers" in this hospital. The particulars of the above credentialing were not clarified by the social worker interviewed. There is no distinction made in the professional practice of the nurse case managers and the social work case managers.

Social worker case managers in another setting also share identical responsibilities with their nurse case manager counterparts; however in this setting the title of social worker does not exist. Both social workers and nurses in this role share the same title of "case manager". All aspects of the discharge planning process are the responsibility of these generic case managers, from admission to discharge, including all insurance reviews normally the sole purview of nurses. Additional professional "case management credentialing" for social workers was not mentioned by those interviewed. In this Case Management Department a distinct social work practice role does not exist.

Lastly, in the hospital with the sole social worker, her experience has been very distinct. Nurse case managers develop and implement the entire discharge plan and she, the only social worker in the building, offers and assists with discharges as she sees fit. She assumes other roles within the setting that the administration deems as "social work roles". Currently she is responsible for ensuring that all advanced directives for each patient are addressed, assesses each post partum patient for depression prior to discharge and is being asked to serve as the patient advocate for the building.

Psychiatric, Inpatient Assignments (3 social workers):

Three social workers within this subcategory were interviewed. One was employed in a centralized social work department, in a residential psychiatric program. Two social workers were working in hospitals in which the medical social workers were merged with other disciplines but the psychiatric social

workers were reconfigured as part of Psychiatry or Behavioral Health Departments. For this study, these latter two social workers are considered an example of a "Unit Based" organizational structure. For the most part, inpatient psychiatric social workers held responsibilities similar to inpatient social workers elsewhere with regards to assessment and discharge planning. With psychiatric social workers there was an added inclusion of treatment interventions to their responsibilities, describing some professional overlap with psychologists in this area described. In one setting, the Department of Behavioral Health included social work assistants who were responsible for the more concrete aspects of discharge planning.

Non – Inpatient Assignments (12 social workers): including medical outpatient clinics (rehabilitation, metabolic, oncology, dialysis, speech and language); free standing mental health centers; a free standing clinic for children with developmental disabilities; a caregiver resource center and emergency room assignments.

While the range of assignments within this category is broad, the social work responsibilities were similar and included assessment, resource referral and networking. Case managers were usually not involved but if present, their role was mostly to clarify insurance coverage and obtain required insurance authorizations if needed for any treatment or resource plan components. Social workers assigned to outpatient clinics described more opportunities to engage in counseling interventions; the emergency room social workers engaged more in crisis intervention and discharge planning. Within this subcategory, seven social workers were part of centralized social work departments; the two from merged/restructured departments both worked in emergency rooms and of the remaining three, all were unit based, two working in mental health clinics and one assigned to a developmental disabilities clinic.

Chapter Summary

Study participants work in a range of hospital settings, reporting structures and practice assignments.   The major themes that emerge from an analysis of the diversity of these experiences are discussed in the chapters that follow.   Social workers by and large have a clear perception of their distinct professional framework and how their unique expertise distinguishes them from other disciplines in the settings.   It is the implementation of these concepts that is challenged in the hospital environment. Factors both external and internal to the social work profession will be highlighted and discussed as the impact of these forces is represented in this study.   The comments made by the study subjects are assigned fictitious names to maintain confidentiality and to facilitate ease of discussion; hospitals are not identified by names.

Table 1 – Study Sample Demographics

Hospital	Department Structure	Name	Director	Formal Supervision	Yrs. Post MSW	Yrs. At Site	Assignment
A	Centralized	**Alice**	SW	SW	4	0.2	Inpatient
		Brian	SW	SW	14	10	Outpatient
		Carol	SW	SW	20	15	Outpatient
		Christine	SW	SW	4	4	Inpatient
		Daisy	SW	SW	1	0.75	Inpatient
		Laura	SW	SW	5	0.8	Outpatient
		Lisa	SW	SW	2	2	Inpatient
		Marylou	SW	No longer	16	15	Inpatient
		Maya	SW	SW	4	1	Inpatient
		Rachel	SW	SW	3	3	Inpatient
		Rob	SW	SW	1	0.2	Outpatient
		Sharon	SW	SW	3	3	Inpatient
B	Centralized	**Jennifer**	SW	No longer	20	20	Inpt. Psych.
		Samantha	SW	No longer	44	33	Outpatient
		Tiffeny	SW	SW	11	0.1	Inpatient
C	Centralized	**Helen**	SW	None	4	4	Inpatient
		Robin	SW	None	9	9	Outpatient
		Susie	SW	None	26	12	Outpatient
D	Merged	**Joann**	RN	SW	19	8	Inpatient
		Julian	RN	SW	9	9	Inpatient
		Tanya	RN	SW	4	0.25	Inpatient
E	Merged	**Roberta**	SW	None	8	2	Inpatient
		Steve	SW	None	3	2	Inpatient
	Unit-Based	**John**	Rehab	None	23	14	MH Clinic
		Margaret	Rehab	None	25	14	MH Clinic
F	Merged	**Kim**	RN	None	6	6	Inpatient
		Paul	RN	None	7	5	ER
G	Merged	**Nancy**	RN	None	5	0.25	Inpatient
H	Merged	**Francesca**	RN	None	4	1	Inpatient
		Renee	RN	None	31	16	ER

Table 1 – Study Sample Demographics (cont.)

Hospital	Department Structure	Name	Director	Formal Supervision	Yrs. Post MSW	Yrs. At Site	Assignment
I	Merged	**Melanie**	SW	SW	1	0.75	Inpatient
		Melissa	SW	SW	1	0.75	Inpatient
J	Merged	**Justine**	RN	None	6	5	Inpatient
		Kasha	RN	None	7	0.5	Inpatient
		Madeline	RN	None	7	5	Inpatient
		Midnight	RN	None	25	2	Inpatient
K	Merged	**Susan**	RN	None	17	17	Inpatient
	Unit-Based	**Charlie**	MD	SW	7	0.5	Inpt. Psych.
L	Unit-Based	**Sara**	Spec.Ed.	None	18	16	Outpatient
M	Unit-Based	**Lori**	MD	SW	1	0.75	Inpt. Psych.

Abbreviations:

SW = Social Worker
RN = Registered Nurse
MD = Physician
Rehab = Rehabilitation Counselor
Spec. Ed. = Special Education Professional
ER = Emergency Room
Inpt. Psych = Inpatient Psychiatry

CHAPTER V

MAJOR THEMES: Organizational Context

Introduction

The dynamic that controls the definition of social work and shapes social work practice varied from setting to setting and depended on a number of factors. It was originally anticipated that organizational structure would be a primary influence of social work roles. The data revealed a different picture. Organizational structures are not sufficient to explain the nuances of social work practice experiences across organizational settings. This is most apparent in merged and restructured departments where the broadest array of roles appeared. "Control of practice roles" emerged as an overarching organizational theme that was influenced by organizational transitions, non-social work management and interdisciplinary relationships and perceptions. How social work is defined and functionally implemented as a result of these influences provided the background for how social work professional practice is understood and valued. These themes will be picked up again in Chapter 6.

Organizational Transitions

Departments represent organizational subunits established to allocate work and coordinate different roles and are designed in ways to most effectively carry out the work of the organization (Blau & Scott, 2005; Jaques, 1990/2005; Bolman & Deal, 1997; Hasenfeld, 1992). Social workers are impacted by real and perceived consequences of power and influence within these structures as those

with power influence decision making and goal prioritizing to support their agenda (Berger, 1991; Marcus, 1987, Shafritz, et al., 2005).   For those settings in which restructuring have occurred, consolidation of related functions has been the goal. For virtually all of these, this action has been to more efficiently accomplish discharge planning.

Reporting structures not only serve a bureaucratic function but provide as well a social context in which norms, values, expectations and perceptions are prevailing influences. Social context reflects the climate of an organization which "captures the way people perceive their work environment (pg. 739; Glisson, 2007)". Social workers are impacted by influences within their departments through which they perceive how and why decisions are made, their relationships with colleagues and how their roles and functions are delineated.

Restructuring Experiences

Organizational influences are more acutely experienced for those social workers who have been employed during organizational restructuring and were witness to what they perceive as their changing roles and value to the institution. The experiences of subjects greatly vary as some workers lived through different departmental configurations and some became employed after a restructuring had occurred. Social workers reflect how the changing environment within their department and the organization impacts their practice experiences.   Social workers may respond differently to the restructuring or evolving scenarios based on their professional history, exposures and expectations.

Organizational transitions within hospitals in this study have taken many forms and provide a meaningful vehicle through which to look at variations in departmental structures. Most frequently, centralized social work departments have restructured to combine social work staff with case management and

utilization review staff, usually but not always represented by nursing. In most of these instances, nurses have been designated as directors while two restructured departments in this study have continued to have social work directors. Restructuring has most often resulted in decreasing social work staff and increasing case management staff and change in management from having a director with a social work background to one trained differently.   Social workers who have worked through these transitions are impacted in profound ways. Susan described having worked in a traditional centralized social work department for 17 years prior to the recent restructuring three years ago. She was once part of a 65 member social work staff and is now one of seven for the entire hospital.

> …after you see all your entire department decimated and your director, even though you don't like her fired, it doesn't leave for positive feelings. …I have… my own daughter is 24 and if she mentions going to get into social work I'd crush it, so does that tell you something? I think that we're really a dying breed, I that we… I really do… I think that it's a very devalued profession and I don't see the future as rosy at all.   Susan, Hospital K

Her frustrations and anger are evident as she describes her experience.   In this and another hospital, the reorganization of social work went further than merging departments. Medical social work was split from psychiatric social work. This fuels both organizational and intra professional distinctions as to how specific social work expertise is viewed differently. Dichotomy and even a hierarchy within hospital social work is created, allowing psychiatric social workers to perceive their professional identities and roles differently from their medical social worker colleagues, and institutionally more valued based on how staffing resources might be allocated.

While no other social worker interviewed experienced such a drastic change in his or her departmental structure, others shared similar feelings to changes in

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social work staffing and leadership. Participants reported case managers were hired instead of social workers, social workers left and were not replaced, and supervision was lost due to changing supervisory staff and expanded duties for all involved.   In one hospital, the new nurse director made her management direction clear indicating her intention to cut social work staff by more than half and increase the case management staff. Midnight and Madeline share their experience.

> …this new director, her plan is to…we have 15 social workers which is not bad, 2 are out on disability, she wants one social worker for every 2 units which would knock us down to 5 or 6 social workers. She wants to increase the number of nurse case managers to do any and all discharge planning which according to her is their area of expertise.   Midnight, Hospital J

> Now the director of case management wants the nurses to assume more responsibility, in fact she feels the case management nurses should be driving the discharge planning process which was always driven by the social workers. So it almost makes you think, you hope that you are not going to be edged out of a job.
>   Madeline, Hospital J

As reported by all the four social workers interviewed from this setting, the new director believes that case managers should take the lead in discharge planning activities and have the appropriate expertise to accomplish this. Departmental restructuring often changes the power balance within a department in real and/or symbolic ways. This can be experienced as a planned process as in the example above or surface as a perceived vulnerability emanating from what discipline directs the department, assumed bias and shifting roles between interdisciplinary colleagues as discussed later.

Less overt structural shifts have likely impacted participants in all settings to varying degrees as each hospital has had to react to financial uncertainty, most

often reported as a loss of management and/or staffing lines (Berger, 1996; 2003). The impact of changes in social work staffing and administrative lines in the absence of organizational restructuring was noted by some participants. An outcome of a reduction in management staff is a loss of or limited access to supervision and consultation which has the potential to further erode social work role definitions. While a number of participants share this sentiment, Helen best introduces how the downsizing of management staff within her centralized social work department impacts her experience.

> So there were basically 2 [social work] managers that were accessible to us and the department, so half of them were the floor, inpatient workers, and half of them would be the outpatient workers, which I was classified, as a dialysis social worker, umm, and we had this one manager and they all had the other. Then when our manager left, she is now supervising everyone and she could not cover what she had before. It's not that she isn't a lovely person, she really is, umm, but she just can't do it. It just can't be done.   Helen, Hospital C

Helen, in her setting for the four years since obtaining her MSW, attributes her lack of professional supervision to the realities of her departmental staffing. How limitations in management staff and access to social work supervision impacts participants is more broadly discussed below.

Supervision Experiences

Variations in the provision of professional supervision can in part be linked to the restructuring of department management and supervisory staff. Effective practice, professional growth, job satisfaction and decreased burnout have been associated with supervisory activities (Berger & Mizrahi, 2001; Allen, Lambert, Pasupuleti, Cluse-Tolar & Ventura, 2004; Cohen & Gagin, 2005). Professional supervision is a departmental activity that provides meaning to all the social

workers interviewed whether or not it is currently being provided. Most view supervision as a mechanism to advance skills and validate and support their practice. Supervision contributes to an individual's socialization within the profession and within the organization and fosters professional identity.

As professional roles shift, social workers look to social work supervisors to assist them to reframe and validate their roles and professional practice perspective. When reliably provided and available, Sharon and Melissa illustrate the significance as follows.

> I think just really the support it gives me to feel that I am supported that I am doing what I am supposed to be doing, to feel that someone is looking out for me…It is sort of an opportunity to go through it and sort out my feelings related to that. She is available so if I have a difficult case I do call her so supervision becomes just a time to talk about all that is going on. Sharon, Hospital A

> The most valuable part is what I said about the support that is there…I go for specific feedback on what to do, I will try to come prepared with things I need answers for a lot of times I think I might already kind of know and I just like to talk things out.
> Melissa, Hospital I

Most restructured and merged departments have continued to have social work supervisors even if now directed by a non-social worker. The presence of a social work supervisor did not always improve clinical and administrative support avenues because in some settings, the supervisors, sometimes titled as coordinators, have decreased in numbers and are overseeing larger numbers of workers. In other instances, the supervisors are being asked to carry a case load which further limits their availability. When Madeline was asked if she received any structured supervision from her social work coordinator, she answered as follows.

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Not really. As needed, I can call one of the coordinators. They both have case loads, one is the ER social worker and the other coordinator fills in when people are sick or on vacation. There is not a supervisor whose main function is to supervise.

Madeline, Hospital J

Almost all social workers interviewed report that they would first seek out a peer for clinical support and problem solving. A few social workers, again feeling the impact of restructuring, have lost senior social workers in their setting and finding a peer with more experience is also a growing challenge. Kim illustrates this point below.

We lost everything. And a lot of the seasoned social workers left the hospital, 12 or 13 just left, except for one social worker she has been here, 12 or 15 years, she knows everything, everyone else was new and it was sort of like the case managers sort of trained us initially so I think that also plays a role. Kim, Hospital F

In her comment, Kim also raises the issue that as social workers increasingly experience being part of restructured departments, the potential for being "trained" by non-social workers is a reality. This represents a particular challenge for new social workers. Socialization into the social work profession is one function of supervision that promotes the expansion of specific expertise and helps build professional identity as social workers move from being professionally educated to autonomous professionals. Social workers entering the workforce look and even depend on the presence of similarly trained professionals to guide them as they move along this continuum. Participants revealed that this function of supervision is not a universal occurrence and in some instances, can be lost to the new worker, now being supervised and socialized into the organization by a different discipline. One seasoned social

worker, with her MSW since 1990 and at her setting five years, stated that when she was hired she was specifically told that she would not be doing any counseling, that her job was discharge planning.

> When I was first hired, and supervised by a nurse, I was told my responsibilities were discharge planning that I would not be doing counseling, maybe some of the roles social work sees themselves in. I guess that is fine for a nurse to say that, but sometimes discharge planning involves counseling, helping a patient and family accept a diagnosis, you just can't make a referral and send them on their way.   Madeline, Hospital J

This particular social worker did have an understanding that discharge planning could involve clinical components; however that level of role function as defined by a non-social worker might be internalized differently by someone else. Particularly vulnerable to such role defining would be a recent graduate who might not have been exposed to hospital social work as an intern or whose field work experience established a different perspective of role and functions. Daisy, Hospital A, described that very point when her field instructor stated "why would you want to just do discharge planning, it's so not clinical." If in fact individual social workers can shape roles and functions in different ways, having a non-social worker define social work professional roles and responsibilities to a new social worker can be more problematic.

Participants looked towards social work managers and supervisors as a professional resource. Tanya and Paul provide examples of how the loss of social work management impacts them and why they more frequently seek out colleagues for assistance with cases.

> Yes, but she [director] is a nurse and she doesn't know a lot, a lot, a lot of things. I had a young teenage mom on cardiology, her mother wanted services for her, she had a 7 month old and I was

telling the director she has WIC, what's that, did you make a public health nurse referral, no she has blue cross. She doesn't really know. She is a nurse. And all she sees is the nurse's…the medication, why is this person still here, what's the meds, what's their ejection fraction, that is all she sees. The acute reason the patient is in the hospital. She doesn't really always see the social problems that are preventing a discharge. Which there are plenty.

<div align="right">Tanya, Hospital D</div>

What we do also, she is not from a social work background so certain things she doesn't know how to handle, not to bad talk her but just the reality. I don't think she is able to handle certain issues, so the few social workers that are here, we kind of call each other and some of us have more experience in different areas, different specialties, so we kind of like call each other. I get a call from my co-worker – 'I have this issue, what do you think I should do' – so we kind of help each other that way.

<div align="right">Paul, Hospital F</div>

Day to day problem solving support is viewed as compromised as social workers perceive their non-social work directors' professional view to be different and in some instances not helpful when coming from managers trained in another discipline. Paul touches as well on the challenges presented by the loss of experienced peers to turn to as seasoned social workers leave and/or social work lines decrease.

Formats for staff training and development varied tremendously across all different organizational structures. In all the settings represented in the study, this activity, when provided, uses different formats and for different purposes. Nineteen social workers reported some formal format for supervision provided by a social worker. Fourteen of these workers were from two centralized settings (Hospitals A and B); two workers were part of unit-based Behavioral Health Departments (Hospitals K and M) ; and three workers were part of a merged structure described above in which all social workers meet daily for 15 minutes with their social work supervisor (Hospital D). Three social workers from the two

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centralized departments mentioned here did not have formal supervision but have had their MSW degrees for at least 15 years and have worked in their respective settings from 15 to 35 years.

From the third centralized department (Hospital C), none of the participants are receiving formal supervision. Despite having a social work director, this reality was attributed to lack of internal commitment and a recent loss of social work supervisory staff. When asked about the provision of formal supervision or even whether her supervisor had an "open-door policy" found elsewhere, Helen responded as follows.

> That [supervision] is a myth at this place. It is scary, it really is…Right now and I am not blaming them particularly, I don't think it is a personality thing, they are just so short handed in the managerial sector of the social work department here they are just not available. There are times when I have called and they have turned off their beepers or they will call you back 2 hours later which is not very helpful when you have a situation going on.
>
> Helen, Hospital C

Having a social worker as a director was not necessarily a guarantee that formal supervision was provided, as Helen describes, or alternatively, that when lacking a social work director, social work supervision was absent. At one hospital (Hospital D), having a restructured department and a nurse director, the social workers met daily for a 15 minute timeframe with a social work supervisor. This brief connection maintained the social work group professionally distinct within their department which otherwise was fraught with competition and animosity. The focus of this daily encounter was administrative and geared towards information sharing and problem solving. The social workers additionally met every other week with a social work supervisor. This is

occurring in the one hospital in which the social work practice was found to be the most fragmented and variable depending on where one was assigned.

In the majority of the other settings, some administrative functions of supervision are fulfilled through department meetings with only social workers or combined with case managers. These meetings focused more on administrative and educational issues. Many of the social workers interviewed longed for opportunities to present and review patient cases. At one setting, the social workers attempted to have peer-directed case conferences but could not sustain them because they were unable to coordinate social workers who had limited available time. In the absence of formal supervision, most social workers report that they readily had access to their supervisors on an "as needed" basis. Advancement of clinical skills continued to be a valued professional goal for most social workers, even some with greater than 10 years of experience.

Nine of the 40 social workers interviewed were in fact recent MSW graduates (three years or less). An interesting note is that all of these individuals worked in settings with social work directors, with eight of these social workers reporting that they receive formal supervision. One recent graduate, working in a merged generic Case Management Department (Hospital E) with a social work director, and social work coordinator, did not have structured supervision. He does however describe an "open door policy" which suits his defined needs. The professional identity of this worker may in fact be more strongly influenced over time by how his job is configured as "generic" and the same as nurses, then through any "as needed" supervision that might be provided by a social work director.

Finally, organizations vary as to the value placed on the provision of professional supervision to social work staff. Settings in which there was a strong commitment to advance the licensing status of the social workers in the department provided a supervisory structure with both clinically focused

individual and group supervision, designed to meet NYS licensing requirements. This goal was specifically described in two of the settings, one with a large centralized department and in another hospital with a restructured department, both with social workers as directors. To this end, supervision was provided to new social workers with a deliberate emphasis on the advancement of clinical skills. As the new licensing requirements were implemented, one social worker noted the response of her department now with an increase in scheduled supervisory sessions. A number of social workers in other settings have sought private supervision in the community in order to satisfy the state LCSW requirements. The decision to provide structured professional supervision is an example of how priorities set by departmental management impact the experiences of social workers.

Non-Social Work Management

One of the most frequent outcomes of restructuring described was a change of departmental management.   Staff look towards managers to set the priorities of the department, to be their connection to the decision makers in the hierarchy and to provide guidance for practice concerns. Participants from only five of the 13 settings represented in this study had social workers as department directors.

It is at the level of management that social work roles are functionally shaped. Department directors are responsible for determining the practice roles for his or her staff. Social workers in settings without social work directors experience decisions concerning social work roles and responsibilities as lacking clarity and not always consistent with any discipline's specific expertise.   Francesca provides an example of such internal confusion.

> We spend time in staff meetings debating this all the time. Who
> does what around here. Who's job is what and there is a lot of

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> animosity among…social workers are supposed to do this, case managers are supposed to do this, case managers say…no, no, we have too much to do, and social workers are saying that is ridiculous for me to do that.   Francesca, Hospital H

Perceiving a lack of a clear professionally driven rationale, changing roles are viewed with suspicion. In Hospital D where Joann is employed, social workers were only responsible for nursing home placements throughout the building a few years ago have now been assigned to specific units to accomplish pieces of discharge planning referred by case managers. A new responsibility which in some ways elevates the status of social work has been the recent inclusion of social workers on daily team rounds.   As these roles evolve, those interviewed have only been able to view each as an added responsibility to an already impossible work day, as Joann described additional changes occurring.

> Well as the hospital is downsizing in some areas like psychiatric physician assistants, then we tend to pick up the slack. Recently one of my co-workers had to do 4 transfers to other psychiatric hospitals, which was not our role. And now it is…that's been a cause of consternation. Our role is expanding as the hospital looks to cut back and it seems like our department is found to be the ones to take over when other people have cut back. Some of it we fought, like referrals for home care and we clarified that we are not to do that.   But other times, like with this psychiatric liaison position, as they decrease, we are pushed to do their job.
>   Joann, Hospital D

What makes this comment particularly interesting is that in other hospitals, referring patients to psychiatric settings or home care are specific social work professional functions within the broader framework of discharge planning. Yet Joann sees these as burdens. As part of a recently restructured department (just over a year) that included the loss of a social work director, any shifts in roles are

being viewed through their frustrations and vulnerability. The perspectives shared by a number of respondents would suggest that it can be difficult to perceive that non-social work directors would make decisions that are consistent with an understanding of social work practice and not based on bias.

   Preferential treatment by non-social work managers for another discipline is attributed to the perceived loyalty of one professional over those from a different discipline. The negative impact on social work from decreasing staff, differential allocation of resources and increasing work loads is often attributed to bias.

> In my hospital it is very much a nurse's world. The CEO is a nurse, nursing administration is huge, everything is just nurses, nurses, nurses.   Tanya, Hospital D

> With the case manager it's really never been clear when we were taken up we never had clear delineation what social work was supposed to do and what case management was supposed to do. Very often I feel like I'm the case manager's secretary or hand maiden…there is kind of this little tension and they're winning the game because the hospital, is much more, I think, supportive of nurses then social workers. Well, we have, when we had a director of social work we had… to a degree we had more representation. Now our director, I love her, but she's a lovely person, but she's a nurse. Her loyalty is basically to nursing.   Susan, Hospital K

   As organizations streamline patient delivery systems, the most common restructuring that was reported was the merging of social work services with case management staff. It is the manner is which roles and functions between these professional groups are delineated that becomes significant in establishing the quality of collegial relationships on interdisciplinary teams and how each discipline understands how their roles are configured. The framework for how practice roles are controlled emerges from these realities.

Relationships with colleagues with whom social workers share a department can vary depending on the discipline managing the department and the perceptions as to how related functions within settings are assigned. Newly sharing a department with other disciplines, more notably if the management of the department is not a social worker, can set up a climate of competition as roles are reexamined and disciplines jockey for status and security. With social workers sensing loss and heightened vulnerability with this new configuration, concrete examples of how they experience value permeate their experiences. For example social workers from within a merged department, describe instances of not being included in meetings with new administrators; of case managers having more equipment such as laptops and wireless phones to use; and one extreme example where two social workers described that in their hospital department, when case management month was celebrated, the poster from their merged department included the social workers as part of the "support staff".

> Two years ago they had case managers' month and they put all the social workers as support staff with the office staff. I was livid. I mean like, I am a delegate in 1199 and I always try to justify and validate our profession and I had a talk with the case manager…I have made her change the whole bulletin board - we are your coworkers not your support staff.   Kim, Hospital F

Social workers in these environments continually compare themselves to their case management colleagues in terms of having more education, receiving less salary and perceiving themselves as less valued.

> It really shows that we are not valued as much. The big thing is the CCCs, [clinical care coordinators] they get everything, including a lot more money because they are nurses. It is very frustrating because we are licensed, we all have master degrees. Some of them only have associate degrees or bachelors. I am not saying we are better or smarter, but I feel that we had to go through

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all this schooling and to be licensed just to get treated like, not that great. Sometimes it is very apparent. We work weekends, the CCCs just started working weekends last month, just started. We would get calls on the weekend all the time to do home care, so and so needs a walker, we don't do that, and then they get mad. Well 'what <u>do</u> you do"…not that. The whole attitude is frustrating.   Tanya, Hospital D

Not surprisingly, in these settings, the competition between the disciplines plays out on the hospital floors since discharge planning in these types of settings has become fragmented between the disciplines. Patient cases are often controlled by case managers who refer to social work those cases deemed appropriate for social work intervention by their professional assessment. These case managers are most frequently social workers' departmental colleagues. As will be described more fully in a later discussion about social work practice, each hospital setting, and in some instances, individual staff on different units of one hospital defines "appropriate for social work" differently, and case managers' control of the process varies as well. These collegial dynamics are likely defined within departmental structures through departmental management. Differences in perceived power and influence that results creates a professional hierarchy among departmental colleagues as witnessed in one social worker's view when case managers adamantly correct anyone who confuses them with social work.

A lot of the people think we only have 2 years of education, 2 years of an associate degree. When they find out we have Masters degree they are shocked. And you know the nurses who are case managers see us as more of their subordinates, type of profession, because they feel that their profession is more legitimate, it is more medical, and they see our role as caseworkers, simple psychosocial, making calls. They don't appreciate or they don't value our profession as is. They sometimes don't know, the challenges working with the case managers, for them to not to think that they are our supervisors which is very frustrating at times. There are times when they will – oh can you fax this for me

> – I am not your clerk or staff here, you fax it yourself…So for them, they feel their role is a lot more important than us, and god forbid if any one on the floor calls them social workers they get very angry. "We are not social workers, we are case managers, RNs". They emphasize it.   Kim, Hospital F

For the two settings (Hospitals E and I) in which hospital social workers are part of a restructured department, but continue to have a social work manager, less animosity and competition is described.

> In this hospital, it is very helpful to have them there, to have nurses specifically assigned to help the social workers, I feel that it is supplemental support as opposed to a social worker having…I can see how maybe it can become the case manager taking over and the social worker maybe being the additional. But I see them as really a support staff very knowledgeable people.   Melissa, Hospital I

Within this restructured department with a social work director (Hospital I), the social workers view the case managers as supporting the work of the social workers and a sense of competition is not as evident. As case managers are being increasingly utilized, the above worker projected that she could envision how the case managers could at some point take control of the discharge planning process and reverse the dynamics, but that was not currently the case.

The other setting (Hospital E), is unique, as both social workers and nurses in the department, by design, share the identical title and functions of "case manager", including salary equality. This eliminates most comparisons between disciplines within the department structure. Workers interviewed cite examples of mutual respect for each others skill set and more of an atmosphere of collegiality.

We are all doing similar things, the idea is that one complements the other. There are nurses that consult with the social worker about discharge planning and the social worker might consult about something medically that might be going on with the patient that may involve the discharge. It is like we complement each other, that is the model.   Steve, Hospital E

But differing views of interdisciplinary relationships also occurred among participants in the same department based on a worker's day to day experiences. This perspective was found between social workers assigned to different units (Hospital D), one working without a case manager and in control of her role and the other whose practice was highly fragmented and controlled by case managers. The first social worker shared her perspective.

We work weekends here, my colleagues are trained to do home care, but they don't do that. I am, so on the weekend, a nurse approaches me and someone has to go home, and they want home care, if I say no, I will be fired, because I know how to do that, if I say yes, my colleagues would kill me because they don't want to do that. So you kind of get…but if everybody would just realize that there is a way to do this without losing who you are, plus helping another discipline, being part of a team, as opposed to being just a member of a team, but being part of a team, then we will all work better together.   Julian, Hospital D

This is far from the competitive perceptions of her colleague working elsewhere in the same hospital and illustrates the diversity of influences experienced on an individual level.

…on the medical floor where I work, it's not [clear], a lot of the times, it's so and so has a home health aide and wants to see you but it is really the CCC, it is a fine line, but it is the discharge planner's responsibility because they are going home. So I don't think there is a very good…they would not call a dietician for all these random…they call us for everything. A couple of weeks ago I had a man who, he flew in to see his daughter and had a heart

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attack at LaGuardia, his luggage was still there. They called me. I don't work for LaGuardia. We get the phone book, we do find a way to help them, so I guess it is a good thing that we have the reputation of finding a way to help them. So we show each other the referrals, look at this, can you believe this, we have a contest, like the best referral for the week. Real doozies.

<div align="right">Tanya, Hospital D</div>

Despite satisfaction with being able to assist patients and families no matter what is asked of her, Tanya views the randomness of referrals with frustration. When others control the work, autonomy of practice is lost, turf issues accumulate and competition grows. The literature is replete with research reporting the consequences of some of these experiences, particularly how role conflict, role ambiguity and changing work environments contribute to low productivity, increased stress and burnout (Allen, et al, 2004; Siefert, Jayartne & Chess, 1991).

Social workers in this study consistently viewed the lack of a social work leader as a loss of a voice advocating on their behalf through the organizational hierarchy. This creates insecurities that may or may not be valid, but fueled by the realities of the restructuring process and organizational downsizing. The loss of a social work specific voice and a social work perspective within a host organization becomes symbolic as Kim from a merged department without a social worker as manager (e.g. neither director nor supervisor), describes.

Actually our supervisor is pretty good with the social workers, but we would love to have a social work background supervisor who would give us clinical supervision, case studies with us and you know just kind of keep abreast of our profession, and just kind of guide us through what is going on in the hospital. She would be the bridge between the nurse case manager and the social worker, and for her to validate what we do in the hospital. The pecking order in the hospital is the attending, the resident, the nurses, the case managers, and then we are at the bottom. So you feel your

> voice is unheard. We don't have anyone actually advocating for us
> at all. Or just validate what we do.   Kim, Hospital K

Kim is not a new worker. She has been in her setting for almost six years and active in her union. She is able to acknowledge that her current non-social work supervisor is "pretty good with the social workers" and based on the interview of her colleague Paul, her department, led by a nurse, is currently replacing lost social work lines. But her need to have an external "voice" to promote the value of social work is a pervasive theme among participants. If social work roles were more clearly defined or understood, social workers might not express this need for an external "voice" so profoundly to communicate value. But more significantly, it alludes to a perceived loss of power and influence that in her view, only a social work leader can provide within the organization and on her behalf.

Settings with social work directors (there are five in the sample), have also experienced organizational struggles as social workers with longevity describe staffing changes, loss of supervisors and the introduction of case managers. However, in two of the three centralized departments and two of the restructured departments, positive profiles of social work within the setting are reported and attributed to the departmental social work leadership. In the third centralized department represented in the sample, the social worker management is not viewed as effective by the social workers interviewed and they link this to erosion in supervision and support, and a decrease in perceived value within the organization when compared with their nurse case manager colleagues. Helen provides the example below of how her department has been impacted, and also how social work is profiled within the organization; her frustration and pessimistic outlook are evident in her words.

> Nothing gets dealt with in this hospital. And whatever we hear about is usually left on a voicemail or in monthly meetings. They are very big on leaving messages. I find it almost passive aggressive behavior, you know they don't want to talk to you actually, they drop something on you. I don't think it is a personality thing, they are just so short handed in the managerial sector of the social work department here they are just not available…But the personnel cuts have really impaired everybody's ability to do their work right.   Helen, Hospital C

In her setting, Helen finds it interesting that the head of the entire hospital system is a social worker; and yet, her perception is that the organization places a higher value on nurse case managers while hospital social work is considered a "luxury" and would be absent if not unionized.

> The hospital values them a great deal more, they are nurse case managers. I don't know what they make, but my guess is that it is twice as much as I make. And I think that they would like to replace social workers with discharge planners. I don't think there is a lot of respect for social work in this particular hospital system certainly there is not, not very fond of social work and they would get rid of social work if they could is the word but they are unionized here and they really can't.   Helen, Hospital C

Having a centralized department and a social work director in this instance, even with a social worker at the very top of the hierarchy, does not guarantee organizational value and associated professional security. In fact, social work in this hospital appears to be undergoing additional transitions as those interviewed describe an increasing utilization of nurse case managers and changing social work roles.

The impact of department management in Hospital C above can be contrasted with the experiences of social workers in the other two centralized departments

illustrated by Brian's comments below. He described how his department responded when faced with institutional pressures.

> I've been here through this hospital's difficult times and there have been a number of efforts made for addressing that and so a lot of things were handed to the department in terms of cuts and… central organization, things that have changed, you know, and now changed back again and that was clearly handed down from somewhere other than the department… so. But they always seem to be… I mean, I… I hate to sound like Pollyanna but they do… the administration in this department is very geared towards… my estimation, the welfare of the department itself and you always feel that-- I always feel that they're taking that into consideration. They do a lot of wiggling in terms of trying to keep things organized and… people employed at the rate that they want to be employed at and doing the kinds of jobs that they want to do. They're pretty good.
> Brian, Hospital A

The strength and effectiveness of Brian's social work leadership is evident in his words and was echoed by virtually all workers interviewed from this setting. This sentiment was also shared by participants from one of the other centralized department represented in the study. For example, Tiffeny, at her setting barely one month when interviewed, attributes the strength and visibility of social work to her social work departmental administration.

> Here there is a tremendous focus on having social workers involved in several different types of teams, care planning teams, rounds teams, interdisciplinary teams, social workers have input on who comes and goes out of the unit, who is accepted for transfers. Social workers have input on setting up a plan of care, establishing it, carrying it through, discharge plans, care on the floor, the social work piece here is very strong…An institutional setting of acceptance of that [social work]. Being new here I would have to guess it is stemming from social work chiefs and administrative people advocating for social work responsibility and opinion.
> Tiffeny, Hospital B

Based on the varying experiences of the participants from these different centralized settings, it would appear that in some cases the management skills and vision of the director of social work is what mattered and not simply the professional affiliation. This could not be more fully explored in this study however, since except for the psychiatric social workers discussed above, no social workers felt fully secure in the absence of a social work director. No one described having a director from another discipline as someone who they felt reliably conveyed their value through the organization or was invested in safeguarding their positions and roles. Their perceptions were more routinely attributed to real or assumed positive bias towards, in most cases the nurses in the department, when the manager was a nurse.

Implications of Control of Role

How social work practice is shaped and controlled appears to vary between settings and as illustrated above, emerges from the combined influence of organizational forces. By setting the priorities of its staff, department management has been introduced as one of the influences establishing how social work is practiced. Interdisciplinary relationships on teams also impact what is identified as "social work" based on organizationally delineated roles and functions and how each discipline interprets these. Control of practice roles ultimately leads to the realities of who defines social work within the organization. The extent of autonomous practice experienced falls along a continuum of practice models and significantly impacts the day to day experiences of social workers. Marylou provides an example of one end of the practice spectrum.

> What I enjoy about my department is that I have a tremendous amount of autonomy and I am very much respected and valued, my boss never tells me what to do, or how to do it, unless there is a particular situation that calls for it. However, I am always accountable and that to me feels very professional.
>
> Marylou, Hospital A

Marylou, a seasoned worker from a strong centralized social work department, provides an example of how social workers in one setting have complete professional control of their practice and how that contributes to a positive and meaningful experience. Steve, working in a generic case management department similarly has control of his role.

> In my setting it [social work] is known and defined. They see a case manager, social worker or nurse, they understand we are involved in discharge planning. That is really the main focus, the discharge plan. The nurse and social worker complement each other, we are all there for discharge. Ultimately that is the goal, to get the patient out in an appropriate and safe manner.
>
> Steve, Hospital E

Defined to be identical to nurse case managers, he and his department colleagues are responsible for all aspects of a patient case including utilization review and all activities associated with assessment and implementation of a discharge plan. The nurse and social worker assist each other sharing individual expertise in a collegial manner. Turf issues are not present. Steve perceived his daily experience as positive.

The extent of autonomy of practice experienced by individuals is not necessarily tied to whether or not there is social work leadership guiding the process. The composition of the service or team to which one is assigned may play a greater role, the variable being the extent of involvement of case managers. For example, in hospitals in which case managers are only used on certain units,

those social workers who are working independently and fully responsible for discharge planning, report feeling in control and valued by their team. This is best illustrated by workers from the same restructured department with a nurse as director, who have different practice experiences.

Julian, on a unit without a case manager, reports being considered the critical professional coordinating the care and discharge of patients. She describes "the social worker on this unit is the hub." In this same setting, workers who are on the units where case managers control who social workers might see and for what reason, the workers are not as positive as they describe their practice. The following quotes illustrate experiences of Tanya and Joann from the same department as Julian, working on units where case managers refer cases to social work.

> I personally have worked everywhere. Started on psychiatry, worked on brain injury, every medical floor and the emergency room. I found that their expectations are very unrealistic a lot, again with the no insurance – I feel you would not refer for a physical therapy consult for someone with no insurance, but they think that social work, and I understand where the thought process comes from, but it has just been over and over again, someone who is non-compliant with their meds, or they have been to the emergency room 8 times this week, all right, what do want me to do, and like maternity that is another one. I got a referral once for a 35 year old woman who did not have a refrigerator. Get a cooler, stuff like that. You had all these problems before you got to the hospital. They are not going to be fixed in a 3 day stay. On the specialty units the social work role is very clear. Social workers are very involved, they see every patient.   Tanya, Hospital D

> They identify cases that I should see, whether it is substance abuse or placement issues, catastrophic illness. I see them and discuss in rounds. My part might end with the alcohol piece or homelessness, then I would continue to follow the person until they are ready for discharge. Then placement, I would continue to

> follow to discharge…Mostly, they [care coordinators] handle…their task is to meet with the family, discern if they are agreeable to the plan. If they don't agree, then it shouldn't be passed on to me but sometimes it is anyway because they don't feel it is safe for that person to go home…Sometimes I dispute that and it goes back to them. I go and meet with the family and find they do not want placement and it goes back to them.
>
> <div align="right">Joann, Hospital D</div>

Both Tanya and Joann report practice roles that are disjointed and not in the control of social work. Though Tanya's frustration is more evident, both describe processes that are unclear and can be viewed as chaotic. Their social work colleague, Julian, working in a specialty unit has a different day, one in which she sees all patients on her unit and is in full control of her practice focusing on all aspects of a discharge plan. Julian describes her work and being part of a team in the following way.

> The therapist will order walkers, but sometimes there won't be insurance. They are supposed to call the lending closets, but if it is crazy, sometimes I will go to them, on my lunch hour for them. We are a team. Or sometimes I have to get the authorization to send someone to a nursing home, I don't really do that I do not set up transportation. I am busy, I say I cannot do that, but if I have time, I say I will do this for you today. That is a secretary function. But just to get the patient out, I help out.
>
> <div align="right">Julian, Hospital D</div>

While she also is asked to respond to a range of concrete needs including obtaining glasses or socks for a patient, her reaction and tone is different as all her work is viewed as patient driven and related to patient care. What might be considered an inconvenience or an unrealistic referral on another unit is more

readily managed by Julian as consistent with her practice which is in her control. Varying degrees of autonomy appear to influence overall practice perspectives.

Participants from two centralized departments (Hospitals A and B) similarly have control of their role, responsible for discharge planning. Within these settings, the role for case managers in the discharge planning process typically focuses on insurance review requirements and viewed as collaborative.

> That [discharge planning] technically falls under social work however the case manager also is very involved in discharge planning and takes a very large piece….humm, how do I want to put it…they play a large role in pulling the plan together. It actually in a certain way makes it easier for social work because they are the ones who speak with the insurance companies and insurance companies are the ones who say "miss so and so, I am giving you until Friday and that is it" and it is that case manager who has to come to the physician and the social worker to say this is all we are getting and you have to help this person understand it. So in a way it must be easier. Marylou, Hospital A

Marylou provides a collaborative example of how case managers are not threatening in her view but instead can assist in the discharge planning role that is clearly being controlled by social work in her setting. These workers, from Hospitals A and B, attribute their well defined roles to the positive organizational profile of social work perpetuated by their strong social work leadership.

While maintaining a distinct social work organizational structure can be considered as positive, the sentiments expressed from within each of these hospitals is not all similar, particularly in response to organizational changes that have taken place. In one setting, Hospital C, reductions in professional social work staff and social work supervisors have eroded some of their job security and confidence in their department management. Case managers are being increasingly utilized in this hospital for components of discharge planning,

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fragmenting the process between disciplines.   As seen before with those from
restructured departments, control of role becomes pivotal issues for job
satisfaction and job security. Helen describing her practice experiences as
"neutral" offers this perspective as to her role.

> Case management does discharge planning, they focus on durable
> medical equipment, visiting nurses. We do discharge planning
> when it involves going to rehab…there is a line of demarcation but
> there is also an overlap.   We do have to work with case
> management very often if we are placing aides in the house for the
> first time, we do a certain piece of it and then they pick it up…I
> guess it is murky, there are certain areas where you have to look at
> what is needed before you decide whose case it is. Not too often
> though. This is the deal, if someone is going home with home care
> it is case management, if someone is going to rehab, it is social
> work, if somebody is going back to an adult home or psychiatric
> facility, it is social work, and that is pretty clear.   If the case
> manager is who assesses the case first, she would call me she
> would not do it herself, she would call me.   Helen, Hospital C

Helen's experience is very different from social workers in the other two settings
also with social work directors and centralized social work departments.
Decisions are being made within Hospital C to assign case managers pieces of the
discharge planning process that in other settings are in the control of social work.
Helen's experience would seem to be somewhere midway along the continuum of
practice models and autonomy of practice.

Lastly, relationships with other disciplines are impacted by how work roles
are defined and whether or not interactions are perceived as collegial or
hierarchical. A number of social workers interviewed, even when being in control
of the discharge plan, perceive that they are secretaries or "hand maidens" to case
managers in their setting. This was more evident in merged departments that no
longer had a social work director. Susan's experience represents this clearest

since when her department was merged, or was as she describes it "taken up". She has witnessed a massive loss of social work staffing and a resulting shift of responsibilities and perceived value.

> With the case manager it's really never been clear when we were taken up we never had clear delineation what social work was supposed to do and what case management was supposed to do. Very often I feel like I'm the case manager's secretary or hand maiden…You know I do a tremendous amount of faxing and but the case manager will call me that the PRI's done I should come and fax it, that kind of stuff. I do a lot of the scut work, not to say that they don't, but there is kind of this little tension and they're winning the game because the hospital is much more, I think, supportive of nurses then social workers.   Susan, Hospital K

Susan provides a clear example of how vulnerability and loss of influence impact how practice and interdisciplinary relationships are experienced.

Chapter Summary

The work of social workers as reported by study participants is a product of who defines the roles and how these roles are defined and understood by others. Organizational transitions that result in a loss of social work staff and changes in social work management influence how different disciplines understand their roles and functions. The introduction of case management staff changes the interdisciplinary dynamics within departments and of social work practice on patient care units. It is the continuum of how social work roles are defined in relation to the roles of case managers that is linked to how social work roles are functionally controlled and implemented.

Control of one's role and practice was associated with an increased expression of positive experiences, perceived value and sense of security. Having a strong social worker as a director was frequently linked to these experiences. Social workers with non-social work managers repeatedly perceived decisions about social work roles and departmental priorities as influenced by the bias of their manager. Competition among disciplines and vulnerability grow as social workers become less autonomous in their practice. Role clarity is a theme that functionally emanates from how roles are shaped and controlled. Perceptions of practice value become linked to how the unique contribution of social work is understood. The concepts and experiences of participants that contribute to these themes are discussed in the next chapter.

CHAPTER VI: MAJOR THEMES: Role and Value

Introduction

Hospital social work roles are historically ambiguous and different disciplines vary as to how they understand social work and in turn impose their own definitions on their role (Gregorian, 2005). The themes of role clarity and practice value are functionally linked and build from the previous discussion of how social work practice is shaped and controlled. The "control of practice roles" ultimately defines social work roles within the organization. Interdisciplinary relationships evolve based on what is identified as "social work" according to organizationally delineated roles and functions, and how each discipline interprets these.

This chapter will discuss a number of concepts that broaden our understanding of what influences the function of hospital social work, focusing on how social work roles are understood from both an interdisciplinary and intradisciplinary perspective. Role clarity is impacted by the fragmentation and interchangeability of practice roles between disciplines; how one's professional identity is individually perceived and projected to others; and varying intra-professional perceptions regarding practice roles. Differences between what social workers themselves value and their perceptions of organizational value permeate the discussion. The discussion will conclude with an analysis of how role clarity and value shapes the social workers' view of their future within the hospital setting.

Role Clarity

The experiences of one social worker interviewed provide the most striking backdrop for most of the following themes to be discussed. Nancy had recently been hired as the sole social worker for a small 120 bed suburban hospital which during recent times has not had a professionally trained social worker in the facility (Hospital G). Instead the title of "social worker" was given to different staff with varying backgrounds including nursing and education.

The tasks and responsibilities of the "social workers" that preceded her were unclear and poorly delineated; she describes her struggles to create her own job description. Nurse case managers are fully responsible in this setting for all discharge planning activities. There is no structure for professional supervision. She reports to the Case Management Department which includes three nurse case managers and a director who is also new and formally was the administrator of a skilled nursing facility. Quality Management is administratively above Case Management. For "as needed" supervision, Nancy seeks out either the case managers or the individual responsible for Quality Management who used to have Nancy's "social work role".

Nancy is "reinventing the wheel" so to speak as no one in the setting has any idea what a social worker does. She offers some examples.

> **…**I feel that in the hospital where I am they really don't know because they did not have a social worker before me. They had a woman who had a masters in teaching and she was a secretary and they used her, they called her a social worker but she really did not have the background to deal with the social issues and safe discharges so I feel that they are learning now, I had to pretty much change things. I had to make my position, how to…give me a job description…so I wrote up my job description with the help of a social worker from another hospital and I was able to pretty much make my own job. The only thing is now they have given me the

patient advocacy job where they don't want me to ask as a social worker, not sign anything with my credentials after it, they want me to put patient advocate after it. So I am having a little bit of a problem with that. I would like to, before they develop this program where I get every complaint, they want to put my name over every patients' head in the hospital. So if the patient has a complaint, they call me. That is why I am describing how they do not know what a social worker does…

…They have also asked me to type everybody's statistics because the woman before me was a secretary and a patient advocate and I have had to tell them…I'll type your statistics if you type mine, and they asked me to do filing. The filing I will not do. I do my own filing. I don't think I should be doing other people's filing…

As Nancy defines her role within her organization, she finds herself confronting long standing perceptions of others and having to demonstrate her value. An example of what that experience has been follows,

…Case managers do the discharge planning. They have to do the Quality Improvements, they do the utilization reviews, they deal with the insurance companies, they have to get the transportations and approvals, they deal with the families. But I find that they have to do so much paperwork, that they don't have time for the families. I will intervene with them – I would like to see this family – and some of them will say sure, but some of them would not like my intervention because I may find something socially they need and it could hold up the discharge. So I have had this, just this week, there was this elderly couple, and there was, the wife was in the hospital and she was a little confused and prior to this admission she wasn't confused.   The case manager had spoken to the husband and he said he would take her home and they would get a 24 hour live-in and that was her discharge plan. And I looked a little further, spoke with the husband and he did not even know where his wife was, he was calling her by a different name, he seemed very confused, he did not remember how he got to the hospital. So now I have the patient going to a nursing facility and the husband, someone coming in to help him at home so it is a safe discharge…

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Nancy does describe however that over time and as a result of her persistent efforts to demonstrate what a social worker does and can do different disciplines are beginning to understand her value.

> …Yes, I am finding that they are understanding me more. In the beginning if I would say to one of the doctors, that I was a social worker, they did not really respect me, I did not really find that they felt I was important. When they saw that I was the one getting the patients out, sooner than the case managers, and to a safe place, they call me all the time now. And they respect me and they see that I am of value, of importance to them…

Nancy's unique situation is an extreme representation as to how after 100 years of social workers working in hospitals, a consistent professional social work role can be elusive. Variations of these issues have been described by all the social workers in this study. A number of concepts contribute to this theme from an interdisciplinary context and include how practice roles are fragmented and vary between settings, how the roles and responsibilities are interchangeable between professional disciplines and how other professionals view the roles of social workers from the perspective of social workers.

Interdisciplinary Influences

As provided in previous chapters, the practice of hospital social work varies between settings and even within settings. This diversity appears to correlate with how case managers are utilized within a particular setting. The involvement of case managers and the extent case managers control social work practice, principally concerning discharge planning, fall along a continuum. The concept

of how social work roles can appear fragmented was introduced as an outcome of how social work practice is shaped and controlled through organizational influences. The interchangeability of social work roles with differently trained professionals emerged as a related finding. This section expands on these concepts in relation to how role clarity is specifically impacted.

Fragmentation

The most extreme examples can be found in settings in which case managers see all patients first and assess patients and families for discharge needs. Case managers then, based on their understanding of their own responsibilities, refer to social workers for everything else that might be involved.

> On my medical surgical floor, they [care coordinators] do any discharge home, they do. They set up DME, home care, people need oxygen, anybody going home is them. Nursing home, adult home, assisted living is us. We also see people going home but those are the substance abusers, or I don't have insurance, or my heating is not working. We would intervene there. But if someone is nursing home, it is our baby, they say, just so you know, so and so if from a nursing home and we take it from there.
>
> Tanya, Hospital D

In these settings, the discharge planning process is so finely fragmented that the broad and holistic view of patient care can be lost. Examples would include when case managers will refer patients for home care but only when home health aides are already in place or will refer for hospice care and assisted living but not skilled nursing facilities. Anytime there is a complexity involved with the initial plan the patient and family is referred to social work. Examples of such complexity could be a family disagreement, a history of substance abuse or psychiatric illness, or more concretely, lack of insurance or homelessness. Even

here, what is defined as "complexities" may vary from setting to setting, and between individuals making the referrals. Many of the social workers in this position then find themselves in turf battles, where each discipline is reluctant to assume added responsibilities, arguing who has more work.

It becomes difficult for both the social worker and other team members to see the significance of the social work contribution to the larger picture of discharge planning when the process is seemingly disjointed and lacks clarity. The social work role can become merely task driven as we have seen earlier from Joann where the case manager decides which specific piece of the plan is Joann's responsibility and if the plan changes, the responsibility shifts back, compounding an already poorly understood role.

When social work function is not fragmented as above and is viewed as integral to the discharge process the experience is different, workers are in control and feel valued.

> There is a tremendous importance placed on social work feedback here. Very different than anything I have seen elsewhere where social workers are sent to buy socks or tie shoes or collect garbage or whatever it might be. Here there is a tremendous focus on having social workers involved in several different types of teams, care planning teams, rounds teams, interdisciplinary teams, social workers have input on who comes and goes out of the unit, who is accepted for transfers. Social workers have input on setting up a plan of care, establishing it, carrying it through, discharge plans, care on the floor, the social work piece here is very strong.
> Tiffeny, Hospital B

Being considered pivotal in the work of a team elevates the visibility of their contribution and perceived value. Case managers are involved to some extent in all settings but the balance of who controls what is what makes the difference in the experience of the participants. When participants did not have case managers

referring patients to them for pieces of a predetermined plan, the involvement of case managers was viewed as helpful to the plan develop by social work. Midnight, from a merged department (Hospital J), illustrates this relationship.

> The nurse case managers reviews [case manager function]…I deal with them if I am getting authorization like now I am trying to get eligibility information, home care eligibility. Sometimes we split it.   Midnight, Hospital J

Other positive examples provided by participants include completing forms needed for transfers to different levels of care, obtaining needed insurance authorizations, being able to assist patients in understanding the limitations of insurance coverage and assisting the social worker in maneuvering through more medically technical aspects of a discharge plan such as intravenous therapy or feeding tube interventions. In these instances, when their practice seemed more autonomous, social workers view their interactions with other disciplines generally in a positive light reflective of a different power dynamic.

Interchangeability
    A related topic that emerged and impacts on role clarity is how the roles of social work within a hospital can be interchanged between disciplines. To its extreme this would indicate to onlookers that the social work professional role and expertise is not unique and in turn social work may not be a critical component of the organization. This was depicted in one hospital (Hospital D), in which the social worker on one unit is responsible for seeing all patients and implementation of all aspects of a discharge plan, but elsewhere the case manager determines what cases the social worker needs to be involved in and the plan is fragmented between disciplines at the discretion of the case manager. On an organizational level, no distinction is being made as to discipline specific

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functions. To compound this, on weekends, when only social workers are available in the hospital, they are expected to implement all the parts of a discharge plan including what they are not responsible for on the weekdays. Being asked to do so creates resentment as it is not their job. The social worker without such fragmented responsibilities in this hospital is more than willing to perform all aspects of a discharge plan when covering on the weekend, since that is her role weekdays, however she knows her colleagues would view that negatively.

   Julian, sees her social work role more clearly, and approaches interdisciplinary challenges differently based on her practice experience.

> I think if the walls between social work and nursing comes down, and each one of them work together and instead of as separate entities, I think that would help. If we are secure in our own position, we know who we are and who we are not, and then we don't have to feel threatened. That wall is about threats, so if people can feel safe, they will be okay. Because I do home care on this unit, I have that with my own colleagues. We work weekends here, my colleagues are trained to do home care, but they don't do that…but if everybody would just realize that there is a way to do this without losing who you are, plus helping another discipline, being part of a team, as opposed to being just a member of a team, but being part of a team, then we will all work better together.
>
>   Julian, Hospital D

Her confidence and perspective undoubtedly emanates from her different professional experiences in which she is distinctly described by her colleagues on the unit as the pivotal person in coordinating the care of the patient and family and their transition from the setting. She does not view her roles as interchangeable based on her experience. Instead, her strong professional sense and perceived value makes her more willing to share power with team members.

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A transition that is occurring in one hospital (Hospital J) speaks to the issue of other disciplines moving into social work roles. Madeline and her colleagues who were interviewed are part of a merged department. The social workers have had primary control of the discharge process for at least the last five years. The new director, a nurse views that discharge planning can or even should be a nursing responsibility.

> …we are not able to do everything we are supposed to be doing for the most part, the new director of case management wants to get the nurses to assume some of these responsibilities so right now nurses and social workers are kind of overlapping with discharge planning duties.   Madeline, Hospital J

Due to being spread too thin, social workers cannot accomplish all they need to, so instead of hiring more social workers, the new director is adding nurse case managers. The organizational assumption inherent in this is that whatever social workers are doing, a different discipline can simply replace them. The caveat to this statement is that the organization does not appear to value what social workers do as having unique skills. What is interesting is that this particular setting has tried different strategies in the past using this concept of interchangeability. The participants interviewed shared this history.

> I think everything goes around and it comes around. I think based on the history of what I have heard from people here…oh they have tried that here, they just called it different things, and they go through it all and what they learned but somehow it is back here.
>   Midnight, Hospital J

> I guess it is whatever the trend it at that time. I don't know. I have been here 5 years so we have kind of followed the history, we have it written down as to when who did what and when it changed and

so I don't know, I guess it is the trend of that time, who writes a book, who picks up this piece of literature and says let's do it this way. I guess they must have to change it, and it depend on who our administration is going to look for to kind up steer who is going to do what.   Justine, Hospital J

There was more of a sense of resignation than anger in the words of the participants interviewed from this setting. Each currently controlled their practice, felt confident and mostly positive in their experiences, yet on some level understood that hospital social work is always vulnerable to organizational forces. For these workers, a new nurse director, with new priorities, is the catalyst.

In Hospital E, there is a more extreme and unique example of interchangeability of roles by design. The case management department is comprised of both social workers and nurses, all share the same title of case manager and all case managers have the same professional roles within the hospital. The social work case managers have a very clear role and have complete control of their practice however what they accomplish is indistinguishable from their nurse case manager colleagues. Perhaps due to this clarity for themselves and to other disciplines, these social workers viewed their roles positively and their work with nurse case managers as collegial, devoid of any power differential. Each shared their different expertise when needed and learned how to apply new knowledge from the other discipline in subsequent situations that occurred.

…People in society don't really understand what a social worker does. In my setting it is known and defined. They see a case manager, social worker or nurse, they understand we are involved in discharge planning. That is really the main focus, the discharge plan. The nurse and social worker complement each other, we are all there for discharge. Ultimately that is the goal, to get the patient out in an appropriate and safe manner…if there is a patient

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that is homeless, the nurse is naturally going to come to a social worker when we have a homeless person, no insurance. But over time the nurse develops skills from the constant interaction with the social worker to independently do the discharge plan. Usually we are providing them initially with the information, and then after a while they have their own resources they use. So that is the kind of upshot. And it goes similarly for the social worker, I have learned a lot of medical terms and information from the nurses and over time I know medically what things mean and how it relates to the discharge plan.   Steve, Hospital E

Social workers in this setting felt valued and their contributions organizationally recognized as manifest in the same salaries of the nurses with whom they share their professional titles with. Salary parity between social workers and case managers was not reported from other hospitals except one merged department that included two social workers who had become case managers through some added credentialing (Hospital I). This was reported by their social work colleagues who were interviewed as the social work case managers were not part of the study sample. As in the example above, the social work case managers and the nurse case managers were again indistinguishable in their professional roles and responsibilities.

The utilization of social work assistants and discharge planning assistants for discharge planning activities speaks as well to the interchangeability of social work roles. Participants described this as occurring in two merged departments. These employees are performing either components of an established discharge plan, assisting the social worker with contacting skilled nursing facilities or compiling and faxing referral materials, or in one hospital, substitute for the social worker on specific units due to lack of sufficient MSW staff. In this latter example,

> A social work assistant actually does what a social worker does. Remember we primarily do discharge planning, so social work assistants do that. The MSWs are in the critical care areas or on consult since there are not enough of us. There is a LMSW in the ER. The social work assistants assume the same role as us, they probably cannot do the counseling piece as well as us. They have Bachelor degrees, some in social work; some of them don't.
>
> Madeline, Hospital J

Two major issues emerge from this quote. Not only are the social work assistants being observed performing the tasks of their MSW colleagues, but in this example, it is acknowledged that there is a counseling component of discharge planning which the assistants are also engaged in but not "as well as us". That distinction may not be as obvious to other disciplines or administrators. Deprofessionalization occurs as staff with education other than professional social work is engaged in social work functions.

> Well I know they all have high school educations, and I think most of them have at least an associates degree but they definitely have college credits but I don't believe you have to have a college degree in order to be a discharge planner assistants. The ones we have now have been here for years and years, at least 20, so they have been around a long time. So maybe now if a new person came in it might be different as far as qualifying for the job, especially in health care. They are fantastic. I could not do my job without them.
>
> Francesca, Hospital H

A number of social workers welcomed the participation of these assistants as they frequently assumed the more mundane aspects of discharge planning implementation. The specific involvement of a BSW level social worker was described in a third setting, assigned to assist an MSW psychiatric social worker in a unit-based Behavioral Health Department.

And I have a BSW level, she is really like a social work assistant, but she is really the discharge planner…She does not do any clinical work at all. She does all the discharge planning, she does all the aftercare appointments, does anything, the boring paperwork part, that is her job. I would not have taken the job if I had to do her responsibilities.   Lori, Hospital M

For Lori, the inclusion of a BSW level worker is vital and appropriate as in her view her own role is clinical, focused more on treatment than discharge planning. As defined, the distinction between the work of the BSW and that of the MSW worker is in this instance consistent with professional guidelines as outlined in New York State licensing guidelines. In the other settings however, lacking a specified level of education and professional training, "assistants", organizationally interchanged with MSW diminishes the perceived value of social work in the institution.

Perceptions of Social Work Role

The major trends in the data relevant to this theme focus on what other disciplines and even social workers believe social workers actually do. Given the fragmentation and interchangeability, it is not surprising that social work is so amorphous. Social workers describe what can best be termed a series of imprecise descriptions by others which often translate into unrealistic expectations. Social workers often interpret perceptions of understanding through the types of referrals they receive whether appropriate or inappropriate. Jennifer provides a clear illustration of this perception.

I think people perceive social workers as only the individual you can call in when things are dirty and ugly and they are going to have the right washcloth. We are either going into the subway

> pulling out the homeless person and it does not require anything
> but compassion, and it doesn't require any…all you have to do is
> care and you are a social worker. It is not what it is about.
>
> <div align="right">Jennifer, Hospital B</div>

It is the broad scope of "social workers do everything" to "we are expected to be able to fix anything", to the realities that social workers will often involve themselves in "whatever it takes" to accomplish a discharge that contributes to this lack of clarity. One social worker described how her patient had been waiting all day for a test and had not eaten. She finally wheeled the patient for the test to assist the patient. She described performing this task as within what she sees as her role as "after all, we are social workers"; in her view her work encompasses all that is needed for the well-being of her patient. In this light, the adaptability of social workers to "trouble shoot at any time and step into the gap" may add to role definition challenges.

Even amongst those workers who are confident in their roles and value within the organization, they describe that other team members know they do "discharge planning" but do not have a clear understanding of what that entails or more frequently, how involved and how much time the coordination of a plan can take. "They think you snap your fingers and it happens" (Daisy, Hospital A). A recurrent impression provided by those interviewed is that much of the work social workers do is invisible.

> Your note never reflects everything you have done. That is all
> they look at. They don't follow us to see that I am not sitting on
> my hands. When you write a note you can't possibly put
> everything you do.   Kasha, Hospital J

Some social workers, especially those with a holistic view of their practice are able to see challenging or even "wacky" referrals, as Lisa describes, as meaningful.

> When you don't know what to do with somebody, you send the social worker in. So it can be a little bit of… like the… like crisis management, you know you feel… so I feel like the job description maybe isn't as defined… I mean it is, it is, my role is very clear, but it's not as easily defined as maybe in other professions where you have very much a routine in your day. But here, you could get a wacky referral and end up really helping somebody and set them up with some resource or do something that you never would've known that you were ever going to be asked to do.
>
> Lisa, Hospital A

For other social workers, similarly generated referrals are viewed with more hostility, as Kasha expresses in using the phrase "dumping".

> Anyone who is not a social worker, they don't understand what we do. And instead of trying to understand what we do they assume we do everything. If they don't know who does what or you don't want to do something, it is a social workers job. So we get a lot of dumping.
>
> Kasha, Hospital J

Joann expresses ambivalence toward this perception, ultimately concluding that though social workers are turned to for their expertise; their work is not tangibly valued.

> I think we are seen as we can handle anything. There are positives and negatives about that. This rescuing mentality, that we can trouble shoot at any time and we will step into the gap, which is not healthy and of course monetarily it is never addressed.
>
> Joann, Hospital D

For many of the social workers interviewed, they report that others disciplines understand their roles by working side by side and seeing what they do. This is perceived to take time and in most instances involves the education of new team members about what their roles and responsibilities are. Laura and Francesca describe their experiences.

> And then there's the fellows in like their early year, like the Attendings that just kind of within the last 5 years or so and are accustomed to having the social worker around them all of the time are… you know, really willing to call and always like, "yea what do we need, oh this… this is something [the social worker] can do, she can help us on this," that kind of thing and are always accepting of what my roles are and like, listen to everything that I have to say. And then there's the doctors who have been in the field for 20-30 years and, you know, they're not used to it, they did it for 20 yrs without a social worker there and now that there is a social worker there, they forget to call, like that kind of thing, so there's a balance, you know, there's a balance of what the respect-- who understands what really is there for. I think that that's my job to… help them. To know when to call me, to know what I'm about and what the point is.   Laura, Hospital A

> …constant every day part of what I believe I need to do is to help the other staff to understand what the role of a social worker is, what my training is, and how I work and to help them work in a similar fashion…I would rather stay in a certain unit for a while, you can develop relationships that are positive, and they know what to expect from you and there is a lot less time wasted when they understand what you do and things work a lot better.
> Francesca, Hospital H

A "new" team member could be someone who has just completed their professional training or a seasoned professional who had never worked closely with a social worker before.

Lastly, the perceptions of what a social worker does can be linked to whether or not there was a social work presence in a particular area before and similarly is dependent on what precedent the individual social worker may have set in defining his or her practice roles.

> So it is fortunate that the social worker that I replaced was there for 20 years so she set a very good foundation.   Charlie, Hospital K
>
> … she was fantastic and really had such a presence there so that they all know, like they… I think that they're more adept to understanding what the roles are cause she was so there all of the time, so when I come in, kind of like I'm just taking over for her, which is nice. Like she… she paved the way quite well for me…[in the clinic] they never had… they don't have a social worker at all of the entire genetics department…and I have a constant presence there now so they're like really adapting to like me being there, what my roles are, I'm like changing their perspective on what social workers do and stuff, just cause they now have at least a little bit more time and availability, I think that that makes a big difference. Cause if it's not there, how are you going to learn about it, you know?   Laura, Hospital A

Charlie and Laura to a great extent illustrate this point. It is especially challenging to convince other disciplines that social work interventions are of value when they have functioned without it before. The implication that the understanding of what a social worker does is dependent on the understanding and practice of individual professionals compounds this lack of clarity. This is most uniquely represented as well by the experience of Nancy who is carving out her professional role as the only social worker in her hospital.

The understanding of what a hospital social worker does is therefore not driven by a clear professional identity as is true of other team members. Physicians, nurses, physical therapists and nutritionists for example do not have this layer of ambiguity. Social workers by illustration do not always provide a

clear picture of what they do to others. For those workers who are more generally positive about their setting and confident in their practice, they assume this reality also with a more positive perspective.

> I think the nurses on my particular unit are very clear about what I do although they know I am called for discharge planning needs as a priority they are very astute in identifying social needs and as I am coming on the floor or at rounds, they will say "this one is for you…I have someone for you". Meaning that they have identified someone that has more than discharge planning needs but definitely needs to see a social worker. And that is just from their training and from their experience. Difficult patients….I think that we are a teaching hospital so you are teaching those first years coming in, they are being taught – social worker for discharge planning – they do not know what else you can call a social worker for. By the time they leave they know.   Midnight, Hospital J

These workers take pride in the breadth of their expertise and feel that when faced with unrealistic expectations from other disciplines they will take the time to educate them about what is possible and not possible. Social workers in settings where they feel less valued and overall roles are more fragmented often look at such expectations as burdensome and feel they are being asked to do tasks that no one else wants. Such workers express such frustrations as "others believe we do magic" and we are expected to "wave wands". These experiences provide examples of how attitudes are shaped by perceived value and respect.

Definitions of social work practice are additionally influenced by the way other disciplines define their own practice. When social workers are dependent on others for referrals, the perceptions of social work functions can seem to vary by individual professionals based on their own understanding of what they do and what social work does. A number of social workers described such role ambiguity as their assignments move them across different units. The working

relationships and task delineations will vary depending on which case manager they might be working with at the time. When different disciplines are uncertain as to what social workers do or see their functions as limited in scope, relevant cases are sometimes lost to social work intervention. One subject describes that disciplines are clear about her role as a discharge planner but seemingly unaware that someone newly diagnosed with cancer should be referred to her as well.

> I do not really feel that the nurses have a sense of what I do, I don't feel that physicians have a sense of what I do…umm…if you really sit down with a doctor ask them so "what do you think I really do", they really don't know and I get the sense from my referrals from nurses that some more than others have an idea but a lot of times, I get the feeling that they just say "assess" "discharge planning" but they have no idea who needs what or what I do. A lot of times new diagnosis does not get referred to me and that is so obvious to me. That someone with a new diagnosis of cancer, maybe they would want to talk to a social worker, maybe I should stop in. I miss a lot of those unless I am proactive for those referrals.   Sharon, Hospital A

Robin, assigned to an outpatient cancer clinic perceives that when referrals do not reach her one explanation is that nurses are reluctant to refer patients to her. In her view, the nurses do not want to appear unable to handle the situation themselves. Efforts by this social worker as she case finds is then met with confrontation. This finding also speaks to the issue of how other disciplines perceive that social work skills are not professionally unique and that they themselves have the necessary expertise to manage what is occurring equally as well.

> Recently I've been reminded that from many interactions people feel that if they come and get a social worker, it reflects poorly on them as a staff member, that they can't handle things, and that they needed help and that is what I have been finding a lot. I have been involved in different situations with patients and the staff will clearly need my assistance and they would not make any effort to

find me to get assistance and when I provided the assistance to help the patient and the family members calm down, I get a thank you and then when I try to have some discussion about it, they so "oh I just needed to do other things so I am glad you came so you saved me". It wasn't like you helped, this patient was having a hard time and "I did not know what to do". I never get that. Very rarely do I get "I don't know what to do"   Robin, Hospital C

Lastly, if team members gain an understanding of social work from the individuals they interact with, then how a particular social worker approaches his or her roles and responsibilities can add to misunderstandings. When asked about her primary responsibilities, Kasha responded in this way.

Personal therapist, providing supportive counseling, giving them a shoulder to cry on. Because it is very sad up there, people are dying, thinking about hospice and the families…and sometimes it comes on very suddenly and they don't have time to plan, they are a little confused, you try to sit down with them and give them the options and try to like…they don't really know. That is what I do most of the time. The second half of that I am the secretary, I push the paper. You tell me what to do and I will do it.

Kasha, Hospital J

The three other participants from this setting report that social work is primarily responsible for discharge planning, a role Kasha relegates to secretarial. This is also the hospital in which the new department director expressed plans to reassign discharge planning responsibilities to case managers. Kasha's professional bias could influence perceptions of social work practice by others and impact decisions made for social workers in general in the setting. How intra professional distinctions and perspectives influence role clarity are further discussed below.

Intra Professional Context

This section explores a number of themes that emanate from the perspectives of individual participants and how they define and value their professional role and practice. Factors within the profession contribute to how social workers perceive their practice and professional identity and in turn, how they project to others what the social work professional role is and could be. Social work perceptions of discharge planning as a valued hospital function are discussed throughout.

Jennifer best summarizes her journey as she realized her professional identity and value over time.

> My sense of feeling confident in the respect that I could achieve as a social worker was not…easy…I did not think I would have it. I did not really feel that social work had a professional respect, even from my own point of view. I did not have a good feeling about someone asking me what I do and me saying a social worker. I found ways to kind of …try to present social work in a light that had importance, uh, that their was real training involved, that there was real intelligence required for it and that there was a real skill. It took me years to carve out a niche of respect and in the hospital I am working in I do not think that this was a solitary experience.
>
> <div align="right">Jennifer, Hospital B</div>

Jennifer's experience is undoubtedly shared by other social workers as they develop confidence in their unique skills and professional identity. Jennifer continues to work in a traditional centralized social work department with described strong leadership. As discussed in earlier sections, as organizational influences change, social work professional development can be increasingly challenged and interfere with the internalization of a confident professional identity.

A number of themes emerged as participants shared their perspectives, including: internal challenges with defining social work; value laden distinctions between different practice assignments; and how individual workers perceive value in their practice for themselves and the organization.

Self- Definitions

It is not only disciplines outside of social work that struggle with how to describe the work of social workers. Study participants were asked how they would define social work to non-social workers. Again, imprecise descriptions were provided by some participants. One social worker, Helen, stated that defining social work, "it is like grabbing air", and another used the word "limitless". Broad definitions were commonly provided such as what was offered by Roberta.

> It is a really multi-faceted profession, you just have to be open to whoever the patient is before you and creative and able to offer them and satisfy whatever the needs are that they present at that given time. That is really…we know words like flexibility, creativity, and I think those are really 2 very important aspects of the profession and I think you have to be open, be a people person, you have to want to try to enhance the life of the person you are caring for. Roberta, Hospital E

Others were able to define social work more concretely using the tasks associated with their roles in discharge planning or using other responsibilities they may have. Often this entailed first clarifying that they are defining medical social work and they are not defining social work in general. Laura and Tiffeny, both from different centralized departments illustrate some of these definitions.

> Somebody who's involved in the hospital who works with the entire team, works with the doctors and the nurses and the case managers and whatever else is on the floor with your patient and

they are the ones that maybe help the process go a little bit more smoothly for you. They make sure that you're not going to get a 100 dollar bill or a million dollar bill at the end of your stay, they make sure that you understand what's going on with your treatment, why you're here, what's happening, they're, you know, and then they also help you with coping issues, those kinds of things, and dealing with what's happening here and how to find out what's happening. I don't know if that makes sense, but like dealing with it, the hospital experience, they're here to help you deal with it and help with it.   Laura, Hospital A

Coordination, coordination of the care needs and the psychosocial needs for the patients who come in with medical needs. So it is addressing both medical issues as well as their psychosocial issues which could include financial, that is a big one, housing, placement needs after their medical needs are met, discharge when they go back home and coordination of care.   Tiffeny, Hospital B

In settings in which tasks are more fragmented, it then follows that social work self-definitions would again reflect this experience.

Medical social work versus counseling social worker. It is hard to narrow it down because you do so many things. We do many things, we do placements, we do counseling, we engage families, help them to get through things, we advocate for families, for patients, sometimes with our own team, we refer to outside agencies, we do transportation, cancer, we have to know a lot of things that I don't think you can get without experience, you get that over time. Medicaid, we have to know, a lot of things that we are expected to know. Medically we also have to know how to read a chart and get some sense of when this person may be discharged, or when they might be ready for physical therapy.
                              Joann, Hospital D

If social workers themselves find the scope of what they do difficult to explain in an understandable or consistent context, than it only further challenges how others view their roles. This is particularly relevant when workers in the same

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organization define their roles differently, leading to confusion among interdisciplinary colleagues.

　　Some social workers not only found defining social work challenging, but reported being uncomfortable about sharing that they were in fact social workers. For some it was a perception of a negative societal view. One worker stating that now that she works with children, describing her profession is more readily accepted by others; Brian states that when he mentions he is a social worker, he finds it a "conversation stopper". Others simply lie, stating they are bankers or florists, some feeling that non-social workers are uncomfortable, expecting to be "psychoanalyzed" or conversely, see an opportunity for counseling once a social worker divulges his or her profession.

> I tell them I am a social worker, they usually get scared, sometimes I just tell them I am a florist. 　　　　　　　Charlie, Hospital K

> I'll lie, because once you tell them you are a social worker and I also have a small private practice, once you tell them you are a social worker or a therapist, you become the therapist for them. So I try to feel them out first, but honestly sometimes I will tell you I will say I am an administrative assistance in a bank. Now if I meet someone who I am getting a really decent vibe from, I'll tell them what I do. 　　　　　　　　　　　Francesca, Hospital H

Two participants working within the same mental health center offer different perspectives of their self-definitions. John reflected on his struggle with his definition, admitted to using "therapist" or "counselor" before working social work into the description.

> It's funny, it is really reflective of the identity confusion, sometimes there is, even in myself, I can answer I am a therapist, I can say I am a psychotherapist, I am a social worker, I am a psychiatric social worker, a counselor, a mental health counselor…I guess it might depend on where I am, what context,

who's asking me, what is it about for them. Because I know how I answer might affect, impact on how they view me. Generally speaking, I have been asked, like if I am going in to buy a car, a salesperson asks what you do for a living, and I am always kind of, suspicious, am guarded, I am not sure I really want to share too much of it. I think they are just looking to see, they don't really have an interest, it is more about something else. Or if I am at a party…it depends, I am into helping people, I am a professional therapist. Social work would probably come into the response, but not necessarily into the title. And because sometimes social worker, to say that as the answer, is a confusing term because social workers do so many different things. John, Hospital E

Margaret, his colleague in the same clinic proudly states she is a social worker identifying with the unique professional perspective social work she brings to her clients.

Some people say oh I am a psychotherapist, but I don't say that. I think it is the whole picture and that is the way it should be done I am proud to be a social worker and I really think the social work part of it is very important for the betterment of the client.

Margaret, Hospital E

Professional ambiguity emerges from individual social workers, some finding social work too amorphous to describe, others anticipating negative reactions become more selective with their definitions to others. Professional experiences, unique perspectives and personal and professional biases permeated social work self-definitions among participants. The following section expands on the concept of intra-professional distinctions and bias that confounds how social work is understood.

Internal Status Distinctions

As social workers reported on their practice within the hospital setting, it was interesting to hear how individual social workers distinguished themselves from

other social workers having different assignments or professional roles. Such divisions from within the profession itself again fuel professional ambiguity within the organization as administrators and colleagues seek to understand the roles of hospital social workers and the value of their contributions. It additionally speaks to differences in professional social work identity. One example of this is from workers organizationally separated from their social work colleagues. This occurred amongst workers assigned to Behavioral Health Departments, separate from their medical social worker colleagues within the same hospital. For the inpatient psychiatric social workers, structurally part of a unit based structure, this professional separation was quite complete. Both psychiatric social workers interviewed from these organizational structures cite how their professional roles are more clinical than medical social workers.   They were unaware even who the medical social workers were and what they actually did.

> Yes I think there is a social work department but I do not know what they do or where they are or who they are.
> <div align="right">Lori, Hospital M</div>

It was as if these social workers belonged to a different profession altogether.

> …psychiatry is different than medical and I don't think the medical piece gets what we do and I don't really get what they do. My perspective of a medical social worker is discharge planning, a psychiatric social worker does more than just discharge planning, especially on my unit with the kids, I am encompassing so many different resources into why they are here not just when they leave… I think it is better [being separate], because psychiatry is different than medical and I don't think the medical piece gets what we do and I don't really get what they do.
> <div align="right">Charlie, Hospital K</div>

On an institutional level, the psychiatric social workers appeared to be treated differently. In one hospital in which both a medical social worker and a

psychiatric social worker were interviewed, the medical social worker's experience was the polar opposite as she witnessed her department social work staff drop to 10% and professional supervision was totally eliminated. The psychiatric social worker reported increases in social work staff and supervisors. How social work was valued in the organization was graphically depicted and the gap between these professionals became more clearly defined to the social workers themselves and to others in the institution.

This level of dichotomy went further as one unit based psychiatric social worker distinguished whether an issue was "social work" or "clinical" before seeking supervisory assistance.

> Well this current setting is different, this current setting I'd come to the team, we have a team meeting every morning, 9:30 to 11, and we discuss all the patients. So any clinical issues come up that way. I am the only social worker but I get feedback from the other disciplines. If it is specifically a social work issue, I will go to my supervisor and I will question her. If it is more, not necessarily social worker, just a clinical piece, I have a psychologist I work with also.   Charlie, Hospital K

In addition to her physical separation from medical social work and concurrent organizational message of different value, this worker appears able to separate the parts of her work that she identifies as "social work" from "clinical issues" that can be as adequately addressed through supervision from a different professional discipline. This degree of specificity from within the profession continues to erode a more generalizable picture of social work professional identity.

Comparisons between practice roles amongst workers, even within the same hospital setting, was somewhat surprising as it again set up distinctions and hierarchies within the profession itself. Some workers described their work as "more clinical", others stated that they would "never do discharge planning"; and

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one emergency room social worker expressed little respect for the work of her inpatient social work colleagues describing it as "clerical" compared to her work with patients and families in crisis.

> Oh vastly different, their role focus is different…their focus is mainly clerical, getting certain things done and making sure the hospital is paid, meeting the insurance needs.   Renee, Hospital H

Renee contrasts this with how she perceives her work as more involved with people, not paperwork.

> You are at bedside, because you are dealing with real live people and families and the outside world but you are up against the outside world in a less routine way, you never know what is going to happen and that is the other part. So I would much rather be in the ER because you have a much better sense you are with people during an important part of their life and you can do something for them other than just the insurance business, not as clerical.
> Renee, Hospital H

Social workers themselves are attaching value to what they do as individual professionals and creating dichotomies within a profession already struggling with its identity. Intra professional practice and value distinctions are projected through their work and through their interactions with other social workers and other disciplines.   For some, these differing perceptions are evident and frustrating. One worker working in a strong and supported setting for social workers, has a degree of role clarity that might be lost to other workers.

> …but you know I do find a general sort of bias among other social workers of like oh well I want to do clinical work and I'm like alright fine, you know, and I know… but I do find it relatively insulting, you know, I mean just because I do think that I do clinical work and I do think that I have a, you know, I think there's

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something very clinical about the very practical services that I provide for patients. And especially considering that my old position I guess by, you know, all terms, probably more clinical, there was no discharge planning… I almost feel that as a discharge planner my services are more appreciated and sometimes they're a way in to those patients who are not going to open up right away whereas if you can get them the services you need and they've gotten the home care and they say, oh you know, I know that that you're… how are you managing your new diagnosis, that must be hard, and now since you've gotten them home care and you've maybe gotten them this and that and the other thing, they're more willing to kind of engage or at least accept some of the other services. Rachel, Hospital A

Rachel has a strong and clear sense of her professional role and professional value. As Rachel views it, discharge planning, with all its components and activities is a valued responsibility and is consistent with her professional identity. Rachel has only worked professionally in her current setting. Organizational factors, in particular having a strong social work leader who positively profiles the social work role in discharge planning within the organization and who has a commitment to provide professional clinical supervision to her staff, undoubtedly has nurtured this perspective. Not all social workers interviewed shared this perspective. Related themes that expand on how social workers perceive discharge planning as a professional role are in the next section.

Perceptions of Discharge Planning

Social work practice diversity discussed so far can for the most part be linked to the degree of control and involvement social workers have in the discharge planning process. Decreasing lengths of stay is a valued organizational objective

and discharge planning is the associated activity to accomplish this. Discharge planning is a theme that has already permeated the discussion thus far however there are some specific aspects that have emerged that deserve a separate look through the perceptions of the participants. Variations in how social workers perceive this critical function directly influences role clarity and practice value within the organization. As seen historically, hospital social workers interviewed for this study greatly vary in their perspectives and concurrent ambivalence about discharge planning. Exploring specifically the experiences of the 28 inpatient social workers in the study, there are distinct differences as to how each social worker conceptualizes the discharge planning function and how they view the value of the activity, ranging from "would not do it" to acknowledging it as being a pivotal goal of the setting and a valued social work function.

Within a large centralized social work department, all the inpatient social workers interviewed understood discharge planning as a significant social work activity, that it was a clinical process and that it was a highly valued responsibility within the institution. This practice framework began with the director and was integrated through supervision and training processes. Consistent with this perspective, all social workers were mandated to obtain the advanced LCSW license.

> I think discharge planning is actually going to be what keeps social workers in hospitals and I think that there's also a lot of clinical work to be done in discharge planning, so I'd like to say that I hope that it can be incorporated more into the social work education…I remember when I first started here I had a referral and I was very busy, I was covering, I was swamped, and somebody called me and was like oh this patient needs a hospital bed so I just called our rep and I said can you just set this up with this patient and they walked in and the went to go see the patient and the rep calls me and goes that patient does not want a hospital bed and I said oh well the doctor said they did and I made the assumption incorrectly that she had already had the hospital bed, that she'd already spoken with the doctor, needless to say this women had not. She'd walked

in and said, you know, I've shared my bed with my husband for 45yrs, I have no interest, I don't want it and, you know, ultimately it was a very much clinical issue cause she certainly clinically and medically needed the bed and emotionally was not at all ready to accept the idea of, ultimately we were able to figure out a way that she could put the bed in her room. So… it wasn't like she would have to sleep in the living room, they were able to coordinate something, so, but you know, a situation like that is always the example I use.   Rachel, Hospital A

Rachel provides a good illustration of how she perceives discharge planning to be a clinical process and valued. This perspective was consistently shared by most participants from this setting and reflects the organizational context in which social workers practice. Social workers in this hospital were also engaged in educating medical students and residents, involved in research activities and conference presentations. The overall status of these social workers was elevated and their primary activity valued. Individually, these social workers expressed similar frustrations as in other settings, needing to clarify how they do their work or not having sufficient time with patients and families to address additional needs, but their experiences were more generally positive. This was also shared by a worker from another centralized department who eloquently described her view of discharge planning.

> …well age and seasoning has shown me that discharge planning is an art in itself, a very important part, getting someone ready for the next stage. Discharge planning is not necessarily getting someone a nurse at the end of the day. It is getting someone to learn how to really take care of themselves. So it was also myself getting educated as a social worker and the real meaning of some of the things that I had signed up to do in the profession.
>
>   Jennifer, Hospital B

Jennifer's reference that her view of discharge planning has evolved over time speaks to the importance of environmental influences and professional socialization in shaping professional identity and practice perspective.

In settings in which the discharge planning process is much more fragmented among disciplines and not solely in the control of the social worker, the activity has less value as an integrated process for the social worker. For example, a social worker who is only called in when there is a skilled nursing home referral, is more than ready to give the case back to the case manager when the patient's needs change and home care is indicated. While that is consistent with how his or her job is defined, the holistic quality of the process is lost and discharge planning becomes a task driven activity and not a particularly satisfying social work role. Similarly social workers express relief that they do not have to learn medical terminology and can instead defer the technical aspects of continued care to a nurse. This approach to their role provides an impetus to maintain the fragmentation of the discharge process. Added responsibilities are seen as added work and not associated with more control of the process. Even though some of these workers acknowledge that decreasing lengths of stays is a priority of the administration, they do not fully appreciate how controlling this pivotal this role demonstrates value to the organization.

Discharge planning as a specific social work function is repeatedly viewed as not clinical and not necessarily a professional activity for many of the reasons discussed earlier including how different disciplines and lesser trained staff can perform these same tasks. One social worker highlights this distinction, and in her words her evolution in her professional view emerges.

> … I think that I was trained to be in a more clinical setting… I think I'd prefer to be doing that… I've kind of had a mix of both, doing both… I don't mind doing discharge planning… I remember when I applied to do my internship at the hospital and it was a mix

of… it was in transplant, so it was a mix of inpatient and outpatient and I remember a supervisor saying to me, you know, "why would you want to just do discharge planning, it's so not clinical"… and I kind of said you know, "it's something to try, if I don't like it, I don't like it." and I don't necessarily agree with her that its not clinical. I think that you have to seek it out sometimes and find the way… I think that… and at the beginning I don't think I realized, maybe I didn't realize that I really was using my clinical skills… and you do need them, I can't imagine someone walking in, you know, without having been trained the way I was trained, being able to do this job and be confident and… and feel like you knew what to say to people because I mean, just so many different things can come up so I do… I do feel like it is clinical… and that's what I… what I was trained to do. And I think the discharge planning part was just something I learned to do while I was there. It's just additional training that I had.   Daisy, Hospital A

What is also significant from her experience is that social work professionals in hospitals are perpetuating this dichotomy when training new social workers, widening the schism within the profession.

Given the changing social work roles in the discharge planning process, two interesting themes emerged. The first is the concept that social work involvement is not always welcomed since social workers tend to uncover social problems that present obstacles to discharges and unwanted delays.

But I find that they [case managers] have to do so much paperwork, that they don't have time for the families. I will intervene with them – I would like to see this family – and some of them will say sure, but some of them would not like my intervention because I may find something socially they need and it could hold up the discharge.   Nancy, Hospital G

When the discharge process is increasingly condensed with hospital stays shortened, assessment of needs becomes a straightforward and often cursory activity and complexities may not be uncovered unless specifically sought. Using

a different professional framework, social workers explore the broader context of patient lives outside of the institutional setting and are likely to identify barriers to successful discharge. The lack of referrals from interdisciplinary team members can be perceived as purposeful.

In a seemingly different vein, but really emanating from the same organizational pressures, is the perspective that the "patient is the enemy" that was used by one seasoned and bitter social worker. This particular social worker has experienced the tremendous shift in emphasis away from patient centered care to goals solely focused on fiscal concerns. She described that the patient who enters the hospital with complex social needs was looked upon with disfavor and was not wanted in the setting due to the potential for discharge planning obstacles.

> …patients come in, in crisis, that is what an ER is, frequently the patients that they dislike the most are the elderly with multiple medical problems with limited resources, there are very little resources in the community left, their family may owe the hospital a lot of money, and these are the people the hospital wants to eliminate. The homeless patients, anybody that does not have good health insurance, you know a care plan in place, that sort of thing. Because their purpose they are told is to make money for the hospital. Keep the hospital solvent. So the attitude it, rather than us being here to meet the needs of the patient, the purpose of the patient is to keep the hospital going.   Renee, Hospital H

If the social worker is assessed by how effectively he or she can decrease lengths of stays, than it follows that the patient who brings many issues to the process will be "hated". Social workers found they were the first to be blamed when a discharge was prolonged regardless of the cluster of reasons.

> We have a tremendous amount of very difficult patients and some of them can suck the blood out of you and I find that if they make a peep to anybody we get no support at all and that… that's tough.

It's always our fault. I always say… my analogy, this job is like a mother, you can never… you're always at fault. And that's very tough. Susan, Hospital K

If it is something good – "we" faxed the PRI or "we" got the patient out – in my mind I want to say – no I did – but I leave it alone. If it is something bad, then it is all of the sudden it is me by myself. It is every where you go it is the same thing. Here there is no teamwork, no communication.   Kasha, Hospital J

As illustrated above, the perspective each brings to their discharge planning role is informed by their overall experiences, management perspectives, their relationships with other colleagues and the influences of other social workers in the field either as mentors or outside colleagues.   Whether or not individual social workers value this role, and many do, organizational fiscal health depends on this function.

Professional versus Organizational Value

The concept of value has been introduced elsewhere and was discussed by participants throughout their interviews. To varying degrees, social workers reported feeling valued or devalued with respect to different organizational influences. As will be illustrated, even those participants who perceived a lack of respect within their settings, found intrinsic value for themselves in their practice, even if it was not an every day occurrence.

Intrinsic value by definition starts from within an individual. Jennifer (Hospital B), as discussed earlier, best summarizes her personal journey as she realized her professional identity and practice value over time.

My sense of feeling confident in the respect that I could achieve as a social worker was not…easy…I did not think I would have it. I did not really

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feel that social work had a professional respect, even from my own point of view. I did not have a good feeling about someone asking me what I do and me saying a social worker. I found ways to present social work in a light that had importance, that there was real training involved, that there was real intelligence required for it and that there was a real skill. It took me years to carve out a niche of respect and in the hospital I am working in I do not think that this was a solitary experience.

Professional value emerges as a distinct theme as participants reflect on their most meaningful professional contributions to patient, families and to the organization. When the concept of "value" was explored with the social workers in this study, an interesting set of responses was obtained. Most were able to articulate that the hospital primarily values the decreasing patient lengths of stays as a strategy to maximize financial health. At the same time, many social workers identify their greatest contribution to the organization as the professionals able to provide the time to the patients and families that no other discipline is able to. These are opposing values: the organization striving to decrease inpatient time, while the social workers consistently distinguishing themselves as the profession providing the time to the patients. Almost all social workers interviewed wished they had more time with the patients and families to intervene, even while elsewhere acknowledging the financial constraints of the setting. For a number of participants, having more time enabled participants to do what they described as the "work" social work.

> …but I feel that I am not doing the work that a hospital social worker should be doing because I don't have the time.   Helen, Hospital C

The implication in this statement is that organizationally imposed constraints minimize the opportunity for a social work specific contribution. The following sections will explore what participants perceived as the valued work of social work.

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Social Work Practice Framework

Participants working within a range of reporting structures and with varying practice assignments identified their work in ways consistent with a social work professional framework. Tanya, from a merged department with little or no control over her practice expresses her unique social work expertise as follows.

> We see things that you know maybe the doctor or nurse…the doctor or nurse they are looking for straight up clinical evidence of medical issues…They might see a 95 year old who is very thin. We think, is she alone, is anyone with her. I think they are thinking she is not eating; we're thinking is somebody there to take care of her. So that is where we bring in the other pieces.
>
> Tanya, Hospital D

The value of their work with individual patients and families was articulated and in most instances revealed a strong professional identity. A few examples representing a range of experiences are provided. Midnight, from a merged department (Hospital J), currently in control of her discharge planning role conceptualizes her value linking what she does to her social work skills and identity.

> I think the patient satisfaction in terms of their stay. There are many, many people who are alone, frightened, families who never had an ill member before or who have had very sick people before and have had nobody to assist them, navigating this terrific bureaucracy, accessing services, knowing how to just call up their insurance company to find out what they have. You do not know what you have until you need it. So education, advocacy, all our roles as a social worker, every one of them are used in this job and patients are always, always thankful.   Midnight, Hospital J

Joann similarly works in a merged department (Hospital D), however in contrast has a role that is quite fragmented and not in her control. Case managers refer the pieces of a discharge plan deemed appropriate for social work intervention.

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> Engaging the family and the patient and helping to recognize their
> illness. And how it affects them and how it affects the family.
> And still at the same time moving them into a direction. It is very
> confusing being ill or having no direction what to do. Some
> people are more astute than others. They think or they know
> families that have gone to nursing homes, but others are totally
> confused. So it is a gift to be able to do that, to move people
> along. And at the same time hopefully not too upset about the
> whole process.   Joann, Hospital D

Joann in prior sections expressed her frustrations with being misunderstood and
devalued within her setting. She is however able to find professional satisfaction
in her practice, describing her work assisting patients as "a gift". The last
example is from Margaret who works in a free standing mental health clinic, an
example of a unit-based structure.

> We don't only talk to people about their concerns, but help them
> solve their problems so that if they say, I don't have any food, I am
> going to be evicted, that is an issue for a social worker, even if they
> are a psychiatric social worker or a therapist, here's the food
> pantries, here's a housing form, maybe I can call someone for you,
> there is crisis residence I can refer you, there's a whole, things we
> can do. Their lives change…Yes, I really love my work. It is very
> interesting, I love people, I love hearing about their lives, I feel
> very connected to them…that was another thing my professor
> would say – they think they are paying you for one hour a week,
> but they are really paying for you to be part of their lives. You
> carry home with you your thoughts about them, they are in you,
> and I certainly do that.   Margaret, Hospital E

Margaret, in her words, "loves her job", as she changes lives through her
interventions. In similar ways, the majority of participants in the study were able
to see the positive contribution they made in their work with patients and families
no matter what other influences were impacting their day to day work lives.

Social workers identified the use of specific social work skills within a

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professional practice framework as they distinguished their valued contribution from the work of other disciplines. Participants assisted patients and families in the navigation of complex hospital and reimbursement systems, interpretation of medical terminology, provision of support, education and adjustment to illness interventions. Connecting to resources and identifying obstacles to living safely in the community were key activities frequently highlighted.

> I think helping… resolve issues that, you know, many people don't address when they're in their community and… people will come in with enormous problems that are fairly overwhelming and we're the ones that get the task of trying to help them negotiate…I think that our role is essentially to help people stay well in all aspects of their life and I think that's what we contribute to the hospital.
>
> Christine, Hospital A

Social workers are called to be mediators and problem solvers when other disciplines were unable or unwilling to manage a situation. Participants consistently reported that their view of the patient and family system was perceived by them to be different than other disciplines.

> I think social workers are specifically trained to use a different psychosocial perspective than a medical person.
>
> Melissa, Hospital I

> I think social workers have a holistic view. They have to look at the context an individual is in and I don't know that other professions look at that. The individual, the circumstances they are living in, the hospital issues.   Sara, Hospital L

> I think so, I see, I am thinking about how I am going to deal with a case, I look at not just how it is going to him but how it is going to affect the whole environment. Psychologists are just looking at the impact it is going to have on that kid. Not really considering the school, the home.   Charlie, Hospital K

> I really believe nursing they don't see the perspective of the patient and they miss a lot especially when the patient is resistant or is belligerent or seems uncooperative with the discharge plans or with any other interventions and as social workers we know there is something more that is going on with that patient. I think the nursing department as a whole does not recognize that.
>
> Kim, Hospital F

In addition to the practice framework used in their work, participants perceived that their overall approach to patients and families was different than other disciplines and this contributed to the patients and to the organization by enhancing patient satisfaction.

> I think providing, really the support any of the patients in the hospital. Being able to, for the patients to feel heard and empathized with because often times the doctors are really quick in and out and they are really not getting that from other staff. I think that is probably the thing. Melanie, Hospital I
>
> They [case managers] come at the patient…they come at a patient with – how long they have been there, why they have to go, what the insurance is saying, now it is time to go and this is what we are sending you home with, sorry if you don't feel ready. It is not a discussion it is not a process, it is not an education, it is not support that is for sure. Because they are pressured, are hired to decrease the length of stay. We know that what we do impacts on length of stay we are not hired to reduce it, our role is very different.
>
> Midnight, Hospital J

Participants generally felt positive about their practice and in particular took pride in providing a unique perspective within the setting. As sentiments of practice value are provided, a consistent theme that emerges is that the valued work of social workers takes time. Spending time with patients and families is being cited as a distinguishing professional quality.

> I think giving patients the feeling that they are cared about, that there is humanity and dignity in their experience in the

> hospital…we listen to them. We are going to sit down and talk to them and I think that they don't get that from every discipline…I think it is an important role for the patients just to feel that they have someone, and they are also there to assist them with what they need, advocate for them.   Sharon, Hospital A

As staff numbers decrease and patient stays shorten, a frequent frustration expressed by participants is not having enough time with patients to do the work of a social worker Jennifer below explores how this changes the way she practices.

> It is subtle, and that is the biggest concern that I have, that it is changing me as a professional.   Instead of getting the chance to maintain a deeper and stronger relationship with my patients, I am being urged and constrained to make it more superficial. I find that a real tragedy because it erodes the ability to develop human compassion and social skills which is the essence of what social work is. To develop social skills, compassion, a level of empathy and use those skills creatively in order to help people grow and move forward.   Jennifer, Hospital B

The pressure to work quickly and in Jennifer's view superficially creates professional conflicts for participants and impacts how they view their professional role and their specific social work contribution to the organization.

> To the hospital itself, I don't think I am doing anything out of the ordinary. I feel that when I make a really good connection with a patient or a family member, and I can tell that I made a difference, and that is its own reward. It doesn't happen often enough. Because I don't have time to really get into it but when it does happen, that makes it worth it for me. I feel that I am not doing the work that a hospital social worker should be doing because I don't have the time. I actually had an hour to spend with her and it was miraculous, for me it was miraculous that I had that opportunity because that is what I thought I would be doing. That kind of stuff and I feel like sometimes I am a bouncer here, get 'em out, get 'em

> out. That is all they care about. That is what it is, somebody has
> to do it.   Helen, Hospital C

To Helen, the realities of the organizational environment interfere with her professional identity and she struggles to find value in her work. Without time for her work, she characterizes her typical day as "neutral" and remains in her job more for her collegial relationships than her practice role.

Perceptions of What the Organization Values

Decreasing patient lengths of stays is directly linked to the fiscal health of the hospital setting and as such is a valued activity. How discharge planning is perceived by participants was discussed earlier and participants' views varied based on individual perspectives and organizational influences.   The discussion here is about the incongruence of values between what participants value in their professional practice and what is perceived to be valued by the organization. Pressure to discharge patients as quickly as possible creates professional conflict.

> The social worker's role as told is not to meet the needs of the
> patients but to make money for the hospital. They are literally told
> that. The focus is totally to reduce the length of stay so if you
> attended a staff meeting and did not know where you were, you
> would have no idea you were in a hospital. Nothing is ever
> discussed about patient care, clinical issues, ethical issues, nothing
> and that took place before this director. So it has been a total
> deskilling of the department as far as I am concerned.
>   Renee, Hospital H

Expressed more gently, social workers with inpatient assignments are often faced with this conflict of values.

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> You really do get stuck between a rock and a hard place as the patient's' advocate as well as the hospital's discharge planner. You are really in a, you know, in a conflict of interest area I would say.
> <div align="right">Brian, Hospital A</div>

Some of the participants understood that what they themselves value about their work with patients and families is not immediately evident to be of value to the institution.

> We take the time to listen to them, to help them resolve difficulties to acknowledge what they are feeling, to acknowledge their fears. We just listen to them as people and try to help them. So I truly know we make a difference but is there a dollar value to it… I do think we are necessary, social workers make a difference in the hospital setting. I don't know that the top administrators see social workers as that important, they do not bring money into the hospital, they make the patients stay better.   Madeline, Hospital J

Enhancing the quality of the experience for patients and families should be of value to the institution however remains invisible unless social workers can attach a financial benefit to the work. The value of social work to the organization will continue to be elusive as long as social work professionals are unable to tangibly link what they actually do to the financially challenges faced by hospitals.

> I don't know what the… the administrative… administration thinks of social workers. I don't know if they really find them valuable or not, but I do think that we play an important role in the hospitals and I… when I… and I know that in other… like where I'm from, they aren't. And they're not used as much and I would imagine that… those hospitals have greater length of stay and they have, you know, more people who are continually readmitted for social reasons that maybe could've been resolved if they had people working and intervening with them… while they're in the hospital.
> <div align="right">Christine, Hospital A</div>

There is a continuum among those interviewed as to how social workers reconcile their valued roles and retain professional value in light of organizational pressures. Many such as Christine acknowledge the value of her activities in discharge planning and can project what could occur if social workers were not involved. The social workers who are most positive about their roles and the future of hospital social work generally are able to see that their discharge planning role combines both clinical and concrete aspects, is consistent with their view of social work and is most consistent with the mission of the setting. There is less of a conflict of values in their practice experiences.

> I think we make the families feel safe and able to express their needs and wishes for their patients while they are here and seeing that they can really confide in us and we will carry through their wishes and that we are there and we listen. We build that rapport with the patients and the families to kind of execute that plan when the time comes because we are following them from day one to the end. We are not just walking in and saying – come on let's go – and I think that if we are able to do that more I think the hospital would have better discharges, people agreeing with their discharge, feeling confident with their discharge, feeling that they got the services that they needed while they are here.   Justine, Hospital J

Justine provides an example of how customer service, practice time expended and effective discharge planning can be linked. The future of hospital social work depends on the visibility of a unique contribution of social work practice to the financial "bottom line" of the organization. The participants were asked their thoughts about the future of hospital social work based on their experiences. Their perceptions are highlighted below in the final section of this chapter.

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Perceptions of the Future of Hospital Social Work

When asked about the future of hospital social work, the participants responses varied based on what they were currently experiencing and for many, how they have been impacted by organizational restructuring over time. Responses to this question were also informed by the experiences of colleagues elsewhere and through their involvement in professional organizations and union membership committees. Based on the findings of this study, it is not surprising that the future of hospital social work is a critical topic being addressed within professional advocacy groups.

To look at a brief overview of responses, of the 40 hospital social workers interviewed, 24 of them viewed the future as mostly positive, 13 stated it was negative and three were unsure. Of those seeing a positive future, 18 of the 24 were in departments that continued to have a social work director; 15 of these were from centralized social work departments, one was from a restructured department and two were from a generic merged case management department. Of the remaining six with positive perspectives, three social workers were from merged departments with nurses as directors; two social workers worked in unit based inpatient Behavioral Health Departments with social work supervisors and lastly Nancy, as the lone social worker in her hospital, she views the future as positive however in her view it will be more of a clinical position. Nancy does not currently have an official role in discharge planning in her setting. Twenty two of the 24 had access to social work supervisors. Only one social worker in this group reported being negatively impacted by any organizational restructuring that may have occurred.

In general, the majority of those interviewed feeling positive about the future expressed confidence and value in their roles as discharge planners with the impact of case managers being minimal if at all. Twenty one of these 24 social

workers did not identify working with a case manager on discharges and consequently appeared to have clarity and control of their work. Of the three other social workers in this subset, two are from merged departments with nurses as directors, still self describe as having primary responsibility for discharge planning but allude to an increasing utilization of case managers within the organization with increasing conflict and vulnerability noted. The last social worker again is working alone and carving out her role within the hospital which provides her unique perspective.

One social worker in this subset, from the generic case management department, sees the future as positive, however has difficulty distinguishing whether it will be social work or case management that survives, using the terms as fully interchangeable. In his setting nurses and social workers are identical as case managers.

> …I just feel that the main thing is that social work in the hospital environment, case management is definitely going to be a prominent focus going forward so I think…in some places people may think social work is a dying breed, but in the hospital environment, which is a profit based environment, the administrators in the top of the hospital people realize and now know that social work or case managers are very important to the overall function of the hospital. And as time goes by that is becoming more known, and I think that is recognition for us, for our profession. I think there is a strong future for social work, case management. Steve, Hospital E

What is most interesting about Steve as a new social worker is how he views his adaptation to his interchangeable professional role as necessary to be in the hospital at all.

> More on an individual basis, it is more survival of the fittest. You either learn the game, or if you don't learn the game, you are out. It is in a way, a game. You have patients you have to move through the system as quickly and safely and appropriately as you

can and in a hospital environment there is the financial aspect of it, the length of stay comes into play with the patient. There is a lot of utilization that we are aware of, we can't keep the patient longer than they need to be. The longer they are in the hospital, they are at risk for an infection, so there are a lot of factors, there is length of stay, and that is not our primary focus, but is a factor in rounds, why is the patient here, what are we doing for them, so there are a lot of factors in the hospital. Steve, Hospital E

Four of the social workers that felt positive about the future provided the following cautionary caveats: social work will always be needed "since people have needs and they have social needs I think there will always be a place for us. How we are utilized I am not sure" (Roberta, Hospital E); similarly, "there is always going to be a need. They may not call it social work but there will always be some kind of helping profession" (Paul, Hospital F); that the future of hospital social work depends on "who is in the main discharge planning seat" (Justine, Hospital J); and lastly, the future of hospital social work is strong but vulnerable according to Brian who offers the following perspective.

…I think that we have a role in the hospital because… yes, we do help the hospital in terms of its mission statement and providing the services it intends to. But I'm also really cynical in that I think that the reason we're really here and have a role is because we serve the financial benefit of the place as well. And so, as long as we're serving that, I think we're, "in." If there are other ways the hospital could do that with less cost, my guess is that we wouldn't be here. Brian, Hospital A

As confident as Brian is in social work's contribution to the hospital, he still expresses the vulnerability expressed by others throughout this discussion. It is the pervasive concept that the "work of social work" will be needed but not necessarily unique professional social workers that is troublingly.

Two social workers uncertain about the future of hospital social work look at this question in a simple manner. One, newly with her MSW degree, had worked in her setting barely seven months when interviewed. Her perspective more closely reflects her own professional bias as she sees the preferred future role of social workers as more clinical and envisions other strategies for discharge planning such as through case managers or discharge planning teams. The other social worker provides a pragmatic response reflective of her current status. A seasoned worker since 1990, at her hospital for five years, now has a new director, a nurse. According to the social workers from this setting, the new director openly plans to increase the case management staff to assume responsibility for discharge planning and decrease the social work staff.

As stated above, 14 social workers interviewed more clearly expressed a pessimistic view as to the future of hospital social work. Nine of the 14 are part of merged departments; three social workers are from settings with centralized social work departments and three work as part of free standing Unit Based clinics. The workers from the centralized departments have a social worker as a director; all others have members of other disciplines as directors. Supervision for administrative issues, 15 minutes daily, is consistently provided to only two social workers interviewed from one setting. None in these 14 social workers are provided with clinical supervision.

For at least two of these social workers, members of merged departments with nurses as directors, their views have resulted from being witness to the myriad of organizational restructuring and perceived changes in mission of their respective settings, each having been employed there over 25 years. Both expressed great frustrations and anger, one watched her department decrease social work staff from 65 to current staffing levels, she being one of seven remaining social workers; the other, though feeling valued and secure assigned to the emergency room, describes how social work has become more business-driven as it responds

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to the changing organizational environment and social workers are in her words, "clerical" staff.

The majority of this subset of "pessimistic social workers" similarly generates their view from their experiences. The increasing utilization of case managers for parts of or control of the discharge planning process is repeatedly reported. References to competition, of having less value within the organization and feelings of insecurity for the future permeate the interviews of these social workers to a far greater extent than those expressing optimism for the future of hospital social work. Many of these social workers perceive that their roles are poorly understood by other disciplines. Francesca speaks of a lack of vision within the organization as follows.

> I honestly fear the future. There is less and less money in health care, there's less of a vision among the whole administrative organization of the hospital of the importance of having social workers on staff. We are an invaluable resource, not only to the patients but to the staff and I don't see it getting better. I see it getting worse and worse and worse. Francesca, Hospital H

In one merged setting, Kim though working with case managers does have control over the discharge process on her pediatric unit, yet still sees the future as follows based on her experience within her organization and merged department.

> Bleak. I find it is not rewarding, a lot of people get dissatisfied. I know a lot of people who have left. We have hired a few social workers who were outpatient mental health clinics and they could not handle it. There is no respect for our profession in the hospital. The lack of respect is the main reason for them to leave. And it is not, because case managers think that they can do our job, it is like, I don't think it is something that hospitals are going to invest in, in the future, unfortunately. Kim, Hospital F

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Kim proposes that social work's future would improve if social workers were viewed more as consultants which in her view would elevate the status of the social work profession in the setting.

> If they call us we go in as a consultation, that would be a whole different ball park because you call specialists to do consultations, so if they call social work to do consultations, our profession is looked upon in a different light. They will see us as more of a profession, and definitely validate what we do in the hospital and we would have more leverage in dealing with the patient. But we are not called as a consultation.   Kim, Hospital F

Her current pessimistic reality is that in her setting, in her department, social workers have on occasion been listed as "support staff" requiring her intervention to correct this categorization. This view is in stark contrast to her proposed vision of being considered as professional experts. Two other social workers express pessimistic perspectives as a direct consequence of the reported plan of their new director intent on replacing social workers with case managers in numbers and in discharge planning roles, expressed in the example below.

> I think everything goes around and it comes around. I think based on the history of what I have heard from people here…oh they have tried that here, they just called it different things, and they go through it all and what they learned but somehow it is back here. Social workers are being devalued once again and dismissed as significant. Where that has happened before and they increased the numbers and now there is some new idea coming in and saying –no, no, no get rid of them and come in with someone else.
> Midnight, Hospital J

There were three participants from a centralized social work department that are included among those expressing pessimism for the future of hospital social

work. The three social workers from centralized social work departments are all from the same hospital setting (Hospital C), have a social work director and do not receive any supervision. Two of the three repeatedly attribute a lack of strong leadership and vision from their social work managers as the reasons for their pessimism. As stated earlier, Helen believes that the hospital views social work as "disposable", only protected by union membership. The third from this setting feels valued and relatively secure at the moment, in her longstanding niche in an outpatient clinic but can project that the future of colleagues in inpatient assignments in her hospital. She sees the colleagues as being negatively impacted by organizational responses to increasing financial pressures.

Three others in this subset work in Unit Based outpatient settings and base their pessimistic perspective on the observed impact restructuring has had on their inpatient hospital social worker colleagues. Two of these are organizationally employed by the hospital that has the generic Case Management Department represented earlier; the other social worker is employed by a hospital (Hospital L) in which she reports that all social workers in the setting are decentralized, structurally attached to their respective teams, as she is.

What is evident from each of these examples, whether optimistic or pessimistic about the future of hospital social work, organizational influences and social work professional perspectives relate directly to the themes discussed throughout the analysis. The function of discharge planning and/or activities contributing to the financial health of the organization was linked to the future of hospital social work by 26 of the 40 social workers interviewed. Role clarity and perceived value of the social work role, as well as issues related to leadership and vision was mentioned in the responses of 18 social workers when asked about the future of hospital social work. Who does what in an organization and whether a particular discipline "owns" a critical function contribute to perceptions of institutional value. Social work roles in many instances have become

interchangeable with other disciplines and have become fragmented and out of the control of the social workers themselves. As alluded to above, the organizational value and concurrently, the future of social work has to be impacted by these realities as unique contributions are not readily evident. Melissa provides an example of this sentiment.

> I know in this hospital social workers do the financial piece, probably most importantly to show that we need to be in the hospital and that we use discharge planning and other concrete services as the primary focus and then the clinical work comes secondary. So I am wondering if there is any sort of movement or another discipline that is ready to take over discharge planning or any of those concrete roles if that will mean that social workers will have more clinical roles or does it mean that social workers will not be working in a hospital as much. Melissa, Hospital I

In this final quote, Melissa effectively summarizes the issues relevant to the current practice of hospital social work, how its value is recognized and at the same time, its professional vulnerability in the setting.

Chapter Summary

Role clarity emerges from the functional realities of how social work roles are defined, implemented and understood. Hospital social work practice varies significantly from setting to setting and even within the same setting. In settings in which social workers did not control their role, where others defined their tasks, role clarity and role consistency was compromised. Professional identity and role clarity was challenged as social work roles by practice or redesign have become fragmented and interchangeable with other disciplines and differently

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trained staff. This fuels the perception that social work roles and functions do not represent a clear and unique expertise.

In the best case scenario, professional clarity was strongly promoted within the institution through the efforts of an effective social work leader. As non-social workers are increasingly shaping social work practice, more frequently others understood what a hospital social worker did by observing their activities or having social workers continually clarifying their roles and functions. Within the profession, imprecise social work definitions and varying intra professional perceptions of practice roles projected to others, further compounded role ambiguity within the setting.

The activity of discharge planning is consistent with the financial health of the hospital. Social workers differed as to how they viewed their role in discharge planning and were not always able to reconcile the value of their individual professional social work contribution with this critical hospital function. Professional identity formation and recognition of a clear social work professional contribution becomes compromised as all these themes and concepts intersect.

CHAPTER VII: DISCUSSION AND CONCLUSIONS

Summary of Study

Dane and Simon (1991) offer the following view of social workers employed in hospital settings.

> Social workers in host organizations must make their stay of continuing interest to their employers by providing evidence on a regular basis of their indispensability to either the mission or overall welfare of the host. (p. 208)\

It is the above statement that summarizes the ongoing challenges faced by hospital social workers. An identifiable and distinct professional contribution is needed to maintain a presence in a host organization. The findings of this study suggest that the status of hospital social work practice in many settings is far from meeting the above challenge. Social work roles lack clarity, are frequently in the control of non-social workers and often interchangeable with other disciplines across a range of hospital settings. As guests in a host agency, social workers have an uphill battle convincing decision makers to preserve their roles. The elusive nature of social work definitions in general and the pervasive ambiguity of hospital social work in particular make this climb steeper.

Authors have reported that social work services are being provided in varying reporting formats with changes in management and staffing patterns (Berger et al., 1996, 2003; Neumann, 2000; Globerman & Bogo, 1995; Sulman, et al, 2004). This qualitative study looked at the current status of hospital social work practice within the realities of changing organizational structures. It is the experiences of hospital social workers that tell the story of how changes in structures,

management and interdisciplinary relationships impact their roles and professional identity. Imprecise and varying perceptions of their roles and value in hospitals are revealed though their words adding complexity to their practice stories.

 It is the diversity of hospital social work practice between settings and within settings that sets the stage for how social workers experience differences in their day to day work. The findings explored factors influencing the extent of professional autonomy experienced, how social work roles are shaped in different settings and how perceptions of value emerge through these lenses. These findings point to the issues of role clarity for social workers, non-social work professionals and organizational decision makers and threaten the future of professional social work in hospitals.   Professional identity becomes compromised as non-social workers increasingly shape and control social work practice in hospitals.

Forty social workers from thirteen different hospital settings were interviewed using a semi-structured interview guide. The purposive and self-selected sample was comprised of Masters level social workers currently employed by hospitals and with no supervisory responsibilities at the time of inclusion. Anonymity was maintained as participants used fictitious names and all identifying information was destroyed once interviews were transcribed. Hospital settings are not identified. Interviews lasted from 30-60 minutes and occurred at a time and place at the convenience and choosing of the participants.

All interviews were transcribed and analyzed for emergent themes. Codes were developed from initial reviews of text and applied to interviews using MAXqda qualitative analysis software.   Codes were condensed as relationships across data and themes emerged. The findings presented in this study are the result of a continual review and sorting of data.

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Limitations of Study

A number of limitations emerged from the study design itself. Interviews represent a rich source of data; however the quality and extent of the information obtained can be subject to the idiosyncrasies of the interaction between interviewer, interviewee and environmental context. A significant limitation in the research design was only allowing for a single interview, eliminating any opportunity to further probe subjects for clarity in their responses or to explore gaps in information that might have added to the themes that emerged during data analysis. Follow-up contacts were not part of the design and not possible since data analysis was anonymous. All identifying information linking subjects to their interviews was destroyed once the interview was completed.

Perhaps the greatest limitation to the data collected was the sample itself. Recruitment was more challenging than anticipated, extending over a six month period to capture the first 40 social workers that volunteered. Originally it was anticipated that access to potential volunteers would be facilitated once professional colleagues overseeing hospital social workers were contacted. The reluctance to permit investigator access to recruit was unexpected. Additional strategies that more broadly advertised the study were employed with some success, through advertisements in professional newsletters and literature distributed at conferences. The bulk of the sample however was from snowballing, once one participant completed the interview, they then engaged their colleagues to participate. For settings where access was granted, follow-up reminders from department administrators were helpful for recruitment.

As discussed earlier, the design was meant to include different organizational structures, and preferably to have fewer settings with more volunteers from each. This might have validated the findings to a greater extent. However, the broad range of settings represented by subjects did provide the richness of diversity that

was unexpected. Particularly of concern was the limited number of social workers from hospitals that have fully decentralized its social work services. Only one participant from such a setting was included, and she was assigned to an outpatient setting. The experiences of social workers with decentralized reporting structures assigned to inpatient units would have broadened the diversity of the analysis. Despite outreach efforts that would have reached these social workers, particularly through strategies targeting the 1199 union members, no individuals from this category came forward. Lastly, recruitment only targeted a specific metropolitan and suburban region limiting the potential breadth and depth of perspectives.

Data collection through individual interviews presented its own set of limitations for this study. Subjects entered into the interaction with some apprehension, and in most cases, had to "squeeze out" a small timeframe for the interview from a highly charged work day. For a number of participants, that meant beepers and phones kept interrupting despite their efforts to focus for this brief time on the interview. This might have restricted thoughtful reflection that could have provided more meaning to their responses. The benefits of having time for reflection during the data collection was evident as a number of participants shared additional insights off tape while walking with me to the elevator or out of the building. A follow up contact or a prepared list of questions provided before or after the interview might have allowed for additional depth of data obtained. This could be included in the design of future research. In some instances the questions asked were not immediately understood and required more input from the interviewer than anticipated; this could have introduced bias by possibly leading the respondent.

Another concern was that all interviews occurred in sites chosen by the volunteer and the interview environment may have been a factor in data collection. Some locations were more private and conducive to openness whereas

other sites, such as cafeterias, presented challenges with potential eavesdropping that might have inhibited discussions and disclosures. For example, one participant requested that we change our location in the middle of the interview after seeing case managers sitting around us. Other settings such as coffee shops became noisy and distracting.

Lastly, the overall quality of the findings might have been influenced by the following two concerns. All interviews and all coding were performed by me alone. While all efforts were taken to identify and account for potential investigator bias and primary data was reviewed repeatedly to confirm emerging concepts, a second coder might have provided a layer of validation that may be missing in the analysis. In addition, the dependence on a self-selected sample does skew the data to some degree as only those social workers motivated to share their voice are included. The voices missing may have a different story to tell.

Discussion of Key Findings

The experience of hospital social workers is intertwined with the realities of an evolving health care environment. Consistent with organizational systems theory, hospitals have responded to external fiscal challenges in varying ways to maximize efficiency through departmental restructuring and reconfiguration of staff roles and functions (Blau & Scott, 2005; Jaques, 1990; Bolman & Deal, 1997; Hasenfeld, 1992). Study participants described working within a spectrum of reporting structures, having undergone changes in staffing, shifts in management and in many settings, now sharing their department with colleagues from other disciplines. Some were witness to department transitions; some were new to the settings after changes had occurred.   In one setting, some were in the midst of organizational and role changes; others were anticipating restructuring of

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roles and functions based on the plans of a new manager. The majority of participants are either currently practicing in an environment in flux or aware that they are continually vulnerable to organizationally imposed shifts in their day- to-day roles and responsibilities. Four of the participants seemed insulated from such forces, Margaret, John and Sara working in free standing clinics and Susie, structurally part of a centralized social work department but in a longstanding and autonomous niche in an outpatient clinic. These individuals still articulated how their colleagues elsewhere were being daily impacted as structures and practice roles continued to change. All participants provided their perceptions about leadership, practice, relationships with colleagues and place in the organization.

What is the Role of Hospital Social Workers?

This study was designed to capture the experiences of hospital social workers within three broadly defined reporting structures – centralized, restructured and unit-based. However, the extent of diversity of departmental environments and practice roles described was unexpected. Social workers reported practice roles that not only varied between settings but within settings. Participants with inpatient assignments all reported having some role in discharge planning; however how that role was defined was most often linked to the degree of involvement of case managers from other professions. The significant themes that emerged centered on how participant's practice roles were defined and controlled and how the work of social work was understood and valued by other disciplines and even among social workers themselves. Control and clarity of one's practice role become connected through the influences of organizational forces.

The most informative findings were found within three particular settings, specifically Hospital A (a very large, centralized social work department with

social work management); Hospital D (a smaller hospital that was recently restructured and merged with case managers) and Hospital E (a small, restructured hospital where nurses and social workers equally share the title and perform the roles of case managers). It is through a comparison of these settings that the major themes of control of practice and clarity of role can be best illustrated.

When the perceptions and experiences of the social workers from these settings were compared, not only were the parameters of their practice roles different, but how they felt about their roles varied. Social workers with control of their practice roles were generally more positive about their experience and their practice and felt respected within their setting. Participants from Hospital A and the worker on the specialty unit in Hospital D represented this perspective. Their primary role in discharge planning was acknowledged and valued. They approached the day-to-day challenges of their work with adaptability and confidence; they were willing to clarify to others what their roles and responsibilities were if needed.

In contrast, the other participants from Hospital D experienced more frustrations with what they considered inappropriate referrals and perceived an increased level of competition among disciplines. The lack of control and fragmentation of practice roles influenced how they describe their daily experiences. As tasks were altered, for example to include their participation on daily medical rounds or psychiatric setting placement, these added responsibilities were considered only as extra work and not viewed as consistent with social work functions. The descriptions of their practice experience were more generally negative and seemingly unpredictable.

Hospital E provides a more unique window into the myriad of practice roles of hospital social work. By design, this restructured department is comprised of social workers and nurses; all share a generic title of case manager, have identical

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job responsibilities and functions and have salary parity. As a result, there is no competition between disciplines and relationships are collegial. Over time each discipline is said to incorporate the skills and knowledge of the other to manage their cases on their own. Steve's words best describe his reality.

> People in society don't really understand what a social worker does. In my setting it is known and defined. They see a case manager, social worker or nurse, they understand we are involved in discharge planning…But over time the nurse develops skills from the constant interaction with the social worker to independently do the discharge plan. Usually we are providing them initially with the information, and then after a while they have their own resources they use.

The discharge planning role is understood and valued within the institution. Participants were positive about their experiences and felt that the "case management" role provided a secure institutional presence for social work in the institution, even if as another worker indicated, aspects of "traditional social work" were lost in this configuration. The blurring of roles between disciplines was not acknowledged as a significant professional concern by these social workers, considered more a strategy to survive in the setting.

The experiences of all the participants in this study fell along a broad and diverse spectrum of how they experienced control and clarity of roles. The involvement of case managers appeared as an organizational influence linked to how social work practice was shaped and controlled. In general, participants were more likely to characterize their experience as positive when they had control of their practice role and the involvement of case managers was considered helpful to them. When the power differential was reversed, when patient cases were first assessed by case managers and then referred according to a prescribed division of discharge planning tasks, participants appeared less secure and perceived other disciplines did not understand social work. Along the continuum of experiences,

as social workers witnessed changes in their roles and the utilization of case managers increased, vulnerability, interdisciplinary competition and questions about their future were articulated

Building from the above examples, differences in department management and department composition were explored as organizational factors influencing the practice roles and experience of participants.   The department director likely would be the pivotal influence as roles and functions of employees were delineated. Participants attributed their experiences, positive and negative, to the actions of their department directors.   It was participants who were once part of a centralized social work department and were then merged with case managers that expressed this most acutely. Real or perceived, participants felt more vulnerable as to their functions and future when their manager was not a social worker.

 Feeling vulnerable to power shifts, social workers continuously made comparisons with other non-social work professionals and practitioners, which fueled negative interdisciplinary relationships. In most instances, these were the same colleagues who controlled the practice of the social workers within the hospitals. Perceptions of management bias by non-social work managers permeated the interviews with concrete examples of case managers preferentially being given laptops or wireless phones or in the case of Hospital F, Kim reporting that in her department social workers were listed as "support staff."

Having a non-social worker manager was considered a loss of an organizational advocate. Participants consistently believed that only a social work director would be able to positively and accurately profile the needs and value of social work staff to the organization executives. Three settings, two of the hospitals with centralized social work departments and the hospital in which social work services was restructured as generic case management, support this perception. Social workers from two of the three hospitals (Hospitals A and B) with centralized social work departments and social work directors shared this

experience. Concretely, salary parity between social worker and nurse case managers within the generic case management department (Hospital E) can be perceived as an example of the effectiveness of having a social work leader.

Participants from Hospital C, despite having a social work director in a centralized social work department, had a different experience. Transitions within this setting had resulted in a loss of staffing, loss of structured supervision and an increased utilization of case managers assuming components of discharge planning. Changes or challenges in their practice role were attributed to the ineffectiveness of their social work director in advocating for them in the organization. Helen expressed this most intensely with her view that if they were not unionized, social work services would be eliminated. Having a social work director did not guarantee a positive and secure experience for participants.

Leadership qualities, interdisciplinary relationships and individual practice experiences all appear to have influenced the perceptions of participants more than whether or not a social worker was in place as a manager. This is represented in Hospital D reviewed earlier. Participants from the same department, with the same non-social work director, viewed both their practice experiences and their interdisciplinary relationships differently. The distinction between these social workers was in the degree of control of role and role clarity each experienced in their day to day work, the difference being that one social worker had her practice shaped through referrals from case managers; the other worked autonomously without the involvement of case managers.

Different perceptions of one's practice experience may also be impacted by the strength of one's professional identity. Years post-MSW and the availability of structured supervision by a senior or peer social worker may contribute as well to individual participant's perceptions of his or her practice experience. Distinctions attributable to these latter two variables were not readily explored since the sample included only nine participants three years or less post-MSW and

eight of these had a social work director. All but one received formal clinical supervision from a senior level social worker.

The clarification and value of social work roles should be articulated and understood at the departmental level, particularly within structures merged with different disciplines. Collegial relationships are influenced within the departmental climate. Departmental climates dictate the degree of mutual respect and professional understanding between colleagues that transfer to working relationships elsewhere in the hospital.

A direction of future research would be to examine strategies employed during transitions and restructuring and look at the resulting departmental climate, exploring its impact on social work roles and relationships with non-social work colleagues. As outlined in an earlier chapter, authors have explored both the process and impact restructuring has had on social workers elsewhere, citing decreases in job satisfaction, morale, and motivation as role ambiguity and disempowerment were perceived consequences (Globerman, et al., 2002; Michalski, et al., 1999; Siefert, et al, 1991; Jayartne & Chess, 1984). Allen et al. (2004) more specifically looked at organizational commitment and job satisfaction and linked these to factors that influence one's work environment, such as job autonomy, job variety, job stress and the availability of supportive supervision. While not a specific focus of this study, a number of related issues were raised by participants, particularly when an outcome of transitions involved reporting to a non-social work manager, changing role assignments and a loss of supervision was experienced. Further research is needed to critically examine the relationship between organizational factors and social work role and perceived value within the context of department environments.

Relevant to the results outlined in this study was the work of Globerman et al. (2002) who found that the most positive and most productive social workers described settings in which their role was clear and valued. Workers who could

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proactively define their roles and perceived themselves to have a voice within the organization, believed they were best understood among disciplines. Conversely, social workers who described their work environment as unstable and toxic, and themselves as "victims," felt others defined their roles and they were less respected on their teams. Study participants mirrored these findings. Similar to what was found in other studies, each participant, despite reporting negative perceptions from forces around them, identified value in their work at the direct care level with individual patients and families. At issue was how non-social workers perceived the value of the work of social work.

As hospitals explore different patient care strategies, where social work fits in again depends on how its contribution is understood and communicated by social workers and others in the setting. Case management teams are increasingly being implemented as hospitals seek to streamline patient care activities (Baker, Diamond, & Ruwoldt, 1991; McNeil, 1991; Robbins & Birmingham, 2005; Guo & Company, 2007). These authors outline a number of strategies to formalize the collaborative activities of social workers and nurses on interdisciplinary teams, identifying and supporting the professional expertise of each involved discipline. Robbins & Birmingham (2005) provide a framework for case management practice that acknowledges the commonalities and the distinctions between the standards of practice of social work and nursing. The key to a successful working relationship that avoids "turf" battles starts with the formation of the team. Each discipline has to fully understand and respect the scope of practice of their colleagues and understand and be accountable for what each brings to the process. Division of labor has to be a mutually agreed upon process that is consistent with each expertise, not interchangeable, and be dynamic as patient and family issues can be unpredictable. As discharge planning and case management teams are implemented, it is the responsibility of the directors/managers of social work services (whether social worker or non-social workers) to be part of the decision

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making team as a social work voice and to create a climate within departments that is accepting of discharge planning partnerships (Guo & Company, 2007). Based on the experiences of study participants, proactive efforts to cultivate effective working relationships are not routinely occurring or are ineffective since competition and role ambiguity are routinely expressed.

The results in this study are consistent with other reported outcomes of reorganization; however, most other studies examine the shift from a discipline specific reporting structure to fully integrative or unit-based models (Berkman, 1996; Globerman, et al., 2002; Globerman & Bogo, 1995; Michalski, et al.,1999; Sulman et al, 2004). Such studies do not illuminate the spectrum and nuances of practice roles and influences among participants as in this current study, particularly among merged departments. It is the significance of this finding that will be discussed below.

Is Hospital Social Work Practice a Professional Role?

Given the experiences of study participants as to the broad diversity of practice roles and how these roles are defined and controlled, questions about a professional social work identity and professional role in hospitals becomes relevant. The study findings suggest a "yes and no" response to the above question. Virtually all participants appear to have a strong professional identity when outlining their unique expertise and how their contribution to the organization is different from other disciplines. But identity formation is also an interactive process in which others confirm and reinforce what each of us internally has constructed. The response of others should be consistent with one's own understanding of one's identity (King & Ross, 2003; Adams & Kowalski, 1980). It is both who defines the practice role of participants and how this role is

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understood by others that combine to address the question above. The themes that have emerged from the perceptions of the participants inform this discussion.

Variations in the control and definition of the practice role of participants have been previously discussed but are reintroduced here as one way professional identity is assessed. Autonomy of one's practice is one of the historical hallmarks of a profession (Trice, 1993). Participants for example from Hospital A appear to come close to this benchmark, with control over their role in discharge planning, and which is acknowledged and valued by other disciplines. Participants from Hospital D appear to be at the other end of the spectrum, with others defining who they see and for what reason. Participants from Hospital E would appear to have autonomy of practice; however, their experiences introduce a different challenge to the question of professional identity: the concept of interchangeability.

Interchangeability between disciplines brings up a second hallmark of a profession: the utilization of a distinctive and superior body of knowledge in one's practice that is recognized as such by the public (Trice, 1993). On the extreme end, interchangeability is represented by the generic case manager role in Hospital E. Varying degrees of interchangeability are in other participants' reports. For example social workers report being responsible for discharge planning tasks on weekends that case managers control during the weekdays (Hospital D). In other settings, ambiguity and deprofessionalization of the social work professional role occur when discharge planning assistants with varying educational backgrounds are assigned tasks for which licensed social workers are responsible for elsewhere.

A profession and professional identity are assessed by how recognizable their expert practice is to others. The experiences of the study participants tell a story of many challenges to this recognition compounded by the examples of interchangeability and deprofessionalization of practice roles. The perception that the work of social workers is boundless or that social workers somehow "wave

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wands" rather than provide identifiable services in their work perpetuates the view of an imprecise scope of professional practice.

Many participants perceive that other disciplines misunderstand what social workers do by the range of cases that do or do not get referred for social work interventions. Even here, what an individual social worker views as an "appropriate" referral can vary depending on the lens being used. This lack of consistency sends conflicting messages to other professionals. Examples revealed in this study include being asked to intervene with a new mother having trouble breast feeding and not being asked to see a patient newly diagnosed with cancer. A newly diagnosed patient with cancer would no doubt benefit from social work intervention and should be referred. A new mother might need emotional support to better breast feed; however, the participant citing this example did not even consider that perspective when the referral came to her, interpreting without question that the referral belonged to the nursing staff.

How the social work profession presents their practice to others is further challenged from within the profession. Participants distinguished themselves by their practice assignments and create hierarchical dichotomies: clinical versus concrete practice; psychiatric versus medical social work. These value laden distinctions become evident during interdisciplinary interactions and can further erode professional role clarity.

Lastly, socialization into a profession occurs as specific knowledge and skills are acquired within the context of a new professional role. The formation of a professional identity can be viewed as a maturation process. Mentors or supervisors are used to move emerging professionals along the continuum from student to seasoned professional, and to nurture new professionals to feel as part of an organizational group (Alutto & Hrebiniak, 1971). As participants report on a loss or lack of professional supervision and a loss of seasoned social workers in some settings, professional socialization opportunities can be absent to new social

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work professionals. While not examined in this study, this is an important area for future research because it can also impact the future professional identity and professional role of hospital social work.

The most profound challenge to professional identity was provided through the experiences of Nancy, the sole social worker at her setting, who followed a series of employees that were considered "social workers" by the hospital administrators. Nancy was struggling to carve out her professional niche, educate other disciplines about what a social worker does and fill roles that had been occupied by non-social workers before her. Nancy was also faced with confronting administrators when job responsibilities were assigned that conflicted with social work ethics and values or simply should not have been in her scope of practice. Her examples included being asked to enter the work statistics of other disciplines or to serve as the patient advocate for the hospital but not to identify herself as "social work". Nevertheless, her value was acknowledged by her coworkers when her interventions with challenging discharges resulted in shorter lengths of stay. Significantly, discharge planning was the primary function of the nurse case managers discharge planning and not a defined role for Nancy. Nancy, though happy to assist when she saw a need, did not feel discharge planning should have been part of her responsibility. Nancy's view of her role as a hospital social worker was distinctly different than a colleague working elsewhere.

For many of the study participants, hospital social work is in fact a professional role. What the above discussion is meant to illustrate is that in a number of settings represented in this study, identifying a professional role for social work is becoming more challenging.   For the social work profession in general questions about professional identity have permeated the literature for decades. Attempts to define a social work professional identity have been ongoing since the writings of Abraham Flexner in 1915 (Gibelman, 1999; Sowers & Ellis, 2001; Wong, 2001). Gibelman (1999) acknowledges this debate and

expands on how social work identity continues to evolve. In her view, social work definitions and its boundaries are fluid and change in response to the needs of society at a given time. The adaptability of the profession in her view is a positive attribute. In a changing health care environment, Gibelman predicts if social workers are not able to adapt and incorporate the needs and knowledge of a changing health care delivery system, they might be excluded from it. From the experiences of study participants, social workers are being asked to adapt their practice in response to a range of changing organizational forces such as the introduction of different role descriptions from a new director or increasing utilization of case managers for discharge planning. The distinction that Gibelman makes in her discussion of adaptability though is that as the professional identity of social workers evolves over time, it is social workers who are choosing to adapt their practice to the meet the needs and opportunities that present. Some of the practice shifts that participants have experienced have not been in their control and definitions and control of social work are increasingly in the hands of non-social workers.

Shaping Social Work Role in Hospitals

The above discussion suggests the following two graphic representations of how the major themes of this study combine to influence the experiences of hospital social workers and in turn reinforce how decisions regarding social worker roles may be impacted. Diagram 1 depicts the experience of hospital social workers when social workers have primary control of their practice roles and Diagram 2 suggests through the findings in this study how these same interactions and influences occur when non-social workers control how social work practice is shaped. In both instances, role clarity and the understanding of

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how social work is understood is impacted by how the social work practice role is projected to others, including how social workers themselves project their roles.

Decisions regarding the delineations of roles and functions in both scenarios occur at the organizational level, most likely clarified and implemented within departments. The difference between them has to do with how social work is understood by non-social workers, those making decisions about social work practice, and how do the daily experiences of their practice in turn inform this understanding.

In *Diagram 1*, social work leaders have a role in influencing how organizational decisions about social work practice are made. Participants spoke often about how significant this organizational voice was in elevating a positive profile of social workers up through the organizational hierarchy. In addition to being a source of influence on the organizational level, a strong social work leader also provided a practice framework for the social workers that supported their sense of security and confidence in their practice roles within the organization. The term "leader" is being used purposefully since having a social work manager was not a guarantee of an effective voice advocating on behalf of social workers or to create a positive departmental climate for social workers and interdisciplinary relationships.

Practice roles tended to have more role clarity and consistency when in the control of social workers. Discharge planning activities were more holistic with social workers completing patient assessments and implementation of the plan that was developed. Role clarity provides non-social workers the opportunity to better understand social work roles and these positive perceptions can formally and/or informally influence how social work is understood throughout the organization.

Social workers expressed a greater sense of feeling valued by their team and described collegial relationships with case managers. Positive and flexible

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attitudes towards their roles contributed to role clarity as how others viewed social work was confirmed through the actions of social workers. Distinct and understood profiles of social work roles support a positive professional identity for social workers and promote a professional social work role within the hospital.

Diagram 2 provides an alternative scenario suggested by the study findings. In settings in which social work roles are controlled by others, more interacting influences contribute to how social work is understood and practiced. As seen in *Diagram 1*, roles and functions are delineated at the organizational level; however in this scenario, decisions are most frequently made without the influence of a social work leader to represent the professional practice of social workers. Decisions then are more closely tied to variations in how others perceive social work roles.

Participants described two significant practice realities. The first is that case managers review all patient cases and refer to social work those patients that require social work intervention based on what appears to be a predetermined delineation of discharge planning component tasks. For example, social workers are responsible for skilled nursing home placements while case managers refer for home care. This cataloguing of task assignments appears to vary from setting to setting. Participants report that if the patient's needs change and the discharge plan changes, responsibility for a new task might shift back to the case manager. This results in the observation of a fragmented practice role that compromises role clarity as projected to others. Examples of being misunderstood are represented by participant stories of what kinds of referrals they receive.

The second structurally determined practice reality is that social work roles are frequently reported to be interchangeable with differently trained personnel. This has a profound influence on how others view social work and directly links to the organizational decision makers and their lack of understanding or appreciation of a unique social work role. Similarly, as with having a fragmented

and variable practice role, interchangeability between disciplines to the extent reported, further compromises role clarity as understood by others.

Social workers themselves contribute to how others perceive social work practice by what they project to others. Participants who experience the shaping of their roles by others, and compromised role clarity, tend to have a negative attitude towards their practice, reacting more rigidly to referrals from other disciplines. Their roles became task driven and increased levels of competition and turf battles were reported. As different social workers perceived "appropriate referrals" differently, this lack of consistency also compromised the role clarity seen by others. The absence of a social work leader compounded perceptions of vulnerability and conflict, which permeated the overall experiences of social workers within interdisciplinary relationships.

Intra professional distinctions and imprecise self-definitions were expressed by social workers across all settings and can further confuse on-lookers as they attempt to understand social work. However, these influences have a potentially greater impact when social work role clarity is already compromised and a social work leader is not available to counter these perceptions at the organizational level.

In contrast to what was seen in *Diagram 1*, in *Diagram 2,* social work role clarity is directly linked to the perceptions of others depicted by reciprocal and repeating relationships between structural practice influences and how perceptions are shaped through the daily experiences of social work practice. These perceptions feed back up the organizational hierarchy and further impact decisions regarding social work practice. The lack of a clear and unique social work role creates a questionable future within the hospital and has a negative impact on professional identity through a loss of autonomy and distinct practice role.

Diagram 1
When Social Work Roles are Controlled by Social Work

How Social Work is Understood

Social Work Leader

Organizational Influences and Decisions

Social Work Controls SW Role

SW Experience
Positive attitude
Holistic Role
Adaptable
Valued
Collegial

ROLE CLARITY
Valued Role

Perceptions of Others

FEEDBACK→ **Understanding of SW**
Support professional identity
Supports professional social work role
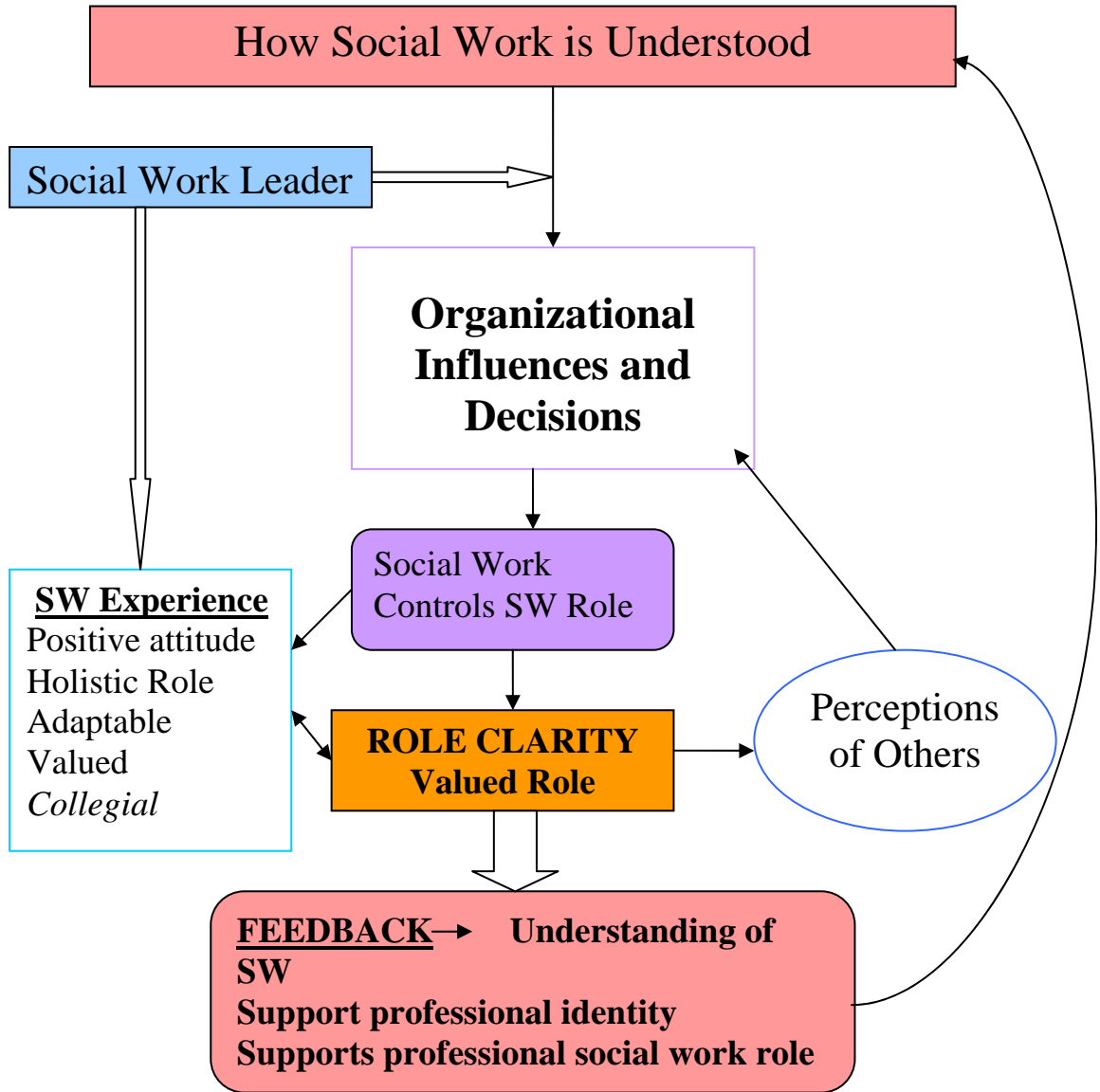
Diagram 2
When Social Work Roles are Shaped and Controlled by Others

How Social Work is Understood

Organizational Influences and Decisions

Interchangeable Roles

SW Controlled and Shaped by Others

Perceptions of Others

SW Perceptions
Negative Attitudes
Intra SW Distinctions
Imprecise Self Definitions

Fragmented Roles

Compromised Role Clarity
Lack of Unique Role

FEEDBACK → **UNDERSTANDING OF SW**
Negative impact on professional identity, perceived value and overall experience Questionable professional future role for SW in host agency

Implications of Study Findings

Losses of autonomy and control of social work roles, fragmentation and interchangeability of functions and erosion of role clarity have broad implications for both hospital social work practice and the internalization of a distinct professional identity. This section will explore what the findings tell us about the future of hospital social work and the implications of the findings on professional identity. Implications for social workers in hospitals, policies impacting social work practice and implications for social work education will be discussed. Strategies to ameliorate the consequences of study findings will be suggested.

The Future of Hospital Social Work

The findings tell us that within the range of experiences, hospital social work is professionally thriving in some institutions, while in some settings, practice roles are being increasingly fragmented and the discharge planning role is no longer a primary social work function in the control of social work. This is not a new finding as reviewed earlier, nor is a diminished role in discharge planning viewed as a loss for many social workers. Social workers have never been consistently clear as to what they professionally see as their practice role and their contribution to the hospital setting. Ambivalence to the discharge planning role has been previously documented as social workers sought a therapeutic professional niche along side their mental health provider colleagues (Holliman, et al., 2001). Such ambivalence has persisted as a number of participants in this study shared their perspectives that discharge planning was not clinical or not clinical enough and therefore not their preferred role.

Participants in some instances welcomed the potential of other disciplines assuming responsibility for discharge planning activities thereby freeing their time for more clinical functions. As a result, there was an incongruence of values

between what participants viewed as their valued contribution to the institution and what many understood as the valued mission of the organization. Most participants reported that it was the time they spent with patients and families that was what they as social workers contributed of value even when acknowledging that decreasing the time patients spent in the hospital was the primary objective of the organization . Not having sufficient time for "social work", however individually defined, was distressful for many participants. Participants that felt most secure and validated in their professional roles in hospital settings acknowledged the value of discharge planning activities as part of their practice, seeing it as consistent with the fiscal wellbeing of the organization. These participants acknowledged how time constraints also impacted their interventions; however they appeared better able to adapt to such pressures.

Maintaining a viable and meaningful social work presence in hospitals requires the acknowledgement of a number of realities. The fiscal challenges of health care settings will persist, potentially worsen. Bureaucratic entities on the federal, state and local levels seek to decrease health care expenditures with each budget cycle. Third party insurers continually are restricting reimbursement for care. Hospitals will continue to restructure to minimize costs and streamline functions to maximize the efficiency and effectiveness of patient services.

In times of retrenchment, those in decision making capacity determine organizational structures and roles based on their understanding of the significance and value of an employee or a discipline. Hospitals represent host agencies for social work practice and social workers make up a small percentage of employees in hospitals. As such, the contribution of social work must be clearly understood as unique, visible to others and critical to the overall well-being of the institution (Dane & Simon, 1991). As illustrated in this study, the clarity of social work roles and contributions is not always clear, frequently misunderstood and increasingly, interchangeable with other professions and/or

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differently trained bachelor level employees. Without tangible evidence that the specific expertise of social work professionals is needed, the argument to maintain social workers in the setting is compromised. Employees who create no measurable revenue nor can link their interventions to decreases in expenditures; and whose contribution is not justified through evidence-based research would be the least valued. Similarly, employees who are closely identified with critical tasks that directly relate to the economic functioning of the institution would be greatly valued (Berger, 1991, Ross, 1993).

Discharge planning in hospitals has become a pivotal function that directly influences internal and external resources. As budgets are challenged, hospitals have restructured to more efficiently utilize their staff often combining related functions. Examples of role reassignment for efficiency was presented in a study of 58 hospital discharge planners which found that social workers were most often employed at larger hospitals, those with greater than 250 beds and absent in smaller settings in which nurse discharge planners were more prevalent (Holliman, et al., 2003). As critical responsibilities shift to other professions, power to have input into how decisions are made also decreases (Berger, 1991). In some settings, social work may become fully marginalized, defined by others and no longer be a consistent presence in these hospitals.

The absence of all professional social workers from a hospital would be an extreme end of this apparent slippery slope scenario. There continues to be settings in which social work maintains a strong and valued presence, often attributed to the effectiveness of a leader, traditionally a social work director, championing the merits of the social work role to institutional policy and decision makers. As managers are increasingly non-social workers, social workers have to find other strategies to ensure that their contributions are meaningfully represented.

Social workers themselves have to first be clear and confident with what they can and hope to provide as professionals within hospitals. The cultivation and recognition of a strong professional identity become critical to this discussion. Professional identity is an interactive process. Social workers individually have to be clear about their professional role and identity for themselves but also how this identity matches what is being expected by others. Internalized meaning of a role identity can be altered in a given situation if not confirmed by others (Stryker & Burke, 2000). As non-social workers define and shape social work practice and a distinct social work function is not evident to onlookers, the capacity to generate a reliable internalized professional identity is compromised. It becomes much more challenging to self-promote one's value when individually there is identity conflict and uncertainty. As guests in a host setting, what social workers contribute has to be a unique expertise and/or a demonstrated cost effective intervention that is consistent with the valued objective and mission of the institution. Social workers individually need to become proficient and comfortable with language that communicates and markets their professional value to others.

Social Work Field

Social work as a profession has to take the lead in self promotion. To do so, there needs to be clarity and a consensus as to what professional social work practice provides to its various constituents. The social work profession encompasses a broad range of skills, target populations and practice settings. Social workers provide direct care, and are community organizers, administrators and policy makers. For many, defining social work is challenging even within the field itself. For hospital social work in particular, definitions are even more daunting.

Hospital social workers need to acknowledge that their ambivalence as to their own role has impacted how others perceive social work practice expertise. How hospital practitioners and managers perceived the professional skills of nurses and social workers has been explored by social work writers for almost 30 years (Carrigan, 1978; Cowles & Lefcowitz, 1992, 1995; Egan & Kadushin, 1995). For example, nurses and physicians view psychosocial assessment as functions shared between social work and nursing; social workers view counseling and psychosocial issues more exclusively as social work functions. Differing and competing perceptions are known to exist and repeatedly studied; however, strategies to counter these perceptions and/or strengthen the organizational view of social work are lacking.

Gregorian (2005) acknowledges this challenge and the need to clarify and "sell the profession" as follows.

> Social workers in settings where the department has been decentralized or merged face a huge challenge. They must retain the desire, energy, commitment and vision to be self-directed, strategizing to promote social work values and ideas without the direction of a social work manager. (pg. 9)

This involves shifting not only the framework of other disciplines but of social workers themselves. For example, in this study and elsewhere, social workers are identified as the discipline that can manage the difficult cases, those issues involving unstable or indecisive family dynamics; complex social needs such as having no health insurance, homelessness, substance abuse and psychiatric histories. Meeting the social needs of at-risk populations has always been the domain of social work. As social workers internalize organizational changes that are occurring, their framework shift has to look towards the opportunities that present instead of what has been lost. For example, challenging referrals can be

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an acknowledgment of expert skills and not simply work no one else wants. Within a more positive framework, it becomes easier then to make team members aware that patients with traumatic and/or life altering diagnoses are also appropriate referrals often missed without social workers having more control and input into the patient assessment process.

One study participant suggested social workers should only be consultants in hospitals called in for complex patient cases. While that can be a professional option in some settings, it short changes what social work can offer more routinely as a vital member of the interdisciplinary team. Discharge planning is not exclusively a social work skill but social workers bring a perspective that can enhance the process. Social workers and nurses as team members already work together on discharges but as study participants described, these interactions and relationships are not always professionally satisfying and may not be efficient. For these collaborations to be successful, each discipline has to acknowledge and respect each others contributions. Relationship building has to be an organization-wide process, but starts with social workers and their management. As departments increasingly merge disciplines, how these relationships are cultivated and nurtured within reporting structures will impact the success of working relationships on teams.

The discussion returns to the need for social work to be its own advocate. As social determinants emerge as significant components of health, opportunities for social work interventions in inpatient and outpatient settings should increase. Unless social workers can find an understandable language and demonstrate through research their professional contributions to their interdisciplinary colleagues and to the executive levels of the organization, a viable professional niche will continue to be challenged. The work of changing perceptions must occur at the individual practitioner level and spread throughout all levels of an organization. Using strengths, empowerment, political and systems interventions,

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social workers can identify the specific expertise they can offer the hospital and to clarify why social work services are needed to further the mission of the institution. Social workers as such are uniquely trained in the necessary skills to effect micro and macro change; however, they are often reluctant to use their interventions for their own benefit. This was evident in this study by respondents' perceptions of needing social work leaders to be their organizational voice and their sense of powerless reporting to a non-social work manager.

The inability to have a clear and mutually agreeable definition of social work roles and expertise invites others to define our professional work for us. Educators, social work researchers and professional advocacy groups all have a hand in creating a language and strategy to effectively market the value of professional social work practice to hospitals and similar settings. The work of individual social workers can affect small changes in his or her immediate work environment; however, the challenges hospital social workers face need a response from the social work field through the educational arena and professional advocacy organizations.

The Role of Education

The major challenge within hospital settings is to demonstrate the value of what social work provides in financially relevant terms. While this is not usually a perspective emphasized within social work education, this would be where it makes sense to start. Curriculums currently include coursework on organizational systems to provide students with the skills to identify stakeholders and understand organizational structures and different sources of power. Most often the learning objective is to develop the strategies to assist client systems to remove obstacles for services or more broadly effect policy change. It is less often that the objective is to assist social work practitioners to develop strategies to better

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promote their own services, to secure employment niches and learn to market their worth to decision makers. Navigation of all political environments but specifically management of the unique struggles presented by employment in host agencies should be a distinct educational objective.   Self promotion of the profession is typically not an educational emphasis.   If offered, it may not be individually absorbed by students who may not want to hear that there are challenges to the profession that might interfere with their practice goals. In order to "sell others" as to the merits of professional social work, understandable data must be generated. Although the teaching of research methodologies has a long history within social work school curriculums, most students do not see the relevance to their work as practitioners. Applied research such as evidenced-based models, need to be more strongly emphasized so that social work can establish the contribution of their interventions to patient care and the goals of the hospital. Practitioners in private practice outline short and long term goals and record stepwise progress to satisfy reimbursement streams; social service agencies similarly look for measurable outcomes for services. For hospitals and other host agencies, their funding is not usually targeted for social work services so the burden to demonstrate effectiveness becomes greater. Not only do hospital social workers have to prove to decision makers that what they contribute has a positive impact on organizational goals, but also that what they provide enhances the quality, efficiency and effectiveness of what other disciplines can offer.

A clear understanding of the organization's valued goals, internal power structures and external environmental challenges is necessary to frame studies of effectiveness. For example, most often the objective of a hospital is to provide effective and efficient patient care. A particular setting may emphasize filling beds as a primary goal to ensure a reliable funding stream. Customer service may be a focus to market the hospital in the community for new and return patients.

For other settings, especially those that rely on many managed care providers for reimbursement, shortened lengths of stay may be the only goal to consider. Timely discharge planning becomes the focus. Social workers need to learn which organizational goal is primary. Maybe a study of the unique health needs of the surrounding community would reveal opportunities for new programming to offer a financially struggling hospital. For settings such as hospitals, practice effectiveness needs to reach the level of cost effective or cost benefit analysis to communicate their contribution to stakeholders using the language of fiscal survival.

Shifting the frameworks of students to acknowledge these learning objectives can be accomplished on the curriculum level and reinforced in field placement experiences. As funding streams for all social services tighten, measurable outcomes and best practice modalities will be sought. Schools of social work are increasingly offering doctoral programs that have a research emphasis. This will serve to elevate the significance of research for all social work students and allow the inclusion of needed research efforts that originate from a professional social work perspective. For social work schools that are part of health sciences centers, applied research can be a collaborative effort that includes the disciplines most likely to become practice colleagues. Relative to hospital social work, relationships with nursing students and academic nursing researchers can be fostered through these efforts. Collegiality and mutual respect once in the field can emerge from these activities. Health sciences centers have unique opportunities to include in each program's curriculum interdisciplinary course offerings to increase the interactions and expand their awareness of each discipline's scope of practice. The commitment to this process has to begin at the academic levels of professional development.

Lastly but not insignificantly, schools of social welfare need to focus more attention on health care specializations in their curriculum to better equip social

work graduates with the knowledge and confidence to be more effective professional medical team members. Too often, social workers in this study deferred to their more technically trained colleagues while at the same time acknowledging the power differential that exists for those having medical knowledge in hospital settings. Social work students would benefit from understanding the dynamics of interdisciplinary relationships and be better prepared to clarify what social work practice entails in hospital settings. Social work students need to be educated about what discharge planning should be. This language needs to begin at the educational level.

The Role of Advocacy Groups

Professional advocacy groups can and should be at the forefront of efforts to promote the benefits of social work interventions. The National Association of Social Workers (NASW) has taken the lead in outlining the Code of Ethics and standards of practice for social workers in all arenas, including health care. NASW provides credentialing in a range of specialty areas and actively lobbies for licensing of social workers. With 150,000 members, NASW is the largest membership organization of professional social workers in the world and represents an invaluable resource for the profession, provides a loud advocacy voice for policy and legislative actions and funds relevant research projects (www.socialworkers.org). While practice standards provide a meaningful framework for how social expertise is applied within various settings and with different populations, it does not provide strategies to maintain a presence to do the work. NASW is currently studying the status of social workers in health care settings at the national level and through the local chapters, and has begun to present their findings.

The New York City Chapter of NASW partnered with the health workers union 1199SEIU to explore the current status of hospital social workers. Unpublished findings presented at a conference held April 2007 from a mailed survey indicated similar trends to the current study as social workers described the impact of restructuring, including the loss of social work leadership, lack of supervision, decentralization of social work services, role blurring, feelings of powerlessness and perceived impact on the quality of patient care. The goal of the survey was to create a current snapshot of the problem. Descriptive research of this type, including the findings in this study, continue to support that there is a significant concern for the future of hospital social work, but fails to provide meaningful data to clarify the distinctive value of social work services as a professional employment category in hospitals. The NASW/1199 Task Force plans to bring the problem to the attention of public and legislative arenas with a clear statement of the value and financial efficiency of social work services, in hopes to reverse the trend. While this is a meaningful start, without the scientific data that supports the efficacy of the social work interventions over other disciplines, this advocacy effort may be futile.

On the national level, in 2004, NASW conducted a survey of licensed social workers across a range of practice concentrations and produced studies that sorted for specific specialty areas. Within this larger study, 10,000 social workers in health care were surveyed to help predict if the workforce will be sufficient over the next few decades to meet the health care needs of this country's changing demographics (NASW Center for Workforce Studies, www.workforce.socialworkers.org, April, 2006). More than half of the sample of social workers (49 % survey response) who identified health as their practice focus was employed by hospitals. These workers similarly described changes in their work environment that included decreasing staff, increased workloads and declining opportunities for supervision. Stress was most often cited as the reason

for leaving hospital employment. Significantly, the researchers found that there is an aging out of the social work health care workforce with fewer new graduates entering this critical arena. Such studies continue to be meaningful but compound the challenges of maintaining a hospital presence for professional social workers. While the profession clearly acknowledges that the burgeoning social and health needs of the population are precisely matched by the unique expertise of social workers, neither new graduates nor hospitals see the opportunities.

The Society for Social Work Leadership in Health Care (SSWLHC) is another association with 1300 members that provides a forum to address many of the issues outlined throughout this discussion. Through research, education and political and legislative advocacy, SSWLHC confronts the concerns of practitioners and health care delivery systems. Hospital social work managers across the country are able to electronically pose questions to the entire SSWLHC membership and continually search for research and best practices to demonstrate practice effectiveness to organization administrators. The SSWLHC specifically focuses on the development of leaders who can strategically design and implement solutions to the challenges occurring in health care. The SSWLHC has a unique opportunity to bring a social work voice directly to hospitals as the association maintains an affiliation with the American Hospital Association. The research has to again accompany advocacy efforts specifically targeting hospital administrators.

Professional social work associations have an uphill battle incorporating research and marketing language into their advocacy efforts. Practitioners individually and collectively need to shift their own practice frameworks to envision opportunities instead of losses and to understand that changing the perceptions of decision makers, interdisciplinary colleagues and within the profession itself is necessary work. Adaptable and broadly defined practice

boundaries can be of tremendous benefit during chaotic times as long as professionally we are in control our professional practice.

The Role of Policy

What has been missing thus far from the discussion of hospital social work is perhaps the most troubling, the implications of current professional licensing and more broadly the absence of a social work specific standard within hospital accreditation processes. Both of these represent huge roadblocks towards supporting a meaningful professional social work presence within hospital settings. In terms of licensure, nationally there is no standard definition of social work, so the push to create professional titles for social work is strongly sought by professional advocacy groups and educational centers.

In New York State, education law was changed effective September 1, 2004 and the LMSW and LCSW professional titles were created (www.naswnys.org). Scopes of practice permitted within these two different licenses was outlined at that time. Only those licensed under the title of LCSW can independently provide "clinical social work services" that include diagnosis, psychotherapy and assessment based treatment planning. A practitioner with an LMSW title can provide clinical social work only if supervised by a LCSW. To qualify for advancement to LCSW practice a practitioner has to provide documentation of three years of both qualifying clinical experience and clinical supervision. Qualifying supervision has to be provided by someone with an LCSW title, a licensed psychologist or psychiatrist. Of significance to this discussion, professional experience within a hospital setting will not be considered by the New York State Department of Education as clinical experience for advancement to an LCSW title (www.naswnys.org).

As efforts to elevate the perceptions of social work within hospital settings continue, licensing distinctions, such as those described above create potential obstacles. It supports a dichotomy and hierarchy within the profession, implying that clinical social work is a more advanced level of social work. Those with LMSW titles in hospitals who incorporate clinical work in their practice are not recognized by their own licensing bodies. This additionally creates even more inter – and intra - professional ambiguity at a time when clarity and consensus is desperately needed for hospitals social work practice. By legislating that hospital social work cannot be considered experience worthy of the LCSW title, it becomes that much more difficult to alter perceptions and convince others that the social workers on their team have a unique professional expertise. To add to this confusion, social work managers at a number of hospitals within this study believed strongly that hospital social work practice is clinical and that having the LCSW title elevates the status of social work within the setting. These managers have committed their resources to provide individual and group clinical supervision to qualify for advancement to LCSW titles. Based on current Department of Education law, these workers will not be able to sit for the LCSW exam even after accumulating what they and their superiors believed was qualifying experience and supervision. This current reality has created new barriers for the future of hospital social work. Defining social work as a distinct and professional discipline in hospitals has become more difficult and convincing new MSW graduates to enter the field of hospital social work practice is unlikely without opportunities for advancing professional credentials.

The uphill battle for demonstrating the unique professional contribution of hospital social work continues to become steeper. At the state level, a tremendous effort was exerted to obtain licensed titles for social work practice. Amending Education Law at this time would present an almost impossible challenge for the profession. As research endeavors reveal a specific and meaningful contribution

of hospital social work to institutions, licensing bodies need to reconsider where such practice fits in along the spectrum of professional clinical interventions. As a profession, there needs to be a consensus as to how social work can best serve the growing health needs of the community. Social work understands what is needed, has documented gaps and disparities in services and has a unique professional framework that links social and health issues. As a profession, social work needs to ultimately determine what if any professional role it should have in hospitals and take back control of its practice definition. If the trend is to continue to fragment what social work does into tasks that others determine for social workers, then maybe the cost to a professional profile is too great. In fact, the Joint Commission does not specify that social work practice is needed at all in their standards for hospital accreditation; instead that professional discharge planning and professional counseling be provided without specifying a particular responsible discipline. Hospitals are encouraged to define their own strategies to meet the described standards of care (Joint Commission on Accreditation of Healthcare Organizations, 2000). If maintaining a hospital presence is a professional objective worth battling for, then it is up to the creation of a reliable data base of research to strategically demonstrate professional value within financially challenged institutions, and advocacy groups need to bring that message to decision makers and external licensing and accreditation bodies.

Lastly, social workers can look beyond the walls of hospital settings for professional niches that impact health care through the provision of direct care and/or policy change. For example, strategically targeting outpatient and community clinics, social work interventions can be expanded to proactively address social determinants of health over a longer timeframe than what would be possible in contracted inpatient stays. Interventions and programs could be developed and implemented to keep individuals out of hospitals and maintained in the community. Legislative action to mandate programs such as Medicare,

Medicaid and third party payers, increase fee-for-service reimbursements for ongoing social work services in community settings should be advocacy targets. Through the development of continuum of care strategies with attached reimbursement streams, patients can be followed once in the hospital, to ease and potentially expedite discharges. Reimbursement to fund social work expert interventions as consultants within hospitals might be a viable strategy to remain in the inpatient setting, acknowledging their unique expertise working with the most challenging cases. This might be most useful in smaller hospitals where social work professional staff is reportedly being lost to a greater degree (Holliman, et al., 2003).

Summary

The literature, including the findings of this current study is replete with examples of the changes in social work services within hospitals, how reporting structures have changed and how individual social workers are impacted. However, few strategies to regain control of our professional practice are offered. Practice models that are emerging within hospitals such as case management teams can be a viable professional role; however, it is critical as to who is at the decision making level when these models are designed. It is equally critical that research on the efficacy of alternative models for case management and discharge planning be supported. This study would indicate that in many settings, social workers and case managers work side by side but not as a professional dyad that might enhance outcomes. Such relationships are not always thoughtfully created or nurtured. Their success is dependent on each discipline having a clear and respectful understanding of what each brings to the process. To return to a quote

from Brian, the challenge facing hospital social work is most honestly and objectively stated.

> We do help the hospital in terms of its mission statement and providing the services it intends to. But I'm also really cynical in that I think that the reason we're really here and have a role is because we serve the financial benefit of the place as well. And so, as long as we're serving that, I think we're, "in." If there are other ways the hospital could do that with less cost, my guess is that we wouldn't be here.

Brian has worked for Hospital A for almost 13 years, a hospital in which social work is strongly established, visible and valued. Yet his awareness that at any moment, social work can vanish from the setting is the most telling. Clarity of what professional social work is and what its value can be within the hospital setting has to be the building blocks of any discussion of a meaningful and sustaining future for hospital social work.

Recommendations for Future Research

The results and conclusions of this current study suggest additional areas for future research. The perspectives of social workers from a broader geographical area should be considered since rural settings and states with different licensing policies would add to the presentation of professional social work in hospitals. Similarly, more creative recruitment strategies to engage the participation of social workers in decentralized structures needs to be implemented so these voices are not lost to analysis. Research designs that include a follow-up interview to clarify perspectives or questions provided in advance of interviews would allow for more thoughtful responses that might add depth to these finding.

A quantitative design with a probability sample would increase the validity of the findings and allow the themes to be analyzed more objectively. A survey

instrument that expands on the findings in this study can be used to further explore the roles of hospital social workers and document the variety of practice models that might exist across a larger and more diverse sample. A national sample can be obtained from the National Association of Social Workers where a data base of social workers self identifying as hospital employees can be sorted for and randomized for a large scale mailing. Findings from an objective quantitative study with a broader reach would be more generalizable.

The diversity of social work practice found suggests a number of future research avenues. As restructuring and role reassignments result in alternative discharge planning models, a particular emphasis for future research is evidence-based studies. This would provide a framework for identifying the efficacy of different discharge planning strategies. For example, from the participants in this study, discharges often seem disjointed and can involve different disciplines at a given time. A closer look at how interdisciplinary discharge planning teams functions through the perceptions of physicians, case managers, social workers, patients and families would expand on the findings of this study and provide insight into the efficacy of the process. How communication flows and who is identified as responsible for implementing the plan can become fragmented, be confusing and may actually slow the process.

A challenge to be considered when designing research on efficacy was illustrated in a recent study by Auerbach et al., (2007). These authors looked for evidence of social work value by retrospectively examining 64,722 discharges from medical-surgical units of one hospital from 2002 to 2004. Discharges involving social work interventions were compared to discharges without social work services. The mean length of stay with social work involvement was 11.4 days, significantly longer than the mean length of stay of 4.2 days for patients not seen by social workers. This finding was attributed to the older and more complex patients selectively referred to social work, a reality seen in the current study with

respondents asked to intervene with the most difficult cases. Factors anticipated to prolong discharges could be developed into acuity scales to account for this reality in any comparative research design efforts. Auerbach et al. (2007) additionally proposed the creation of a data tracking infrastructure that would more precisely capture the day to day activities of hospital social workers to allow outcome comparisons.

A number of additional research studies have been suggested through the data analysis process. A closer look at how restructuring transitions of social work services were implemented might provide insight into how social work roles were defined or reassigned and how relationships between disciplines were fostered. The vulnerability and competitiveness that emerged from this current study could be better understood if research focused specifically on the transitioning events. Managers and staff, social workers and non-social workers who have experienced such transitions would be interviewed.

As restructuring has occurred, participants in this study reported a loss of professional supervision as well as a loss of seasoned social work colleagues to turn to for guidance. Research specifically focused on how new social workers are socialized into the profession in the absence of more senior peers and with non-social work directors would expand on the current study's discussion of professional identity formation. New workers from restructured departments were not sufficiently represented in the sample to explore.

Customers can have a powerful voice within organizations and social workers need to determine what is of value to these and other stakeholders. In addition to discharge planning, social work interventions that are not as tangible, such as the provision of emotional support, education and advocacy need to be converted to measurable functions that can be assessed and promoted for effectiveness related to organizational goals. For example, a patient that feels he or she has an advocate within the organization might be more accepting of a discharge plan.

Similarly, studies should be designed that capture what hospital administrators value and how they see the future contributions of professional social work. Such data can then inform how studies of social work practice should be framed.

It is the communication using research derived data of how professional social work uniquely benefits the organization through cost containment and customer retention that determines if social work continues as an invited guest of the setting. The final caveat to this discussion is that studying the effectiveness of social work practice alone is not sufficient to maintain a professionally meaningful role. The profession itself has to agree on, promote and control the parameters that define professional social work practice in hospitals for all stakeholders including social workers themselves.

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APPENDIX A: CORHIS Approval

STONY
BROOK
STATE UNIVERSITY OF NEW YORK

TO: Candyce   Berger   *Abdul Samad*   *Office of the Vice President for Research*
Research Compliance

FROM: **Office of Research Compliance**

SUBJECT: **Approval for Research Involving Human Subjects**

DATE: **1/9/2007**

The project referenced below was reviewed by the Committee on Research Involving Human Subjects (FWA#00000125) and approved for exempt status on **1/5/2007**   . Attached is a copy of the approved consent form and the human subjects application with the endorsement of CORIHS and the Institution.

THIS APPROVAL IS VALID AS LONG AS THE PROJECT CONTINUES AS STATED IN THE ORIGINAL PROPOSAL.

PLEASE NOTE THAT CHANGES OF ANY KIND MUST NOT BE IMPLEMENTED UNTIL FIRST REVIEWED AND APPROVED BY CORIHS.

PLEASE NOTE:
1. Study qualifies for a waiver of documentation of consent.
2. Project qualified for exemption status under 45 CFR 46.101b.2.

This approval is subject to recall if at anytime the conditions and requirements of the CORIHS are not met. This is for the protection of all parties: the subjects, the investigators, the University and CORIHS.

If this research involves the use of University Hospital patients, facilities or services, it is your responsibility to obtain UHRC approval from Dr. William Greene prior to initiating your research activities.

Description of Study:

Project ID: 20066478

Project Title: The Influence of Organizational Structure and Change on Clinical Social Work Practice in Hospitals

Call for Research Study Volunteers

Help us better understand hospital social work practice and professional development within a changing health care environment.

Your contributions to the social work profession have great value.

To be included, the following criteria must be met:
Be employed by a hospital
Hold MSW degree
Have no supervisory responsibilities
Willing to participate in one brief, fully anonymous
interview, scheduled at your convenience

Interested? For more information, please contact:

Shelley A. Fleit, LCSW
Stony Brook University
(631)689-9480
safleit@aol.com

MEDICAL SOCIAL WORKERS NEEDED FOR RESEARCH STUDY
Consider volunteering if you:
- Work in hospital setting <u>but are not</u> part of social work department
- Hold MSW degree
- Willing to commit to one fully anonymous interview

For more info:
Contact**: Shelley A. Fleit, LCSW at (631)689-9480/safleit@aol.com**

<u>APPENDIX D</u>: Consent Form

Stony Brook University
Health Sciences Center

School of Social Welfare

CONSENT FORM

Investigators: Candyce S. Berger, Ph.D, Shelley A Fleit, LCSW

Project Title: The influence of organizational structure and change on clinical social work practice in hospitals.

You are being asked to volunteer in a study.

Purpose: The purpose of this study is to explore what impact if any current hospital structures may have on clinical social work practice and professional identity.

Procedures: If you decide to be part of this study, your participation will involve one interview, face-to-face, or by telephone if necessary, lasting no more than 1 hour. Forty-five volunteers from different hospital settings will comprise the study sample.

During the interview you will be asked a series of broad questions relating to your professional roles, relationships and experiences as a professional social worker in a hospital setting. Responses are voluntary, and while your fullest participation is hoped for, you are not required to answer any questions that you choose not to. The interview will be audiotaped; all identifying information (e.g., your name, name of hospital) will be replaced with a fictitious name. Once the tape is transcribed and checked for accuracy, it will be destroyed.

Risks/Discomforts: There should not be any risk or discomfort from participation in this study.

Benefits: There is no direct benefit to you from participation in this study. However, the information you share will contribute to the field of social work research regarding professional practice.

Payments to you: You will not receive payment for your participation in this study.

Confidentiality: The following procedures will be followed in this study to keep your personal information and identity confidential. You will be provided a code name prior to the interview taping. The audiotape will be transcribed using only the assigned code name. Any identifying information regarding your identity or your place of employment will be replaced with your assigned fictitious name. Once the transcript is checked for accuracy, the audiotape will be destroyed. There will be no way to link your name to any specific transcript. Audiotapes will be kept in a secured location with access limited to the research team. There is no identifying information is recorded, even temporarily, for research purposes.

Stony Brook, NY 11794-8231
Tel: (631) 444-2138

STONY
BROOK
STATE UNIVERSITY OF NEW YORK

IRB Approved: 1/5/07
Expiration Date: EXEMPT
CORIHS, SUNY Stony Brook

To ensure that this research activity is being conducted properly, Stony Brook University's Committee on Research Involving Human Subjects has the right to review study records, but confidentiality will be maintained as allowed by law.

Subject's Rights:

- Your participation in this study is voluntary. You do not have to be in this study if you do not want to.
- You have the right to change your mind and withdraw your participation at any time without giving any reason and without penalty.
- Any new information that may change your mind about being in this study will be given to you.
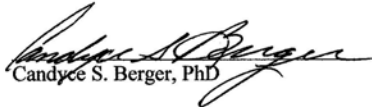- You will receive a copy of this consent form to keep.

Questions about the Study or your Rights as a Research Subject:

- If you have any questions about this study, you may contact Dr. Candyce Berger at (631) 444-6909
- If you have any questions about your rights as a research subject, you may contact Ms. Judy Matuk, Committee on Research Involving Human Subjects at (631) 632-9036.

If you wish to participate:

If you would like to participate in this research project, please contract either Shelley Fleit at 631-689-9480 or Dr. Candyce Berger at 631-444-6909 to schedule an interview. The time and place of the interview will be at your convenience.

If you contact us to schedule the interview, it means that you have read (or have had read to you) the information contained in this letter, and would like to be a volunteer in this research study.

Candyce S. Berger, PhD

Shelley A. Fleit, LCSW

<u>APPENDIX E</u>: Interview Guide

<u>**Interview Guide**</u> (note: * indicates a probe)

Demographic Data

1. When did you obtain your MSW? ____ (year)

2. Was your degree from an accredited school?

   Yes ___ No ___ Don't Know ___

3. Did your studies involve a health specialization? Yes ___ No ___

   If not, did you have a field placement in a health setting? Yes __No__

4. How many years post MSW have been in health settings? ____(years)

5. How long have you been working at this hospital? ____ (years)

   Name of hospital – to be coded for study based on organizational

   structure 1 __ 2 __ 3 __

6. Have you worked in other settings as a professional social worker?

   Yes ___ No ___

      If "Yes", what kinds of settings?

7. Do you report directly to a social worker? Yes ___ No ___

   If not, what is the professional background of your supervisor?

8. Though content of supervision changes, on average, what percentage

   of time is devoted to   _____ % clinical issues

                                _____ % administrative issues

                                _____ % other issues (please describe

<u>Current Hospital Experience</u>

(Note: an * indicates a probe)

What is a typical day like for you? (Tell me about your primary responsibilities in setting.)

* In general, how would you characterize your experience of your day (positive/negative/neutral).

In your work setting, how is what you do different or similar to other professionals?

* How would other professionals describe what you do – in relation to other professionals in setting? For example, are there certain tasks other professionals may specifically ask you to be involved in or assist with?

* Discuss instances in which you have been asked to do something that you felt was not consistent with your view or understanding of your roles and responsibilities?

<u>Organizational/Administrative Structures</u>

Tell me about your administrative structure:

* Do you work as part of a centralized department; one merged with other professionals, are you decentralized, other configuration?

Describe what the structure and significance of supervision is for you and others in this setting; individual, group, formalized peer consultation; length and frequency?

* If you are provided with formal supervision, what would you consider is the most significant aspect or function of supervision for you?

* What is the significance/value if any of informal or "hallway" consultations that may occur throughout your day with colleagues?

    *   What challenges/problems, if any, do you see in the present structure for clinical supervision?

What might be some examples of how your organizational/administrative structure affects your work; how decisions are made regarding your roles and responsibilities.

    *   What if anything would you change in your organization to enhance your work/professional experience?

Professional Identity/Socialization

During your work day, describe any professional interactions

    *   With other social workers? Context – formal/informal?

    *   What other professionals in your setting do you feel you interact with the most? How would you describe these relationships?

Professional development can occur in a number of ways. How would you rate the contribution of each of the following mechanisms using a scale from 1 to 5; 5 indicating a most significant impact, 1 indicating no impact on your professional development:

Professional education

Professional supervision at your current job

Professional supervision at previous jobs

Peer interactions

Personal efforts at professional growth (continuing education, conferences, journals, etc.)

Membership in professional organizations

Accumulated knowledge gained through day to day practice exposure or experiences

Additional Comments

What do you see as the future, in general, of hospital social work?

     * What do you think is the greatest contribution hospital social workers currently make to your institution; or could make, if things were different…what things?

     9. Are there any additional comments you would like to make about your role as a hospital social worker?

Social Work Definition

To bring this discussion full circle, how would you define medical social work, in general, to non-social workers?

Conclusion

Do you have any additional comments, including your experience of this interview, that you would like to add at this time?

APPENDIX F: Code List

Code	All Coded Segments
control of role	10
"case management"	64
"indescribable descriptions"	20
autonomy	11
cases	28
characterization of day	44
what contributes to day	57
colleagues	100
dichotomy within profession	48
descriptive words	37
discharge planning	79
definition of profession -self	135
expectations	74
fragmentation of professional role	30
future of social work	48
hidden complexities	4
licensing	8
need to educate	41
organizational structure	84
perspectives of others about social work	122
preparedness	10
public view of social work	9
relationships with others	48
role overlap	70
roles and responsibilities	177
social work leadership	62
supervision	251

Code	All Coded Segments
survival	12
time	48
transitions	28
unique skills and focus	9
unique skills/focus	61
value - organization	114
value - self	118