# The (Inter)Professional Identity of Hospital Social Workers: Integration and Operationalization of Profession-Specific Knowledge, Skills, and Values with Boundary-Spanning Competencies

Tracy N. Brazg

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Reading Committee:

Paula Nurius, Chair

Kevin Haggerty

Brenda Zierler

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**University of Washington**

**Abstract**

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Tracy N. Brazg

Chair of the Supervisory Committee:

Paula Nurius, Professor

School of Social Work

**Purpose**: This dissertation examines the professional identity narratives of hospital social workers in a way that is conceptually grounded and relevant to efforts to engage with interprofessional collaborative practice. Although significant literature exists to describe the roles and contributions of hospital social workers, less is known about their perceptions of their professional identity as it relates to their efforts to collaborate with interprofessional healthcare teams. This study helps to fill that gap by analyzing interviews conducted with hospital social workers.

**Methods**: Data include interviews (n=20) with Masters in Social Work-trained hospital social workers from three large university-affiliated hospitals in the Pacific Northwest region of the United States. Interviews were conducted in the summer of 2012 as part of the University of

Washington TL1 Translational Research Training Program. Data were analyzed using the qualitative method of interpretive thematic analysis.

**Results**: Three analyses were conducted in this study. First, was the examination of the unique elements of professional social work identity (knowledge, skills and values). This analysis yielded three themes: 1) Social Workers as "*Bigger Picture People*", 2) Soft Skills Pervade, and 3) The Influential Code of Ethics. Second, was the examination of boundary spanning competencies required for effective collaboration. This analysis yielded four themes: 1) Collaborative Spirits, 2) Cross-Profession Synthesizers, 3) Boundary-Spanning Communicators, and 4) Owners of Practice Domains. Third, was the examination of social workers' experiences working on interprofessional teams. This analysis demonstrated that facilitators and barriers to collaboration are impacted by variables across multiple levels. Five themes emerged: 1) Social Workers' Confidence, 2) Role Ambiguity, 3) Time for Collaboration, 4) Institutional Support, and 5) Hierarchy and Power. Together, the analyses present a depiction of the "dual identity" or "interprofessional identity" of hospital social workers, and their experiences operationalizing this identity in their practice settings.

**Discussion and Implications:** Findings from this study demonstrate strengths and possible areas of weaknesses related to the professional grounding and boundary-spanning capacities of hospital social workers. Several social workers were able to articulate a strong sense of what it means to "belong" to the profession, but at the same time social workers described challenges with their professional identities. Most provided positive reports related to their ability to work alongside their team members and effectively collaborate. However, some provided examples of feeling misunderstood, under-utilized, or unappreciated by other health care professions. Role

ambiguity and overlap were commonly cited barriers to collaboration. Findings have implications for social work education and research priorities.

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## Acronyms

IPCP: Interprofessional Collaborative Practice

IPE: Interprofessional Education

IPEC: Interprofessional Education Collaborative

MGH: Massachusetts General Hospital

MSW: Masters in Social Work

SW: Social Worker

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# CHAPTER 1: INTRODUCTION

This dissertation examines the professional identity narratives of hospital social workers in a way that is conceptually grounded and relevant to efforts to engage with interprofessional collaborative practice (IPCP). The study analyzes interviews that were conducted in 2012 with 20 Masters in Social Work (MSW)-trained hospital social workers from three large university-affiliated hospitals in the Pacific Northwest region of the United States.

## Social Work and the Emergence of the Healthcare Team

Social work in healthcare can trace its origin more than a century back in the United States, to the vision and partnership of Dr. Richard Cabot, a physician at Massachusetts General Hospital (MGH), and Ida Cannon, who was first trained as a nurse and is considered the founding matriarch of medical social work. The birth of hospital social work as a specialty that was intended to be distinct from yet complementary to nursing or medicine, resulted in a significant paradigm shift within healthcare—one that broadened a narrow focus on disease, to an approach that recognized the relationship between illness and patients' personal, familial and social circumstances.

The shift also had significant implications for what constituted a healthcare team. To this end, one of the first publications in the United States to introduce the concept of teamwork in healthcare was authored by Dr. Cabot alongside the emergence of medical social work at MGH. His seminal book, *Social Service and the* Art of *Healing*, Cabot argued for teamwork as a means through which to improve the practice of medicine (Cabot, 1909). He called for "respectful collaboration" between the physician and the social worker; between the physician, the educator, the psychologist, the minister and the philanthropist; and between the physician and the patient (Cabot, 1909).

Along with drawing attention to the need for multiple professions on the healthcare team, the birth of medical social work highlighted the importance of incorporating patient's broader life circumstances into clinical care. In a 1930 address, Ida Cannon remarked on the unique contribution of social workers in approaching patient care in this way: "The medical social service movement recognizes that there should be within the hospital…someone definitely assigned to represent the patient's point of view…and to work out with the physician, an adaptation of the medical treatment in the light of the patient's social condition" (NASW, 2004). Thus, the birth of social work may also signify the emergence of a patient-centered approach to care, a concept that has gained increased prominence since the turn of the century (IOM, 2001).

**Challenges Confronted by Social Work in Hospital Settings**

For the first several decades, hospital social work was generally met with acceptance of its unique and valuable contributions to caring for patients. The period from 1905-1930s has been described as a period of significant growth for the profession, in which the number of social service departments in hospitals increased steadily across the United States and their claim over social and mental health domains were mostly unimpeded by other disciplines (Gehlert & Browne, 2012). A team-based approach that included social workers was formally established to care for the "whole person", social workers were authorized to include social summaries in medical records, and team conferences were established so that professionals could engage in joint planning on behalf of patients (Bartlett, 1975).

Toward the middle of the 20th century, at least two significant factors began to challenge hospital social workers' contributions to healthcare delivery, and the integrated and collaborative vision set forth by Cannon and Cabot. First, other professionals entered the medical sphere (e.g., psychologists and other social scientists), and social workers began to compete for roles (Gehlert

& Browne, 2012). Second, healthcare system reforms began to focus on cost and the rationing of healthcare resources, and changes in payment structures within healthcare organizations limited funding for attention to the psychosocial elements of disease—this limited social workers' ability to contribute their professional expertise (Gehlert & Browne, 2012). Many hospital social workers were relegated to practicing with an overly narrow emphasis on discharge planning, which they felt discredited the knowledge of how to contribute skillfully to the biopsychosocial model of care (Zimmerman & Dabelko, 2007). In some cases, payment structures and reimbursement policies have affected hospital social workers by replacing them with lower-paid "discharge planners" or "care coordinators" (Long & Heydt, 2000), which suggests the vulnerable nature of the professions from the perspective of healthcare systems and an associated diminishing of professional status.

**Social Work's Professional Closure Project**

In response to such circumstances, social work implemented its "professional closure project"—a concept described as a profession's effort to ensure exclusive ownership of specific skill and knowledge areas, for the sake of effectively securing economic reward and status (Abbott, 1988, 1995; Freidson, 1970; Witz, 1990). To this end, social work professional identity scripts have, in many ways, become incompatible with the ideas that are central to collaboration and integration. Despite the reality that social workers almost always work alongside other professions, the social work profession has been described as claiming and maintaining jurisdiction of practice *in competition with other professions* (Abbott, 1995; Olson, 2007). Most well-known for this theory of social work professional identity is Abbot (1995), who argues that social work is not shaped by an inner function or purpose of transcending interprofessional spaces. Instead, he explains that the profession is shaped by conflicts or boundaries.

Stringent boundaries around social work, in interprofessional settings such as healthcare, are problematic for at least two reasons. First, boundaries in healthcare become a point of conflict and an inhibitor to collaboration because they result in groups competing to assert knowledge claims and value in interprofessional spaces (Abbott, 1995; Cameron, 2011; Evetts, 1999; Hall, Weaver, & Grassau, 2013; Michalec & Hafferty, 2015; Oliver, 2013; Reeves, MacMillan, & Van Soeren, 2010). Second, boundaries are often defined and controlled by more powerful occupational groups, which is indicated by a strategy of demarcation that allows boundaries drawn by dominant groups to result in their maintaining advantage over subordinate ones (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Witz, 1990). For example, historically medicine has played a central role in defining areas of competence for professions referred to as 'caring professions' (Baker et al., 2011). Social workers' roles have been defined by their interactions with other professionals (Bywaters, 1986), which often results in discrepancy between self-described roles and contributions and those assigned by other professions on the team (Craig & Muskat, 2013). Due to professional boundary maintenance and existing hierarchical structures, the undermining of social workers' roles has been legitimized by medical profession's dominance (Davidson, 1990 as cited in Craig et al., 2013). In response, 'caring professions' engage in a dual closure strategy of usurpation, as a way to resist and challenge the dominance of other professions, and exclusion strategies to protect and demarcate boundaries of their work and relative rank on the healthcare team (Baker et al., 2011; Witz, 1990). Through a lens that is attuned to the implications of power on healthcare teams, impenetrable boundaries likely do not serve the profession's effort to ensure status and reward on the interprofessional healthcare team.

**The Need to Critically Re-Examine Professional Identity Narratives**

In the face of challenges confronting social workers trying to integrate in interprofessional settings, it is important for the profession to critically examine the construction of its professional identity, especially in healthcare settings. The profession has "identity branding work to do" (Nurius, 2017), which includes a twofold process of sharpening its appeal or "brand" and taking initiative to equip itself for collaborative work (Nurius, 2017). Oliver (2013) provides a path forward for the *interprofessional* identity formation of social workers across fields of practice. She re-focuses the discussion of social work professional identity on "boundary spanning" as an integral and valuable attribute of the profession, and an important element of interprofessional collaboration. "Boundary spanning" is a term that emerged in the organizational literature of the 1970s, to describe people who work in ways that cross organizational boundaries and/or service sectors, and who mediate between their organization and the wider environment (Alrdich & Herker, 1977; Oliver, 2013). Key to the boundary-spanning approach is the ability to operate competently in different contexts, and with a variety of partners with whom a person does not share a professional identity (Oliver, 2013).

Leaders in the field of social work education have proposed training approaches that support discipline-specific preparation, while integrating meta competencies to foster integration and collaboration (Mor Barak & Brekke, 2014; Nurius, 2017; Nurius, Coffey, Fong, Korr, & McRoy, 2017). Such ideas suggest an important shift in the professional identity narratives of social work, however, little empirical work exists to examine social workers' identities in these terms, especially surrounding IPCP in healthcare settings. This dissertation will examine the professional identity scripts of 20 hospital social workers with an eye to "boundary spanning" as a component of professional socialization, and will make the argument that an "interprofessional

identity" is preferable and will add value to the profession's efforts to demarcate a respected and impactful space in healthcare.

**Contributions to the Literature on Social Workers and Teamwork**

In her foundational text, social welfare scholar Annie Opie (2000) describes two key problems with existing investigations of teamwork in healthcare. First, she points out that much of the writing is focused on the performance of specific professions in a team context. In other words, she claims, "the argument is about claiming turf and enhancing the visibility and power of specific disciplines" (Opie, 2000, p. 37). This is certainly the case in the social work literature, which is full of examples of studies and discussion pieces aiming to "make a case" for the social work profession in the healthcare sphere (Brazg, Dotolo, & Blacksher, 2015; Itzhaky & Zanbar, 2014; Judd & Sheffield, 2010; Kitchen & Brook, 2005; Megan Moore et al., 2016; Shanske, Arnold, Carvalho, & Rein, 2012). Efforts to enhance visibility and power, without attention to the nuanced factors influencing teamwork at multiple levels, is problematic because it inscribes a generalized, but slightly superior professional body that suppresses difference between professions that are worthy of investigation (Opie, 2000). By paying attention to the profession-specific and boundary-spanning capacities of hospital social workers, this dissertation aims to provide a more robust and nuanced description of how social workers operate and contribute to the delivery of healthcare and the function of interprofessional collaborative teams. A second critique posed by Opie, and addressed in this dissertation, is that existing examinations of teamwork rely on the creation of a dichotomy between the ideal and the real; and that such a dichotomy suppresses how the actual production of teamwork is the result of institutional, organizational, and professional discourses that are specific to particular sites. This dissertation

examines the multiple and multi-level factors that influence social workers' experiences and ability to integrate their knowledge with other professionals.

**A Word on Other Professions**

This dissertation aims to unpack and examine the experience and perceptions of 20 hospital social workers, as related to their profession-specific roles and contributions, their ability to address competencies related to collaboration, and their experience working on interprofessional teams. While analysis and discussion focus on the profession of social work, many of the observations about how social workers act and react in interprofessional spaces is likely relevant and similar across multiple professions.

The need for interprofessional education (IPE) emerged in part because there was a realization that health care professionals could not effectively collaborate without better understanding each other's roles and responsibilities. Therefore, social workers' experiences of being misunderstood by other professionals is likely not unique to the social work profession.

Each health discipline has evolved under their own and society's historic forces and sociological processes; each has struggled to define its identity, values, spheres of practice and roles in patient care (Hall, 2005). For example, a recently published qualitative study by Joynes (2018) found that many professionals struggle to develop and assert a strong professional identity, especially as it relates to their work and confidence in interprofessional settings. Based on results from interviews with 33 health care providers from 12 professions, Joynes claims that across health professions, the most experienced clinicians were more confident in their professional identities, and that respondents from various professions closed boundaries around themselves, by claiming ownership over territories of practice or making negative comments about other professions (Joynes, 2018). Another qualitative study by Suter and colleagues

(2009), interviewed 60 health care providers from different professions, and suggested that many health professions are cognizant of their lack of understanding of other profession's roles. While other professions may be grappling with similar issues related to professional identity formation and the ability to effectively collaborate with teams, this study aims to better understand social worker's perspectives and experiences, specifically. Future research is needed to be able to better understand the perceptions and experiences of multiple health care professionals, and how their professional identities manifest and influence IPCP.

# CHAPTER 2

## CONCEPTUAL FRAMING

This chapter describes the empirical and conceptual foundation for this dissertation. Included is a brief clarification of concepts as they relate to teams, collaboration, and description of two conceptual frameworks that guide analyses in this dissertation.

### Multi-, Inter-, and Trans- Disciplinary: A clarification of terms

With a growing complexity of today's health and social problems, comes an increased need for teams of multiple professionals to join forces, share knowledge, and collaborate. The terms, 'multidisciplinary', 'interdisciplinary' and 'transdisciplinary' are used to describe this effort of coming together, and characterize a progression of increasing disciplinary integration (Nurius, Kemp, Kongeter, & Gehlert, 2017). While the terms are often interchanged, they maintain specific meanings that impact the *process* and *outcomes* of collaboration (Mitchell, 2005). Clarifying terms is important in any examination of cross-disciplinary collaboration. Table 1 provides basic definitions for each of these terms, along with specific examples of how they manifest in clinical healthcare settings, such as the ones investigated in this dissertation.

**Table 1.**

*Multidisciplinary, Interdisciplinary, and Transdisciplinary Definitions*

| **Term** | **Definition** (Rosenfeld, 1992) | **Example in Clinical Practice** |
|---|---|---|
| Multidisciplinary | Professionals **work in parallel** or sequentially from **disciplinary-specific bases** to address common problems | An outpatient primary care setting where professionals operate independently, meeting seldom, if ever, to coordinate care or make decisions. |
| Interdisciplinary | Professionals **work jointly**, in an integrated fashion, but from **disciplinary-specific agendas** to address common problems. | The interdisciplinary care conference in an inpatient hospital setting, in which multiple professionals gather, sometimes alongside the patient/family, to discuss care and engage in shared decision-making. |
| Transdisciplinary | Professionals **work jointly,** in an innovative and generative fashion, using a **shared conceptual framework** that draws together concepts, theories, and practical approaches from the parent disciplines. | A less well-articulated concept in clinical practice of medicine, though could be applicable to practice areas such as hospice, bioethics and palliative care, in which professionals from multiple disciplines, are trained together and practice using a shared conceptual framework. |

Within the landscape of collaborative healthcare, the terms "multidisciplinary care" and "interdisciplinary care" have been replaced by the term interprofessional collaborative practice (IPCP) or interprofessional education (IPE) (Nester, 2016). The suffix of "-disciplinary" has been replaced with "–professional", for the sake of clarity. For example, in fields like medicine, there may be multiple within one profession (e.g., family medicine, internal medicine, psychiatry) (Burditt, 2006). Adopting the suffix "professional" clarifies the intent of IPE and IPCP—to include different health professionals (Oandasan & Reeves, 2005). The prefix "inter" is preferred over "multi", with recognition that "inter" implies a partnership where members from diverse domains work collaboratively toward a common goal (Oandasan & Reeves, 2005).

The concept of trans-professionalism/ transdisciplinarity has not been well explored in the IPE/IPCP literature to date.

**Interprofessional Dual Identity Formation**

This dissertation aims to qualitatively analyze the professional identity narratives of 20 hospital social workers in a way that is conceptually grounded and relevant to efforts to engage in IPCP. Improved interprofessional collaboration calls for re-examination of the socialization and identity formation of healthcare professionals that are often rooted in identity politics of exclusion, resistance and professional closure that impede efforts to work together (Abbott, 1995; Payne, 2006; Witz, 1990). A proposed approach to countering the silos inherent to professional identity formation is to train and develop team members' interprofessional identities alongside efforts to train and develop their uni-professional identities. Khalili and colleagues (2013) refer to this as a dual identity formation, which results from a process of socialization that integrates interprofessional values, beliefs, behaviors, knowledge and skills with an individual's professional identity scripts. *Dual identity formation encourages developing a sense of belonging to one's own profession, as well as an interprofessional team or community*. A proposed three part interprofessional socialization process includes: 1) breaking down barriers to a collaborative perspective, such as myths and misperceptions, 2) providing interprofessional role and skill learning that incorporates the norms, values and behaviors necessary for collaboration, and 3) supporting dual identity development (Khalili, Orchard, Spence Laschinger, & Farah, 2013).

A critique of the concept of dual identity is that Khalili and colleagues do not provide compelling suggestions for "How?" or "Why?" trainees or professionals would gravitate toward an interprofessional identity (Michalec & Hafferty, 2015). Such critique suggests the need for a more robust articulation of the process and outcome of professionals developing a dual identity.

This dissertation aims to layer on relevant conceptual frameworks to examine the interprofessional identity of hospital social workers, with the intention of providing a more robust description of "how?" and "why?" this kind of identity formation is preferable. Framing of research questions and analysis of qualitative data are guided by the integration of two conceptual frameworks.

1) *T-Shaped Training Approach* (Donofrio, Sophrer, & Zadeh, 2010; Nurius, 2017; Nurius, Coffey, et al., 2017; Nurius & Kemp, 2018; Nurius, Kemp, et al., 2017; Uhlenbrook & DeJong, 2012)

2) *Professional Capital* (Beddoe, 2011).

**Description of Guiding Conceptual Frameworks**

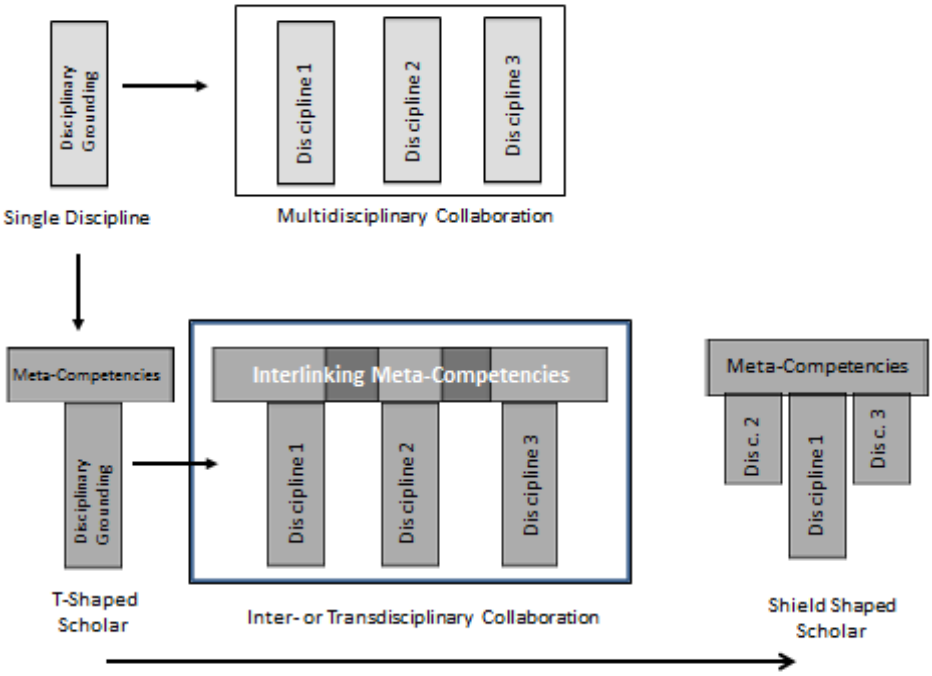
Competency-based education is an outcomes-oriented approach to curriculum design that has been adopted in social work (CSWE, 2015), as well as within the landscape of IPE (IPEC, 2016). Competency-based education is aimed at ensuring students are able to demonstrate the integration and application of competencies in practice (CSWE, 2015). Competencies are defined as broad, general abilities that go beyond knowledge acquisition and include the use of clinical, technical, and communication and problem solving skills (Norman, 1985). Training around competencies provides a foundation for the "How?" of interprofessional socialization.

The T-Shaped framework is a competency-based training approach that allows for focus and integration of both professional identity and depth (the vertical trunk of the "T"), and development of specific knowledge and skills necessary to engage in boundary-spanning interprofessional collaboration (the horizontal bar of the "T") (See Figure 1). In essence, providing a training approach to honing both components of an "interprofessional identity". "Boundary spanning" is a term that emerged in the organizational literature of the 1970s, to

describe people who work in ways that cross organizational boundaries and/or service sectors, and who mediate between their organization and the wider environment (Aldrich & Herker, 1977 as cited in Oliver, 2013). Key to the boundary-spanning approach is the ability to operate competently in different contexts, and with a variety of partners with whom a person does not share a professional identity (Megan Moore et al., 2017; Oliver, 2013). The concept of the T-Shaped professional originated in the field of engineering (Oskam, 2009), and has more recently been discussed in the context of team science and preparing social work scholars for collaboration in research (Nurius, 2017; Nurius, Coffey, et al., 2017; Nurius, Kemp, et al., 2017). This study is the first to apply this framework to social work practice in clinical settings.

**Figure 1.** "I", "T", and Shield Shaped Readiness for Cross-Disciplinary Collaborations

(Nurius & Kemp, 2018)




Within the context of inter- and transdisciplinary collaboration, Nurius and Kemp (in press) have outlined specific boundary spanning competencies that describe the skills needed to work

deliberately and effectively across professional boundaries. Competencies are described as falling under four domains: values/attitudes, and beliefs; knowledge-based competencies; interpersonal competencies; and habits of mind. Proposed as a useful strategy for preparing emerging social work scholars, the concept of the T-Shaped professional arose from, and is relevant in more applied settings such as healthcare delivery (Donofrio et al., 2010).

The T-Shape framework is not referred to in the literature on IPCP and teamwork, despite the fact that a number of competencies are referenced as necessary for effective collaboration in healthcare environments (e.g., IPEC, 2016; Canadian Health Services Research Foundation, University of Toronto, 2006; University of Minnesota, 1996). I have chosen to analyze social workers' readiness for collaboration using the T-Shape framework as a conceptual guide. There is a close proximity of this framework to the most commonly referred to IPE competency-based approach: the Interprofessional Education Collaborative (IPEC) Core Competencies for IPCP (IPEC, 2016). The IPEC Core Competencies were published by an interprofessional group of health professionals in 2011, for the purpose of preparing students to demonstrate IPCP. These core competencies are used to guide IPE curriculum design and implementation that engages students of different professions in learning actively with one another (IPEC, 2016). There are four competency domains, each with a number of relevant sub competencies: 1) Values/Ethics for Interprofessional Practice, 2) Roles/Responsibilities, 3) Interprofessional Communication, and 4) Teams and Teamwork (relationship-building and team dynamics) (See Table 2; visit: https://www.ipecollaborative.org/resources.html for full list of competencies and sub competencies)

When examining interprofessional socialization and identity formation, the T-Shape model expands on the IPEC competencies in two ways: first, through the attunement and integration of

uni-professional skills, knowledge and competencies with those needed for collaboration (allowing examination of the "dual" or "interprofessional" identity); and second, through the explicit calling out of "habits of mind" competencies, none of which are referred to in the IPEC Core Competencies. The habits of mind include necessary qualities or character traits that ought to be developed in training of healthcare professionals: curiosity and open-mindedness, non-defensive reflectiveness, critical thinking, and developing confidence (See Table 2).

**Table 2.** *Boundary-Spanning Competencies for Cross-Disciplinary Collaboration* (adapted from Nurius & Kemp, 2018; IPEC, 2016)

| **T-Shape Boundary Spanning Competency Domain** | **Boundary Spanning Competencies** | **Corresponding IPEC Competency Domains** |
|---|---|---|
| **Values, Attitudes, and Beliefs** | -Valuing interdisciplinary or transdisciplinary collaboration<br>-Contextual and Multi-level Perspectives<br>-Collaborative Orientation | **Values/Ethics**: Work with individuals of other professions to maintain a climate of mutual respect and shared values. |
| **Knowledge-Based Competencies** | -Disciplinary Grounding<br>-Other Disciplinary and Stakeholder Knowledge Accrual<br>-Cross-Disciplinary Synthesis<br>-Participating in Collective Integrative Processes | **Roles/Responsibilities**: Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations. |
| **Interpersonal Competencies** | -Interdisciplinary Communication: Understand Others<br>-Interdisciplinary Communication: Be Understood by Others<br>-Interdisciplinary Communication: Managing Differences<br>-Interdisciplinary Communication: Social and Relational Skills | **Interprofessional Communication**: Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.<br>**Teams & Teamwork**: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable. |
| **Habits of Mind** | -Curiosity and Open-Mindedness<br>-Non-defensive Reflectiveness<br>-Critical Thinking<br>-Developing Confidence | *Not articulated in IPEC Core Competencies* |

Professional Capital

The question of "Why?" an interprofessional identity should be a goal for trainees and professionals can be answered with reference to the concept of 'professional capital'. New Zealand scholar Beddoe (2011) applies Bourdieu's (1984) concept of social capital and the idea of 'distinctive space' to her exploration of health social workers' professional identities. Social capital is defined as a form of economic and cultural capital, in which social networks, relationships, reciprocity and cooperation are central (Bourdieu, 1984). Beddoe defined the concept of 'professional capital' as the aggregate value of mandated educational qualifications; social 'distinction' based in a territory of social practice; and economic worth as marked by artifacts of professional status, occupational closure marked by a profession closing entry to the profession to the unqualified, and protection of title (Beddoe, 2011). Table 3 describes the ten attributes of professional capital. Many of the key attributes of professional capital require the ability to work effectively with other professions, and are reflected in the boundary spanning competencies suggested by the T-Shape model (e.g., being trusted by other professions, mutually rewarding relationships with other professional groups, holding a sense of professional "self-esteem".)

Beddoe points to the lack of independence that social workers have experienced in healthcare settings, suggesting that they have historically been under the "benign control of medical and nursing professions". The result, she claims, is a complex professional identity development which is formed within contestable territory (Beddoe, 2011). Professional capital is a desired outcome that is likely equated with a strengthened professional identity, and the ability to thrive as a professional within the context of the host settings in which social work so frequently operates.

**Table 3.**

*Key Attributes of "Professional Capital" (Beddoe, 2011)*

1. Having congruent **values within the profession**
2. **Being trusted** by users of professional services, key stakeholders and other professions
3. Having **reciprocal relationships**, with some form of exchange
4. **Visibility** in the public discourse for its distinctive contributions to social well-being
5. Having **mutually rewarding relationship** with other professional groups
6. Being able to **perform roles of leadership** in a field
7. Clear and understood **knowledge-claim for practice**
8. Opportunities for **continuing professional development**
9. Holding a sense of collective identity and '**self-esteem'**
10. Clear and well **differentiated territory of practice**

**Integration of Frameworks and Relevance to Research Questions**

The conceptual frameworks described in this chapter guide the investigation of the professional identity narratives of hospital social workers examined in this dissertation. The concept of interprofessional dual identity formation supports the need to examine the discipline-specific *and* cross-disciplinary components of professional identity, the competencies needed for effective collaboration, and the necessary attributes of collaboration. Together, these frameworks provide insight into the process (how?) and outcome (why?) of dual identity formation. Ideas from the two frameworks provide conceptual grounding for the following three research questions:

**RQ1:** How do hospital social workers articulate the knowledge, skills, and/or values that

define the profession? (Vertical trunk of T-Shape Professional model)

**RQ2:** How do hospital social workers articulate their approach and perceived ability to operate competently in different contexts, across organizational boundaries, and with other professions? (Horizontal cross-bar of T-Shape Professional model)

**RQ3:** How do hospital social workers describe the facilitators and barriers to engaging collaboratively with interprofessional teams? (i.e., their lived experience of collaboration examined with eye to 10 attributes of "Professional Capital" described in Table 2).

The next chapter describes the qualitative methods implemented, and provides more detailed description of how the conceptual frameworks discussed in this chapter influenced analysis.

# CHAPTER 3

# METHODS

## Study Design

This qualitative study includes a sample of 20 MSW-trained hospital social workers from three hospitals affiliated with a large academic medical center in the Pacific Northwest. The study was designed and implemented as part of the University of Washington TL1 Translational Research Training Program during the summer of 2012 (mentors: Benjamin Wilfond, MD and Paula Nurius, PhD). The original aim of this descriptive study was to examine the roles and self-perceived competencies of hospital social workers in the interprofessional practice of clinical ethical decision-making. Although the study did not explicitly set out to explore the nature of professional identity, a preliminary review revealed aspects of their work in hospital settings (both in the context of ethical decision-making and more generally) that can contribute to improved understanding of their professional and interprofessional identities. Therefore, the research questions guiding the analyses in this dissertation were developed inductively after the preliminary analysis. Thus, the research questions addressed in this dissertation are a form of secondary data analysis, as data collection was initially guided by different conceptual framing and research questions.

## Human Subjects Considerations

The study was approved as minimal risk by the University of Washington Human Subjects Division (HSD study #43243).

## Research Questions

Three separate analyses are included in this dissertation, that together help describe the uni-professional and interprofessional identity of hospital social workers. Analyses provide

descriptive evidence about the 1) discipline specific knowledge, skills, and values of hospital social workers, 2) perception of their boundary-spanning capacities, and 3) perception of facilitators and barriers to engaging collaboratively with interprofessional teams. Analyses were guided by the following research questions:

**RQ1:** How do hospital social workers articulate the knowledge, skills, and/or values that define the profession?

**RQ2:** How do hospital social workers articulate their approach and perceived ability to operate competently in different contexts, across organizational boundaries, and with other professions?

**RQ3:** How do hospital social workers describe the facilitators and barriers to engaging collaboratively with interprofessional teams?

## Methods

### *Study Sample*

This study includes a sample of 20 social workers who were employed by three university-affiliated hospitals in the Pacific Northwest region of the United States—a pediatric hospital, a public safety net and trauma hospital, and a large regional academic medical center. A combination of convenience and purpose sampling was used to identify and select "information-rich" cases related to the phenomenon of interest (Patton, 2002). Purposive sampling requires purposeful selection based on the characteristics of a population and the objectives of the study. Purposive was the selection of the three hospitals from which social workers were recruited. The hospitals were chosen because they are known to have large, prominent and active social work departments that serve high volumes of patients with diverse needs. Each of the several-hundred-bed hospitals have over 5,000 employees and admits over 15,000 patients per year. In addition,

each provides over $100M in uncompensated care, suggesting a significant patient population who are vulnerable and underserved (See Table 4). Within the hospitals, convenience sampling methods were used to recruit social workers for interviews. I contacted the head of each social work department and requested a recruitment e-mail be sent to all social workers within each of the three hospitals. Social workers who were interested in participating in an interview contacted me, and we arranged a time for an in-person interview.

**Table 4.**

*Characteristics of Hospitals Included in Study (FY2017)*

| | **Pediatric Hospital** | **Public Safety Net Hospital** | **Regional Academic Medical Center** |
|---|---|---|---|
| Total Employees | 7,282 | 5,491 | 5,595 |
| Total Number of Beds | 403 | 413 | 529 |
| Uncompensated Care | $164,605,000 | > $206,000,000 | $417,000,000 |
| Admissions | 16,501 | 17,158 | 18,964 |

Study participants represented a broad range of practice areas within the hospital. In addition, the sample represented a range of experience, with more than half reporting over ten years of practice experience. The sample was predominantly white and overwhelmingly female, which is representative of the profession as a whole (NASW, 2011b). See Table 5 for detailed description of sample demographics.

**Table 5.**

*Demographics of Social Work Participants*

| | n (%) |
|---|---|
| **RACE** | |
| White | 17 (85) |
| Asian, Native Hawaiian or Pacific Islander | 3 (15) |
| **GENDER** | |
| Male | 3 (15) |
| Female | 17 (85) |
| **HOSPITAL** | |
| Pediatric Hospital | 7 (35) |
| Academic Medical Center | 6 (30) |
| Public Safety Net Hospital | 7 (35) |
| **HEALTHCARE SETTING** | |
| Inpatient (Child Abuse, Intensive Care Unit, Psychiatry, Palliative Care, Med-Surg, Oncology, Transplant) | 12 (60) |
| Outpatient (Primary Care Clinic, Prenatal Clinic, International Medicine Clinic, Family Medicine Clinic, Mental Health Clinic, Specialty Clinics) | 6 (30) |
| Inpatient & Outpatient (Pulmonary, Family Medicine) | 2 (10) |
| **YEARS OF EXPERIENCE** | |
| 1-2 | 1 (5) |
| 2-4 | 1 (5) |
| 4-6 | 3 (15) |
| 6-10 | 3 (15) |
| 10+ | 12 (60) |

*Data Collection & Management*

Data were collected during the summer of 2012. A semi-structured interview guide focused on a range of topics related to social workers' involvement on interprofessional teams. Prompts were developed by me, with input from faculty mentors (Ben Wilfond and Paula Nurius), in response to gaps in the literature related to social workers' contributions to ethical decision-making (Brazg et al., 2015). In particular, participants were asked to describe their

personal, professional and educational background; relationships with members of the healthcare team; and their roles and responsibilities on their teams as perceived by themselves and other professionals. They were also asked to comment on their perceived preparedness and participation in clinical ethical decision-making (See Appendix A for Interview Guide). Interviews were conducted in-person at a location that was convenient for the participants. Participants were asked to provide verbal consent to their participation in the study. Prior to interviews participants completed a demographic questionnaire. All interviews were recorded, and lasted approximately 30-45 minutes. Interviews were transcribed by a medical transcription service and personal identifiers were removed from the transcripts. I read through transcripts to ensure quality of transcription, and de-identified transcripts were uploaded into Dedoose® qualitative analysis software.

*Data Analysis*

Separate analyses were completed to address each of the three research questions central to this dissertation. Interviews were analyzed using the process of thematic analysis (Braun & Clarke, 2006). This analytic approach relies on an iterative process for identifying, analyzing, and reporting patterns (themes) within data. Table 2 outlines a proposed process for engaging in thematic analysis, which I used as a guide. Each analysis was conducted separately, and resulted in development of its own codebook (See Appendix B) and three separate reports of results (chapters 4, 5 and 6). Ideas developed in each of the results' chapters are integrated in the final chapter of the dissertation, which provides discussion and implications related to the interprofessional identity and readiness for collaboration of hospital social workers (chapter 7).

I used interpretive thematic analysis to move iteratively between the data and the literature, making the coding process both inductive and deductive. The purpose of the analysis

was to provide a detailed description of interprofessional identity, as informed by a pre-determined set of conceptual frameworks (See Chapter 2). My approach aimed to identify and examine underlying ideas or assumptions, rather than focusing more narrowly on the semantic or surface meaning of the data. The underlying epistemological stance of this dissertation is constructionist, meaning that I operate from the assumption that meaning and experience are socially produced and reproduced. Self-awareness and integration of my own experiences and belief systems were considered throughout the analyses (more on this in the sections below about quality and reflexivity). I followed a stepwise process of analysis suggested by Braun and Clarke (2006) (See Table 6).

As described in Chapter 2, framing of research questions and qualitative analyses were guided by two conceptual frameworks:

1) *Competency-Based T-Shaped Training Approach* (Donofrio et al., 2010; Nurius, 2017; Nurius, Coffey, et al., 2017; Nurius, Kemp, et al., 2017; Uhlenbrook & DeJong, 2012)
2) *Professional Capital* (Beddoe, 2011).

The T-Shaped Professional framework guided the development of codes used to explore the two elements of interprofessional identity: the discipline-specific grounding of hospital social workers explored in Chapter 4 (e.g., the knowledge, skills and values that define the profession), and the boundary-spanning competencies explored in Chapter 5 (e.g., values/attitudes/beliefs about collaboration, habits of mind, knowledge base competencies, and interpersonal skills related to collaboration). Elements of 'professional capital' informed the development of the codebook for the final chapter of results (Chapter 6), which focused on facilitators and barriers to effective collaboration as perceived by hospital social workers (e.g., holding a sense of 'self-esteem', clear and well differentiated territories of practice, being trusted by others, visibility,

and mutually rewarding relationships with other professional groups). I aimed to achieve a clear, detailed and nuanced description of the three separate research questions identified above.

**Table 6.**

*Phases of Thematic Analysis (Braun & Clarke, 2006)*

| **Phase** | **Description of the Process** |
|---|---|
| 1. Familiarizing yourself with your data | Transcribing data, reading and re-reading data, noting down initial ideas |
| 2. Generating initial codes | Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code |
| 3. Searching for themes | Collating codes into potential themes, gathering all data relevant to each potential theme |
| 4. Reviewing themes | Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis |
| 5. Defining and naming themes | Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme |
| 6. Producing the report | The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis. Tell the complicated story of your data in a way that convinces the reader of the merit and validity of your analysis. |

**Evaluation of Research Quality**

While positivist scientific research quality criteria demand objectivity, validity, systematic rigor, reliability and generalizability, alternative sets of criteria have been proposed to judge the quality and credibility of qualitative inquiry (Shenton, 2003). Most widely accepted are constructs presented by Lincoln and Guba (1986), who proposed that constructivist inquiry demands different criteria than "traditional social sciences":

a) Credibility (replaces internal validity)

b) Transferability (replaces external validity/generalizability)

c) Dependability (replaces reliability)

d) Confirmability (replaces objectivity)

Together, these criteria are described as addressing 'trustworthiness', a concept that has been seen as analogous to rigor in qualitative research (Lincoln & Guba, 1986). I utilized approaches to ensure trustworthiness of my analyses (Shenton, 2003). For example, I engaged in discussion with members of my dissertation committee, as well as friends and colleagues who provided the opportunity for me to receive outsiders' perspective on my perception of data and their meaning. Such interactions (in person or via e-mail) served as a sounding board, and the opportunity to uncover biases or preferences, thus promoting the credibility of my interpretation. In addition to receiving outside perspective through debriefing sessions, I engaged in "reflective commentary" (Shenton, 2003) through the ongoing and iterative process of writing and returning to memos about my observations, coding and interpretations of data.

Quality of this analysis is further enhanced by incorporation of reflexivity into the analytic process. Reflexivity has entered into the qualitative lexicon as a way of emphasizing the importance of self-awareness, and attending to the contexts of our knowledge construction throughout the research process (Patton, 2002). Being reflexive requires critical self-examination, self-questioning, and self-understanding. To be reflexive is to continuously engage with the questions: *What do I know? and How do I know it?* Reflexivity requires the researcher to take seriously the responsibility to communicate authentically the ideas of participants involved in inquiry (Patton, 2002).

To guide my engagement in this area, I followed an approach that places researcher positionality and reflexivity at the center of the evaluation agenda (Stige, Malterud, & Midtgarden, 2009). Stige and colleagues (2009) propose seven elements of quality evaluation in qualitative research: engagement, processing, interpretation, critique, usefulness, relevance, and

ethics (acronym: EPICURE) (See Table 7). Each element includes several questions that deserve thoughtful reflection by researchers. According to their model, reflexivity is central to high quality qualitative research. My reflection on the questions presented by the EPICURE agenda are summarized in the final section of this chapter, titled, "Reflexivity Statement".

**Table 7.**

*EPICURE Agenda for Evaluation of Qualitative Research (Stige et al., 2009)*

| **Element** | **Description** | **Examples of questions to reflect on** |
|---|---|---|
| Engagement | Researcher's continuous interaction with and relationship to phenomenon or situation studied. Subjectivity becomes part of the study; explicit reflection is required to articulate how subjectivity does not result in bias | What is researcher's access to the field or phenomenon studied? What are researcher's motivations and pre understandings? |
| Processing | Process of producing, ordering, analyzing and preserving empirical material. Allows for challenge to the idea that method is the main arbiter of truth and value (i.e., inter rater reliability); rather relies on reflection. | How is the research focus clarified? How is the empirical material systematized, analyzed and presented? Are the researchers' position and perspective clarified? |
| Interpretation | The act of creating meaning by identifying patterns and developing contexts for the understanding of data. Recognizes the prominence of situated interpretation and requires reflexivity in relation to preconceptions and theoretical frame of reference. Interpretation can be discussed between multiple people involved in interpretation. | Are there possible other interpretations? Why are certain interpretations more appropriate for purpose of study than others? |
| Critique | Appraisal of merits and limits of research—self-critique and social critique. | What are the researcher's positions and perspectives that influence research? How does study contribute to positive social change or to repression and disempowerment? |
| Usefulness | Value of the research in relation to practical contexts. | How are the research process and products useful for practice and understanding in relation to real world problems? How is research useful for participants, professionals, agencies and policies? |

| | | |
|---|---|---|
| Relevance | How study contributes to development of the involved disciplines or interdisciplinary field. | How does study fit within relevant literature? How is study original and pertinent for development of disciplines field or understanding of body of knowledge? |
| Ethics | How values and moral principles are integrated into the actions and reflections of research. | Is research process respectful to all participants? Does researcher demonstrate awareness of consequences of research? To what degree does study reflect diversity of interests in group of participants? |

**Reflexivity Statement**

This dissertation is informed and driven by my interest and commitment to combining multiple perspectives to address health and social problems. Thinking across boundaries is intuitive for me, and is an approach that has guided my academic and professional pursuits. I am a unique social work scholar, in that my graduate level training spans three of the six health science schools at the UW—social work (MSW, PhD), public health (MPH), and medicine (MA in bioethics). My training and experiences working in the inherently interprofessional spaces of bioethics and IPE provide me with diverse touch points with healthcare delivery, diverse ways of understanding issues in healthcare, and the desire to break down silos that diminish the quality of healthcare delivery.

While I am trained across professions/disciplines, I consider social work my "home" and approach my work in interprofessional spaces in academic and healthcare practice as a social worker first. In interprofessional spaces I am often an advocate for the profession, for example by clarifying educational components of professional training or explicitly stating a "social work perspective". I am guided by the values and ethical principles of the profession, in particular, a commitment to helping people in need and addressing social problems, social justice, client/patient self-determination and the importance of relationships. I have worked closely with

social workers in the medical field (e.g., through teaching ethics to hospital social workers; through my clinical work as a bioethicist in three separate hospitals; through my work developing curriculum for interprofessional education; and teaching health/mental health track MSW students). These experiences, along with my MSW training, provide me with context for the profession, have informed my interest in social workers' roles on interprofessional healthcare teams, and gave me access to the participants involved in this study.

My research questions rest upon assumptions about the skills that MSW-trained? social workers have to contribute to healthcare delivery, and observations about the inclusion, acceptance and respect for the profession in healthcare settings. However, in thinking about how my experiences influence a particular lens and appreciation of such issues, I realize that I am missing the ability to integrate the realities of clinical experience of hospital social work, with the assumptions and observations I have gathered through other professional and educational experiences. I have never worked as a hospital social worker! I see myself as both an "insider" of the profession of hospital social work, and someone who has observed from somewhat of an "ivory tower". My perspective has the potential to over emphasize the theoretical/idealized contributions of social work, based on my understanding of social work training, how healthcare teams operate, and my perception that certain values are gaining prominence in our healthcare system (e.g., patient-centered care, quality improvement, addressing social determinants of health, integration of behavioral and physical health).

To counter this potential place for bias, I am attuned to paying attention to and "differentiating competency from ideology", an idea described in the literature by Spitzer and colleagues in their effort to inform how to adequately prepare social workers for the realities of their organizational settings (Spitzer, Silverman, & Allen, 2015). The distinction calls for the

balance of professional values/perspective and the operational realities of the work. It encourages me to consider how I might communicate and market social work, by looking outside of profession-based values and ideologies (what social workers are theoretically capable of or trained to do), and exploring with genuine curiosity the talents, competencies and knowledge base of professionals in practice. In addition, beyond the motivation of individuals, it will be important to be attuned to the influence of organizations on hospital social workers. It means reporting 'negative findings', and staying attuned to the potential of overemphasizing the contributions of the profession that I am ultimately hoping to 'bolster up'.

In addition to the potential to idealize the contributions of the profession, I maintain awareness about assumptions that influence the way I have framed my research questions, and the ways in which I interpret social workers' potential and actual contributions to teams. First, I believe that psychosocial elements must be attended to in the delivery of healthcare, and that there needs to be professionals specifically trained and dedicated to this aspect of care (social workers are not the only professionals who can accomplish this need, but they are among those who can). Second, I believe that hierarchy in the field of healthcare exists, and that the persistence of hierarchy often results in the underutilization/under appreciation of hospital social workers. Finally, I believe that highly effective collaborative interprofessional teams result in provision of higher quality and safer care (an underlying assumption of IPE and IPCP).

Within interprofessional spaces, professionals bring with them the unique perspective of their professional training—the values, ethics, skills, knowledge and assumptions. While my experiences and perspectives led me to investigate the questions central to this dissertation, it was important throughout my analysis and reporting of findings to make efforts to identify potential biases (professional bias, personal bias, sampling bias), and to see other points of view.

The methods and analyses for this dissertation were guided by current literature describing methodological approaches for high quality and rigorous qualitative research. The next three chapters provide the results of analysis for the research questions articulated above (Chapters 4, 5, 6).

# CHAPTER 4: RESULTS – RESEARCH QUESTION 1

## PROFESSION SPECIFIC FEATURES OF HOSPITAL SOCIAL WORKERS' PROFESSIONAL IDENTITY

## (THE VERTICAL TRUNK OF THE T-SHAPED PROFESSIONAL CONCEPT)

This chapter proposes several features of hospital social worker's professional identity, as perceived by the sample of hospital social workers interviewed in this study. Professional identity—or how a social worker thinks of herself or himself as a social worker— develops over time and is often described as resulting from the combination of profession-specific knowledge, skills, attitudes, beliefs and values that are shared amongst those within a particular professional group (Hall, 1986; Watts, 1987; McGowen & Hart, 1990 as cited in Adams et al., 2006). Three of these components of professional identity were explored in the first research question of this dissertation: *How do hospital social workers articulate the knowledge, skills and values that define the profession?* Results of analysis related to this question are presented in this chapter and include discussion of the following themes: 1) Social Workers as "*Bigger Picture People*",2) Soft Skills Pervade, and 3) The Influential Code of Ethics. A number of sub-themes are also described.

**Results: Key Elements of Hospital Social Work Professional Identity**

Social workers interviewed for this study confidently described their unique contributions to healthcare delivery, the knowledge and training that informs them, the skills they believe they are well equipped to contribute to patient care, and the values and ethics that guide their practice. They also described their involvement in a broad range of roles and responsibilities, including discharge planning, psychosocial assessment, advocacy, facilitation/ communication, care coordination, assistance with resources, crisis intervention, and mental health treatment. Several empirical investigations exist to support such roles for hospital social workers (Craig, 2007;

Craig, Betancourt, & Muskat, 2015; Craig & Muskat, 2013; Megan Moore et al., 2017; Megan Moore, Ekman, & Shumway, 2012). Thus, this dissertation does not explicitly elaborate on findings related to specific roles and responsibilities as articulated by the participants. Rather, it aims to better understand the perceived *knowledge*, *skills* and *values* that underlie their roles and help describe the professional identity of hospital social workers. For the purpose of the analysis I define *knowledge* as the theoretical or practical understanding of a subject—that which is often learned during professional training; *skill* as the ability to do something well; and *value* as an individual's belief that motivates them to act towards what is "good" or "right". These terms and their definitions provide structure for the analysis and reporting in this chapter. See Table 8 for an overview of the organizing concepts, themes and subthemes described in this chapter.

**Table 8.**

*Themes Regarding Knowledge, Skills and Values Underlying Hospital SW Professional Identity*

| Organizing Concept | Theme | Subthemes |
|---|---|---|
| Social Work Knowledge | "Bigger Picture People": The Person-in-Environment Knowledge Claim | -Knowledge of Psychosocial Elements of Care<br>-Knowledge of Diversity and Difference in Practice<br>-Knowledge of Community Resources |
| Social Work Skills | Soft Skills Pervade | -Skilled Problems Solvers and Resource Navigators: "The Team's Google"<br>-Skilled Communicators |
| Social Work Values | The Influential Code of Ethics | -A Commitment to the Underserved<br>-Attention to Power/Vulnerability |

**"Bigger Picture People": The Prominence of the Person-in-Environment Knowledge Claim**

The person-in-environment perspective is a practice guiding principle in social work which highlights the importance of understanding an individual and their behavior in the contexts in which the person lives and acts. These contexts include social, political, communal,

historical, religious, physical, cultural and familial environments (Mizrahi & Davis, 2008). At the broadest level, knowledge of how to assess and incorporate the contexts of people's lives is what respondents identified to be their most impactful and unique knowledge claim. When asked for words that can describe their professional identity, one described herself as the "bigger picture person" on the healthcare team.

> *A bigger picture person, I think social work is really good at that and a more holistic team member. I am not specifically interested in the physical pain of somebody, I am interested in the physical, the emotional, the social, the spiritual, the practical, the financial piece.* (SW11)

In order to attend to the many contexts that influence a person's health, social workers described a diverse knowledge base that includes knowledge of psychosocial elements of care, diversity and difference in practice, and knowledge of community resources. Findings related to these knowledge claims are presented below as sub-themes related to social work's "big picture" knowledge claim (also outlined in Table 2 above).

Knowledge of the Psychosocial Elements of Care

In many cases, social workers perceived their knowledge about psychosocial and other contextual issues central to a patient's life to be important and contributory to the team. Several described feeling that the team depended on them for their perspective and contribution of knowledge about patients in their life contexts.

> *And the [chief of the service] always remarked that one of the things that amazes him the most about our team was how much – they'd have these big long discussions about the technical aspects of a treatment plan, but the crux of the matter was based on what the social worker had to say about the patient's interest in the family's ability / coping skills of getting thru. And so I think that on the team, we're depended upon for that.* (SW15)

> *The patients come in to see their doctor primarily because it's a medical clinic and they have medical issues. But a lot of patients come in and the first thing they say is something that has to do with their psychosocial kind of environment and that's the big issue. And so it's not necessarily something that the doctor is going*

> *to be dealing with so they refer to social work. So I feel like that's a big part in this clinic particularly because of the kind of vulnerable sort of high risk patient population this is.* (SW05)

Some social workers described the importance of finding "a seat at the table" to ensure that the larger contexts of patients' lives are considered in decision-making. For example, one social worker described how knowledge and application of a patient's context can help the team approach decision-making at end of life. In particular, when the patient's preferences do not align with what the healthcare teams believe to be in the patient's best interest. The social worker draws attention to the significance and ethical relevance of a patient's social environment, and calls on other social workers to articulate this perspective when working alongside other professionals.

> *Well I think it's a strong rooting in seeing the individual as a person in the social environment. […] When it comes to end of life decision making in the view of autonomous decision making around end of life, where there's really a lot of the discussion focuses on what the patient really wants around end of life decision making. And sometimes it's forgotten what the patient really wants is contingent on a whole host of things. Yeah sure he may be staying alive to please his wife, but that can be viewed as a person in a human environment. That's what gives him meaning right now. So that perspective that social work has to bring to the table, it's not just the slice of the person in front of you but who they're within the social environment. And that's so important and social work should be a more articulate voice at the table talking about that.* (SW08)

Another social worker described her belief that her presence at a meeting helped to refocus conversations about a patient's care—that she was able to articulate a broader perspective that influenced clinical care and complex decision-making.

> *I think it's definitely been helpful because I think about some of the times that we've had those meetings, and like if I hadn't been there, I don't know who else would have brought some of those contextual issues to the surface.* (SW12)

Knowledge of the psychosocial elements of patients' lives, and the ways in which these elements impact patient care and decision-making, were commonly discussed by participants in this study.

Several described the importance of articulating and sharing this knowledge with the team, and the potential for it to shift the course of care.

Knowledge of Diversity and Difference in Practice

Part of being "bigger picture people" and understanding patients in the contexts of their broader environments, is bringing to practice awareness of the ways in which diversity impacts healthcare. Social workers aim to demonstrate commitment to engaging diversity and difference in practice, which is a key competency of social work education. According to the educational policy and accreditation standards for social work education, social workers are trained to "understand how diversity and difference characterize and shape the human experience" (CSWE, 2015). Understanding and working with patients, in the context of their broader environments, requires attention to a person's life experiences such as oppression, poverty, and marginalization, and social workers are trained to apply and communicate understanding of the importance of diversity and difference in shaping life experiences.

Many respondents described knowledge of and attention to diversity as a central feature of preparatory education for the profession. For example, when asked how social work training may be different than other professions, one referred to their "*excellent basic grounding in the issues of disparities and cultural issues, spiritual differences*." (SW05) Another, noted that many providers bring attention to larger societal influences on patients' lives, but that this knowledge and perspective is particularly central to social work.

> *Some kinds of things in larger society that are going on, and understanding of underrepresented groups, or whatever it might be in the larger context […] We bring that, everybody does in a certain sense but that's part of social work's focus.* (SW09)

Another social worker described how issues around diversity and social justice are often at the forefront of her approach to patient care. She reflected on how patients may perceive information

presented to them, through a lens impacted by their social, economic or racial position in society.

> *People often feel, depending on how you present the information, that when you talk about non-treatment, they're in the back of their heads or wondering, is this something you mentioned to everybody or is this something you just mention to people of color or people who live in the [name of neighborhood]. You have to present it as a true clinical option and acknowledge the external influence off society.* (SW15)

Social workers also described bringing awareness to diversity in discussions about patients. One social worker, in a somewhat frustrated tone, described how and when demographic information is relevant to treatment decisions, implying her perspective about the potential misuse of diversity as an element of patient care.

> *When I hear words like 'he's a really nice guy' that throws me over the edge. When I hear words like 'this person's Hispanic' that drives me crazy because the reality of the issue unless there's a social context for that, unless we need to understand that this person is Spanish speaking and they need some kind of special assistance…that's one thing. But to pick out these random arbitrary things and try to make a decision based on that, it makes me crazy.* (SW16)

Knowledge of the ways in which diversity impacts a patient's experience was demonstrated by several social workers, and described as a central focus of professional preparation and training. Knowledge in this area is related to the driving values and ethics of the social work profession, which prioritize social justice and attention to power and vulnerability. These values will be discussed in more depth later in this chapter.

<u>Knowledge of Community Resources</u>

Finally, with regards to practicing with a "big picture" perspective, social workers talked frequently about their knowledge of community resources. Social workers agreed that they must be knowledgeable about community resources that can be leveraged to address patient's sometimes complex needs. However, they described some amount of conflict or dissatisfaction with the way this knowledge can become the primary knowledge for which they are recognized.

For example, they described a kind of under-valuing, even by themselves, related to this area of knowledge. This was exemplified by comments about the misalignment between social work training and the task-oriented nature of resource allocation and assistance. One social worker, in particular, commented several times on the conflict between how she perceived her professional training, and the ways in which her perception differed from how she believed other professionals understood her expertise.

> *The reality of what I find myself doing so much of the time here is this stuff that, it's not unimportant, it's important because if you have access to cancer care in one of my clinics here, but have no way to get here from [name of city], then it does no good to have access to the care. So it's important. However, arranging transportation, is that what I took out loans and went to graduate school and changed my career to a much less lucrative…is this the best use that can be made of me?* (SW07)

Throughout the interview, this social worker described how her more "professional" knowledge around psychosocial assessment were sometimes dismissed, and expressed a preference for the opportunity to implement what she perceived to be higher status knowledge claims. For example, she described efforts at another institution, which aimed to "elevate" social workers' roles to better fit their training and skills. In her description, she stated a preference for being aligned with the "more professional" psychiatry over patient navigation.

> *They've created a level of worker called patient navigators or care navigators. These are people who don't even necessarily have a bachelor's in social work, I hope they have some education, but they are filling this incredibly important role of coordinating transportation, making sure just the basic needs are being dealt with for someone who's being referred there for cancer treatment, transplant, all of these things. The idea being that they wanted to kind of elevate their social workers to be considered more professional and really use their skills and training more sort of. I think they [the social workers] are aligning themselves more maybe with the psychiatry department, being much more a part of a thorough assessment and evaluation of each patient.* (SW07)

The sentiment that knowledge of resources is a "simple" kind of knowledge came through in others' reflections of what they contribute, even when they described the importance and

centrality of this knowledge for good patient care. An example of this is a response from a social worker, who began describing her part in helping patients to apply for Medicaid. She began her response by saying, *"[My contribution] can be, you know, as simple as helping them apply for Medicaid*..." After a brief pause, she corrected herself and went on to say,

> *…which isn't really that simple because if they don't have Medicaid they are going to have bills […]. and we have a fairly large population of pretty sick individuals with depression and anxiety, bipolar or schizophrenia in pregnancy. So in that setting helping them engage in services and making sure that they can be a good a parent in the end and assessing that, and if they can be then taking action at delivery of how to assist them.* (SW10)

The social worker made the link between her knowledge of how to access resources, and the trickle down effects on a patient's life and health status. Another social worker drew attention to the perception that knowledge of community resources can be an underappreciated area of knowledge, and went on to clarify how social work's training prepares them to be more than just "*discharge oriented*" people.

> *Sometimes within the hospital setting social workers are seen as very practical people and very discharge oriented people. They forget that they have incredible interpersonal skills and counseling skills and skills in the psychological makeup of people. We are really good at finding a nursing home and then helping the person adjust to the grief or the change or the losses that they will face in it.* (SW11)

This social worker articulated how "*practical*" knowledge (e.g., knowledge of resources) is most impactful when combined with other skills social workers come prepared to share (e.g., interpersonal skills).

Social workers also described the ways in which their knowledge of community resources can result in improved care and health outcomes. For example, one social worker described how ensuring resources are available can allow a patient to achieve treatment goals.

> *So if you've got a patient with a doctor who's diabetic and needs to…their blood sugars are totally out of whack and out of control…and the doctor's like, "You*

> *really need to eat better" but the guy's like "Hey I'm homeless I can't afford to pay for all of this food […] You know, you guys are crazy. I'm just going to eat whatever I can." So that's where I come in, right? Provide them support; see if they are eligible for food stamps if that's a possibility. Just make sure that all the resources are available to them. So I help the patients with their basic needs, like housing, food, mental health, cash income of some kind. Then they can focus more on their biological and physical issues, rather than say, "I don't really care what you're saying to me doc. I just know that I'm going to be evicted tomorrow so what can I do?" So in that sense that's what I do.* (SW02)

Another social worker described the way in which contextual knowledge of patients, combined with knowledge of community resources, can influence decision-making. She described an example of decision-making for a medically complex child who her team has consulted on from out of state. While the focus can often be on providing the highest level of care for patients, the social worker described the importance of understanding access to community resources, and the impact such resources will have on the patient's health outside of the hospital.

> *Well what's available on the east coast is very different than [this state], in terms of just resources, programs, and even the equipment that the kid uses. It may not be something we use in Washington because of cost. But they are moving here and so the team has been just kind of going about their business, scheduling for you know planning. And I've had to say "Yes we want patients to come and we want to provide support, but if we physically cannot get them the equipment they need, we need to be maybe putting our hand up and saying wait a minute. Like let's keep this kid on the east coast for a while longer because it's just not financially possible for our hospital…it is not going to financially support this." And so I feel like my job is sort of to be at the table to say, before we start having these conversations can we explore, what is the reality of the situation? Because I think sometimes the providers are just looking at, we have this child we want to give them the best life possible, and here's what we can give them. But then it's not often looking at what happens when they walk out of these walls and we can't have kids—nobody wants to just live here for the rest of their life you know.* (SW12)

Knowledge of community resources was described as both central, and lacking some amount of status when compared to other knowledge areas. While some social workers suggested that knowledge of community resources can lead to an overly narrow or simplistic perception of

hospital social worker's expertise, many social workers were able to articulate the importance and impact of this knowledge on patient care.

In summary, examination of the knowledge claims of social workers, as they relate to a positive professional self-image and professional identity, suggest that the most prominent knowledge claim is a broad one—that social workers are "*bigger picture people*". In order to assess and integrate important contextual information about patients, social workers described implementing knowledge in the areas of psychosocial elements of care, diversity and difference in practice, and knowledge of community resources. The following section will describe how social workers translate their knowledge into practice.

**Soft Skills Pervade**

In this section I present findings related to the perceived skills of social workers in hospital settings. Assessment of skills was accomplished through analyzing social workers' reflections on their strengths in practice, the tasks they are responsible for, and the ways in which their contributions are valued as a member of the healthcare team. Examination of how hospital social workers perceive their skills demonstrated a pervasiveness of "soft skills" in contrast to "hard skills". Hard skills can be described as technical expertise—they are easy to quantify, measure and demonstrate effectiveness around. Soft skills, on the other hand, are more subjective and include personality traits and interpersonal and intrapersonal capacities (Laker & Powell, 2011). Soft skills described by social workers in this study included problem solving, resourcefulness, and communication-related skills; each elaborated on as sub-themes below.

<u>Skilled Problem Solvers and Resource Navigators: The Team's "Google"</u>

Several social workers described breadth of knowledge and skills to be the cornerstone of their contribution to healthcare, and a source of professional pride and identity. For example, one

used the term "*jack of all trades*" to describe the many and varied skills of their practice.

> *I think social workers are perceived as good jack of all trades in terms of being seen as a gate keeper to patient resources, we're also seen as someone for the team to turn to in terms of holding hope for the patient, in terms of resources being available out there for the patient*. (SW08)

The breadth described by many social workers was associated with two more specific skills: problem solving and resourcefulness. One social worker described her role as "*Google*", demonstrating her pride in the ability to solve any problem, big or small.

> *You know, every year we have to do the spiel to the new residents of what social work does. I think, you know, what I always tell them is that I'm the Google. I'm a live person format. If I don't know the answer I can at least send them to who would know. I feel like what I've described now is really what they come to me for. You can think of anything under the sun that you can think of, they've come to me for. Like how to get a bus stop bench at a metro stop. I don't know, but I'll find out for you. So I think we're on the same page.* (SW02)

Others described themselves as "*problem solvers*", people who "*fix things that go askew*" (SW09), and who "*pick up after the disaster*" (SW15). Several called attention to the challenging circumstances in which their work is situated. For example, mounting difficulties around accessing resources for underserved patients. Within the challenges, they described their ability to successfully navigate systems in ways that benefit patients.

> *Since 2008 when the economy went bad…we've seen a lot of drastic reduction in resources. So trying to find people resources problem solving, there's more steps, there's more criteria now that bars people from getting access*. (SW04)

> *Lack of resources, for sure. Especially more recently as programs have been cut. It's becoming more and more challenging to find resources that our patients and families need. […] And I find that if I can explain, so for example, just navigating systems even within the hospital here, or a lot of our patients are, they're outpatient care is at another institution, so it's helping people navigate those systems. And sometimes it feels kind of like, it's often just a bit of a challenge to try to navigate those systems. But I also find a lot of collaboration once I explain to those various staff members what we're trying to do to help the patient*. (SW01)

> *I would say efficacy is huge, in the work I do I work with a population that's is pretty medically complex, and so trying to get them what they need in the community is really difficult and so I feel like a lot of what I do is helping bridge some of that and doing some education with the community around what these kids need*. (SW12)

Social workers described feeling particularly useful in their ability to solve problems, big or small. They identified strongly with their ability to skillfully navigate challenging systems, and to help both healthcare providers and patients/families to address the psychosocial and other contextual challenges that can accompany illness.

Skilled Communicators

Many social workers interviewed perceived themselves to be skilled in the area of communication, describing their ability to communicate effectively with members of the healthcare team, as well as patients and families.

> *I feel like social workers are pretty good communicators usually. And also can be good mediators, and have experience managing a family care conference, a lot of times social workers might facilitate that. So [we] are able to communicate with the team and with patients and then obviously [we have] the understanding of patient needs and preferences*. (SW03)

> *We're good communicators, we're good advocates, we mediate well, we read body language, we deal with the sub text of conversations, we're able to help people articulate what it is that they really want. (SW04)*

One described her unique ability to communicate with patients and families, and her capacity to elicit important contextual information that can help steer the direction of care.

> *I mean I have heard many, many times from people like how did you get them to say that? Why did they tell you that? They haven't mentioned anything about depression or domestic violence or wow, their husband uses heroine where did that come from? You know, I think just being that liaison to general better care.* (SW10)

Several talked about how they utilize their communication and interpersonal skills to facilitate team meetings when emotions are running high.

> *We are identifying the right people to have or we believe the right people to be there at the table to have the conversation. And then we are the ones who are the facilitator at the meeting. We are laying out the meeting structure, the purpose of it and how this is going to flow out and how we're going to have some structure in discussing these issues. Here are the questions and then we keep people on track. (SW18).*
>
> *I feel like when [expletive] hits the fan, excuse my language, the social worker's there and the social worker is the one who's like, "let's get everybody together, let's sit down, let's think about this." (SW16)*

Related to their ability to organize/facilitate the team through difficult conversations, social workers described how their communication skills are relied upon to assist with difficult conversations. For example, one social worker described working with a family who was not proficient in English and needed to make difficult decisions related to their child's transplant. After several conversations, the team was having difficulty assessing how much the patient's mother understood about the transplant and how her language ability was influencing her decision-making. The social worker articulated her ability to engage in "*difficult conversations*" with the patient's mother. "*So it was my job to have those difficult conversations and understand what she understood. And I feel like that happened." (SW17)* A social worker reflected on the intersection between her communication skills and the ability to provide emotional support to those who are in need (patients, families or other members of her team).

> *We're also able to deliver challenging truth to be there for people for loss and grief. I think we're a very supportive emotional capacity that also the capacity to actually be very structured with the process and help move things along. And not just for the patients who might be going through things but also for other providers who may be struggling*. (SW04)

Another social worker referred to herself as the "*communication tool"* when physicians and others don't know how to approach a difficult situation.

> *I think doctors rely on us for everything. I think that we are the communication tools when they don't know how to speak. I think that we are the people standing there when they are scared. We're the people that are sitting in the conferences*

> *when a family member has died and a physician is nervous that they might cry. (SW16)*

Believing that they are relied upon for their skills in communication was commonly articulated, along with their ability to operate in situations of extreme complexity. "*I think they rely on us to help them through complex, difficult situations whether it's involving discharge planning, whether it's involving family dynamics, whether it's involving communication*" (SW13).

In sum, social workers interviewed for this study articulated a number of soft skills that are important and contributory. Many identified with being resourceful and ready to solve problems, and they described their skills in communicating, especially within emotionally or otherwise complex circumstances, with key stakeholders in the healthcare setting. The final section of results will describe the way in which professional values influence the identity of hospital social workers.

**The Influential Code of Ethics**

The National Association of Social Workers (NASW) Code of Ethics (2008) for the profession describes the commitment to six core values and ethical principles that drive social work practice: service, social justice, dignity and worth of a person, importance of human relationships, integrity and competence. The code calls out the uniqueness of the profession's purpose and perspective, stating that the professional values and ethical principles its foundation (NASW, 2008). Analysis of interviews suggest that several values and ethical principles, as outlined by the profession's code of ethics, strongly influence social workers' perceptions of their work in hospitals and their discipline-specific contributions to care. In particular, social workers demonstrated a commitment to the underserved and attention to vulnerability and power differentials embedded in the healthcare interaction.

<u>A Commitment to the Underserved</u>

Social workers described deep commitment to serving and supporting the underserved, disenfranchised and marginalized. The commitment to these patients, communities and populations within hospital settings is central to social workers' descriptions of their work. Service to the vulnerable is described as a personal value, along with a professional one, and is described as a primary motivator and something that drew many to the profession.

> *[I was drawn to social work] because I was interested in working with vulnerable and underserved populations.* (SW05)

When asked to reflect on the most compelling or enjoyable aspect of their job, several social workers described their enjoyment and absolute commitment to working with patients and populations who exist at the margins.

> *My favorite actually is that I get to work with people, at least at this hospital, our mission population…so the people who are homeless, limited English speaking, folks coming out of jail or in jail, the HIV population, you know the really mentally sick, and refugees. I love that because for some of them just by me reading a letter for them that makes their day. […] And all I am is just the messenger, but because they feel like they have access to a source they feel more empowered. That's what I really love about this. You help people feel like a normal person. Treat them like you want to be treated with respect, at least the basics, and they get that here and I just love being part of that.* (SW02)

Social workers described their interest and curiosity in the complexities and nuances of human lives. Interacting with these complexities, and trying to help patients navigate them, is a central feature of the work for many social workers.

> *This is the one hospital in the city I wanted to work at, I was really happy to get a job here. I think working, I mean just the mission population, I mean I like working with people that are underserved in the community. I actually really think it's interesting working with a lot of immigrant patients and working with interpreters. I mean many people that work in hospitals and just in social work have no exposure to like having to use interpreters or they refuse to use interpreters and I just feel like I learn a lot, it's interesting.* (SW03)

> *It's very interesting what goes on with human beings and their lives and how different things impact them. There's the medical setting…a lot of medical issues*

> *bring them in but…there's different cultures, languages. I in particular like being in this clinic because there's wide variety of people, refugees and immigrants that are coming from all over the world. So it's a lot of exposure to places I probably wouldn't be thinking about as much, but now I do, because I have patients who are from those places*. (SW04)

Social workers described a mission-driven approach to their choice of profession, and articulate a clear relationship between the profession's guiding value of service and their perception of their work in hospital settings. Related to a commitment to serving the most vulnerable, social workers describe commitment to issues of vulnerability and power, which is explored in the following section.

Attention to vulnerability and power

Social workers are trained in an ethical framework of social justice, attuning them to issues of power and vulnerability that can impact a patient's ability to meaningfully engage in healthcare and decision-making. Many social workers interviewed described how they integrate a social justice perspective into their work. One social worker explicitly described social justice as an ethical framework.

> *There's a whole sort of ethical outlook of social workers in general, of you know, you are patient or client advocates and you work for social justice and meeting their needs…that sort of ethical framework.* (SW06)

Another described social justice as being at the "*forefront*" of social work practice. She articulated her belief that social workers "*attend to*" issues of social justice, perhaps more directly than other healthcare professions.

> *I think the social work perspective of meeting a patient where they are, a social work perspective of social justice all fit right in. I think we do a really good job of attending to those things specifically because they are kind of, you know, kind of forefront in our practice.* (SW05)

The social justice framework requires social workers to understand and consider how broader circumstances and systems impact patients and their health. One social worker references how

other professionals, besides social workers, may bring attention to the needs of underrepresented groups, though concludes her thought saying that it is "*part of social work's focus*" (SW09).

While social justice was described as a guiding value by many of the social workers interviewed, there was also recognition that this value does not always comport with the way institutions operate or the reality of the healthcare system. Some social workers felt empowered to contribute a social justice perspective, even when institutions or systems appeared to not be operating from the same framework. For example, one described her role as a challenger.

> *If I'd have to sum up what social work does, it's challenging truth to power. Bringing truth to power because institutions have a lot of power. And the disenfranchised that's giving voice to people who aren't educated, who are poor, who are disenfranchised for whatever reasons. So I think social work is the profession that gives that visibility like no other profession does.* (SW18)

Another described how she tries to work against injustice. She finishes her thought with a statement of hesitation about whether the healthcare system, and her place in it, is amenable to this kind of lens or approach.

> *Systems and how systems we are all a part of contribute to social injustice and then that effects individuals. And I've just never been able to think about my life or what I wanted separate from the context of other people. I don't mean just my personal relationships- I mean the society. And so at least that's some of how I saw myself that drew me to social work. Whether that ends up being possible is another story.* (SW07)

Some social workers described their efforts to orient others on the team or in the intuition to understand the social justice issues at play in treating a particular patient or group of people. For example, one social worker described how she tried to impart a social justice perspective on a challenging ethical case.

> *One of the things that I tried to do when that case happened was say, you know, nobody's looking at the issue of social justice here …. One of the things driving the family to help make sure their daughter could stay in their home was related to not having enough resource to take care of her in the first place. That's an issue of*

> *social justice where there's not enough resource to take care of adults with significant physical and intellectual disabilities.* (SW15)

Advocacy is a primary function of hospital social workers, and one that is rooted in and guided by the value of social justice. Several social workers described how power can manifest between patients, especially minority patients, the healthcare team, and or the medical system. They described advocacy as a direct response to this uneven distribution of power.

> *I think when you are a person in general in a medical setting especially if you are a person of color or any minority of any kind you need to be empowered in the medical field because you can get lost really easily and doctors can kind of run over you. So learning to help people empower themselves, to stand up for what they need in the medical field and to know what resources are available to them is really key I think.* (SW10)

> *I know for a fact this isn't all the social workers here. All the social workers here would say "Yes, my role is to advocate for the patient." But they don't necessarily mean it in the same way. I really don't care what policies and rules are…I mean…that doesn't sound right! I am not completely a rogue. But to me, whatever is at all legitimately within my prevue to do to advocate for a patient- that to me is always clear. That's what I care about. As opposed to advocate for the patient and also think of what's best for the hospital. I think there are enough people who worry about how to preserve the organization. I'm here for the patients.* (SW07)

Some described examples of feeling emboldened and raising difficult questions with the team—to ensure fairness of treatment for vulnerable patients.

> *I think there was a thing where a lot of folks were just kind of going, "Oh this guys is just making my life horrible" and they weren't trying to really think about objectively: What is the right thing to do for this guy? What have we not done? And so, you know, myself and the clinic manager started talking about this. And I had to talk about it with my supervisor too. Just to make sure that I was treating him as fairly as I would anybody else. If he were a little granny who was so sweet and was all hugs and kisses and said, "honey"- wouldn't we drop everything to help this lady?* (SW02)

> *People get really incensed when they feel like you're accusing them of being racist or biased against poor people or whatever they call it when you say things like that. Or like, well, I'll never ever do that. And I said, I'm telling you that that's people often feel depending on how you present the information that when you talk about nontreatment, they're in the back of their heads or wondering, is*

> *this something you mentioned to everybody or is this something you just mention to people of color or people who live in the [name of neighborhood] or you know, you have to present it as a true clinical option and acknowledge the external influence off society.* (SW15)

Operating from a social justice perspective leads social workers to recognize how systemic issues such as race, social class, and the power differentials between patients and healthcare professionals can impact care. The social workers interviewed for this study discussed the importance of social justice in their practice, the ways in which it guides their work, as well as the potential challenges of working from this framework within a system that does not necessarily operate from the value.

In summary, social workers interviewed in this study described a strong commitment to values that are articulated in the profession's code of ethics—in particular a commitment to the underserved and reliance on a social justice framework that is attuned to the implications of vulnerability and power in the healthcare interaction. While other professions may share commitment to similar values, the values are uniquely prominent in social work's professional code of ethics and interviews suggest that the values are strongly tied to professional identity.

**Chapter Conclusion**

This chapter examined the vertical "trunk" of the T-Shape professional framework. Findings demonstrate that social workers perceive their knowledge claims to be rooted in the broad person-in-environment approach to practice. They see themselves having knowledge about psychosocial elements of care, the influence of diversity and difference on the delivery of healthcare and pursuit of health, and the community resources needed to support patients during their illness. They also described several "soft skills", including their ability to problem solve and communicate. Finally, they made strong connections between the profession's guiding values, as described by the NASW Code of Ethics, and their perception of their roles and duties

in hospital settings. Together, examination of how hospital social workers perceive their knowledge, skills and values, contributes to depiction of their professional grounding and expertise (the vertical "trunk" of the T-Shape framework). The next chapter discusses the boundary-spanning competencies of hospital social workers, as they relate to their ability to collaborate interprofessionally.

# Chapter 5: Results- Research Question 2

## Boundary-Spanning Competencies and Social Workers as Collaborators

## (The Cross-Bar of the T-Shaped Professional Concept)

This chapter provides results related to the second research question of this dissertation: *How do hospital social workers articulate their approach and perceived ability to operate competently in different contexts, across organizational boundaries, and with other professions?* Analysis of this question provides description of the boundary-spanning competencies of hospital social workers, with a focus on the individual-level characteristics that are critical for effective interprofessional collaboration. Four interrelated individual-level domains: 1) values, attitudes and beliefs; 2) habits of mind; 3) knowledge-based competencies; and 4) interpersonal competencies described by the concept of the T-Shape professional (Donofrio et al., 2010; Nurius, 2017; Nurius, Coffey, et al., 2017; Nurius & Kemp, 2018; Nurius, Kemp, et al., 2017; Uhlenbrook & DeJong, 2012) and supported by the IPEC Competency Domains (IPEC, 2016), were explored (See Appendix C for complete description of T-shape competency domains and sub domains that guided analysis). Themes that emerged in this analysis often relate to more than one competency domain, but were organized in Table 9 under a primary organizing concept/domain. Social workers reported awareness and competency in several of the concepts relevant to being effective collaborators, but also identified some areas of limitation.

**Table 9**.

*Themes and Subthemes Related to Boundary-Spanning Competencies*

| Primary Organizing Concept* (Boundary Spanning Competency Domain) | Theme | Sub Themes (if any) |
|---|---|---|
| Values, Attitudes, and Belief-Based Competencies | Collaborative Spirits | N/A |
| Knowledge-Based Competencies | Cross-Profession Synthesizers | N/A |
| Interpersonal Skill-Based Competencies | Boundary-Spanning Communicators | -The Power of Language<br>-The Inclusion of Multiple Points of View<br>-The Perceived Need to "Sell Social Work" |
| Habits of Mind-Based Competencies | Owners of Practice Domains | - "Bigger Picture" vs. "Wearing Blinders"<br>-Perceived Moral Superiority |

*The competencies are interrelated and often overlapping. Therefore, several of the themes discussed are relevant to and make reference to more than one competency domain. I chose to categorize themes based on primary (most relevant) organizing concept.

**Collaborative Spirits**

Social workers interviewed for this study exemplified collaborative spirits, as they made several comments suggesting that they place a high value on an interprofessional approach to care. As part of the interview, social workers were asked to reflect on the most enjoyable aspect of their job. Without being further prompted, two immediately commented on their experience working on interprofessional teams.

> *I think providing what's called multidisciplinary care is among my favorite parts of my job…We know our providers, at least that's one of the aspects of my job that I really treasure and I really enjoy, is really getting to know the providers, even if they're just there a short time. But, you know, making, building rapport so that it helps us work together collaboratively and helps us do our best with the patients and families.* (SW01)

> *My favorite part is being on an interdisciplinary team. I think this hospital does a good job of incorporating everybody. It's not just physician led and so I really appreciate that I'm here. They are very diligent about including nursing input, therapy input, social work input, chaplains, anybody that's involved with the patient they really believe in kind of having everybody at the table.* (SW12)

The fact that social workers described their participation alongside interprofessional colleagues as a favored part of their job suggests that they understand themselves as functioning in relation to other professionals and the team as a whole, and that they hold high regard for this connection to the team. The enjoyment of a collaborative approach also came through as social workers' articulated a sense of curiosity and willingness to learn about diverse perspectives. For example, one commented:

> *I've always been interested in learning about and appreciating peoples own perspectives on things and how they fit or don't fit with others. […] I just like dealing with people. And then with staff here they become friends, colleagues and friends and then to see them on a day to day basis. And you have sort of a working relationship that builds overtime and one that runs well and they know what you can do and vice versa and who they are, where they come from their own backgrounds. That's pretty nice and I enjoy that a lot.* (SW09)

Learning how different perspectives "fit or don't fit" points to this social worker's ability to engage with the complex task of integrating perspectives, as well as her willingness to explore and try to understand approaches other than her own. Another social worker described enjoying the ever-changing and complex circumstance of the healthcare environment. Within her description is an appreciation of working through and understanding the team and interdisciplinary dynamics.

> *I really liked healthcare because it was always changing. And it was – there is always something new happening and it's multifaceted, so now only are you dealing with the actual patient, and again, kind of in connection with the systems methodology, I you're dealing with the family system, then you had to deal with the system of the illness and/or injury. Then you had to deal with the team staff and the interdisciplinary system. Then you had to deal with the hospital system, then you had to deal with the insurance system. And then embedded in that are all*

> *the things like culture and language and education and all of that. So never boring, I'm somebody who likes multitasking.* (SW15)

Social workers also demonstrated an appreciation for collaboration when they described it to be the "*ideal*" way to deliver care. Though, they also recognized that the team-based approach is not always realistically available.

> *What will happen is we'll get a referral for a baby with fractures and babies don't break their own bones, so we will often go interview the family together. Ideally, that's really the best way to do it is for us to sort of have a team approach and go and interview the family together. (SW20)*

> *In an ideal world, we would all go in together and talk to the patient, that isn't exactly how it happens. Palliative care team does their own interview of the patient just as social work kind of does their own interview as the nurse and physicians. And then we kind of come together and do we need one family conference that we all sit down and try to get a better understanding what the patient family want or where do we go from there. So it starts kind of separate and hopefully if communication is good, then we're all coming together knowing that each other is a part of the patient's care. The worst scenario is if we don't know each other are involved.* (SW13)

The satisfaction and appreciation that social workers described in relation to working on teams is suggestive of important boundary-spanning competencies; in particular, those related to values, attitudes and beliefs necessary for effective team functioning.

**Cross-Profession Synthesizers**

Effective teamwork involves engaging with different knowledges, in an integrated way. It is constituted by the interrelating of the different knowledge domains and different modes of practice represented by interprofessional team members (Opie, 2000). Social workers provided several examples of how the integration and synthesis of knowledge and perspectives is central to their practice in hospital settings. As mentioned above, meaningful participation on interprofessional teams is central to the experience of hospital social workers. This is because social workers rely on the integrated biopsychosocial approach to healthcare, in order for their

profession to be relevant in healthcare spaces (Horevitz & Manoleas, 2013). For example, when asked to provide words associated with her hospital social work identity, one social worker responded: "*I think of myself as a true interdisciplinary provider because I feel like as a social worker – we're in a host setting. It's not primarily psychosocial".* (SW15) Social workers' situatedness in a "host setting" and their reliance and commitment to the biopsychosocial framework requires the multi-directional exchange of knowledge and information, and an integrative approach to providing care.

It was common for social workers to describe their role as knowledge integrators, and their beliefs about the necessity of working together with other professions to address the complex needs of patients. One person described herself as the "*link between all the different professions*", and when pushed to elaborate on this description of herself she described her approach to working with multiple other professions to support families. She was explicit in describing that the team works together to create the best care plan for the patient.

> *Recognizing that the needs of our families are so great and that we can't meet all their support needs, so that means I work really closely with child life. I work really closely with palliative care and that kind of together we figure out how we can support our families best.* (SW14)

Integration of different knowledge is not always easy, and sometimes results in tension or disagreement. One social worker clearly articulated her perspective that disagreement or difference of opinion is a strength of collaborative practice. Her perspective is demonstrative of a truly integrative approach, one that values and thrives on multiple and diverse perspectives.

> *And frankly, just because we don't always agree all the time doesn't mean that the dynamics are bad. You know, I think that's healthy. There's healthiness out of disagreements or dissention. And that's what makes oftentimes a better outcome because you have that push and pull and we're challenging each other and we bring different perspectives. And then you come out with something that's much healthier and much more thoughtful.* (SW18)

Some clearly articulated the way that their teams work to integrate the expertise of various professions into care and decision-making. For example, one provided the step-wise approach to a team-based child abuse assessment. She describes how the team ultimately "*works the case together*"

> *The doc will take the medical history and I'll take a social history. And then from there on, we will manage as a team. Once a week there's a reserved spot for case staffing where we bring everybody to the table; so law enforcement, CPS, PCPs, our team. And we discuss. Everybody shares information, so we can share information and get everything out there, so we can make the decisions for these kids. And so we will work the case together.* (SW20)

Collaborative practice requires each profession to bring their content knowledge and experience together to address complex patient problems, and to value the approach and knowledge from different perspective. This allows for the team, together with the patient/family, to come up with a joint plan of care that includes shared understandings of the patient and shared goals. The quotes above demonstrate how social workers described their participation in this kind of integrated care. Next, is discussion of how social workers articulated their aptitude to communicate across boundaries in ways that impacted interprofessional collaboration.

**Boundary-Spanning Communicators**

Chapter 4 described the ways in which social workers interviewed for this study perceived themselves to be skilled communicators. Deeper examination of their comments about communication and interpersonal skills, that was guided by the competencies needed for effective collaboration, provides insight into their abilities to cross boundaries, build bridges, and encourage IPCP and the effective delivery of healthcare. Interpersonal skills are considered a crucial boundary-spanning competency needed for effective interprofessional collaboration. This includes learning the language and methods of other disciplines, and having the ability to effectively navigate conflict, build relationships with diverse partners, and explain one's work in

terms that are understandable to other disciplines (Nurius, Kemp, et al., 2017; Nurius & Kemp, 2018; IPEC, 2016). Discussion of communication and interpersonal skills in this chapter aims to unpack social workers' perceptions of these skills, as they relate to effective interprofessional collaboration. Three subthemes are discussed below: the power of language, the inclusion of multiple points of view, and the perceived need to "sell social work".

The Power of Language

Social workers interviewed were attuned to the concept of "*language*" and the importance of "*speaking languages*" in the clinical encounter. Several described their ability to effectively communicate and be understood by healthcare teams, patients and their families. This idea of "*speaking both languages*" refers to the language of the healthcare team/system and that of patients and families, and is an ability that often places social workers in the position of interpreting information. The goal of these kinds of communications is improved understanding—by all involved parties.

> *I think the social worker is in a unique role and that we can sort of speak both languages. It feels like the core of my job is eliciting from the family what's important and what that means. And being able to communicate that in a context that the providers can understand, and how it relates to the decisions that providers are asking families to make. There's so often that if you were in a room and it was just the parent and the physician having that conversation-- it gets misconstrued and misunderstood […] I think a big part of it is being a bridge between the families and the healthcare system because I think there are so many times, where there's a lot of miscommunication and goals are not aligned.* (SW12)

This social worker later described herself as a "*messenger*", a person who can share information from the team with the family "*in a different way*", and someone who is situated in the "*middle"* of the multiple stakeholders. Similarly, another social worker described herself as an "*interpreter of information both ways— between the health system and the patients and families*." (SW09) Another said that she is able to identify when communication has gone wrong, and sees herself

as the person who can ensure that the back-and-forth between the healthcare providers and the patient/family are effective.

> *Helping the family members […] articulate to the team what their concerns are, and sometimes I can see that communication just go the wrong way. So helping families tell the team what they are thinking in a manner that the team can hear it and then also helping the team communicate back to the family in a way that the family and or patient can hear it. So calling it out, identifying it, helping the communication of it.* (SW11)

One social worker described herself as a "*hub*" who is responsible for encouraging effective communication between the patient/family and healthcare providers, but also amongst various institutional components. She also described enjoyment of this boundary-spanning role.

> *I've often found that when I do have that chance to talk to patients, their understanding of what's been told to them is so out of line with what's really going on. I very much feel, and this is maybe particularly me specifically, because I'm not American and I'm particularly dedicated to helping people who might understand some of the words but they're not really following. I often find myself in the role of communicating with the doctors. I'm kind of being a hub. Communicating with the doctors, communicating with financial, communicating with patient and being the one to kind of facilitate understanding among the three different entities. I like that role*. (SW07)

Effectively communicating with multiple stakeholders in the clinical interaction is of high value and featured centrally in interviews with social workers. This was articulated in both their descriptions of acting as the communication bridge or liaison between multiple parties, and also in comments made about the challenges they confront in communicating with other professionals. To this end, some social workers described communication challenges, including the experience of "*speaking a different language*" from other healthcare professionals.

> *As a social worker, I feel like I'm constantly speaking a different language to these people. And things that seem like the right thing to do or setting a boundary or this is not appropriate because this, a lot of those people don't get that. So that's really challenging.* (SW16)

> *It can be very lonely because we speak a very different language than they do and no matter how bad they want to speak it, no matter how bad I want to know what the*

> *potassium of 12 means, I don't speak that language. So it can be very lonely because they will say the potassium is 12 and everyone will nod and I am thinking does that mean he is dead, does that mean he is better, does it mean he is fine? What should it be? Is it like earthquakes where one to two is very big, or is it like pounds where one to two isn't any?* (SW11)

Both of the social workers who described challenges understanding or being understood by other professionals, also described their persistent efforts to improve communication and overcome the challenges presented by "linguistic" differences. One, for example, commented on her efforts to bring her perspective forward in a way that can be understood by others.

> *I also have the great fortune of people who really want to hear my perspective, so it also carries. I feel a weight of really bringing it forward, being able to say it in a manner that they understand and can accept. Because some of them are quite scientific people, they really like the practical, they like to know an answer and in social work we are like yeah, there is maybe no answer here and that's fine.* (SW11)

In sum, social workers demonstrated awareness of the importance of language, and a commitment to serving as the hubs, messengers, and interpreters of information between various parties.

Inclusion of Multiple Points of View

Related to social workers' value of a common language, several described the important boundary-spanning work of ensuring that all perspectives are conveyed, heard, and appreciated in clinical encounters. This includes the perspectives of healthcare providers, patients, and families, and requires strong skills in communication. One saw herself as the "advocate" for a decision-making process that is inclusive of patient and providers.

> *My role is to try to see if people can appreciate each other's point of view. Listening and letting people know that they have a voice even though it may not be the ultimate one with an outcome. Try to decide whose advocate I am to be […] if that includes being the patient advocate or the family advocate or the other staff. The advocate for "I don't think you've been hearing this"* (SW09)

The idea of advocating for a process was brought up by another, who described her role as an "*advocate within the team*", meaning that she advocates for clear understanding by everyone. She described a tactic of "*asking question of the healthcare team*", to ensure clarity of information exchange between patients and providers.

> *The physician and palliative care did the primary presentation and I was present as well to offer support and to offer support…at times to ask questions of the healthcare team. One of the things that I think is helpful is, and I'll always ask permission from the family or from the patient to say, "Is it ok if I ask a question". I'll ask before the meeting. But to think of questions that might be allow for more explanation so that the providers can address that in more detail. I think it may be helpful for the family or patient to have that explanation.* (SW01)

Others were more clear that their role was to advocate strictly for the patient, to ensure that the patient's voice and perspective is heard and considered. Sometimes this occurs through an empowerment approach of encouraging patients and families to "*speak up*".

> *And I think it's really hard for families when there are – in the [name of unit] we have three residents, a fellow and at least one attending. That's five doctors in a minimum that a family sees during any real conversation about their child's care. And frequently there are multiple other consulting providers. And I don't think we do a great job of keeping conversations small and intimate for families. And part of that is we want them to have access to all of the experts who can weigh in with separate opinions. And I think we do a very poor job at times of realizing how overwhelming and intimidating that is for families. And so a big part of how I see my job is helping families feel comfortable and encouraging them to ask questions and to speak up because I feel like a lot of them don't do that.* (SW19)

Other times, social workers restate patient perspectives amongst other care providers, to ensure that their perspective is included in decision-making.

> *My role has been basically to kind of restate things in a care conference that focuses again on what the family's opinions are. There are a couple of physicians in the meeting who I think do a good job without needing any setup or coaching to say things like choosing the options, there are options here. Often the hardest thing is that people are not talking about the option of not doing something. And the fact that the option of not doing something is not something that we're going to judge you about sort of thing.* (SW15)

One understood herself to be knowledgeable and responsible for sharing patient perspectives with various members of the team.

> *So a lot of times it's to make sure that conversation that you know – […] I mean it comes up when there's a barrier to care. And maybe we can give some insider some background as to why the family is having this challenge meeting the needs of the care team and what's being done.* (SW14)

Social workers interviewed understood themselves to be engaged squarely in the process of communication between patients, families and teams. They identified with being advocates for patients, but also for the processes needed to ensure that multiple perspectives were clearly communicated and incorporated into decision-making and care.

The Perceived Need to "Sell Social Work"

Expressing one's knowledge and perspective in terms that are understandable to other disciplines is another important element of communication that results in improved interprofessional collaboration. All of the social workers interviewed recognized the importance of demonstrating their own value, and effectively communicating their roles, responsibilities, skills, knowledge areas and contributions to the healthcare team. Embedded throughout discussion of this subtheme is the idea that social workers exert significant effort and energy to "sell their profession".

> *I think sometimes the social worker has to work harder to be more visible or to sell social work services in a way that people respond, instead of just be like you're just the CPS worker or a negative. It's more like there's a wide variety of things that social workers do so we're doing our jobs; we're also educating people about the type of work that we are capable of doing.* (SW04)

Needing to sell the profession suggests that social workers' do not perceive their roles and contributions to be well understood by other professions. One social worker stated, *"Sometimes I put my foot down about things that are not my role or educate when they are my role"* (SW10). Needing to put one's "foot down" indicates that the way the team learns about how social work

contributes is not always through a process of working together and learning from each other, but rather as a result of tension when a social worker is told to do something that they feel is outside of their scope of practice. This illustrates that skills not only need to be understood, but also must be seen as having value. Power differentials inherent in healthcare may influence whose roles are understood and appropriately called upon (this is discussed in more detail in Chapter 6 section titled "Hierarchy and Power").

Several designated themselves the responsibility of educating other members of the team about their roles and contributions, which is a central rationale for IPE (IPEC, 2016). One saw herself as "*significant and respected*" on her team, yet in order for this to be her reality, she described the need to educate other professionals about the fundamental value of the profession.

> *If the perception is neutral then social workers themselves are able to publicize or help educate people to know what we do. It's a malleable thing where people can actually learn and take advantage. They can go 'okay we've got a social worker in the clinic and I don't know what to do with them'. And it's like, 'well this is what I do this is how I get help'. Once they see that, you can break down barriers that way. So I think being a teaching hospital helps us to do that.* (SW04)

This social worker went on to describe her efforts to formally educate new medical residents rotating through her clinic about the social work role, so that "*they can inquire about that service in other arenas or other hospitals where they may go*" (SW04). Another talked about intentionally working to establish themselves as a contributing member of the team.

> *I think that around here you really do have to establish yourself as someone that's important and contributes to the team in order to be used. And so it's very intentional and it takes a lot of work, but I think over time you do it less after you've kind of done the work upfront […] You know, just I think showing the value you can add or the insight you can bring and also kind of balancing when, what do people need to know. (SW14)*

The assumption underlying such efforts is that the very basics of the social work role are not explicit for others to understand (team members and patients). This is also discussed in chapter 4 section titled "Skilled Problem Solvers: The Team's Google".

Social workers also described varying styles and approaches related to educating other members of the team about their roles. One described the way that she gently nudges other team members to recognize her contributions.

> *I think it's a fair amount of education in the moment. My goal is to, you know, rather than say, 'Oh, I wouldn't do that' to say 'Hey, let me just clarify here's my role, but let me find out who that is.' To be a liaison to make sure that that role is addressed and covered, that you don't just leave the person hanging or scrambling to figure it out.* (SW01)

Sometimes the approach is less gentle, and it is necessary to firmly take a stand about what falls within or outside of the social work role. A social worker with more than ten years of experience described her frustration with being asked to solve unsolvable problems. She expressed the desire to become more firm in her communication with the team, and also used the metaphor of "putting a foot down".

> *I talked with another social worker this morning who put a foot down and said "No I will not try to find housing one hour before the patient leaves" as though we are supposed to fix that too. That was just too much, so she said "No I'm not going to, you get it lined up then you put them on a plane and come down here because we don't have the staff and the time to do it." […] The expectation levels that I've met are high. Then we try to educate the people referring patients and that's an ongoing process. Because they want to believe that we will just fix them if they send them down here.* (SW09)

Lastly, some described difficulties in self-promotion. For example, a social worker drew attention to the value of having someone from "outside" the healthcare team educate the providers about the roles of social workers.

> *We just went to this conference and there was a social worker that spoke there—she's like one of the big researchers and names out there. And she gave a basic presentation on what social work does for nurses and everyone else. Sometimes it*

> *takes hearing from someone outside of your institution what the people in your institution can do for you. And we even talked about bringing her out here just kind of this to talk to her physicians about this kind of this excitement about what are the things that we are doing that you maybe don't know we're doing because it feels really weird to talk about yourself like that. And especially for social workers.* (SW14)

Findings suggest that social workers feel they are responsible for improving the perception of their profession in healthcare settings. While it is possible that other professions have the same responsibility, at least one social worker in this study explicitly stated her perception that social workers "*work harder*" than other professions to be understood and accepted. Findings also suggest that social workers may not always feel that they are as inherently valued as other members of the team may be. Posturing with confidence, intentionally spending time to educate other members of the team, or relying on others to promote the profession were cited as ways to improve the perception of social workers specific and unique contributions to healthcare delivery.

**Owners of Practice Domains**

As described in Chapter 1, "professional closure" is an aspect of professionalization that describes a group's effort to ensure exclusive ownership of specific areas, for the sake of effectively securing economic reward and status (Abbott, 1995; Witz, 1990). Professional closure projects help to draw important boundaries around professional groups, though also require professions to work in competition with each other to maintain jurisdictions over practice (Abbott, 1995, 2010; Olson, 2007). While the 20 social workers interviewed for this study demonstrated some level of affinity and capacity for collaboration, a minority of them also made comments suggesting limitations in their collaborative spirit. In particular, they commented several times on the strength of their professional training and perspective, in contrast or competition with other professions. Comments of this kind were not always exceedingly explicit,

but were deemed worthy of examination and discussion in this dissertation. The comments illustrate challenges to the "habits of mind" competencies, and they demonstrate the natural tension between being open to collaboration and the very real difficulties inherent to integrating different viewpoints.

"Bigger Picture" vs. "Wearing Blinders"

A concept that arose several times was the idea that other professions, especially physicians, operate with an overly narrow focus. This was described with a comparative tone, suggesting that the "bigger picture" social work perspective is presumed to be superior. For example, social workers were critical of physicians focusing so narrowly on medical diagnoses that they fail to see the patient as a person. Two social workers talked about taking the responsibility of reminding other providers to treat patients with respect. These are comments that suggest judgments and assumptions about the lens and intention of other professions.

> *A lot of times the teams get so specialized in their spot that they forget that it's a complete person. So as a social worker I think we really keep hounding that in that the patient is actually a person. Remember the patient is a person and not just a system, so those are off the top of my head*. (SW11)

> *Working with some providers is challenging because their goal sometimes is so medically focused and survival based and statistics that they forget about the fact that this is a person and there's a human being. And here I am like…so let's look at this. Like, let's hear what the patient wants. So let's understand – you know, if the patient can't speak, let's understand more from the family. What were they like?* (SW16*)*

One of these social workers went on to describe how her "*bigger picture*" view compliments and is balanced by the "*pinpoint*" view of medical staff. While at face value this seems to be a comment suggesting a collaborative approach, the claim that physicians "*have blinders on*" can be interpreted as a subtle jab.

> *I think medical staff in particular are so narrow focused. And it's almost like they have blinders on. And then here we are seeing the bigger picture. So it's a kind of*

> *a balance, like they can see the pinpoint and we see the bigger picture. And I think that that's what I represented. (*SW16)

One social worker commented on her ability to listen and spend time with patients to gather a deep understanding of their situation. She went on to say that other medical providers may not have the time or the training for these tasks. While there may be some truth in her perception, the belief that social work "owns" listening and spending time with patients suggests a lack of open-mindedness about what other professions can contribute to patient care.

> *To begin with, hopefully good listening skills. To perceive what patients are saying and maybe not exactly saying. Being attentive enough to that to go a little deeper so to get very clear, whereas a lot of other medical providers just don't have the time or necessarily the training for that.* (SW07)

Social work is undeniably attentive to the broader psychosocial and environmental factors related to patient health (ref)? while physicians and many other providers tend to be more focused on the clinical components of a patient's health. While the overall tone of interviews (as described in previous sections of this chapter) suggest that social workers believe in and operate from a place of integration, the examples highlighted in this section suggest that there are underlying beliefs that the "narrow" focus of clinical professions is misguided and that the "bigger picture" view is superior. The following section will provide additional examples of perceived moral superiority that came through in social workers' descriptions of their work on teams.

<u>Perceived Moral Superiority</u>

The original intention of the interviews analyzed in this dissertation was to better understand social workers' participation in ethical decision-making. Thus, several of the questions were focused on their perception of ethical issues in care and how those ethical issues are resolved. While analysis for this dissertation does not focus directly on their responses to these questions, discussion of their involvement in ethical dilemmas uncovered interesting

beliefs about the overall values and ethics of the social work profession. In particular, analysis uncovered several examples suggesting that social workers perceived that they are morally superior to other professions.

One example of the sense of moral superiority is the perception that social workers are better trained than other professions in ethics. All health professions receive ethics training. However, the belief that other professions do not receive adequate training in ethics suggests that these social workers perceive other professions to be operating and making decisions in a less-informed and morally inferior way. One social worker said that physicians don't understand ethics, especially related to respecting patient preferences.

> *I don't think that a lot of the physicians have training in ethics. I don't think they understand it. I don't think they understand that there is a patient preference. I don't think they understand that saying things like will they own car dealerships, that's not appropriate in this setting, so I would say the ethics.* (SW16)

Another with the belief that social workers are somehow better trained in ethics eluded to professions outside of social work lacking concern related to ethical challenges.

> *And I think that's one of the things that social workers have training on in ethics in healthcare. Other disciplines might have done an online article thing on, a couple of CE credits on unethical experiments or Willowbrook or something but for the most part people, those things happened so long ago—people don't worry about it anymore.* (SW15)

Social workers also made comments about social work's self-awareness and self-reflection, and the lack of such attributes by other professions. For example, when discussing engagement in ethical deliberation, one commented on other professions being less likely to be critical and reflective about the influence of personal values in professional spaces.

> *So that you'll have a lot of surgeons and dentists and nurses and pediatricians and social workers. So they all have that professional identity. They're all involved in the day to day care, but each person brings with them first of all their personal ethics and their personal why they got into what they are doing, part of it. And I think there are a lot of people who try to pretend like those things are*

> *separate but they're not. […] I think for people who aren't trained like social workers, they don't see it. They just see a discussion. Like, oh the doctor is talking about surgery, the nurse is talking about the post op care. And the social worker is talking about the resources. Now, that's not what's happening. And so I think that the interdisciplinary stuff is exhausting because a lot of people like I said pretend like their personal beliefs don't influence their professional performance. And so if you end up having to call somebody on that, either they're defensive or angry or both or they get it. That happens sometimes. But people don't like to have that pointed out because they're like, oh, I never let my personal beliefs get involved. You totally are. And it's human, it's human nature*. (SW15)

Another commented on other providers' lack of attunement to patient needs, while describing themselves as empathetic and trying to understand where people come from.

> *Being more attuned to patient needs and preferences I think is important. I mean that's like you know, a big part of the equation and that's sometimes where other members in the healthcare team maybe struggle or maybe aren't as aware, just in their different focus. You know being more focused on the treatment versus you know, patients first. So I mean I feel like in that way just being empathetic and trying to understand where people are coming from is important and helpful.* (SW03)

Through each of these comments about superiority, is the sense that the professional training of social work is different from other professions.

> *I mean I think it's just because our training is so different from the other disciplines that they don't always look at people from like a strengths perspective. So I mean I would like to see more of that, or as doctors are kind of trained to look at what's wrong.* (SW06)

What is ironic about this comment is this social worker's unwillingness to see the physician point-of-view from a strengths perspective. Applying the principles and practice approaches learned in professional training (e.g., communication skills, critical self-reflection, and acceptance of diversity) ought to evenly apply to work with patients and work with colleagues.

While the interviews in this study did not specifically ask social workers to examine their biases and judgements around other professions, a close look at the data suggest that there is judgement or a lack of open-mindedness related to their perceptions of how other professions

approach their work. The comments suggest the lack of a presumption of good intent, and demonstrate the perspective that the social work approach is superior in terms of practice approach and moral principles. They also demonstrate a lack of knowledge about scopes or practice and roles/responsibilities of other professions. Because of their lack of appreciation for the different kinds of skills/knowledge that are needed to effectively deliver healthcare, they assume that others aren't trained as well as they were.

**Chapter Conclusion**

While in many ways social workers see themselves as inextricably linked to interprofessional teams, analysis of the interviews for this dissertation suggest the need for deeper understanding of the socialization processes and opportunities to learn and become effective as boundary spanners on interprofessional teams. The next chapter will provide results for the final research question, which examines the operationalization of social workers' interprofessional identity, through examination of the facilitators and barriers to collaboration that hospital social workers confront.

# Chapter 6: Results- Research Question 3

## Multi-Level Factors That Impact Social Workers' Experiences with Teams

The previous two chapters of results were informed by the concept of the T-Shaped Professional, which provides the structure for investigation of both disciplinary identity and depth (the vertical trunk of the "T"), and the specific knowledge and skills necessary to engage in boundary-spanning interprofessional collaboration (the horizontal cross bar of the "T"). Combining these two elements provide description of an interprofessional identity, which is defined as having both a sense of belonging to one's own profession, as well as an interprofessional team or community (Khalili et al., 2013). The purpose of this chapter is to present the ways in which hospital social workers described their ability to operationalize their interprofessional identities—through an articulation of the perceived enablers and barriers to integrate with their teams.

The chapter provides results related to the third research question of this dissertation: *How do hospital social workers describe the facilitators and barriers to engaging collaboratively with interprofessional teams?* Analysis of this question uncovered multi-level factors that influence social workers' experience of collaboration—factors at the individual, team, institutional, and societal levels. A recent paper published by Moore and colleagues (2017) provides a socio-structural analysis of emergency department (ED) social work services. Using Bronfenbrenner's (1977) socioecological framework, the authors identified several factors that influence the interactions between ED social workers and the teams and patients with whom they interact. The analysis for this research question similarly applies a socioecological framework to examine facilitators and barriers to interprofessional collaborative practice (See Figure 2). While the model was not used a priori to guide the development of research questions

and coding schemes, it was applied inductively as multi-level factors began to surface during analysis. The levels of the model (micro, mezzo and macro) were used as organizing concepts to categorize themes and subthemes as they emerged (See Table 10).

***Figure 2***. Sociocultural Framework as Applied to Examination of Social Workers' Experiences of IP Collaboration (adapted from Moore et al., 2017)

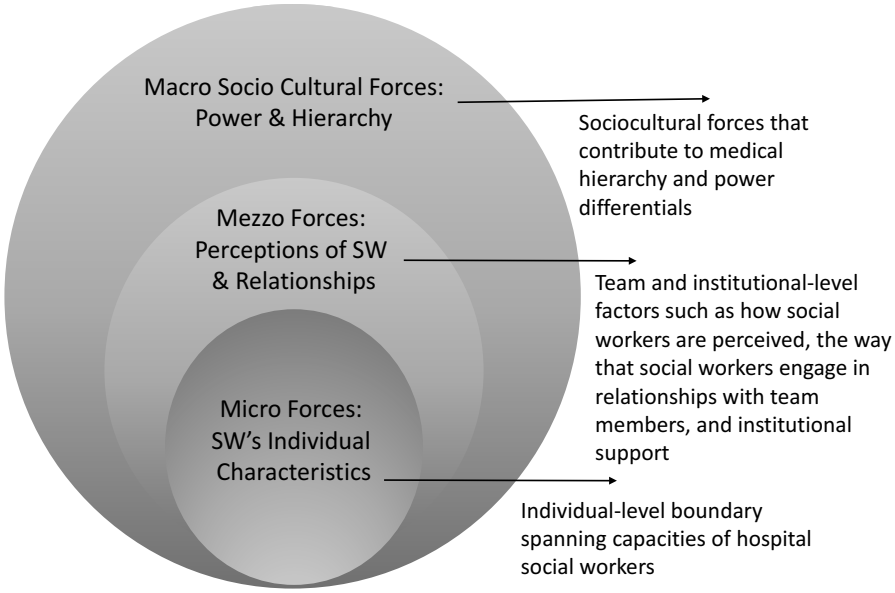


**Table 10.**

*Themes and Subthemes Related to Perceived Facilitators & Barriers to Interprofessional Collaboration*

| Organizing Concept | Theme | Sub Themes (if any) |
|---|---|---|
| Micro Forces | Social Workers' Confidence | N/A |
| Mezzo Forces | Role Ambiguity | -Broad and Ambiguous<br>-Narrow and Confined |
| Mezzo Forces | Time for Collaboration | N/A |
| Mezzo Forces | Institutional Support | N/A |
| Macro Forces | Hierarchy and Power | -Socio-cultural influences of power and hierarchy in medicine<br>-Hierarchy dismantled |

**Social Workers' Confidence**

The boundary spanning competency related to developing confidence suggests the need for professionals to "understanding how one's own expertise adds value to interdisciplinary efforts" and the need to balance "assertiveness with patience" (Nurius & Kemp, 2018). Social workers commented on their abilities and challenges related to demonstrating these elements of confidence and discussed confidence as a key factor in successful collaboration. Their perception about the need to demonstrate confidence was discussed in Chapter 5 (section titled "The Perceived Need to Sell Social Work"). Pulling from that section, I've exemplified the kinds of comments that social workers made about the relationship between their ability confidently make

the case for their presence for the sake of working alongside the other professionals on their teams.

> *If the perception is neutral then social workers themselves are able to publicize or help educate people to know what we do. It's a malleable thing where people can actually learn and take advantage. They can go 'okay we've got a social worker in the clinic and I don't know what to do with them'. And it's like, 'well this is what I do this is how I get help'. Once they see that, you can break down barriers [to collaboration] that way.* (SW04)

> *I think that around here you really do have to establish yourself as someone that's important and contributes to the team in order to be used. And so it's very intentional and it takes a lot of work, but I think over time you do it less after you've kind of done the work upfront […] You know, just I think showing the value you can add or the insight you can bring and also kind of balancing when, what do people need to know.* (SW14)

Social workers also articulated how lacking the ability to confidently demonstrate their value results in decreased ability to function effectively as part of their teams. Hierarchy (a topic discussed in the final section of this chapter), was cited as a challenge to acting confidently. For example, one social worker described lacking confidence, due to not "*speaking the language*" of physicians or other professionals.

> *Because if you don't have the language, then it's hard to feel like you have the confidence in a room full of doctors or whatever; other people that maybe don't have that are in a different part of the hierarchy than you. You may not feel like you have the permission authority or whatever, you know, to call that out.* (SW 15)

This social worker went on to say that interprofessional education, which she refers to as "*parallel training*", would allow social workers to "*connect the dots and feel more confident*". Another who referred to the impacts of medical hierarchy, described several other factors that influence a social worker's ability to act with confidence. These include, individual factors such as personality, as well as factors such as the culture of the hospital, and support from management and leadership.

> *I think sometimes the confidence is not there in terms of challenging a physician really sort of comes down to there or a group of people who may disagree with you. And I think the social workers who know their teams and who are*

> *consistently working with the same people can do that well, but I think in the ER and in other places where it rotates constantly and you don't have that relationship. […] Some of it's personality based and some of it is just the culture of the hospital, not really providing a safe space for some people to be able to do that. And I think that comes down to just clinical supervision and support from your manager.* (SW20)

While there are likely several other individual-level characteristics that influence collaboration, the ability to exercise confidence when interacting with other professionals was the most commonly discussed topic with regards to facilitators and barriers of integrating with teams. As described above and in Chapter 5, demonstrating confidence is often associated with the need to "sell the profession", to ensure that other professionals understand how to utilize and engage with social work. The following section expands on the issue of role ambiguity, and how misunderstandings about the role of social work can be a barrier to meaningful inclusion on teams.

**Role Ambiguity**

Lack of role clarity and role overlap are barriers to interprofessional collaboration (IPEC, 2016; Suter et al., 2009), as well as the development of a cohesive and strong professional identity (Khalili et al., 2013). This study demonstrated that, in many ways, social workers hold a strong sense of their roles and contributions to healthcare (See Chapter 4). However, findings also suggest that social workers struggle with role ambiguity and overlap, and discussed these as being central challenges to collaboration. In particular, they commonly talked about how they perceived other professions to mis-understand their knowledge claims and territories of practice. They also described an interesting paradox—how other professionals see their roles as both overly broad and ambiguous, and as exceedingly narrow and concrete. Both of these characterizations of social work roles were described as damaging to collaboration and the ability of social workers to be called upon and meaningfully included in patient care. These

findings are supported by other literature suggesting such struggles by hospital social workers (Egan & Kadushin, 1995; Mizrahi & Abramson, 1985; Vungkhanching & Tonsing, 2016).

Broad and Ambiguous

All social workers interviewed agreed that they have a range of roles and responsibilities to patients and healthcare teams. While some of the social workers described breadth as the trademark of their practice (see Chapter 4 discussion of being the "Team's Google"), others felt it problematic when team members understand social work too broadly. For example, one social worker described being perceived as the person who is called upon when others on the team do not know what to do with a situation. She understood this as problematic when it results in other providers lacking clarity about the specifics of social workers' roles, skills and contributions.

> *There's been some health systems where I feel that the providers see the social worker as the – 'I don't know what to do with this so I'm going to give it to them'. Like sort of this catch all of like anything not medical that kind of falls into his bag. I don't know that there's a lot of providers who could actually define for somebody, like if they would ask, all the things that the social worker does.* (SW12)

This social worker went on to clarify the implications of a lack of role clarity by other professionals. In particular, she stated that the lack of awareness about roles results in limited engagement of social workers in patient care.

> *I think some of it is the definition of what social work does, in a way it's nice because it keeps you really broad because people just come to you with whatever it is. But I think it can be a barrier sometimes in that there is a lot of times I see providers, kind of struggling with things or they wait a long time before they get social work sometimes because they are not really sure how we can help in a situation. And so I would say that's definitely one kind of barrier.* (SW12)

A more ambiguous understanding of social workers' roles can also manifest in unrealistic or inappropriate expectations of social workers' engagement with teams, patients and families. For example, one social worker described her experience of being asked to interact with families in

ways that she perceived as outside of her scope of practice. She mentioned the need to partner with nursing staff to ensure that her role is clearly understood by the team and by the patient/family.

> *I kind of joke sometimes that I didn't get my training in law enforcement […] Like there are times when I get to be the support role for the family. And now I'm telling them they can't eat pudding from the meal tray. So as I've been here longer, I've learned my partners. And so before I would go in and say, 'you really need to stop asking for the pudding from the meal trays because it's really for the patients'. But now I can say, this needs to be a nursing issue and I need to partner with the nurses and I'll go to nursing management and let them step in, so that I'm not confusing my role and I think tarnishing my ability to support the family.* (SW14)

The social worker's facetious comment about being trained in law enforcement may suggest that she feels a disconnect between her perception of her training and knowledge, and the expectations by the system and team that she works within. Another described how being seen as the "catchall" suggests that others do not understand the nuances of social work's role, and that this is a barrier to collaboration.

> *They just have a picture of what social work's role looks like…like be my monkey, write my letter, can you just deal with that. A lot of situations happen, not in my clinic, but where patients or doctors or nurses will…a patient's freaking out and they'll be like "Uh can you just call social work?" Like social work is supposed to be the catchall. So I think those are some of the barriers [to collaboration]…not understanding the role.* (SW02)

Interestingly, another social worker also described how "*some people feel like they're just a monkey*" (SW13). The perceived association of social work with a monkey is a powerful metaphor and may suggest, not only a lack of clarity, but potentially a perceived lack of respect related to the function of social workers in hospital settings.

It is undeniable that social workers cover broad territory in healthcare settings. Therefore, it is not surprising that other professionals rely on social workers to provide a wide range of services. However, the perceived inability to articulate specific skills and contributions

of social workers on teams can be damaging to collaboration. Interviews for this study confirmed that some of the social workers associated an overly broad or ambiguous understanding of their roles with a lack of respect and recognition. They perceived that a misunderstanding of their roles resulted in their services being called upon inappropriately.

Narrow and Confined

Paradoxically, social workers also shared the perceptions that their roles are understood too narrowly as logisticians or task-oriented discharge planners. Perspectives about roles is discussed in Chapter 4, under the theme "Bigger Picture People", and will be expanded on here. Several of the social workers interviewed were resistant to being perceived in narrow terms. As touched upon in in Chapter 4, the narrow understanding of social workers as discharge planners, and as discharge planning as purely logistical, creates a scenario where social workers' other knowledge and skillsets are overlooked. The role of social workers at the institutions from which interviewees were recruited, have a broad description of the social work role (See Appendix D for real job postings from each of the institutions). Regardless of the jobs that social workers were hired to complete, they often described their perception that others did not recognize their breadth of skills and potential contributions. For example, one social worker tried to clarify the many skills that allow her to participate in effective discharge planning. She sees these skills as important, yet often overlooked.

> *Sometimes within the hospital setting social workers are seen as very practical people and very discharge oriented people and they forget that they have incredible interpersonal skills and counseling skills and skills in the psychological makeup of people. We are really good at finding a nursing home, and then helping the person adjust to the grief or the change or the losses that they will face in it.* (SW11)

Similarly, another described discharge planning as a significant portion of her work, though felt that the particulars of discharge planning are undervalued or misunderstood by others on the team.

> *There's the discharge planning is absolutely huge. Under that then you have numerous other things. […] By nature of being here, something bad has happened and so to help put things in perspective, to help them say goodbyes, to help them do end of life issues as well that come up, legacy work, all of those things as well. I think most providers would very much say discharge planning is a key role and probably the primary role, but there's a lot of things like that I just mentioned that fall under that as well.* (SW13)

Another seemed unenthusiastic when she described her sense that some providers see social work as valuable "*because some of my patients need a ride home*" (SW07).

Two social workers who work in the same hospital talked about the expectation to focus on tasks that are outside their scope of practice, and are the responsibility of an administrative department in the hospital called Guest Services. One described being relied upon to address concrete needs, while simultaneously seeing the hospital system shift such responsibilities to the Guest Services department. She expressed frustration with the lack of clarity and role overlap.

> *In a lot of ways it feels like my job function is being shifted to concrete needs like meal vouchers, housing, transportation. And at the same time those parts of my job are being transferred to guest services. Guest services here does housing and transportation and is going to take on meal vouchers. And so it kind of feels like leaving me in a place of part of my job is going here and part of my job is going here. So what exactly do you want my role to be? And that's very difficult.* (SW19)

Another talked about her understanding that when people first think of social work, they associate it with housing and concrete needs. Though this may be within the roles and responsibilities of social workers at other institutions, she went on to clarify that coordinating housing for patients is actually not a part of her role at this hospital (it is Guest Services). This social worker saw an opportunity in being called upon, even for tasks she considered outside of

her scope of work—that it provides the opportunity for face-to-face interaction with a patient that can lead to other kinds of involvement with their care. She described how she takes the opportunity to educate team members and families about the range of roles and support she can provide.

> *The first thing people usually think about is housing and concrete needs. And that's fine. We don't actually do housing anymore. Guest services does, but a lot of times that's our introduction into even being able to do a concrete needs assessment for a family and we can contact guest services, work on housing and figuring out what housing looks like for the family. Then for other people it's this patient's acting up, can you fix? But you know, I think it's a balance between meeting their expectations and also educating them on our roles.* (SW14)

Understanding the roles of all members of the healthcare team is paramount to successful interprofessional teamwork (Orchard, Curran & Kabene, 2005; Henneman, Lee & Cohen, 1995). While social workers described several examples of recognition and appreciation for their contributions to care (See Chapters 4 and 5), they also commented on how providers can demonstrate a limited understanding about the range of roles that social workers contribute in the healthcare setting. The conflict between broad/ambiguous and narrow/confined has been defined elsewhere as "role fluidity", and has been described as both an asset and a challenge in another qualitative study that examined the barriers/facilitators to collaboration for medical social workers (Ambrose-Miller & Ashcroft, 2016).

**Time**

Several social workers talked about time as a factor that influenced their ability to work collaboratively with other professions. Their comments suggest a number of ways in which time can influence team work and social worker's integration with teams. Time constraints were described as a significant barrier to effective collaboration. One social worker commented on previous experience working in the ED, "*It was all really super-fast paced, everyone was*

*stressed out and there wasn't really you know much collaboration at all."* (SW05) Another described her team as collaborative almost all the time, and mentioned time constraints as the prominent barrier to effective team functioning. More specifically, she articulated the inability to "*sit and process*" alongside other professionals as the barrier to collaboration that results from limited time.

> *I think that 99.7% of the time there's a real collaborative dynamic on the part of all providers. There are occasionally providers who just may not be as available, due to lack of their time, and I think physicians and practitioners are finding themselves spread really thin. So I think it's more their lack of availability or time to really sit and process and talk about sometimes the issues that we need to help our patients and families sort out or identify. Most of the time, however, it's very collaborative.* (SW01)

Another social worker similarly talked about the positive environment for social workers, but mentioned the time limits imposed by the hospital system on patient care. She shared her belief that the 15 minute appointment structure does not allow adequate time to address patients' health in a holistic way. Interesting, is this social worker's reflection on how the time structure for appointments not only discourages her participation, but may also contribute to negative interprofessional dynamics.

> *This hospital in particular is very supportive of social workers, we have a really strong department. So I think overall we are supported. But I think you know doctors especially with healthcare the way it is these days they often have 15 minute appointments to see a patient and they need to keep clearing the rooms and moving thing along in the outpatient setting. So if a social worker needs to come talk about mental health or domestic violence and it takes 45 minutes it can be frustrating on the other end to keep kind of the flow going. So I think that's one place that it can get kind of tricky and just doing a lot of educating with physicians of why our role is important.* (SW10)

Another way that social workers talked about time was to articulate its importance with regards to building relationships. They described the importance of spending time with each other; and the impact of time spent on working effectively together. One social worker talked about the

organizational influences on the ability to have time with the team. For example, she described the difference between "floating" in and out of different teams, versus working within a "core team".

> *I float in and out of a lot of different teams which I guess is what social workers do. I have a core team, so within the core team, the dynamics are I guess fairly good because we do work with each other more regularly than outside the team. But it's always challenging even if you kind of know each other. But you get to know what works best with each other because you know those sort of idiosyncrasies and things.* (SW18)

One talked explicitly about how time on her team has allowed for an increased understanding of each other's roles, perspectives and contributions.

> *This is like I'm speaking a different language all the time. But as the years have progressed, I think we have kind of gotten used to each other and kind of understanding what our roles are and respecting what that person's bringing to the table. So, challenging but also interesting and seeing all the different angles.* (SW16)

Related to needing to spend time to develop meaningful relationships with team members, social workers also described the importance of physical presence, which is only realized when teams intentionally carve out opportunities for face-to-face interaction. One social worker talked about the detriment of not having enough team huddles (time for teams to come together quickly to discuss issues).

> *Communication with your colleague partners whether it's another social worker, whether it's a physician so that it's timely, it's understood clearly. Because that's where I do a fair number of QI reviews and there's where things get misunderstood and where things could be improved is if there were more huddles as we say is kind of the buzz word now; to be sure that the handoffs go well, to be sure that the physician understands what the social worker brings to the value of the intervention with the family.* (SW18)

Another described the challenge of being "*spread very thin*" and her belief that physical presence is necessary for her inclusion on the healthcare team. This social worker also reflected on the mismatch between the good intentions of the team toward collaboration, and the time-related

constraints imposed upon her by the structure of her position (i.e., being spread thin). This has to do with another organizational level influence—staffing resources.

> *In the ICU, I feel much more adjunct, but not because of their lack of desire, but because of how my particular position came into being. I was spread very thin and I'm still kind of spread thin, so it's harder for me to have a physical presence. And I feel like their respect for an inclusion is dependent on a physical presence.* (SW17)

The quotes above demonstrate that social workers described the concept of time as having multiple effects on their efforts to effectively collaborate with their teams. More than simply describing how rushed environments can be challenging for collaboration, social workers described the ways in which time ought to be thoughtfully and intentionally spent to develop relationships that result in clarified understanding of roles.

**Institutional Support**

Several social workers described institutional factors that influence effective collaboration. For example, they talked about the necessity of strong leadership from the highest levels of the institution, as well as from within the social work department. One talked about the influence of the medical director on the attitudes of the team towards social work's presence. This social worker's comments suggest that the culture of an institution toward interprofessionalism can be modeled from the top ranks of leadership.

> *The team I work on very much believes [in working together] and I think it comes from medical director on down. He is very much a believer in interdisciplinary teams he would never want a team without the other players on it. If anything he is a huge advocate for social work and so he's asked for more at times when yeah we couldn't get it. And so I feel very valued and the team definitely looks to me to bring things to the table that they know that they probably don't know. […] They don't sort of wait to refer to me a lot of times they just kind of anticipate that I'm going to know what's going on. So it's definitely a shared kind of model of care.* (SW12)

Another social worker talked about the importance of the perception of value (of the team, role, or specific members?) coming from the "top" of the institution, which requires strong leadership to articulate the necessity of different professions and their contributions to care.

> *My view is usually that there has to be a respect for or a valuing of a role, of a function, within a work setting. Within any team, there has to be that view from the top because otherwise you're always sort of swimming up hill. And so you kind of have to have some strong leadership, people who look at the bigger picture of things.* (SW07)

This social worker went on to also describe the importance of effective social work leadership and supervision. She talked about social work leadership needing to advocate for the profession, to help "*raise the perception of social workers*" held by physicians and high-level administrators.

Along with leadership helping to bolster the profession of social work in hospital settings, interviewees commented on the relationship between institutional priorities and the status of social work (social work or social workers?) in hospital settings. To this end, one talked about how cost savings and its impact on incentivizing efficient discharge have resulted in an improved perception of social workers and their usefulness.

> *I think that quite a while ago there wasn't the pressure for length of stay, you just kept the person here till they got ready to go. And […] now I think it's more of everybody watching money a lot more. And so that determines a lot of what we are doing, how fast we do it and studies and program changes and new ideas that people come up to make it work better. And as far as the dynamics of that and the way in which we work I think the social works are in a pretty good position because of our contribution to a safe timely discharge. So people look to us for that and give us a little more leeway, if they have trust in what we can do, so I think that were respected that way pretty well.* (SW09)

A palliative care social worker articulated the process for including the first-ever social worker as part of the interprofessional palliative care team—that the director of the program advocated for a social worker as part of team, and that those efforts had to be aligned with the hospital's priorities around cost savings and quality of care.

> *It's been very hard to fund any team member on the palliative care team, it was many years of proving the cost savings, the quality of care, the attention to goals of care, the patient satisfaction, the family satisfaction, so it's a lot of proving all of that. And in a teaching hospital they rarely think outside of physician and then they broadened it to nurse practitioner. But the director of the program always wanted a social worker and actually a spiritual care person as well. So far we've got the social worker which was a big deal.* (SW11)

Social workers interviewed highlighted or acknowledged the need for institutional leadership to be explicit about the importance of social work as a valuable and contributing profession. The reliance on people with power to help bolster the position of social work in hospital settings is related to the final theme discussed in this chapter—power imbalances and hierarchy in the practice and delivery of healthcare.

**Hierarchy and Power**

Hierarchy in healthcare teams has been defined as a set of integrated levels, within which members are ranked by two independent categories: their profession and level of authority (Liberatore & Nydick, 2008). The existence of hierarchy in the healthcare field is a known barrier to interprofessional teamwork, and attention to the discourses of power and status is necessary to develop effective collaborators (Baker et al., 2011; Hart, 2011; Kuper & Whitehead, 2012; Thylefors, 2012). Results of this analysis provide insight into how social workers understand and experience hierarchy, and the ways in which it is influenced by sociocultural forces such as gender, socioeconomic status, and race. Though the social workers in this study were not specifically asked about hierarchy, many social workers commented on it. Some described how hierarchy in healthcare is beginning to flatten, while others reported its persistence and the ways in which it acts as a barrier to collaboration.

<u>Sociocultural Influences on Hierarchy in Healthcare</u>

Social workers made explicit reference to the gendered, class, and racial dynamics of medical hierarchy, and how hierarchy impacts their roles as social workers and the experience of patients. One social worker with over ten years of experience attributed the breaking down of hierarchy over her career to changes in the way professionals are socialized, and an increasing number of women who are becoming physicians.

> *Some places people have felt that the social work is just sort of a means to the process of physicians, who are all important and so forth. But I think that with younger medical students and the residents they have a certain humility after a certain point where they don't know a lot, we can help them learn to stay and to learn really quite a bit. […] And also with more women entering medicine there's been a shift in terms of an approach to understanding a lot more things rather than 'I'm just a doctor, here's what I want, write the order, do it bye bye'. Now there's more collaborative kind of a process that goes.* (SW09)

Despite the positive changes that this social worker described, her familiarity with how hierarchy unfolds was palpable. For example, her decision to quote a physician (*'I'm just a doctor, here's what I want, write the order, do it, bye bye'*) may suggest that she has likely perceived an interaction to have such a tone. Another social worker similarly associated gender with hierarchy in healthcare, though in her experience these dynamics persisted and remained a significant barrier to social work's involvement on teams.

> *Within a medical setting you've got to realize that it is still coming so much from the tradition of doctors are gods. It is really still male and MD oriented. Even though, sure, there are lots of nurse practitioners being hired now. And many doctors, I'm sure would say, 'Oh, our social worker's an invaluable part of the team.' I think that some doctors when they say that, they mean it the way I would like for them to mean it. […] But there are many that look at it as 'Oh, our social worker is valuable because some of my folks need a ride home.'* (SW07)

Though the two social workers quoted above had different experiences with hierarchy's persistence or dismantling, their comments shed light on the way that sociocultural factors have created and perpetuated professional hierarchy in healthcare.

Along with describing how sociocultural influences have contributed to hierarchy in healthcare and how this hierarchy impacts team functioning, social workers also made numerous comments about the power differentials that impact patients. As described in Chapter 4 (Section Titled, "The Influential Code of Ethics"), social workers provided numerous comments suggesting their attention to the underserved and issues of power and vulnerability. These kinds of comments provide insight into their perception of the dynamics at play within the differential power dynamics that occur between themselves and other members of the healthcare team, as well as between patients/families and healthcare institutions. I have pulled a few exemplary comments from Chapter 4, which illustrate the ways in which interviewees understand sociocultural influences to be shaping the power dynamics in hospitals. The social workers in this study often talked about their roles in countering such dynamics, as they relate to the interactions between patients and the healthcare team or institution. For example, when asked to provide words that described her professional identity, one social worker referenced the centrality of a lens informed by power and how that translates into an empowerment approach to practice.

> *Empathy and empowerment, I think because when you are--, and a little bit in a different scope I think when you are a person in general in a medical setting especially if you are a person of color or any minority of any kind you need to be empowered in the medical field because you can get lost really easily and doctors can kind of run over you. So learning to help people empower themselves, to stand up for what they need in the medical field and to know what resources are available to them is really key I think.* (SW10)

Another described her role as someone who "*challenges truth to power*", and goes on to speak about when and why institutions often have power over patients.

> *If I'd have to sum up what social work does, it's challenging truth to power. […] Because institutions have a lot of power. And the disenfranchised that's giving voice to people who aren't educated, who are poor, who are disenfranchised for*

> *whatever reasons. So I think social work is the profession that gives that visibility like no other profession does.* (SW18)

The quotes provided in this section intend to demonstrate how social workers articulated the perceived relationship between sociocultural forces and hierarchy in healthcare. Next, is discussion of their experiences breaking down hierarchy within their teams, clinics and organizations.

Hierarchy Dismantled

While some social workers described how persisting hierarchy played out in their experiences with interprofessional teams, several provided specific examples of how hierarchy was flattened or dismantled within their teams, clinics and organizations. They described the need for other professionals to advocate for social work's value, and provided examples of how their teams cultivated environments that encouraged respect amongst professionals.

One social worker clearly articulated her view that flattened hierarchy resulted in improved patient care, as all team members contributed their expertise. Interestingly, she also associated the collaborative approach to care with improved empathy from the team toward patients. She described the influence of her clinic director, a physician, who was inclusive of all and outspoken about flattening hierarchy.

> *[The director of the clinic told me] it can't be a hierarchical kind of way of looking at things, like the doctors can't be on top and everyone's on down at the bottom. He's like it's more of a very flat everyone is at the same level and you need all of those parts to work together in order to make things happen for the patients. And it's like no one is special no one is more important than the other. And that comes off you know amazed this is important as the physician is just the front desk or social worker or nurse. So it's a very strong interdisciplinary team that values each other's roles and has a lot more empathy for patients because of that lack of hierarchy that is inbuilt into the structure of the clinic.* (SW04)

Another social worker referenced the hospital's culture of inclusion, and attributed it to being "*diligent*" about including diverse input from the care team.

> *I think this hospital does a good job of incorporating everybody. It's not just physician led and so I really appreciate that I'm here. They are very diligent about including nursing input, therapy input, social work input, chaplains, anybody that's involved with the patient they really believe in kind of having everybody at the table.* (SW12)

One described the kinds of behaviors that contributed to a flattened hierarchy and an inclusive environment. She talked about doctors and nurses "*going out of their way*" to provide praise and a friendly, open and respectful work environment.

> *Doctors and nurses go out of their way at least in this clinic to praise front desk staff, medical assistants and people get awards, people are recognized, there is a lot of potlucks, you know. There is a lot of just curbside, like if something is going on you know stop in the hallway or talk about it real-time, so it's open communication and respect.* (SW03)

A social worker who described her team as "*completely collaborative*", referred to the flattening of hierarchy in her clinic and the ways in which team member's respect and help each other across disciplinary lines. She stated, "*I feel like I can go to them, and I feel like they can come to me. So it's a very nice dynamic. There's no power struggle and no one feels like, 'How dare you go to my territory and do this.'"* (SW02). Central to her comment is the idea that professionals do not feel territorial. While role clarity is an important element of interprofessional collaborative practice, the comments by this social worker may suggest that flexibility and a lack of individual "ownership" over some areas of practice is likely also beneficial. The push and pull between the need for both role clarity and integration are likely central to discussions of hierarchy in healthcare and deserve deeper attention.

While the general sense was that a flattened hierarchy led to a more collaborative and inclusive environment, one social worker who was part of an interprofessional child protection team commented about the utility of hierarchy in some circumstances. She provided the scenario

of giving recommendations to a physician outside of her team, and said that if her recommendations were not appreciated she would call on her team's attending physician.

> *I feel comfortable saying or even to a doc in the ER, we're not taking that hard line. And if they have problems, we're going to have more conversations. And then if they still have problems, I'm just going to call my doc, because it's hierarchy, right? So the doc is more powerful. So the docs can really weigh in on the experience of working in cases like this and share what works and what has been to work based on their experience, seeing hundreds of these cases.* (SW20)

Of interest, is that the social worker went on to share that the physician always asks for her input and often defers to her and other members of the team when making difficult decisions about child protection. *"I think that it's a team and that we [social work] bring a different perspective",* she said, and then specifically described the particular awareness of social risk factors that social work is relied upon to contribute. The constellation of this social worker's reflections on hierarchy suggest that its existence and potential impacts are complex. Overall, interviews demonstrated that hierarchy was acknowledged by hospital social workers, and that its flattening or persistence were commonly associated with their ability to effectively collaborate with other professionals. Power and conflict are elements central to interprofessional care, though attention to these issues is sparse in the IPE literature (Paradis & Whitehead, 2015). Further investigation, debate and discussion about the nuances of professional hierarchies that exist in healthcare, the power that comes with specific kinds of knowledge and expertise, and the impact of all of this on interprofessional practice is needed (Fox & Reeves, 2015).

**Chapter Conclusion**

Limited studies have examined the experience of social workers on interprofessional healthcare teams. However, the few that do exist largely support the findings discussed in this chapter (Ambrose-Miller & Ashcroft, 2016; Glaser & Suter, 2016; Reese & Sontag, 2001). Most notable are findings from a qualitative study by Ambrose-Miller and Ashcroft, which similar to

this study found that multi-level factors influenced collaboration, including individual attitudes and beliefs, the nurturing of leadership, issues with role clarity and scope of practice, and power differentials. The final chapter of this dissertation is presented next and aims to integrate and situate the findings in existing literature, and will provide recommendations for social work education and training.

# CHAPTER 7: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

This dissertation aimed to examine the professional identity scripts of hospital social workers with an eye to "boundary spanning" as a component of professional socialization. I proposed in Chapter 2 that improved interprofessional collaboration calls for re-examination of the socialization and identity formation of health care professionals that are often rooted in identity politics of exclusion and professional closure. I proposed that applying the concept of an interprofessional identity or dual identity formation can begin to counter such silos and provide a framework for re-examining professional identity in the context of IPCP. Dual identity formation encourages a socialization process that allows trainees and professionals to develop a sense of belonging to one's own profession, as well as an interprofessional team or community (Khalili et al, 2013).

I cited the T-Shape framework as a training approach that can help achieve the integration of professional identity and depth, and the development of skills and knowledge necessary to engage in boundary-spanning interprofessional collaboration (the "How" of interprofessional identity formation) (Donofrio et al., 2010; Nurius, 2017; Nurius, Coffey, et al., 2017; Nurius & Kemp, 2018; Nurius, Kemp, et al., 2017; Uhlenbrook & DeJong, 2012). The concept of "Professional Capital" (Beddoe, 2011) was described as justification for "Why?" social workers and social work educational institutions should be interested in fostering an interprofessional identity. In particular, that professional status relies on social workers' ability to effectively work and be recognized by other professions.

The analysis for this dissertation was organized into three Results chapters that examined the profession-specific features (Chapter 4), boundary spanning competencies (Chapter 5), and the experience of hospital social workers collaborating with interprofessional colleagues (Chapter 6).

In examining and unpacking these three distinct features of social workers' professional identities and experiences with collaboration, I gained insight into the strengths, weaknesses, and operationalization of their interprofessional identities—their sense of belonging to their own profession, as well as the interprofessional team or community of healthcare professionals. Findings across chapters were often related, suggesting the need for an integrated discussions which is presented in this chapter.

**Social Workers' Sense of Belonging to their Own Profession**

Strong professional grounding is central to professional identity development, and is a precursor for effective collaboration and integration with teams (Beddoe, 2011; Donofrio et al., 2010; Nurius, 2017; Nurius, Coffey, et al., 2017; Nurius & Kemp, 2018; Nurius, Kemp, et al., 2017; Uhlenbrook & DeJong, 2012). For example, this is often achieved through the development of "disciplinary identity and depth" (Nurius & Kemp, 2018), and having agreed upon values and clear and well understood knowledge claims for practice (Beddoe, 2011). Findings from this study demonstrate strengths and possible weaknesses related to professional grounding of hospital social workers.

Many of the findings presented in Chapter 4 suggest that social workers were able to articulate a strong sense of what it means to "belong" to the profession, and several key findings are supported by the existing literature. A number of studies have described the ways in which hospital social workers consistently align themselves with a broad knowledge claim, often citing the person-in-environment perspective (e.g., Craig et al., 2015; Craig et al., 2013; Judd & Sheffield, 2010, Ambrose-Miller & Ashcroft, 2016). For example a qualitative study titled, "Thinking Big, Supporting Families and Enabling Coping: The Value of Social Work in Patient and Family Centered Care", suggests that health social workers bring a broad perspective to their

work with patients. The authors claims that social workers perceive their perspective to be broader than the "typically applied" medical model (Craig et al, 2015). Studies have also supported the finding that communication and problem solving skills are prominently and pridefully described by hospital social workers, and featured as central elements of their professional identity (Craig & Muskat, 2013; Hartman-Shea, Hahn, Fritz Kraus, Cordts, & Sevranksy, 2011; Moore et al., 2017). Though few studies have examined the operationalization of social work values in hospital settings, literature exists to support health social workers' commitment to addressing social justice and health equity in clinical settings (Baum, Shalit, Kum, & Tal, 2016; Beddoe, 2011; Craig, Bejan, & Muskat, 2013). Other scholars have argued that social work's core values, such as the central commitment to social justice, are what makes the social work professional identity most distinctive (Webb, 2017).

The findings from this study also elaborate on the professional identity of 20 hospital social workers as related to IPCP, and draw attention to areas of possible professional weaknesses. In particular, social workers described what I refer to as internal role strife. I define internal role strife as the tension that hospital social workers described related to an idealized depiction of the profession vs. how they perceived the reality of their everyday practice in organizations and with teams. Evidence of internal role strife presents across multiple chapters in this dissertation. In Chapter 4, social workers described a tension related to their knowledge of community resources and related activities. More specifically, several social workers described this area of knowledge as necessary and important, and simultaneously expressed dissatisfaction with an overly simplistic perception of their professional contributions (e.g., *"So it's important. However, arranging transportation, is that what I took out loans and went to graduate school and changed my career to be much less lucrative…is this the best use that can be made of my*

*skills?"* (SW07)). They perceived themselves to leave their masters-level training with important skills related to providing psychosocial elements of care, but felt that their roles were sometimes simplified and relegated to less skilled tasks.

In Chapter 6, social workers supported the moving of resource allocation and assistance with concrete services away from social work and into other professionals' scope of practice within the hospital. For example, to guest services (SW19, SW14), or to a different "level" of worker called patient navigators or care navigators who do not require masters-level training (SW07). These kinds of comments suggest that the logistics/resource-oriented aspects of the social work role are not always enjoyed or appreciated by social workers, despite them being central and expected elements of their positions in hospitals (Judd & Sheffield, 2010). This is a challenge to the notion of having a sense of "belonging" to one's own profession, and suggests a weak element of hospital social workers professional identities.

A significant body of literature exists to describe hospital social workers' perception of their roles (e.g., Ambrose-Miller & Ashcroft, 2016; Baum et al., 2016; Beder & Postiglione, 2013; Craig & Muskat, 2013; Kramer, 2013; Megan Moore et al., 2016; Pugh, 2016; Pullen-Sansfacon & Ward, 2014; Vungkhanching & Tonsing, 2016). Studies have also demonstrated that social workers are not always satisfied with the operationalization of the social work role in hospital settings. For example, a recently published study demonstrates that task variety which includes psychosocial care and involvement in *complex* discharge planning or case management has been linked to positive job satisfaction for hospital social workers (Pugh, 2016). In other words, social workers may be less satisfied when they are relegated only to the realm of resource allocation and/or discharge planning. Most relevant to findings from this study, is a qualitative study of urban hospital social workers in Canada that reports differences in status related to

social workers' perceptions of their daily roles (Craig & Muskat, 2013). Status was related to the amount of "expertise" required for various roles, and the authors pose that higher status roles may reinforce existing ideas of social work identity. Roles such as "janitor" or "broker" were perceived as having low status and were not considered to require a significant amount of expertise (Craig & Muskat, 2013). Furthermore, the authors report that low status roles appeared to be maligned by some of the participants, and that social workers perceived their masters-level education to make them overqualified for such roles. Interestingly, a role that received higher status was that of "glue", in which social workers identified that they are a critical component of the functioning of interprofessional teams (Craig & Muskat, 2013).

Oliver (2013) states that the professional identity of social workers is weakened by conflicting message within the profession itself. Findings from this study, with support from the literature, suggest that such conflicting messages exist, manifest, and cause social workers to struggle in their attempts to determine the nature of their role within the interprofessional team. More investigation is warranted to understand whether there is sufficient congruence between the messages about the professional roles, responsibilities, and knowledge claims developed during training vs. the realities of how social workers are called upon to fulfill their roles in hospital settings.

**Social Workers' Sense of Belonging to the Interprofessional Team and Healthcare Community**

The second half of the interprofessional or dual identity requires professionals to hold a sense of belonging to the interprofessional team or community. Social workers provided many positive reports related to their ability to work alongside their team members and effectively collaborate. In Chapter 4 they described how their profession-specific knowledge, skills and

values contribute to and even steer the direction of interprofessional care, and healthcare more generally. In Chapter 5, they described tendencies toward a collaborative spirit, to synthesizing and integrating information, and their ability to communicate effectively across professional and organizational boundaries. In Chapter 6 they described the multi-level facilitators and barriers to effectively collaborating. As described in Chapters 4-6, they honed in on their experience of being perceived as valuable and unique contributors to patient care, and described the ways in which they are trusted, relied upon and respected by other professionals.

Social workers in this study also provided many examples of feeling misunderstood, under-utilized, or unappreciated by other health care professions. For example, in Chapter 5 social workers described the need to effectively "*sell social work*", suggesting that the profession is not well understood or accepted. Chapter 6 expands on this in the discussion of role ambiguity—in particular, how social workers perceived other professionals to understand their roles either too narrowly or too broadly. Either of these perceptions of the social work role resulted in them being called upon inappropriately. For example, that providers see social workers as the "I *don't know what to do with this so I'm going to give it to them*" (SW12). Or that when social workers are seen as "*very practical people*" providers "*forget*" that they have other important skills (SW11). Role ambiguity, role creep, and blurred boundaries were commonly cited barriers to interprofessional collaboration, and have been demonstrated as such by other qualitative studies of hospital social workers (Ambrose-Miller & Ashcroft, 2016; Craig et al., 2015; Glaser & Suter, 2016; Reese & Sontag, 2001).

Related to the discussion of role ambiguity, is attention to power and hierarchy in the construction of health professionals roles. Social work has often seen its identity as formed by the attitudes of other more powerful professions, especially medicine (Payne, 2006). To this

point, Fox and Reeves (2015) assert that by 'sharing' power with other professions, physicians may not necessarily be relinquishing power, but rather extending their reach beyond their own professions. While healthcare organizations, policies, professional organizations, payment structures and other factors interact in complex ways to determine who is hired and paid to deliver healthcare, this study along with supporting literature, suggests that physicians can remain the primary gatekeepers of access to a range of other health professionals and services (Engel, Prentice, & Taplay, 2017; Fox & Reeves, 2015). This means that social workers, for example, may rely on physician perceptions of them to be included and called into patient care.

This concept of physician-as-gatekeeper was certainly seen in the interviews for this study, as social workers consistently and explicitly made reference to the importance of fostering support and inclusion by physicians. Many of their positive experiences with collaboration were related to the physicians they work with demonstrating appreciation of the social work role (e.g., Ch. 6- the physician who advocated for a social worker to be involved in the palliative care team). Social workers also made several comments about the need to "sell" social work, in order to be called upon by physician gatekeepers (e.g., Chapter 5- educating medical residents about the social work role, demonstrating value, gaining their trust). Despite the fact that a minority of social workers commented explicitly on the persistence of hierarchy on their healthcare teams (Chapter 6), a more nuanced examination of how hierarchy impacts the work of hospital social workers suggests that power and hierarchical structures have more subtle influences on the ability of social workers to find a meaningful and well-respected place on the team.

Also relevant to findings related to role ambiguity as a perceived barrier to collaboration, is the fact that transcendence of professional boundaries is an important element of the collaborative process (D'Amour, Ferrada-Videla, San-Martin Rodriguez, & Beaulieu, 2005).

Healthcare professionals must feel secure in their specific roles, but also flexible and open within these roles; they are expected to be both static and fluid, confident and open to others' perspectives (Khalili et al., 2013; Michalec & Hafferty, 2015; Nurius & Kemp, 2018). There is some evidence that social workers interviewed for this study may not always feel secure enough in their own roles to graciously share practice space with other professionals.

Social workers frequently commented on their unique skills or contributions to patient care, suggesting that they are the only professionals on the team capable of integrating a broader person-in-environment framework, operating from a commitment to social justice and the vulnerable, "seeing patients as people", and applying a robust ethical framework to decision-making and care (See Chapters 4-6). Furthermore, social workers' comparative statements toward other professions, suggest they "own" certain areas of practice (e.g., *"I think medical staff in general are so narrow focused" (SW16)* or *"they don't have training"* in deep listening (SW07) or ethics (SW 15, 16)). A study by Gachoud and colleagues (2012) reports similar findings, with social workers (and nurses) reporting their perception that they were more patient-centered than other professions. The authors claim that nurses and social workers perform a kind of boundary work around the concept and implementation of patient-centered care (Gachoud, Albert, Kuper, Stroud, & Reeves, 2012). For social work, the yearning for role clarity and "ownership" over a "distinctive space" (Beddoe, 2011) of practice is likely linked to the desire for improved professional recognition (Healy & Meagher, 2004) or "professional capital" (Beddoe, 2011). However, this kind of boundary closing has not generally been successful in gaining acceptance of the social worker role (Payne, 2006), and it is counter to the theoretical underpinnings of interprofessional collaboration that call for some amount of role-blurring alongside professional specialization (D'Amour et al., 2005).

**Developing Social Workers as Collaborators: Recommendations for Social Work Education**

As discussed in Chapter 6, social workers described multi-level facilitators and barriers to collaboration. They described personal characteristics, team and organization level issues, as well as sociocultural influences on their ability to effectively work with other professionals in the hospital setting. Given that professional identity development occurs early in the education and socialization of health care professionals, findings of this dissertation have the most immediate implications for social work education. Below are several recommendations that can help move masters-level social work training in a direction that better prepares its graduates to develop a strong interprofessional identity.

1) *Require social work students to participate meaningful interprofessional education (IPE).* Few social work education programs have incorporated IPE learning as an integrated component of course work or field placement (McPherson & Moss, 2001), despite the fact that formal and informal methods of IPE have the potential to enhance teamwork. Opportunities to learn how to collaborate effectively must happen across the learning continuum, from foundational years of professional learning all the way through the integration into practice settings (Institute of Medicine, 2015). With regards to professional identity development and its relationship to collaboration, practice opportunities are particularly important (Joynes, 2018).
2) *Attend to and manage profession-engendered power issues in social work education and in interprofessional education.* Power and hierarchy in healthcare is both explicitly portrayed and implicit and nuanced. Some attention has been given to the impact of power and hierarchy on collaboration e.g., (Baker et al., 2011; Kuper & Whitehead, 2012), but more

attention is needed to understand how it manifests and how best to develop appropriate educational and practice interventions to address it. Hall and colleagues (2013) have suggested that IPE should explicitly incorporate professional development and boundary work, for example, by encouraging discussion of topics such as idea dominance, inclusion and exclusion from professional boundaries, and professional cognitive maps (Hall et al., 2013).

3) *Prepare social work students to become "T-Shaped" professionals.* Nurius (2017) has argued for the "strategic preparation" of doctoral students and early career social work scholars to be able to meaningfully contribute to cross-disciplinary and integrative research. This call to action is in the context of social work scholars confronting perception challenges as they aim to bring their scientific potential to the marketplace (Moore, Martinson, Nurius, & Kemp, 2017; Nurius, 2017). Similar perception challenges impede hospital social worker's abilities to integrate with interprofessional teams, thus supporting the need for clinically oriented social workers to acquire both strong professional grounding along with training in boundary-spanning competencies that lead to enhanced integration with other professions. In particular, findings from this dissertation suggest that social work education should encourage attention to "habits of mind" related competencies for collaboration. Social work is guided by the "respect for human diversity" (CSWE, 2015). This value is imparted as central to the social worker-client interaction, and ought to be taught as important professional standards for interprofessional collaboration as well. Social workers interviewed for this study perceived themselves to have a collaborative spirit in many ways, but analysis revealed that qualities such as curiosity and open-mindedness to contributions of other professions could be enhanced.

In addition to the recommendations related to masters-level social work education, there are also system-level implications of the findings. In particular, findings suggest that advocacy for the social work role may be needed in institutions and at higher levels of the healthcare system. Related, in order for social work to be meaningfully included in IPCP, payment structures need to align with a value and priority for psychosocial care as an element of healthcare quality improvement. This level of advocacy and change requires being able to demonstrate and then measure the impact of the knowledge and skills of social workers in improving health care quality and outcomes. However, there is consensus among leaders in the field that the current evidence of social work's effectiveness is inadequate, that more work needs to comprehensively document social workers impact in hospital and other health care settings (Andrews et al., 2015), and that cost-effectiveness of social work practice ought to be a top research priority (Andrews et al., 2015; Andrews et al., 2013; McCabe & Sullivan, 2015). Emerging literature on the "Science of Social Work" demands that social work is capable of developing a rigorous research portfolio (Gehlert, 2016), which has the potential to guide future efforts to improve quality of care, cut costs, and improve collaborative practice that include social workers as key members of the team. Thus, continuing to develop rigorous outcome-based research measuring the effectiveness of hospital social work continues to be a key priority for the field.

**Limitations**

It is important to note some of the limitations encountered during the design, data collection and analyses phases of this study. First, data for this dissertation was gathered in July-August 2012, for a study that was designed to answer different research questions than those addressed in this dissertation. The main limitation of a secondary data analysis is that I was not able to explicitly ask questions that would get at the research questions I addressed in this paper.

For example, with regards to the elements of professional identity that I explored, it would have been beneficial for me to have participants explicitly reflect on the knowledge, skills and values that they believe they rely on in their practice. In addition, given the passing of the Patient Protection and Affordable Care Act in March 2010, there may be significant changes in the social workers' experiences as implementation has occurred over the past five years. Second, data analysis was completed mostly on my own, with limited opportunities for debriefing sessions and the inability to return interpretation to the social workers who participated in this study. I intend to revisit this long-format dissertation for preparation of manuscripts for submission to peer-reviewed journals. When I do this, I will engage co-authors in a more robust debriefing process that includes discussion of coding approach and code application. Finally, there were study limitations related to recruitment and study sample. Convenience sampling was used to recruit participants, which could have resulted in sampling bias (e.g., recruitment of social workers with a particular kind of experience or interest in interprofessionalism or ethics). As is always a limitation of qualitative work, the findings of this study are not generalizable beyond the experiences of those interviewed. That being said, many of the findings are supported by a growing body of literature aimed at understanding how hospital social workers perceive themselves and function on interprofessional teams.

**Conclusion**

This qualitative dissertation examined the professional identity narratives of 20 hospital social workers in a way that is conceptually grounded and relevant to efforts to engage with IPCP. The study was the first of its kind to examine the interprofessional identity of hospital social workers, by integrating the discipline specific attributes of professional identity with the boundary spanning competencies required for collaboration. Findings from this study indicate

that hospital social workers have much to contribute to the function of interprofessional healthcare teams, but also that there are several barriers and circumstances that inhibit meaningful participation and integration in the hospital setting.

"*We cannot construct identity unless we participate with others in that action, because it is only in relationship with others that we can construct identity. Equally, we need to give meaning to our participation—about the ways in which we are important to others, and the ways in which we are making a contribution—for it to contribute to our identity. By constructing our identities in relation to others, we are creating communities of practice, where there is mutual engagement in a joint enterprise through a shared repertoire of behavior*" (Payne, 2006, p. 147)

## References


Abbott, A. (1988). *The System of Professions*. Chicago, IL: Chicago Press.

Abbott, A. (1995). Boundaries of Social Work or Social Work of Boundaries? *Social Science Review, 69*(4), 545-562.

Abbott, A. (2010). The system of professions. An essay on the division of expert labor. *Chicago: Univ. of Chicago Press*.

Alrdich, H., & Herker, D. (1977). Boundary Spanning Roles and Organization Structure. *Academy of Management Review, 2*(2), 217-230.

Ambrose-Miller, W., & Ashcroft, R. (2016). Challenges Faced by Social Workers as Members of Interprofessional Collaborative Health Care Teams. *Health Soc Work, 41*(2), 101-109.

Andrews, C., Darnell, J., McBride, T., & Gehlert, S. (2013). Social Work and Implementation of the Affordable Care Act. *Health and Social Work, 38*(2), 67-71.

Andrews, C. M., Browne, T., Allen, H., Coffey, D., & Gehlert, S. (2015). *Social work and the Affordable Care Act: Maximizing the profession's role in health reform*. Retrieved from

Baker, L., Egan-Lee, E., Martimianakis, M., & Reeves, S. (2011). Relationships of power: implications for interprofessional education. *J Interprof Care, 25*, 98-104.

Bartlett, H. (1975). Ida M. Cannon: Pioneer in Medical Social Work. *Social Service Review, 49*(2), 208-229.

Baum, N., Shalit, H., Kum, Y., & Tal, M. (2016). Social workers' role in tempering inequality in healthcare in hospitals and clinics: a study in Israel. *Health Soc Care Community, 24*(5), 605-613. doi:10.1111/hsc.12234

Beddoe, L. (2011). Health social work: Professional Identity and Knowledge. *Qualitative Social Work, 0*(00), 1-17.

Beder, J., & Postiglione, P. (2013). Social work in the Veterans Health Administration (VA) System: rewards, challenges, roles and interventions. *Soc Work Health Care, 52*(5), 421-433. doi:10.1080/00981389.2012.737906

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brazg, T., Dotolo, D., & Blacksher, E. (2015). Finding A Seat at the Table Together: Recommendations for Improving Collaboration between Social Work and Bioethics. *Bioethics, 29*(5), 362-368. doi:10.1111/bioe.12106

Burditt, A. (2006). Defining Family Medicine as a Scientific Discipline. *Canadian Family Physician, 52*(10), 1206-1207.

Bywaters, P. (1986). Social work and the medical profession: Arguments against unconditional collaboration. *British Journal of Social Work, 16*(6), 661-667.

Cabot, R. (1909). *Social service and the art of healing*. New York, New York: Moffat, Yard and Company.

Cameron, A. (2011). Impermeable boundaries: Developments in professional and inter-professional practice. *J Interprof Care, 25*, 53-58.

Craig, R. W. (2007). A day in the life of a hospital social worker: presenting our role through the personal narrative. *Qualitative Social Work, 6*(4), 431-446.

Craig, S., Bejan, R., & Muskat, B. (2013). Making the Invisible Visible: Are Health Social Workers Addressing the Social Determinants of Health? *Social work in health care, 52*(4), 311-331. doi:10.1080/00981389.2013.764379

Craig, S., Betancourt, I., & Muskat, B. (2015). Thinking Big, Supporting Families and Enabling Coping: The Value of Social Work in Patient and Family Centered Health Care. *Social work in health care, 54*(5), 422-443. doi:10.1080/00981389.2015.1017074

Craig, S., & Muskat, B. (2013). Bouncers, brokers, and glue: the self-described roles of social workers in urban hospitals. *Health Soc Work, 38*(1), 7-16.

CSWE. (2015). Educational Policy and Accreditation Standards for Baccalaureate and Master's Social Work Programs. Accessed online: https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx.

D'Amour, D., Ferrada-Videla, M., San-Martin Rodriguez, L., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *J Interprof Care, 19*, 116-131.

Donofrio, N., Sophrer, J., & Zadeh, H. (2010). Research-driven medical education and practice: A case for T-shaped professionals. *Medical Jounral of Australia, Retrieved from: http://www.ceri.msu.edu/wp-content/uploads/2010/06/A-Case-for-T-Shaped-Professionals-20090907-Hossein.pdf*.

Egan, M., & Kadushin, G. (1995). Competitive allies: rural nurses' and social workers' perceptions of the social work role in the hospital setting. *Soc Work Health Care, 20*(3), 1-23. doi:10.1300/J010v20n03_01

Engel, J., Prentice, D., & Taplay, K. (2017). A Power Experience: A Phenomenological Study of Interprofessional Education. *Journal of Professional Nursing, 33*(3), 204-211.

Evetts, J. (1999). Professionalisation and professionalism: issues for interprofessional care. *J Interprof Care, 13*, 119-128.

Fox, A., & Reeves, S. (2015). Interprofessional collaborative patient-centred care: A critical exploration of two related discourses. *J Interprof Care, 29*(2), 113-118.

Freidson, E. (1970). *Profession of Medicine: A Study of Sociology of Applied Knowledge*. New York, NY: Harper & Row.

Gachoud, D., Albert, M., Kuper, A., Stroud, L., & Reeves, S. (2012). Meanings and perceptions of patient-centeredness in social work, nursing and medicine: a comparative study. *J Interprof Care, 26*(6), 484-490. doi:10.3109/13561820.2012.717553

Gehlert, S., & Browne, T. (Eds.). (2012). *Handbook of health social work* (2nd ed.). Hoboken, N.J.: John Wiley & Sons.

Gehlert, S. (2016). Social Work and Science. Research on Social Work Practice, 26(2), 219-224.

Glaser, B., & Suter, E. (2016). Interprofessional collaboration and integration as experienced by social workers in health care. *Social work in health care, 55*(5), 395-408. doi:10.1080/00981389.2015.1116483

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *J Interprof Care, Supplement 1*, 188-196.

Hall, P., Weaver, L., & Grassau, P. (2013). Theories, relationships and interprofessionalism: Learning to weave. *J Interprof Care, 27*, 73-80.

Hart, C. (2011). The "elephant in the room": using emotion management to uncover hidden discourses in interprofessional collaboration and teamwork. *J Interprof Care, 25*, 373-374.

Hartman-Shea, K., Hahn, A., Fritz Kraus, J., Cordts, G., & Sevranksy, J. (2011). The Role of the Social Worker in the Adult Critical Care Unit: A Systematic Review of the Literature. *Social work in health care, 50*(2), 143-157.

Healy, K., & Meagher, G. (2004). The reprofessionalization of social work: collaborative approaches for achieving professional recognition. *The British Journal of Social Work, 34*(2), 243-260.

Horevitz, E., & Manoleas, P. (2013). Professional competencies and training needs of professional social workers in integrated behavioral health in primary care. *Social work in health care, 52*(8), 752-787. doi:10.1080/00981389.2013.791362

Institute of Medicine (IOM). (2001). *Crossing the Quality Chasm. Crossing the Quality Chasm: A New Health System for the 21st Century*. Retrieved from Washington, D.C., National Academy Press:

Interprofessional Education Collaborative (IPEC). (2016). *Core competencies for interprofessional collaborative practice*. Retrieved from Washington, DC: Interprofessional Education Collaborative:

Itzhaky, H., & Zanbar, L. (2014). In the front line: the impact of specialist training for hospital physicians in children at risk on their collaboration with social workers. *Social work in health care, 53*(7), 617-639. doi:10.1080/00981389.2014.921267

Joynes, V. (2018). Defining and understanding the relationshi between professional identity and interprofessional responsibilities: implications for educating health and social care students. *Advances in Health Sciences Education, 23*(1), 133-149.

Judd, R. G., & Sheffield, S. (2010). Hospital social work: Contemporary roles and professional activities. *Social work in health care, 49*(9), 856-871.

Khalili, H., Orchard, C., Spence Laschinger, H., & Farah, R. (2013). An interprofessional socialization framework for developing an interprofessional identity among health professions students. *J Interprof Care, 27*(6), 448-453.

Kitchen, A., & Brook, J. (2005). Social work at the heart of the medical team. *Soc Work Health Care, 40*(4), 1-18. doi:10.1300/J010v40n04_01

Kramer, B. J. (2013). Social workers' roles in addressing the complex end-of-life care needs of elders with advanced chronic disease. *Journal of Social Work in End-of-Life & Palliative Care, 9*(4), 308-330. doi:10.1080/15524256.2013.846887

Kuper, A., & Whitehead, C. (2012). The paradox of interprofessional education: IPE as a mechanism of maintaining physician power? *J Interprof Care, 26*(347-349).

Laker, D., & Powell, J. (2011). The differences between hard and soft skills and their relative impact on training transfer. *Human Resource Development Quarterly, 22*(1), 111-122.

Liberatore, M., & Nydick, R. (2008). The analytic hierarchy process in medical and health care decision making: a literature review. . *European Journal of Operational Research, 189*(1), 194-207.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *Naturalistic Evaluation, 1986*(30), 73-84.

Long, D., & Heydt, M. (2000). Qualitative Analysis of a BSW Field Placement with a Hsopital-Owned Physician Practice in a Skilled Nursing Facility. *Health Soc Work, 25*(3), 210-218.

McCabe, H., & Sullivan, P. (2015). Social Work Expertise: An Overlooked Opportunity for Cutting-Edge System Design Under the Patient Protection and Affordable Care Act. *Health Social Work*, 40(2), 155-157.

McPherson, K., & Moss, H. (2001). Working and learning together: good quality care depends on it, but how can we achieve it? *Quality in Health Care, 10*(Suppl II), ii46-ii53.

Michalec, B., & Hafferty, F. (2015). Role theory and the practice of interprofessional education: A critical appraisal and a call to sociologists. *Social Theory & Health, 13*(2), 180-201.

Mitchell, P. (2005). What's In A Name? Multidisciplinary, Interdisciplinary, and Transdisciplinary. *Journal of Professional Nursing, 21*(6), 332-334.

Mizrahi, T., & Abramson, J. (1985). Sources of strain between physicians and social workers: implications for social workers in health care settings. *Social work in health care, 10*(3), 33-51.

Mizrahi, T., & Davis, L. E. (2008). Encyclopedia of social work. In (20th ed.). Washington, D.C.: NASW Press.

Moore, M., Cristofalo, M., Dotolo, D., Torres, N., Lahdya, A., Ho, L., . . . Fouts, S. (2017). When high pressure, system constraints, and a social justice mission collide: A socio-structural analysis of emergency department social work services. *Social Science & Medicine (1982), 178*, 104-114. doi:10.1016/j.socscimed.2017.02.014

Moore, M., Ekman, E., & Shumway, M. (2012). Understanding the Critical Role of Social Work in Safety Net Medical Settings: Framework for Research and Practice in the Emergency Department. *Social Work in Health Care, 51*(2), 140-148. doi:10.1080/00981389.2011.610872

Moore, M., Martinson, M., Nurius, P. S., & Kemp, S. (2017). Transdisciplinarity in Research: Perspectives of Early Career Faculty. *Research on Social Work Practice, X*(XX), 1-11.

Moore, M., Whiteside, L. K., Dotolo, D., Wang, J., Ho, L., Conley, B., . . . Zatzick, D. F. (2016). The Role of Social Work in Providing Mental Health Services and Care Coordination in an Urban Trauma Center Emergency Department. *Psychiatr Serv, 67*(12), 1348-1354.

Mor Barak, M., & Brekke, J. S. (2014). Social work science: Dilemmas for identity formation and transformation in doctoral education. *Research on Social Work Practice, 24*(616-624).

NASW. (2004). National Association of Social Workers (NASW) Social Work Pioneers: Ida Cannon. Retrieved from http://www.naswfoundation.org/pioneers/c/cannon.htm

NASW. (2011b). Social Work Salaries by Race & Ethnicity: Occupational Profile Accessed online: https://www.socialworkers.org/LinkClick.aspx?fileticket=m_-S90OGQss%3D&portalid=0.

Nester, J. (2016). The Importance of Interprofessional Practice and Education in the Era of Accountable Care. *North Carolina Medical Journal, 77*(2), 128-132.

Norman, G. (1985). *Assessing clinical competence*. New York, NY: Springer.

Nurius, P. S. (2017). Social Work Preparation to Compete in Today's Scientific Marketplace. *Research on Social Work Practice, 27*(2), 169-174.

Nurius, P. S., Coffey, D., Fong, R., Korr, R., & McRoy, R. (2017). Preparing professional degree students to tackle Grand Challenges: A framework for aligning social work curricula. *Journal of the Society for Social Work and Research, 8*(1), 99-118.

Nurius, P. S., & Kemp, S. (2018). Individual level competencies for team collaboration with cross-disciplinary researchers and stakeholders. In K. Hall, R. Croyle, & A. Vogel (Eds.), *Advancing Social and Behavioral Health Research Through Cross-Disciplinary Team Science: Principles for Success*. New York: Springer.

Nurius, P. S., Kemp, S., Kongeter, S., & Gehlert, S. (2017). Next generation social work education: fostering transdisciplinary readiness. *European Journal of Social Work, 20*(6), 908-920.

Oandasan, I., & Reeves, S. (2005). Key elements for interprofessional education, Part 1: The learner, the educator and the learning context. *J Interprof Care, 19*(supl1), 21-38.

Oliver, C. (2013). Social Workers as Boundary Spanners: Reframing our Professional Identity for Interprofessional Practice. *Social Work Education, 32*(6), 773-784.

Olson, J. (2007). Social Work's Professional and Social Justice Projects. *Journal of Progressive Human Services, 18*(1), 45-69.

Opie, A. (2000). *Thinking Teams/Thinking Clients: Knowledge-Based Teamwork*. New York, NY: Columbia University Press.

Oskam, I. F. (2009). T-shaped engineers for interdisciplinary innovation: an attractive perspective for young people as well as a must for innovative organisations. In 37th Annual Conference–Attracting students in Engineering, Rotterdam, The Netherlands (Vol. 14).

Paradis, E., & Whitehead, C. (2015). Louder than words: power and conflict in interprofessional education articles, 1954-2013. *Medical Education, 49*, 399-407.

Patton, M. (2002). *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: 3rd Sage Publications.

Payne, M. (2006). Identity politics in multiprofessional teams: palliative care social work. *Journal of Social Work, 6*(2), 137-150.

Pugh, G. L. (2016). Job satisfaction and turnover intent among hospital social workers in United States. *Social work in health care, 55*(7), 485-502.

Pullen-Sansfacon, A., & Ward, D. (2014). Making interprofessional working work: Introducing a groupwork perspective. *The British Journal of Social Work, 44*(5), 1284-1300. doi:10.1093/bjsw/bcs194

Reese, D. J., & Sontag, M. A. (2001). Successful interprofessional collaboration on the hospice team. *Health Soc Work, 26*(3), 167-175.

Reeves, S., MacMillan, K., & Van Soeren, M. (2010). Leadership of interprofessional health and social care teams: a socio-historical analysis. *Journal of Nursing Management, 18*, 258-264.

Rosenfeld, P. (1992). The potential of transdisciplinary research for sustaining and extending linkages between health and social sciences. *Social Science & Medicine, 35*, 1343-1357.

Shanske, S., Arnold, J., Carvalho, M., & Rein, J. (2012). Social workers as transition brokers: facilitating the transition from pediatric to adult medical care. *Social work in health care, 51*(4), 279-295. doi:10.1080/00981389.2011.638419

Shenton, A. (2003). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63-75.

Spitzer, W., Silverman, E., & Allen, K. (2015). From organizational awareness to organizational competency in health care social work: the importance of formulating a "profession-in-environment" fit. *Soc Work Health Care, 54*(3), 193-211. doi:10.1080/00981389.2014.990131

Stige, B., Malterud, K., & Midtgarden, T. (2009). Toward and Agenda for Evaluation of Qualitative Research. *Advancing Qualitative Methods, 19*(10), 1504-1516.

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *J Interprof Care, 23*(1).

Thylefors, I. (2012). All professions are equal but some professions are more equal than others? Dominance, status and efficiency in Swedish interprofessional teams. *Scandinavian Journal of Caring Sciences, 26*, 505-512.

Uhlenbrook, S., & DeJong, E. (2012). T-shaped competency profile for water professionals of the future. *Hydrology and Earch System Sciences, 16*(3475-3483).

Vungkhanching, M., & Tonsing, K. N. (2016). Social Workers' Perceived Role Clarity as Members of an Interdisciplinary Team in Brain Injury Settings. *J Soc Work Disabil Rehabil*, 1-15.

Webb, S. (Ed.) (2017). *Professional Identity and Social Work*. New York, NY: Routledge.

Witz, A. (1990). Patriarchy and Professions: The Gendered Politics of Occupational Closure. *Sociology, 24*(4), 675-690.

Zimmerman, J., & Dabelko, H. I. (2007). Collaborative models of patient care: new opportunities for hospital social workers. *Social work in health care, 44*(4), 33-47.

Appendix A

## Interview Guide

Semi-Structured Interview Guide: Examining the Dynamics of Interdisciplinary Involvement in Clinical Ethics: Social workers' perspectives on ethical decision-making

**Section 1: Personal, professional and educational background**

1) Can you tell me a little bit about your social work education?
    a. What is your degree (BSW, MSW?)
    b. Where did you go to school?
    c. When did you graduate?
    d. Was there a focus of your social work program? (clinical, community organizing, non profit management, etc.)
2) Can you tell me about what drew you to the field of social work?
    a. What about to the field of medical social work?
3) What is your favorite part of your job as a hospital social worker?
4) What are some of the challenges you face in your job?

**Section 2: Relationships with members of the medical team**

1) How would you describe the dynamics of the interdisciplinary medical teams that you are a part of?
2) How would you describe the relationship between social workers and various members of the medical team?

**Section 3: Role on the interdisciplinary medical team**

1) Can you describe how you perceive your role on the interdisciplinary team?
    a. What kinds of tasks are you responsible for?
    b. How clear are your roles and responsibilities to you?
    c. How distinct is your role from other members of the care team? (especially other psychosocial care providers)
    d. How much do you feel that your perspective is valued as a member of the medical team?
    e. Describe any systems that are in place to allow you to "do your job"
2) Can you describe how other care providers perceive your role? How do you think physicians perceive your role? Nurses? Palliative care? Ethics consultants?

**Section 4: Personal Experience with Ethics**

1) How often would you say you confront ethical issues in your practice?
2) Can you describe a time when you were involved with a patient/family who had an ethical issue, and the issue was NOT referred to the ethics committee or ethics consult service?
    a. What happened?
    b. Who brought attention to the problem?
    c. Who was involved in the resolution of the problem?

    d. How involved were you in the resolution of the problem? What did your involvement look like?
3) Can you describe a time when you were involved with a patient/family who had an ethical issue, and the issue was referred to the ethics committee or ethics consult service?
    a. What happened?
    b. Who brought attention to the problem?
    c. Who was involved in the resolution of the problem?
    d. How involved were you in the resolution of the problem? What did your involvement look like?
4) Have you ever attended or participated in the hospital's ethics committee?
    a. If yes, what was it like?
    b. Is this something you would like to be more involved with?
5) From your experience and observation, which members of the healthcare team do you think are best-equipped (in terms of knowledge and skills) to be involved in ethical decision making?

**Section 5: Understanding of Ethics Process**

1) What do you do if you are involved with a patient/family and have an ethical concern? Who can you turn to for advice?
    a. Who typically becomes involved in an ethics case?
    b. Who is responsible for resolving the issue?
    c. What is the role of the social worker in decision-making and resolution?
2) Have you ever had an encounter with the hospital ethics committee? The ethics consultation team?
    a. What was the encounter like?
    b. What role did you play in the encounter?
    c. What did you observe about the process of the ethics committee or ethics consultation team?

**Section 6: Role of social worker in hospital ethics**

1) How well do you feel your social work education prepared you for engagement with ethical issues in the hospital setting?
2) What strengths do social workers have to contribute to ethical decision-making in the hospital? (skills, knowledge, characteristics?)
3) What are some barriers for engagement of hospital social workers?
    a. Is there anything you can think of that would improve your ability to participate in ethical decision-making? (training, additional support, time, etc.).
4) How satisfied are you with the degree to which you have participated in the resolution of ethical issues in the hospital?

**Section 7: Concluding thoughts**

1) Is there anything else that this interview brought up for you that you'd like to talk about?

Appendix B

## Code List

**Professional Identity of Social Workers (Chapter 4)**

I. "Social Work Perspective"
   a. attention to vulnerability, under representation
   b. awareness of social risk factors
   c. broad, holistic, person-in-environment
   d. critical self awareness
   e. long-term thinking
   f. meet patients where they are
   g. patient centered, patient perspective
   h. strengths perspective
   i. systems oriented
   j. tolerate ambiguity

II. SW Roles on IP Teams
   a. As perceived by other professionals
      i. Discharge planning
      ii. Importance of sw demonstrating confidence
      iii. Respectful toward sw, roles valued, important contributions
      iv. Roles misunderstood, bulldogs, secretaries
   b. As perceived by SWs
      i. "google", jack of all trades
      ii. advocate
      iii. asks hard questions/difficult conversations
      iv. assessment
      v. go-between (hospital, team, patient)
      vi. bring team together, facilitate meetings
      vii. care coordinator/resource allocation
      viii. crisis intervention/mental health treatment
      ix. discharge planning
      x. end-of-life
      xi. help patients understand information
      xii. interdisciplinary collaborator
      xiii. participate in decision-making
      xiv. participate on specialist teams (palliative care, transplant)
      xv. provide information to team (psychosocial information)
      xvi. relationship building

III. Social Work Values
   a. Competence
   b. Dignity and worth of person
   c. Integrity
   d. Relationships
   e. Service
   f. Social Justice

**Boundary Spanning Competencies of Social Workers (Chapter 5)**

I. Boundary Spanning Competencies
   a. Interpersonal Competencies
      i. Speaking the language
      ii. Communicating across boundaries
      iii. Communication hub
   b. Knowledge-Based Competencies
   c. Values, Attitudes and Beliefs
      i. Value of collaboration
      ii. Belief that it's necessary
   d. Habits of Mind
      i. Closed mindedness
      ii. Ownership of practice domains
      iii. Curiosity

II. Descriptions of Team Dynamics
   a. Comments about relationships
   b. SW needs to demonstrate value
   c. SW operates in host setting
   d. Challenges/enablers of collaboration (code list expanded below)

**Enablers and Barriers to Collaboration (Chapter 6)**

I. Challenges
   a. Communication
   b. Hierarchy/power
   c. Time constraints
   d. Undervalue of SW role/perspective
   e. Confidence

II. Enablers
   a. Appreciation of SW perspective
   b. Constructive disagreement
   c. Seen as equals
   d. System Level Support
   e. Team-based approach
   f. Confidence

Appendix C

**Boundary-Spanning Competencies for Productive Participation in Team Science**

**(Nurius & Kemp, 2018)**

| Competency | Examples |
|---|---|
| | **Values, Attitudes, and Beliefs** |
| Valuing Interdisciplinarity or Transdisciplinarity Collaboration | Attitudes that predispose one to seek and integrate knowledge from varied disciplines and stakeholders<br><br>Beliefs that such efforts are necessary, that support greater relevance, innovation, impact of outcomes |
| Contextual and Multi-level Perspectives | Belief that complex problems should be approached from and appreciation of contexts and multi-level factors |
| Collaborative Orientation | Values that emphasize qualities important to inclusion of multiple and diverse perspectives and team work (e.g., building trust, taking intellectual risks) |
| | **Habits of Mind** |
| Curiosity and Open-Mindedness | Broad intellectual curiosity, maintenance of open-mindedness in light of differences |
| Nondefensive Reflectiveness | Openness to examining assumptions and limitations of one's disciplinary or personal predispositions |
| Critical Thinking | Critical awareness about one's biases in collaborative situations, suspending judgment, deliberately taking into consideration multiple perspectives, re-evaluating in light of new information |
| Developing Confidence | Understanding how one's own expertise adds value to interdisciplinary efforts; balancing assertiveness with patience |
| | **Knowledge-Based Competencies** |
| Disciplinary Grounding | Cultivation of deep knowledge within one's home discipline |
| Other Disciplinary and Stakeholder Knowledge Accrual | Understanding core substantive and conceptual knowledge from selected disciplines and stakeholders relevant to problem focus |
| Cross-Disciplinary Synthesis | Personal and interpersonal capacity to make connections across varied concepts, theories, or research methods |

| | |
|---|---|
| Participating in Collective Integrative Processes | Develop shared interdisciplinary vision or models with disciplinary and other partners; joint questions or hypotheses; integrated research protocols and methods; modify work based upon the influence of others |

**Interpersonal Competencies**

| | |
|---|---|
| Interdisciplinary Communication: Understand Others | Learn the language and methods of other disciplines sufficiently to work together effectively; actively engage perspectives of other stakeholders |
| Interdisciplinary Communication: Be Understood by Others | Explain one's own work and perspectives in terms understandable to other disciplines and non-academic partners |
| Interdisciplinary Communication: Managing Differences | Collaborate respectfully and equitably with disciplinary partners and stakeholders; effectively navigate tensions and conflicts |
| Interdisciplinary Communication: Social and Relational Skills | Build effective relationships with diverse partners: self-awareness; sensitivity to cultural and power differences; active engagement with project and other team members. |

Appendix D

## Typical Social Worker Job Postings from Study Hospitals

Below are current job posting for social work positions at each of the three hospitals recruited from for this study. The intention of including these is to demonstrate the congruence and incongruence between social workers perceptions of their roles, the way they perceive themselves to be understood by their teams, and the intentions of organizations in hiring them as members of the interprofessional healthcare team.

Language from job posting for Social Worker II, Academic Medical Center

This position will **conduct comprehensive psychosocial assessments** of potential kidney transplant patients to **assess for psychosocial, support and resource barriers, as well as the patient's ability to adhere to lifestyle changes required post-surgery**. In addition, this position will **follow these patients through the patient's inpatient stay, assisting with discharge planning and post-surgical resource needs**. An ability to conduct and document **psychosocial assessments**, **work with an interdisciplinary team**, and **provide one-on-one and group support to patients and families is required**. This position assists in developing the social work component of the program, supports the team and patients/caregivers by ensuring that the **psychosocial and tangible needs of the patient are met**, including initial and ongoing assessment of psychosocial functioning, assisting the patient and caregivers with resources that help manage care and treatment, and participating with team members in ongoing care planning.

Language from job posting for Social Worker I/II, Pediatric Hospital

Provide clinical social work services to children with acute and chronic illness, their families, the staff and the community in a managed care environment. Assist in **promotion of culturally appropriate family-centered care** and wellness of patients and families by **identifying, interpreting, and reducing psychosocial factors contributing to illness**. **Counsel and aid patients** and their families to understand medical recommendations and options. **Assess and assist with non-medical problems** interfering with effective patient care. **Interview, coordinate, and plan programs and activities to meet the social and emotional needs of patients** and/or patients' family. Provide **crisis intervention** and **assist families in understanding** the implications and complexities of the medical situation and its impact on lifestyle.

Language from job posting for Social Worker, Public Safety Net Hospital

Job Responsibilities:

- Conduct comprehensive **assessments of psychosocial, financial, medical support and environmental needs**.
- Develop **individualized case management service plans** to assist the hospitalized and ambulatory care patient to obtain needed medical, social, financial, legal and home care services, housing, psychiatric and drug treatment and emotional support.
- **Implement**, **coordinate** and **monitor the service plan**.

- **Attend case consultations**.
- **Provide social work coverage** for the [name of associated clinic] as scheduled to coordinate social work services with medical, psychiatric, nursing and front desk staff and manage information and referral requests.
- **Accept referrals of HIV+ individuals** who are not yet engaged in care but are considering receiving primary care through [name of associated clinic].
- Work with individuals to **assist them to link to care and other services**.
- **Provide knowledge of community resources** relevant to the target population.

# Curriculum Vitae — Tracy N. Brazg

## EDUCATION

| | |
|---|---|
| PhD | **University of Washington,** School of Social Work<br>Anticipated graduation date: Fall 2018 |
| MA | **University of Washington,** School of Medicine, Dept. of Bioethics and Humanities<br>June 2014 |
| MSW/ MPH | **University of Washington,** Schools of Public Health & Social Work<br>March 2008 |
| BA | **McGill University,** Depts. of Women's Studies and Anthropology<br>April 2004 |

## CURRENT EMPLOYMENT & CLINICAL BIOETHICS TRAINING

**Assistant Director,** UW Center for Health Sciences Interprofessional Education, Research and Practice — 2016-present

**Ethics Consultant,** University of Washington Medical Center; Northwest Hospital & Medical Center — 2015-present

**Clinical Bioethics Fellow,** Seattle Children's Treuman Katz Center for Pediatric Bioethics — 2012-2015

## TEACHING EXPERIENCE

**Human Behavior and the Social Environment** — 2012; 2014
*Teaching Assistant & Sole Instructor, UW School of Social Work*
400-level required course for undergraduate social work students

**Interprofessional Education Foundation Series** — 2013-2015
*Teaching Fellow, UW Health Sciences Administration*
Year-long program for pre-licensure health science students; Assisted with curriculum development; Co-facilitated case-based learning sessions with faculty and students from the six health sciences (social work, nursing, medicine, pharmacy, dentistry, and public health)

**Carol LaMare Seminar on Palliative Care and Oncology Social Work** — 2013-2015
*Teaching Fellow, UW School of Social Work*
Elective course for MSW students interested in oncology, palliative care and bereavement; Developed and delivered bioethics content

**Community Service Learning** 2012; 2013
*Teaching Assistant, UW School of Social Work*
300-level required course for undergraduate social work students

**Advanced Health Practice II** 2012
*Teaching Practicum Instructor, UW School of Social Work*
500-level required course for MSW students in the health/mental health concentration; Developed and delivered bioethics content

## SELECTED BIOETHICS-RELATED EDUCATION FOR POST-LICENSURE CLINICIANS

**Brazg, T.** (2016). *Overview of Ethics Committees, Consult Services, and Key Ethical Issues.* Developed and presented a 3-part educational series for Overlake Hospital and Medical Center Ethics Committee. Bellevue, WA.

Anaman, G., **Brazg, T.,** & Campbelia, G. (2016-2017). Coping with Moral Distress in Nursing. Presenter at Nursing Education Days at University of Washington Medical Center. Seattle, WA

**Brazg, T**. & Dotolo, D. (2014, May; 2014, April; 2015 April). *Ethical Decision Making Across the Lifespan: Applying Tools from Bioethics to Social Work Practice*. Co-creator and facilitator of 3-credit continuing education workshop for medical social workers: Seattle, WA and Vancouver, BC.

**Brazg, T.** (2015, April). *Learning the Bioethics Lingo: Tools for Engaging in Ethical Deliberation in the Healthcare Setting*. Presenter at 2015 Council of Nephrology Social Workers Symposium: Issaquah, WA.

**Brazg, T.** (Summer 2014; Summer 2013). *Research Misconduct*. Facilitator for Biomedical Research Integrity Program mandated research ethics discussion groups for early career scholars who are supported by Public Health Service training grants: UW Department of Bioethics and Humanities.

Dotolo, D. & **Brazg, T**. (2014, April). *Ethical Decision-Making in Oncology Settings: Applying Tools from Bioethics to Social Work Practice*. Co-creator and facilitator of 1-credit continuing education workshop for oncology social workers: Cancer Lifeline, Seattle, WA.

Dudzinski, D., **Brazg, T.,** Dotolo, D. (2013, October). *Taking your Pulse: Coping with Moral Distress in Clinical Practice*. Co-presenter at Social Work Grand Rounds: University of Washington Medical Center.

**Brazg, T.** (2012, November; 2012, October). *Exploring the Role of Hospital Social Workers in Ethical Decision-Making*. Presenter at Social Work Grand Rounds: University of Washington Medical Center & Harborview Medical Center.

## RESEARCH EXPERIENCE

**Cancer Care in the PICU: A Study of Social Worker and Chaplain Roles** 2015-present
*Research Coordinator, Qualitative Research Associate*
PI: Dr. Kelly Michelson, Lurie Children's Hospital of Chicago
Coordinate study activities and data management for Seattle Children's site, conduct interviews with parents of children in the PICU and social workers/chaplains, and lead data analysis.

**Seattle Paid Sick and Safe Time Policy Evaluation**
*Pre Doctoral Research Associate* 2012-
PI: Dr. Jennifer Romich, University of Washington School of Social Work 2014
Implemented qualitative portion of a mixed-methods study with Seattle employees and employers impacted by the city's Paid Sick Leave Ordinance.

**Examining the Dynamics of Interdisciplinary Involvement in Clinical Ethics: Social Worker's Participation in Ethical Decision-Making** 2012
*Principle Investigator*
Designed and implemented a qualitative research study examining the role of hospital social workers in ethical decision-making. Received funding from the TL1 Multidisciplinary Predoctoral Research Training Program. Data collected will be analyzed as part of my dissertation.

**Seattle Children's Treuman Katz Center for Pediatric Bioethics**
*Qualitative Research Associate II* 2009-2013
Conducted qualitative research related to a variety of pediatric bioethics issues

## SELECTED PEER-REVIEWED PUBLICATIONS

**Brazg, T.,** Lindhorst, T., Dudzinski, D., Wilfond, B. (2015). Defining Patient Advocacy for the context of Clinical Ethics Consultation: A Review of the Literature and Recommendations for Consultants. Journal of Clinical Ethics, manuscript submitted for publication.

**Brazg, T**., Dotolo, D. and Blacksher, E. (2015). Finding A Seat at the Table Together: Recommendations for Improving Collaboration between Social Work and Bioethics. Bioethics, 29: 362–368.

Guon, J., Wilfond, B., Farlow, B., **Brazg, T.,** & Janiver, A. (2014). Our children are not a diagnosis: the experience of parents who continue their pregnancy after prenatal diagnosis of trisomy 13 or 18. American Journal of Medical Genetics, 164(2), 308-318.

Tabor, H.K., Stock, J., **Brazg, T.,** McMillin, M.J., Dent, K.M., Yu, J.H., Shendure, J., & Bamshad, M.J. (2012). Informed consent for whole genome sequencing: a qualitative analysis of participant expectations and perceptions of risk, benefits, and harms. American Journal of Medical Genetics, 158A(6): 1310-9.

Tabor, H., **Brazg, T**., Crouch, J., Namey, E., Fullerton, S., Beskow, L., Wilfond, B. (2011). Parent Perspectives on Pediatric Genetic Research and Implications for Genotype-Driven Research Recruitment. Journal of Empirical Research on Human Research Ethics, 6(4), 41-52.

**Brazg, T.,** Bekemeier, B., Spigner, C. Huebner, C. (2011). Our Community In Focus: The use of photovoice for youth driven substance abuse assessment and health promotion. Health Promotion Practice, 12(4), 502-511.

## CONFERENCES

**Brazg, T.** & Sanders, C. (2018, November). *Innovative Approaches to Involving Social work in Interprofessional Education Across the Learning Continuum*. Accepted oral presentation at the 2018 Council for Social Work Education Annual Program meeting in Orlando, FL.

**Brazg, T.** (2018, August). *Overview of Ethics Committees.* Faculty presenter at University of Washington Summer Seminar in Healthcare Ethics. Seattle, WA.

Dotolo, D., Fantus, S., **Brazg, T.** (2015, October). *The Intersection of Bioethics and Social Work: Teaching ethics and ethical decision-making.* Accepted panel discussion at the 2015 Council for Social Work Education Annual Program meeting in Denver, CO.

Lagunas, M., Simpkins, S., Dotolo, D., Taylor-Swanson, L., & **Brazg, T**. (2014, October). *Ethics as a Vector for Teaching Interprofessional Skills*. Co-presenter at the American Society for Bioethics and Humanities 16th Annual Meeting in San Diego, CA.

Romich, J., **Brazg, T.**, & Johnson, C. (2014, June). *Employer Perspectives on Seattle's Paid Sick and Safe Time Ordinance*. Co-presenter at the Work and Family Researchers Network Annual Conference in New York, NY.

Shannon, S. Danielson, J., **Brazg, T**., & McDonough, K. (2014, June). *Implementing a Longitudinal Case-based Curriculum for Interprofessional Education Learners using Faculty Teaching Teams*. Co-presenter at the All Together Better Health Annual Conference in Pittsburgh, PA.

**Brazg, T.** & Dudzinski, D. (2014). *What Does it Mean to Advocate for Vulnerable Patients in Ethics Consultation? Who Should Do It?* Presenter at the 10th Annual International Conference on Clinical Ethics Consultation in Paris, France.

**Brazg, T.**, Dotolo, D., Blacksher, E. (2012). *Social Work and Bioethics: A Call for Collaboration*. Presenter at the American Society for Bioethics and Humanities 14th Annual Meeting in Washington, D.C.

Guon, J., Wilfond, B., Farlow, B., **Brazg, T.,** & Janvier, A. (2011). *Our Children are not a Diagnosis: Parental perspectives on Trisomy 13 and 18*. Presenter at the American Society for Bioethics and Humanities 13th Annual Meeting in Minneapolis, MN.

Tabor, H.K., **Brazg, T.,** Crouch, J., Namey, E., Fullerton, S., Beskow, L., Wilfond, B. (2011). *Parental Perspectives on Pediatric Genetic Research*. Presenter at Genetic Alliance 25th Annual Conference in Washington, D.C.