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Social work is what social workers do: A study of hospital social workers' understanding of their work and their professional identity.

Christine Perriam
Edith Cowan University

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**Social work is what social workers do: a study of
hospital social workers' understanding of their work
and their professional identity.**

**This thesis is presented in partial fulfillment of the degree of
Master of Social Science**

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Edith Cowan University
Faculty of Health Engineering and Science
School of Psychology and Social Science
18 December 2014

Bachelor of Arts
University of Sydney

Bachelor of Social Work and Social Administration
University of Western Australia

ABSTRACT

Hospital social work in Australia appears to be undergoing a crisis of identity. The current socioeconomic context of economic rationalism and managerialism is not always compatible with social work values and social workers working in hospitals talk about feeling threatened, despite evidence of numerical growth comparable to other professions. In this study I interviewed five social workers who were practising in hospitals. The method used was the Long Interview which allows the responders freedom to express their thoughts while providing a common framework for all the interviews. Using grounded theory methodology I distilled their common understandings about what it meant to be a social worker and to do social work in a hospital. Using a theoretical framework of critical theory I also examined how the hospital setting influenced these social workers perception themselves and their work. Overall the results were positive. The social workers were insightful and articulate and demonstrated good understanding of their context and how it influenced their practice. They all felt the hospital environment was not supportive of social work but believed they made a positive contribution both to the outcomes for individual patients and for the hospital as an organisation. They all drew strongly on their social work values to confirm their identity so there was a strong common understanding of what being a social worker meant.

The 'doing' of social work was illustrated by the social workers by the use of bridge metaphors. They identified that they built bridges between patients in the hospital and their lives outside the hospital. As patient advocates they also built bridges between the patient and other staff to help the other staff understand the patient's perspective. A third bridge between discourses, the dominant discourse of economic rationalism and the quieter discourses about upholding rights was described but not named. The only problematic area for all the social workers was their difficulty in naming the skills and knowledge used in their practice. This is noted as an area for development.

Despite acknowledging the contextual difficulties confronting hospital social work, the results of this study showed the social workers interviewed to be confident in all their roles and optimistic about their future.

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Signed.....

Date.....

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A huge thank you to the five inspiring social workers who volunteered as subjects for this study and allowed me to give voice to their wisdom.

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PREAMBLE

When I returned to social work study after many years as a practitioner, my primary aim was to learn how to use research techniques to understand and evaluate my own work. However, a colleague also pointed out to me that to sustain an interest in a piece of research that would absorb a good deal of my time and energy also required some degree of passion about the subject matter. That began some soul searching about what I was passionate about, a search that kept leading me back to my own belief in myself as a social worker and my belief that my profession makes a valuable contribution to society.

As a practising social worker I am acutely aware that social work seems to be experiencing a crisis of identity, a crisis that is not only in hospitals (the site of my own practice). This crisis of identity appears to be occurring at a time when economic rationalism is the dominant economic and political paradigm impacting on how individuals are viewed, both singularly and in groups. Hugman (1991) notes that in a social political climate where economic rationalism dominates the caring professions, which include social work; such professions often become unsure of their role and identity. In my view this is happening to social work at the moment. Darlington and Scott (2002) observe that qualitative research often emerges from the experience of the practitioner, and my experience at present is of working in a profession (social work) that feels at odds with its agency location (public hospitals).

This study grew out of my attempts to make sense of this.

CHAPTER ONE – INTRODUCTION

This is a study of the experience of five social workers working in several Perth public teaching hospitals and how they make sense of their work. The big question behind this study was whether or not social workers make a difference; in this context whether they contribute to hospitals in a useful and recognized way and if so, how this happens. This study does not seek to answer this big question, but to contribute to the thinking about this. Social work's contribution to the business of hospitals has been studied in many ways: by role (Davidson, 1990); by task (Davis, Baldry & Milosevic, 2004); by what value social work adds (Auerbach, Mason & LaPorte, 2007) and by how social work maintains its relevance by adapting and integrating into changing hospital structures (Globerman, White, Mullings & Davies, 2003). In this study I have chosen to examine how social workers working in hospitals view themselves, an "inside looking out", rather than an "outside looking in" study. The focus of this study was how experienced social workers (experienced being defined as having practiced for three years or more) understand and explain their contribution as social workers in a public hospital setting. This is a study of the shared perceptions and understandings of these social workers. The initial purpose of this study was not to evaluate social work, but rather to provide a description of how these social workers understood and described their work, the essential social *work-ness* that could potentially provide insight and understanding about why social workers may sometimes feel that their profession is disconnected from the agency in which it works. However, this study became more than that. The social workers who contributed to this study contributed more than insight and understanding. They also contributed strongly expressed beliefs in the value of the profession of social work, so that the conclusions drawn at the end of the study, while asking questions about the best way forward, also contain a strong note of optimism for the continuation of social work in hospitals.

Context

Social work needs to be studied in its context as the work done by social workers is shaped by problems that develop out of interactions between people and society, where structural factors of the society cause some of its members to become disadvantaged and where there is a socially sanctioned concern about this inequality. Since its beginnings, social work has been contextually caught between two strong influences, the drive to maintain the status quo in society that allows those who have power to maintain it, and the desire of the same society to be seen as caring for those who are casualties of the social structure (Dominelli, 2004). Because it is caught between these concepts social work is continually being challenged to find compromised solutions that balance the two (Adams, Dominelli & Payne, 2009). Walker & Walker (2009) observe that because social workers work at the front line in dealing with the consequences to individuals of socially condoned inequality, it is important that they understand the social policies that create the disadvantages. The critical theory framework on which this study is based allows for consideration of the contextual influence on social work practice in hospitals, and the influence of those groups which hold the power over how and where social work is allowed to operate. How social workers hold their own power and manage the existing power structure became an important finding of this study. While it is acknowledged that the notion of power and how it is held and operates is widely contested, a simple definition involving the ability of some groups to influence other groups is adopted for the purpose of this study. Giddens (cited in Thompson, 2003, p.44) provides a succinct comment on this type of operation of power.

Power is an ever-present phenomenon in social life. In all human groups, some individuals have more authority or influence than others, while groups themselves vary in terms of the level of their power. Power and equality are closely linked.

Furthermore, Thompson (2003) distills one common theme from the various conceptions of power, describing it as “the ability to control people, events, processes or resources” (p.44).

The impact of the hospital setting on the practice of social work

Hospitals are traditionally seen to be institutions run by doctors under a medical model. The medical model focuses on illness and the interventions provided by doctors, who are seen as the professionals with the most expertise and skill to treat illnesses. The medical model reinforces the status and power of the medical profession (Sargent, Nilan & Winter, 1997). Thompson (2003) also notes that the medical model itself contains a set of associated power relationships with doctors being the dominant professional group. Historically, hospital social work, along with many other professions, has developed within the context of medical dominance and in turn has been shaped by it. Willis (1989) has argued that medicine has dominated the division of labour of health occupations in Australia, maintaining a health workforce that is structured hierarchically both by gender and occupation. Social work, therefore, has historically operated within territory allowed by this hierarchy. Holosko (1994) suggests that this historical context has been both a help and a hindrance to hospital social work.

The medical model has had a decidedly mixed blessing effect on the development of social work practice in health care settings. On one hand, it has inadvertently legitimized social work practice in that, historically, social workers have served patient needs in areas that essentially doctors told them to. On the other hand, the medical model has cast a long shadow on the profession of social work in health settings which has generally hindered its power base, stymied its potential for role development, caused identity anxiety about social work roles and generally compromised its professional autonomy (p.23).

However, some writers have maintained that in the face of the need for cost containment, a managerial model framed by economic rationalism is gaining dominance in the area of resource allocation to the health care sector (Hancock, 1999), and also that

the medical model has for some time been undermined by other professional groups such as nurses and even community groups such as the consumer rights movement (Sargent et al, 1997). If the established hierarchy is at the very least being challenged, if not changed, it could potentially change how other professions are allowed to operate. For social work to emerge from this 'long shadow' it has had to adapt to the changing context. The experience of social workers in the United States of America, where the delivery of medical services is strongly dominated by private enterprise and economic rationalism, shows that social work is capable of adapting and emerging strongly from changes that could potentially have negative consequences (discussed in more detail in Chapter Two). While my own current experience of Perth teaching hospitals is that mostly the social work department structure is being maintained, there also appears to be some movement into programs which could realign social workers away from a central social work department. It would therefore seem to be timely for hospital social work to examine its function and purpose and be ready to articulate its legitimacy if called upon to do so. This may be an area where social work could be found to be wanting. For example, Healy (2004) comments that, as well as needing to face external challenges, social work continues to be internally challenged by the "limited capacity of social work professionals to articulate their value" (p.109). This study showed some evidence to support this comment.

In the midst of ongoing change, my own experience has been that social work continues to be practiced in hospitals in a way where roles and boundaries are negotiated and re-negotiated on a daily basis. Anecdotally social workers are highly valued by their teams, so whatever it is that they are contributing is valuable to front line hospital staff. Social workers in hospitals also appear to be very good at expressing their roles and purpose through their work. Workload management issues alone force them to prioritize. Advocacy work for patients leads them to articulate their values and so called turf wars are negotiated constantly.

Through their practice, social workers appear to be adapting to changes, but in the literature the issue of how social work should be adapting is contested. One finding of this study was that social workers are builders of bridges, and this study was an opportunity for social workers in hospitals to talk about themselves, forming a bridge between the literature and the lived experiences of these hospital social workers.

Aims and objectives of this study

Aim

The aim of this study was to articulate the nature of hospital social work, particularly the work that it does and its identity, as it was described by practising hospital social workers. This study went back to basics, using a grounded theory approach to identify key components of hospital based social work from the workers themselves and to present their descriptions of their practice. These descriptions included what it is that hospital based social workers do, what knowledge, skills and values shape their identity and how relevant social work was seen by them to be to hospitals operating under a medical model strongly influenced by economic rationalism at a policy level.

Objectives

The key objectives of this study were to

- review literature relating to the social context of health and hospitals, to show how hospital social work has developed historically and then to reflect on the influences of the contextual structures that define and influence social work practice in hospitals;
- interview social workers currently practising in a hospital setting to obtain their understandings of what defines social work in this setting and to distil from these descriptions shared understandings of what components of this practice define social work in this setting; and
- relate these findings back to the hospital context and offer some insights for ongoing thinking about social work practice that may be helpful in resolving current dilemmas about the relevance and future of hospital social work.

Designing the study

As a social work practitioner turning to research, this proved a difficult task. Almost twenty years ago Riesman (1994) observed that research and practice were not well integrated in social work, practitioners tending to see research as something that goes on away from the real world, unhelpful and even irrelevant. Researchers in turn accuse practitioners of being unwilling to evaluate their own work. Reissman further postulates that the schism in social work between practice and research happened because social work researchers were slow to embrace methodological diversity, and much of the published work over-emphasized findings at the expense of the process of investigation. Reissman's observations continue to be echoed in literature about doing social work research. Darlington and Scott (2002) also observed that in social work the world of research and the world of practice have remained largely separate, noting that despite the fact that practitioners working in human services often generate ideas and questions about their practice most practitioners would not actually see this as related to research. Because of this perception they then do not take the time to write down their ideas to share with others, so professional knowledge is dismissed as unresearchable intuition or judgment. Seymour (2006), upon transitioning from social work practice to academia, observed that "the gap between knowing and doing – or more accurately the talking about knowing - has taken me by surprise, proving to be a disjuncture of greater breadth and significance than I had been prepared for" (Seymour, 2006, p. 460). Interestingly, one key finding of this study, that social work practitioners have difficulty talking about their knowledge based, was also my own experience at the start of this research journey. A further complication for social work research is that social work is an explicitly value-laden profession where practitioners' judgments and interpretations play a role, whereas academic research in general is driven by the technical-rational, especially evidence-based practice (Wilkinson, Gallagher and Smith, 2012, p.312). The result of this doing/knowing split is that the novice researcher is faced with a highly contested field that offers very little direct guidance.

For me, the best guidance came from two researchers: Thompson (2003) and Crotty (1998). Thompson (2003) offers a PCS (personal, cultural, structural) model which

provides the researcher with opportunities to illustrate how each level of interaction mutually interfaces with each other as presented in Figure 1.

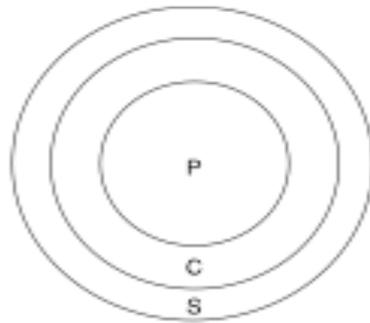


Figure 1: Thompson's PCS Model. Thompson (2003, p.17)

Thompson's model is used to scaffold the literature review that informed this study, by examining in detail the interactions between levels and how social work in hospitals is shaped by each level of the model. The literature review (detailed in Chapter Two) moves through the circles from the outside in (structural to personal), as the finishing point for the study is the five people who took part. As Thompson's model is used as scaffolding for the literature review informing this study, Crotty's scaffolding concept was used to build this study.

Crotty (1998) suggests that in order to craft meaningful research it is important that early in the development of the research process it is necessary to put particular effort into method and methodology which define the researcher's viewpoints. To shape this research I have employed the framework presented by Crotty (1998). He describes this framework as research scaffolding which provides the researcher with a "sense of stability and direction as they go on to do their own building" (p.2). This concept, as presented in Figure 2, supported me to understand my own thinking about the form and direction of my research and gave me a framework to describe it.

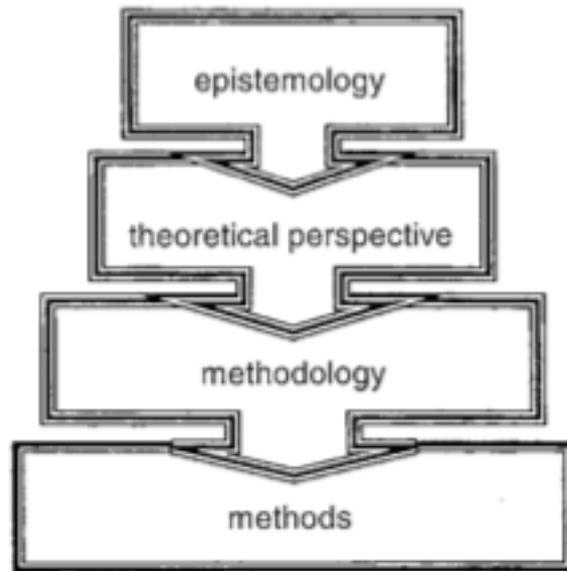


Figure 2: Crotty's framework. Crotty, (1998, p.2).

The scaffolding consists of four elements, the epistemology, the theoretical perspective, the methodology and the methods. At the start of the section describing each element, I will use Crotty's definition of the element, then go on to describe the foundations I have chosen for this study. The first two elements of the framework, epistemology (informed through subjectivist epistemology, constructivism) and theoretical perspective (informed through critical theory) I regard as the basis for this study. Constructivism supports critical theory and my reasons for using both will be described below. My methodology (informed by grounded theory) and method (informed by McCracken's long interview method) I regard as the driving elements that direct how the study was carried out. They will be briefly described in this chapter then discussed in detail in Chapter Three. Each element of Crotty's framework will now be discussed.

Epistemology: Constructivism

Crotty defines epistemology as "the theory of knowledge embedded in the theoretical perspective and thereby in the methodology" (Crotty, 1998, p. 3). Knowledge can be seen as socially produced and defined (Thompson 2003) so at any time society will engage in debates on what is and what isn't knowledge. Flyvbjerg (2001) describes the

'science wars' of the 1990s as a contest about the legitimacy of social science against "natural science" where each side claimed superiority in defining certain types of knowledge. The dichotomy between notions of objective and subjective knowledge has underpinned debates around knowledge for the past century (Darlington & Scott, 2002), and continues to do so in the debates about the superiority of evidence-based practice (Smith, 2004) and the legitimacy, due to methodological limitations, of practitioner-led research (Wilkinson et al, 2012).

Objectivism holds that meaning, and therefore meaningful reality, exists as such apart from the operation of any consciousness (Crotty, 1998). The purpose of an objectivism based study is the uncovering these external truths. The underlying assumption is that this can be done, providing the researcher goes about it in the 'right' way. Objectivism supports the intellectual tradition of positivism, which grew out of the Enlightenment of the 17th and 18th centuries and offers the assurance of "unambiguous and accurate knowledge of the world" (Crotty, 1998, p.16). This thinking confirms the legitimacy of methodologies such as the experimental or scientific method and assumes that a social scientist can objectively study the social system in the same way as a geologist can study a rock. It also assumes that the researcher's own presence is minimal or non-existent (Alston & Bowles, 2003).

This study has been informed by a subjectivist epistemology, specifically constructivism. Constructivism allows for multiple meanings, in that it holds that knowledge is constructed as a product of social and individual assumptions and is developed through language (Crotty, 1998). Thus knowledge becomes constructed through "our lived experience and through our interactions with other members of society. As such, as researchers, we participate in the research process with our subjects to ensure we are producing knowledge that is reflective of their reality" (Lincoln, Lynham & Guba, 2011, p.103). Kincheloe and McLaren also suggest that power relationships are important in assigning meaning. "Critical research traditions have arrived at the point where they recognize that claims to truth are always discursively situated and implicated in relations of power" (Kincheloe & McLaren, 1994, p.153). As previously mentioned social work, a profession shaped by context and constructivism, allows the influence of context and supports critical theory, whereas objectivism does not.

Theoretical Perspective: Critical Theory

Crotty (1998, p.3) defines theoretical perspective as “the philosophical stance that lies behind our chosen methodology which grounds our assumptions”. As I have also acknowledged the role of power in assigning meaning, the theoretical perspective chosen to inform this study is critical theory. Hinchey (1998) offers this working definition of critical theory:

Critical theory is, above all else, a way to ask questions about power. Who has it? How did they get it? How do they keep it? What are they doing with it? How do their actions affect the less powerful? How might things be otherwise? (Hinchey 1998, p.17).

Critical theory has been chosen to inform this study because it also allows for the examination of an understanding of social work within its social context. As pointed out by many writers, critical theory is not a unified approach. It refers to a theoretical tradition emanating from the Frankfurt School of the 1930s and has continued to evolve in multiple forms to the present day. However, Kincheloe, McLaren & Steinberg (2011) claim that even within the context of multiple critical theories, critical research serves to “create an equitable research field and disallows a proclamation to correctness, validity, truth and the tacit axis of Western power through traditional research” (p.173). Hick and Pozzuto (2005) point out that while critical theory is no more divorced from its context than any other, it does have the potential to be self-reflective.

Critical theory has also been shown to provide a framework for examining practice, especially in the field of education. For example, many critical theorists, (Bowe, Ball & Gold, 1992; Ball, 1994; and Hinchey, 1998), have been concerned with education policy being a vehicle for maintaining the existing social structure. This reproduction of the existing structure is what Anthony Giddens calls duality of structure, structure being both the medium and the outcome for the reproduction of social practices (Cassell, 1993).

Social work theorists have also used critical theory to conceptualize social work practice. For example, Ife (2005) views critical social work as important in addressing power inequalities and involves linking the personal and the political.

What sets critical social work apart is its insistence that social work must somehow therefore address the cause of disadvantage, rather than only helping people to adapt, adjust to make the best they can of their lives. Critical social work does not imply simply ignoring or refusing to help the individual, family, group or community; critical social workers of course will offer such help, but they will at the same time insist that it is not enough and will seek somehow to change the “system” as well” (Ife, 2005, p.4).

Ife further observes that social work, without having values based in critical social work, can develop unquestioning obedience to “legitimate” authority as described by Giddens’ duality of structure. The ability of a critical theory framework to question the context of an action or idea was important for this study as it allowed for a dynamic focus. Rather than just being a still snapshot in time of a particular group of social workers, the critical theory perspective allowed the findings to be interrogated within their context as actively interactive.

Methodology: Grounded Theory

Crotty defines methodology as “the strategy, plan of action, process, or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (Crotty, 1998, p.3). My chosen methodology for this study was grounded theory as it appeared to support a critical theory framework. Grounded theory, as described by Glaser and Strauss (1967), was developed as an alternative to the scientific method of the time and uses a phenomenological, ground up approach which ideally suits a study involving the experiences of front line social workers. The original grounded theory approach was based in the positivist tradition of the time in its assumption that the methodology will eventually arrive at consistent “truth”. However, Charmez (2000, 2011) has provided a framework, (discussed further

in Chapter Three), where a constructivist approach can inform grounded theory methodology if the assumption of an ultimate truth is removed. This study's findings are time, person and situation based and offered as part of an ongoing discussion, not a set of definitive answers about hospital social workers' understanding of their professional identity and purpose.

Method: the long interview

The definition of methods offered by Crotty is "the techniques and procedures used to gather and analyze data" (Crotty, 1998, p.3). The method used for this study was McCracken's long interview method (McCracken, 1988). This is discussed in detail in Chapter Three. McCracken sets out a method of using a particular style of questionnaire to guide the interview. This questionnaire incorporates *grand tour* or overview questions supported by floating and planned prompts that allowed the respondents to pursue their own lines of thought rather than limiting them to answers to specific questions. This method has previously been used with good effect in two studies involving hospital social work (Globerman, White & McDonald, 2002; Globerman et al, 2003).

By incorporating the work of both Thompson and Crotty I was able to develop sound scaffolding upon which to build this study, using Thompson to inform the literature review and Crotty to inform the development of the framework.

Limitations of this study.

This is a very small study of only five female social workers working in an area employing a large number of social workers. Respondents were volunteers, therefore self-selected and should not be seen to be representative of the population of hospital social workers in Western Australia.

Highlighting the contextual nature of social work was the time lapse between the phases of the study. Much of the background reading for this study was carried out in 2006, while the design and data collection was carried out in 2007-2008. Analysis then proceeded until early 2010. This occurred because the researcher was also working full-

time in a demanding hospital social work position. As a result of the slow pace of the study there were also continual shifts and policy changes in the health system which caused changes in the social context of this study, necessitating updates in literature supporting the study and illustrating the dynamic nature of social policy. Three changes of supervisor at ECU also brought different ideological inputs at different times. While this was also part of the changing context and required some shifts in thinking, it also brought a rich mixture of ideas that challenged each other and ultimately lead to a more robust analysis of the data.

Despite these limitations and the small number of respondents, this study provides insights into how hospital social workers see themselves. Their viewpoints show a number of themes and consistencies and point up both strengths and problems that could be taken up and explored further in a larger study.

CHAPTER TWO – LITERATURE REVIEW

This is a study of social work practice in hospitals. Accordingly this literature review has two focus points: firstly, there is a review of the historical development of social work, with a focus on Western Australia, to show how social work in hospitals has been shaped by its history; and secondly, specific categories of social work writings have been sampled to illustrate how social work operates across the person and the society and is contextually based.

To illustrate how social work is defined by context, a model developed by Thompson (2003), as outlined in Chapter One, was utilized. Thompson developed this model to demonstrate his consideration of discrimination and inequality in the human services. While this study is not about discrimination and oppression, Thompson's model is useful as it provides a framework to show the operations of contextual influences which he says operate at "three separate but interconnected levels, the personal, the cultural and the structural" (Thompson, 2003, p. 6). I have used this model (described in detail on page 6) to conceptualize how hospital social work as being shaped and influenced and that it can be understood by interrelationships.

The history and practice of hospital social work

From its earliest times the role of hospital social work has been debated. A physician, Dr Richard Cabot, is given credit for one of the earliest appointments of a social worker to a hospital when in 1906 a trained social worker, Ida Cannon, was appointed to the Massachusetts General Hospital. Cannon's initial view of social work was probably shaped by the nature of her appointment. Her view at that time was that the purpose of social work was to gather relevant psychosocial data to help doctors understand their patients' backgrounds and improve the likely success of their treatments, as well as explaining the hospital system to patients and reassuring them if they were frightened (Nacman, 1990). Cannon also came to believe the social work role extended into direct

treatment, asserting that “the social worker seeks to remove those obstacles in the patient’s surroundings, or in his mental attitude, that interfere with successful treatment, thus freeing him to aid in his own recovery” (1923, p.15). This early view of social work as a profession that adds value to medical treatment has remained influential to the present time and as a theme can be seen to be repeated in much of the literature presented below.

The development of hospital social work

Social work in Australia is a relatively young profession. Although it can trace its roots back to the 1920s, the most rapid period of growth appears to have been from the end of the 1950s to the mid 1970s, as reflected in the numbers of graduates and also in the membership of the Australian Association of Social Workers (AASW) which was formed in 1946 (Lawrence, 1976). The rise and development of the welfare state in Australia from the 1950s through to the 1980s created a demand for the type of skills being taught by social work courses (MacDonald & Jones, 2000). An analysis of the 1991 census data showed social work as a “relatively small but apparently stable segment of the rapidly expanding community service workforce and a modest contributor to its management” (Martin, 1996, p.29). By the end of the 1990s and early 2000’s, the growth in social work had been outstripped by growth in other service areas as shown by an analysis of census data from 1996-2001 (Healy, 2004). This analysis indicated that the number of welfare workers (defined as either holding a technical diploma or bachelor’s degree) had grown at twice the rate of social workers (holders of a bachelor’s degree or higher qualifications). Healy interprets this as society possibly devaluing professional qualifications

Public hospitals in Perth always employ qualified social workers in designated social work positions. The first known social workers appeared in Perth public hospitals around 1968 and since then social work has become an established professional group. In a systematic analysis of allied health services undertaken in Perth hospitals in 1999 (Metropolitan Allied Health Council, 1999), social workers made up the second largest allied health profession in Perth public hospitals, behind physiotherapy. It is difficult to know exactly how many social workers are employed in Western Australian hospitals

currently as health service reports tend to be by health service region and social workers are reported in undifferentiated groups along with other allied health professionals under headings such as “allied health” or “medical support” (Metropolitan Allied Health Council, 1999). However, the Metropolitan Health Service’s Annual Report for 2003-2004, the most recent metropolitan wide report prior to restructuring into area health services, showed staffing increases in the area of medical support as being in the order of 4%, similar to nursing. While it is not possible to make definitive statements from this about social work, anecdotal information from all major hospitals in Perth at the time of this study indicated an increase in social work numbers. Despite this, the discourses around hospital based social work from within this sector of the profession were more suggestive of a profession under threat than one showing growth. This is not a new phenomenon and is consistent with Cannon’s early formulation of social work being an adjunct to medical treatment.

The reasons for social work feeling threatened have been described and attributed to structural issues (particularly economic) for many years. For example, Hugman (1991) identified this feeling of threat as being common across all those professional groups that he identifies as caring professions (nursing, remedial therapies and social work), and links it to the tensions between the dominant paradigms of the groups exercising power within the state (economic rationalism) and professions who are delivering welfare services. He explains how the dominant groups reinforce their own legitimacy at the expense of others.

In order to achieve this end (ideological legitimacy) while maintaining social stability it is necessary for those groups exercising power within the state to challenge the legitimacy of state welfare services and consequently that of the professionals whose interests are also served by the development of the welfare state. The outcome is that the interests of the professionals as state employees are threatened (Hugman, 1991, p.21).

More recent literature identifies and names the dominant groups as being those who are associated with cost containment and what is often referred to as “reengineering of services” (Neuman, 2000; Judd & Sheffield, 2010). In the reengineered contexts social

work is often seen as a profession that needs to take some type of corrective action to remain relevant.

As indicated in Chapter One, the traditional association between social work and the medical profession may not be as strong or as useful as it once was. Lawrence (1965) and Holosko (1994) contend that hospital social work's achievement of professional status (along with the requirement for tertiary level qualifications) has been a result of social work's alliance with the medical profession. In the early days of hospital social work, social workers saw patients only as requested by medical staff, but after cementing that relationship social workers have moved on to developing independent roles in screening and assessment. This move towards independence may have actually been largely unnoticed by doctors. Palmer and Short (2000) suggest that hospital social workers work in an institution that poorly understands their role but despite this social workers have developed high level skills in specialized areas such as transplantation medicine and infertility. They now often practice outside the direct control of doctors, largely without interference. This lack of understanding and consequent lack of interference, Palmer and Short suggest, may be because social work is able to work across two policy areas, health and welfare, the latter being poorly understood by the medical profession. While this distancing from the medical profession may be allowing social workers to be more autonomous, it may also be making them generally invisible within the system.

It is also possible that the very nature of social work practice, which often focuses on working within the system in a collaborative way, does not lead to strong recognition by the hospital hierarchy. This ability to work collaboratively is seen as strength and promoted by some writers. For example, Zimmerman and Dabelko (2007) note that traditionally medicine has made a sharp difference between curing and caring (with the focus being on curing) and that social work has a role to work collaboratively with the medical profession to improve hospital service delivery. They conclude:

The professional education and training of social workers are aligned with the empowerment approaches used in collaborative patient care models, and medical social workers are well positioned to play leadership roles in the implementation

of collaborative models of patient care in hospital settings” (Zimmerman & Dabelko, (2007), p.46).

Pockett (2011) also promotes social work as being a profession well skilled to take a leadership role in interdisciplinary care, which should be affirming to social work. However, Auerbach et al (2007) confirm that the very nature of interdisciplinary or collaborative work can make the unique contribution of social work unclear to the hospital bureaucracy.

In summary, the historical consideration of social work in hospitals shows that it has reached a point where it is numerically established in public hospitals in Perth, Western Australia. Hospital social work does also appear to have emerged from the “long shadow of the medical profession” (Holosko, 1994. p.23) but what has been established in place of this alliance is not clearly defined in the literature, which suggests that there is a void which is yet to be filled. The literature does not show social work as a strongly independent or self-confident profession. What will be discussed below is that because context is such a large definer of any social work practice, social work continues to struggle with its own relevancy in the current socioeconomic climate.

The context of hospital social work

How the structural, cultural and personal levels described below continue to shape hospital social work forms the basis of both the literature review and later analysis of the results of the study. As Crotty’s scaffolding concept was used to build this research, so Thompson’s PCS model (referred to in Chapter One) is used as scaffolding for the literature review informing this study.

Thompson's model and hospital social work

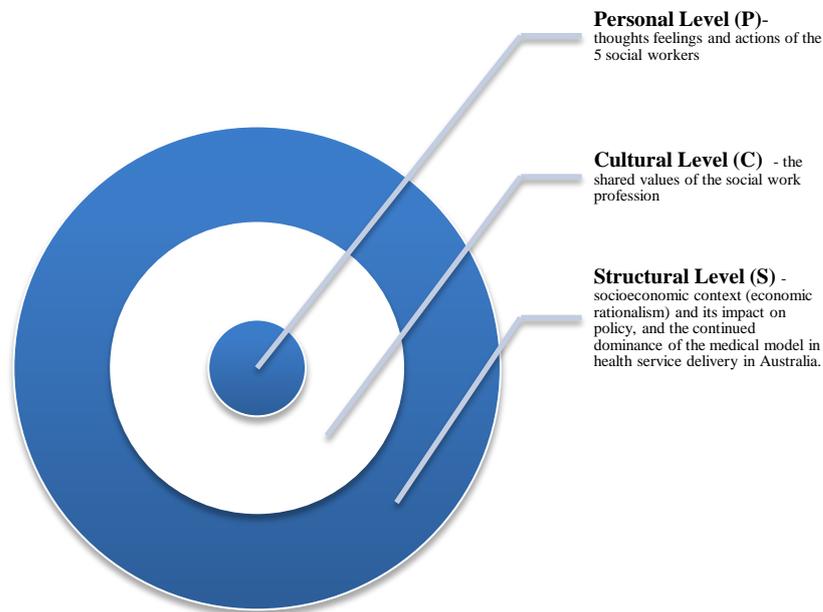


Figure 3: Applying Thompson's Model to Hospital Social Work in this study.

As presented in Figure 3, Thompson uses concentric circles to illustrate how each level is embedded within the others and also that the interactions between the levels are important. For the purposes of this study the circles have been defined as follows:

- i) The centre circle, the "P" refers to the "thoughts, feelings and actions at an individual level" (Thompson, 2003 p. 12). This is the core of what this study is about, looking at hospital social work through the eyes of the five social workers who participated in this study;
- ii) The cultural "C" is taken to mean the professional identity and values that surround social work; and
- iii) The structural "S" is the current socio-economic context and the consequent changes to how hospital-based health care is delivered.

By using these concentric circles and the idea of each being embedded, Thompson's model also offers opportunities to explore interactions between the various levels and also how social work in hospitals is shaped by each level of the model.

For this study, the literature review moves through the circles from the outside in (structural to personal), as the finishing point for the study is the five people who took part.

The structural level (S)

The structural or “S” level “comprises the macro-level influences and the constraints of the various social, political and economic aspects of the contemporary social order” (Thompson, 2003, p. 16). The specific structural factors to be examined here are the socioeconomic context (economic rationalism) and its impact on policy, and the continued dominance of the medical model in health service delivery in Australia. These structural factors are further explored below.

The economic context and influences (economic rationalism)

When looking specifically at health care, the single biggest driver of change in the delivery of health care services appears to be cost constraint. The provision of health care in Australia is expensive. According to the Australian Institute of Health and Welfare (AIHW) (2009) health expenditure in Australia rose steadily over the decade 1990 – 2000 but slowed in 2001-2007, by 2007-2008 being approximately 9.1% of the gross domestic product (GDP) (AIHW, 2009). This was an increase of only 0.6% over this period. However in 2010-2011 (most recent figures available) health expenditure had risen to 9.3% of the GDP (down 0.01% in the previous year) and showed a 0.5% increase in expenditure in just two years. In Australia, the majority of health funding comes from government (69.1%), mainly Commonwealth, with public hospitals accounting for 31.5% of all health expenditure. However, at a state funding level public hospitals occupy the top expenditure spot at 40.3% of state health expenditure (AIHW, 2012). This percentage of state expenditure is substantially down from 50% in 2009 and over 60% in 2008-9 (AIHW, 2012). This is due to the states’ drive for cost containment which has largely taken the form of financial control via funding reforming (AIHW, 2012). By 1980 economic rationalism has become the dominant political paradigm,

resulting in economic efficiency emerging as a dominant value over other values such as equality of access and quality of care (Hancock, 1999). Until the 1980s Australia had no method of comparing expenditure and measuring efficiency in hospitals. Hospitals were funded via historical budgets and there was wide variation across hospitals in costs per patient treated, with the highest cost hospitals claiming their patients were more complex and therefore more expensive to treat. Hospital social work, which, as previously discussed was a product of the welfare state, found itself in a position of no longer being intrinsically valued, but having to join with other health service to justify itself in economic terms. For example by the early 1980s Boyce & Stockton, who managed social work services at Royal Perth Hospital, the largest tertiary hospital in Western Australia noted that “like their colleagues in health and other allied health disciplines, social workers are equally accountable for the distribution of their services, their quality and their cost” (Boyce & Stockton, 1983, p.31).

The influence of Casemix funding

With cost constraint as the primary driver, in 1988 the Commonwealth Government introduced a 5-year Casemix Development Program under the Medicare Agreement. Casemix is a method of hospital funding using the concept of diagnostically related groupings (DRGs) to describe the activity of the hospital. Casemix was one of the tools used to measure activity, the principle of casemix funding was that hospitals received funding in accordance with the type of patients they treated. The 1988 funding also included projects to examine how DRGs might be used to provide consistent and evidence based funding to Australian hospitals in an objective manner (Palmer & Short, 2000).

The introduction of measurement tools such as casemix was seen by many as positive, giving social work the opportunity to review their approaches to patient care, contribute to reducing inpatient costs and improve quality of care (Byron and McCathie, 1998). However, a later consequence of casemix funding for social work was that in the decade following its introduction social work became concerned with losing control of its own accountability due to a lack of clarity in the system about the unique work being done by social workers. The reason for this was the Commonwealth Government’s policy in

the 1990s to fund only bodies that represented all allied health professions, so social work had to join the National Allied Health Casemix Committee (NAHCC) in 1991. This involvement set an agenda for the next 15 years where social work was forced to develop a generic framework for professional activities (Pockett, Lord & Dennis, 2001). During the nineties more than a decade of effort was directed towards producing an allied health classification system that did not appear to acknowledge any uniqueness of any profession. According to Cleak (2002), while this was a system that could collect a lot of data about social work activity, it was not clear that this data could be used to measure the cost/benefit of social work intervention. Additionally, systems such as this may have contributed to social work's pessimism about itself. Writers at the time such as Helen Cleak pointed to the potential adverse impact on the social work profession of not maintaining its own identity. As early as 1995 she was maintaining the position that social work needed to assert its identity and contribution, and over the years continued to see danger in the casemix process. The two quotes below are representative of her concerns.

Social work now needs to assert its identity and contribution to health care through developing an information system which will describe, classify and code the problems, services and outcomes of social work services (Cleak, 1995, p. 19).

and

One of the more disturbing elements of this process of classification has been the paradigm shift from social work working as an independent profession to becoming incorporated as an allied health profession (Cleak, 2002, p.48).

Although the casemix concept has been replaced by other funding models and the current trend is towards evidence based practice (which will be discussed below), current social work literature still largely directs social work to align itself outside the profession to maintain relevance. For example Judd and Sheffield (2010), suggest that "In response to real and potential threats resulting from the reengineering movement, it had been proposed that hospital social workers need to cultivate evidence-based practice in relation to discharge-planning and cost-containment" (p.859).

Evidence based practice

In the past ten years, effort has moved away from generic classifications into developing measures of effectiveness, usually known as evidence-based practice (EBP). The debates around evidence-based practice are not part of this study, but need to be acknowledged as forming part of the current context of hospital social work. Smith (2004) summarizes several positions taken on evidence-based practice. He suggests that in purely theoretical sense evidence based practice should be regarded positively, that social workers are often in powerful positions to do harm as much as they are to do good and therefore should be able to select the best way to work from the available evidence. The difficulty arises when the question of what is being evidenced is asked, especially when it comes to defining a *good* outcome. For example, a definition offered by Brian Sheldon that “evidence-based social care is the conscientious, explicit and judicious use of current best evidence in decisions regarding the welfare of those in need” (Sheldon & Chilvers, 2002 in Smith, 2004, p.8) relies, as Smith points out, completely on the definition of Sheldon’s own beliefs about what is conscientious and judicious. The other side of the debate is argued by Webb (2001) who cautions social workers to question the influence of economic rationalism in the guise of evidence-based practice on their practice. He argues that the support for EBP is “deeply appealing to our contemporary technocratic culture and presents a threat to traditional professional practice while further legitimizing a harsher managerialist ethos” (Webb, 2001, p. 58).

As this study is framed by critical theory (refer to Chapter One), so meanings are regarded as socially constructed and any meaning must be considered within the socio-economic context (Ferguson 2003). That health policy does influence how social workers in the health system practice will be discussed later in this chapter when the cultural level is examined. This examination will show that there is some confusion in the literature between “effective” social work practice and the notion of social work being useful to the organisation in which it is practiced; they sometimes appear to be regarded as the same thing. The critical theory framework is useful in understanding the role of power in how economic rationalism, and the interests of other groups holding power, are interpreted and expressed, sometimes unintentionally, in practice. An

understanding of this relationship is relevant to this study and is explored further in the following section.

Economic rationalism and political influence

In the 1990s many commentators on health policy in Australia regarded economic rationalism as the dominant policy paradigm (Hicks, 1995; Hancock, 1999; Alston, 2002). This has developed during a period of history where there has been a worldwide move towards global capitalism that can be traced back to the end of World War II. Its pace accelerated in the 1980s with what had previously been planned economies (former United Soviet Socialist Republic and China) moving towards a mixed economy model and accepting tenets of capitalism such as the private ownership of goods and services (Gianaris, 2001).

The primary characteristic of global capitalism is the ability to move capital freely around the world with the consequent expansion of the influences of technology and automation. Global capitalism is said to promote individualism over society and seeks to replace traditional ethical values with the spirit of materialism (Gianaris, 2001). Supporting global capitalism is the doctrine of economic rationalism. This doctrine rests on the belief that a free market is the best regulator of production and allocation of resources and that human beings are basically selfish, calculating economic agents who are motivated by drives which are sustained by economic activity (Battin, 1991). These values are seen as directly opposed to the values upheld by proponents of the welfare state, the primary feature of which is universal access to goods and services on the basis of citizenship. The welfare state embodies social justice by developing policies that promote social equity, including access to and participation in the decision-making process (Crimeen & Wilson, 1997).

However, Battin (1991) points out that the term free market is not an economic term at all, but is a political expression masquerading as a neutral economic term. He argues that by representing the marketplace as neutral there is a false dichotomy set up between politics and the market. On its own, the marketplace will not produce goods and services that are accessible to all citizens. In a pure market economy all economic activity is driven by the marketplace. There are actually no pure markets anywhere in

the world (Battin, 1991). What varies across countries is the role of government, which can act more or less to modify markets and redistribute income. The manner in which governments act is a political decision driven by those in positions to influence such decisions, the holders of power. Within a framework that takes these influences into account, the market merely becomes an interest group (Willis, 2002). As an interest group, the capacity of the market to influence the direction of social policy (and hence, how strong the influence of economic rationalism will be) depends on how much influence the government is prepared to allow each group to have (or possibly how much each group is able to influence the government).

Hancock (1999a) comments that there are a number of interest groups in the health care sector which hold varying amounts of influence on public policy. Such groups, whose agenda is primarily the independence and status of its members, include the medical profession as represented by the Australian Medical Association (AMA), divisions of medicine such as the Royal College of Surgeons and other professional groups such as the Australian Nursing Federation and the Australian Association of Social Workers (AASW). Some consumer groups, such as the AIDS Council and state-based carers' groups are also highly organized and politically active. Historically the group that has held dominance within the hospital system is the medical profession, strongly represented by the AMA.

The next section explores how the medical profession continues to be a dominant influence in hospitals despite challenges from other interest groups, including an organisational manifestation of economic rationalism (managerialism).

The Medical Model

The dominance of the medical profession in the delivery of health care and the resultant dominant medical culture in Australia and other Western countries has been noted for many decades. In 1989 Willis produced a major analysis of health care production and delivery in Australia in which he argued that medicine dominated the division of labor, the allocation of resources and the manner in which different types of knowledge were held in esteem. Sargent et al (1997) note that a further effect of medical dominance has been the pervasiveness of the medical model which focuses on disease and treatment

rather than prevention, removes individual responsibility by placing the person in the sick role, and maintains the status of the medical profession. Sargent et al (1997) also claim that the medical model, by placing emphasis on the individual as a passive recipient of medical treatment, discourages public health policies aimed at improving the basic health of groups of people such as Aboriginal people or the elderly. Jamrozik (2005) supports this argument by noting that public statistics used to demonstrate that Australia has high levels of good health are actually measures of disease reduction only. He also notes that the structure of public health care in Australia remains largely unchanged across changes of governments which he claims suggests interest group influence rather than party political interest. He also notes that in Australia the medical profession remains almost entirely fee-for-service (which allows some control over resources) and while the publically funded Medicare offers free access to basic health care, *immediate* access to complex technology (such as MRIs) and to surgery that is not immediately life-saving still depends on a person's ability to pay. If economic rationalism was entirely dominant the influence of managerialism would be strong across the entire health sector. Hancock (1999a) suggests the dominance of the medical profession has been offered some challenge by managerialism but acknowledges that the medical profession itself is still powerful.

Integral to the discussion about power in health policy are debates about the *hegemony of medical power/knowledge* (author's italics). The medical profession has been and continues to be an influential force in health policy debates, although it may be argued that, at least for doctors working in the public hospital sector or primary medical care, the power base is contested and shifting (Hancock 1999a, p.42).

Lewis (2006) affirms that the medical profession still holds a position of considerable influence in Australia, (specifically in Victoria where she conducted her research), by power of association. She found no evidence that the power of medicine to shape health policy had diminished and concluded that medical expertise "is a potent embedded resource connecting actors through ties of association, making it difficult for actors with

other resources and different knowledge to be considered influential” (Lewis, 2006, p. 2134).

One apparent contradiction in the continued dominance of the medicalisation of health (Jamrozik, 2005) is an upward trend in demand for accountability from the medical profession. In the introduction to her book “*Medicine as Culture*” Debourah Lupton provides a succinct statement of this contradiction:

Western societies in the early twenty-first century are characterized by people’s increasing disillusionment with scientific medicine. Paradoxically, there is also an increasing dependence upon biomedicine to provide the answers to social as well as medical problems, and the mythology of the beneficent, god-like physician remains dominant. On the other hand, doctors are criticized for abusing their medical power by controlling or oppressing their patients, for malpractice and indulging in avarice; on the other, in most western societies, access to medical care is widely regarded as a social good and the inalienable right of every person (Lupton, 2003, p.1).

Lupton suggests this is maybe an influence of managerialism with its focus on accountability and outcomes which may have changed some practices without altering the power structure. Economic rationalism and managerialism, however, have considerable ability to influence other less powerful groups within hospitals, such as social workers, as can be seen by the previously described influences of funding models. A major issue for social work is how the profession of social work responds to dominance and any resultant discrimination. For example, Crimeen & Wilson (1997) make the point that to accept economic rationalism as an inevitable driver of health policy is to become complicit in the process, a process in which such professions as social work can be duped into supporting the dominant paradigm. An interesting finding of this study was that the social workers interviewed were very aware of their socio-political context and had developed strategic responses to cope with it.

The cultural level (C), to be discussed next, offers social workers a professional lighthouse to guide them, but is also embedded in the structural and opens to influence.

The cultural level (C)

The second circle in Thompson's model is the cultural level. He cites Giddens to define culture:

Culture consists of the values the members of a given group hold, the norms they follow, the material goods they create. Values are abstract ideals, while norms are definite principles or rules which people are expected to observe. Norms represent the "dos" and "don'ts" of social life. Culture refers to the ways of life of the members of a society, or of groups within a society (Giddens cited in Thompson, 2003, p.14).

Chenoweth and McAuliffe (2008) employ the symbol of the lighthouse to illustrate the significance of culture which they also define as being made up of values and ethics. The culture acts as a lighthouse that is both a beacon to warn of threats and a light to show up a clear pathway. Like Thompson, they argue for the importance of an identity and internalized set of values as being unifying for a defined group. The social work lighthouses that illuminate these paths are the writings and teachings of the profession.

For the purposes of this study, the literature reviewed, in this section, will be considered in two clusters within the cultural element: that which takes a broad focus across the profession (professional bodies); and that which focuses on particular parts or issues (social work practice).

The professional bodies

Examples of broad illumination come from the professional bodies. Both the National Association of Social Workers (NASW) and the Australian Association of Social Workers (AASW) use broad brushstrokes to paint a picture of social work. On both its

website and in its practice standards documents the AASW offers the following definition of social work, which is consistent with a draft definition of social work jointly endorsed by the International Federation of Social Workers and the International Association of School of Social Work.

The social work profession facilitates social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversity are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance well-being (AASW, 2013, p.4).

This definition identifies not only the ethical and value base of the profession, but also acknowledges that social workers operate from a position of knowledge. The same document also reinforces the contextual importance of social work practice, describing social work as operating “at the interface between people and their social, cultural and physical environments. Human needs are always seen in the context of socio-political and environmental factors (AASW, 2013, p. 7).

In defining social work core values the NASW offers similar descriptions, stating that social workers are committed to helping people in need and addressing social problems within their context. The preamble to the NASW Code of Ethics begins:

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed and living in poverty. A historic and defining feature of social work is the profession’s focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living (NASW, 2008, Preamble, para.1).

This promotion of the dual focus of social work as being concerned with both the individual and the society is a defining feature in these descriptions of social work. Not only do social workers need to know and understand both society and individuals, but they also incorporate these multiple levels of analysis into their practice. Another definition of social work contained in the AASW Code of Ethics (2010) also highlights that social work is concerned with both the individual and the society:

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (AASW, 2010, p.7).

Publications from such professional organisations serve to provide both education for the general public and a central reference point for the profession. They do not seek to particularise or debate issues. As the professional associations are dealing with the big picture, it is left to others, the teachers, the writers and the practitioners, to put these definitions of social work into both academic and practice frameworks and engage in the debates.

The next section of the literature review discusses literature chosen because they have something to say about the current context of hospital social work, particularly the influence of globalization and economic rationalization. They have also been chosen as examples of how the literature may help practitioners understand themselves and their practice context, including how the cultural elements can be modified by structure.

The politics of social work

Over time social work has entered different arenas of practice, each having different ways of viewing the interaction of society and the individual. For example, psychotherapy and radical social work position the individual in relation to the society very differently. Social work writers have taken different views on the nature of

interaction between the social work profession and society and how much focus should be placed on either helping the individual or changing the society. Views on what social work is tend to be coloured by this positioning. An explanation for these differences is provided by Payne (2005) who employs social construction theory to explain the differences in how social work is viewed.

Payne (2005) presents and describes three views of social work, which give different weightings to the importance of individual or social factors and are good illustrations of how different approaches to the individual/society duality can subtly change definitions of social work. Payne's approaches are: individualism-reformism, which directs social work practice to the needs of the individual; socialist-collectivist which promotes changing the social structure to empower the oppressed; and the reflexive-therapeutic which involves assisting individuals to overcome their own situation by understanding and personal growth. He describes the processes that support one particular viewpoint over others as "the politics of social work" which he defines in the following manner:

I refer to a politics of social work because particular theories have interest groups that try to gain our acceptance of theory within social work. This goes on in professions in the same way as in ordinary social life, as part of the constant interaction about what is real and true. Groups seek influence in this way because it helps them shift our understanding of the nature and practice of social work and welfare in ways they think will be useful or which fit with their political and social beliefs. In this way proponents and supporters for a particular point of view struggle for acceptance of it, and they use theories that support their premises to gain a greater contribution for it in the overall construction of social work (Payne, 2005, p.8).

Payne's ideas are useful in that they provide a framework for thinking about why particular styles of social work are championed in different circumstances. Although not specifically mentioned by Payne, the champions of social work embracing such methodology as evidence based practice are examples of the politics of social work operating in the culture of social work in the changed environment of globalization and economic rationalism. The following section will demonstrate how different writers

present their views on the impact of societal change on social work practice and how social work should respond to this.

Social work practice and society

Dominelli (2004) believes globalization is having a large impact on social work. She notes that social workers are often publically criticized from many directions for failing to do what is perceived as their jobs. Social workers are blamed for both failing to protect vulnerable individual clients (especially around child welfare) but also failing to control deviant populations in the larger society. In addition, the budgetary restraints imposed by managerialism are forcing social work to do more with less.

In a globalizing world in which the nation-state is being re-structured to promote the interests of global capital and neo-liberal ideologies, social work practitioners find themselves in the contradictory positions of having to justify their existence as professionals explicitly charged with improving the quality of people's lives at both individual and collective levels while being subjected to the "new managerialism" and asked to do more with less by becoming increasingly efficient and effective in rationing their chosen interventions at the same time as demand for their services is rising dramatically (Dominelli, 2004, p.3).

Lonnie (2008) similarly suggests that social workers, because they are mandated for both social care and social control, have to operate under sometimes incongruent policy directions and can therefore be made scapegoats for failures of policy.

Fook (2004) sees practice as taking place in "more complex, uncertain and changing environments" (Fook, 2004, p. 31) where traditional forms of knowledge may be undermined and new skills, such as case management, be demanded. Professional specialist knowledge, which is sometimes value-based, may be seen as non-competitive in the global market.

In a similar vein, Hugman (1991) claims that both the delivery of social welfare services and the practice of the caring professions (which includes social work) have been

changed by the creation of the quasi-market model with accompanying commoditization of services, managerialism and deprofessionalism. The results of these changes include the limiting of resources for service provision and the increase in structural decision making. Policies and outcomes for service are not driven by the professionals themselves but set externally by managers, therefore reduce professional autonomy. The opportunities for discussion of values are also reduced and therefore values become less significant.

A response to such demands appearing increasingly in the literature is that social work must be able to demonstrate its effectiveness in a manner compatible with the prevailing context. Munroe, an early proponent of this approach within a context of child protection work, argues that social work has developed a private and individual style that is based on individual client relationships and informed by formal theories only as a background. This is called practice wisdom which is different for different practitioners and not very accessible to critique by others. This, she argues is a major problem for the profession in the current context where society is demanding demonstration of outcomes and value for money. Her answer (and the answer of many others) is that social work should adopt scientific method to make its skill and knowledge base more transparent. This particular pressure is very strong in hospitals as it reinforces scientific (and especially medical) dominance.

Social work and evidence based practice

In the hospital setting evidence based practice (EBP) that is promoted as the best way practice can be demonstrated to be effective and transparent. The pinnacle of EBP is the randomized double blind trial which employs rigorous scientific method. Because of this social work's ability to engage with EBP has been strongly contested. Brian Sheldon, a long time strong advocate for the use of EBP in social work, claims that use of EBP guarantees high standard social work practice as it will be based on the best evidence available rather than whatever subjective preference is currently in fashion (Sheldon, 1998). One difficulty with Sheldon's position, that what should be being evidenced is based on his own subjective definitions, has been noted earlier. Other writers have put forward criticisms of EBP.

- Smith (2004) argues that in social work, like every other profession calling for the exercise of skill and judgment (including medicine), some practitioners will be better than others and this will be true even if all have equal access to the best external evidence.
- Murphy & McDonald (2004) conducted a study of social workers working in a multidisciplinary team to look at the implications of evidence-based practice for the professional status of social workers. They found that the use of EBP validates and reinforces existing power hierarchies, frequently to the exclusion of social work and concluded that

The incompatibility of the paradigm (EBP) to the humanism of social work practice is reinforcing existing power hierarchies in medical settings. In this context, where the capacity to support practice with evidence is now paramount, the lack of systemic evidence available to social workers contributes to further marginalization and the subordination of the profession (Murphy & McDonald,2004, p.135).

- Plath (2006) acknowledges objections previously raised to EBP (that effectiveness is often contextual and EBP could promote the goals of economic rationalism) and has attempted to craft an evidence-based social work practice by defining evidence in terms of the skills and knowledge social workers draw on as part of their practice. She proposes that a critical reflexive approach be used to consider all available information in each situation, including evidence from research as well as “evidence gained from experience and understanding of contextual factors” (Plath, 2006, p.70).

Plath admits that EBP and reflexive practice are drawn from different theoretical paradigms and therefore are difficult to place together. Again, the issue appears to be whether social work practice is “effective” against some abstract measure of good social work (which, according to Payne, is also politically constructed) or whether social work

within a particular context is useful within that context. As pointed out by Dominelli (2004) social work may be criticized by society for being ineffective in eliminating societal ills such as child abuse, but may be extremely effective in a different way in assisting an individual experiencing child abuse. This is a huge problem for EBP which, in positivist tradition, demands a quantifiable outcome and an external standard to measure against, both which are difficulties for a contextually based profession such as social work.

Another view on this difficulty is offered by Thompson (2009) when he discusses the dilemma of duality (care and control) that faces social workers.

The duality of care and control

Thompson offers a framework to integrate this into practice, conceptualizing these two competing demands as being about power and arguing that social work is a political entity; therefore conceptualization and implementation are always contested matters. Social work, he states, occupies an area where care and control meet and as a result social workers are often caught in the middle. In some ways social workers are almost forced to choose a side, an example of this dilemma being the development of thinking such as deserving and undeserving poor. Within the hospital context, in order to stay relevant, social work has to work as best it can within the existing power structures. Many of the studies from the United States of America which will be described in the “personal” section show that the social work profession has felt a need to respond to the prevailing economic climate by demonstrating its value to that system, while at the same time trying to maintain an acceptable amount of professional integrity. Auerbach, Mason and LaPorte (2007) provide a clear description of the changes to the hospital system that are impacting on social work.

The need for cost reduction in hospitals is the impetus behind promoting discharge planning as a crucial hospital task. Beginning in 1983 the (U.S) Medicare Prospective Payment System paid a flat rate according to patients’ diagnosis and care assessments. Speedy discharges became essential for hospitals to maintain their financial viability. The growth of the managed care

industry and its demands for cost reduction has forced hospital administrators to continually look for ways to increase admission and decrease length of stay. Efficient discharge planning is an important component of the financially necessary “fast in fast out” patient flow. In hospitals in the United States, social workers still remain important providers of discharge planning even when competition from nurses is taken into account (Auerbach et al, 2007, p.19-20).

The following section, which describes the personal level of Thompson’s model, will demonstrate how both the structural and the cultural shape the role of hospital social work and why it is so difficult to define social work outside its context. As will be noted, the personal cannot be considered without reference to the structural and the cultural.

The personal level (P)

This level is described by Thompson (2003) as the “thought, feelings and actions at an individual level” (p.12). In framing this study the personal level is seen as the practice expression of social workers in hospitals, their role and what work they do. At this level it can be seen more clearly how embedded the personal level is in the structural and cultural levels by how difficult it is to distil the social work role outside these levels. Early differences in definitions of the role of social work laid the groundwork for a separation of roles that continues through the years. Butrym (1968) endeavored to categorize and identify the social work and found it as having two distinct areas of activity, direct treatment (working directly with the client) and indirect treatment (working with the client’s environment). Nearly forty years later Morales, Sheafor and Scott (2007) provide a good summary of this difficulty when they describe social work as the most comprehensive of the human service occupations that cannot be understood by looking at one small part. They identify both the individual and societal focus of social work-in the following way:

In simplest terms, social workers help people strengthen their interaction with various aspects of their world – their children, parents, spouse or other loved

one, family, friends, coworkers or even organisations or whole communities. Social work is also committed to changing factors in the society that diminish the quality of life for all people but especially for those persons who are most vulnerable to social problems (Morales et al, 2007, p. 36).

With such a huge mandate it is not surprising that most social work research is much more defined in scope. This, however, has led to problematic differences in interpretation.

Over the past twenty years many studies have attempted to describe the role hospital social work from a number of standpoints. Many of these studies indicate that their purpose is to either demonstrate the value of social work to the hospital hierarchy or to identify those characteristics of social work that allow it to claim unique territory in the hospital and therefore be considered to be a professional equal to other professionals. The result is that different studies have looked at different aspects of social work and, not surprisingly, have come up with different definitions and many ambiguities.

Approaches to identifying the value of social work, or to define a unique role, include the identification of those activities most usually carried out by social workers in hospital, or to examine processes such as expectations of social work held by other hospital staff compared to the expectations held by social work, or the nature physicians and social work collaboration. The results of these studies have produced useful descriptions of hospital social work but have not particularly helped social work either produce a consistent role description or demonstrating unique territory.

The difficulty in trying to define social work through its activity can be seen in a study by Davis, Baldry, Milosevic and Walsh (2004). This study attempted to develop two approaches to assessing hospital social work activity: a snapshot of the activity in a given time period and a longer time account of services throughout a hospital stay. While this study has produced some valuable insights into what a hospital social worker does, it does not contribute significantly to any unique role definitions, and has also noted that “the use of the statistical database as a source of information for this study may not reflect accurately all of the daily activities of social workers, as it is reliant on predetermined activities and codes” (Davis et al, 2004, p. 354).

Cowles and Lefcowitz (1992) similarly failed to identify a unique role when they looked at the interprofessional expectations of the medical social worker role in hospitals and found significant differences in the responses between the doctors and nurses (whose responses were similar), and those of social workers. They concluded that social workers will either have to accept a shared rather than dominant responsibility for many tasks or make a better case for claiming preeminent domain. This conclusion is still relevant after twenty years. Studies that have tried to define social work by identifying social work tasks have usually found shared activities and role blurring, as well as a belief on the part of social workers themselves that their role in the hospital setting is being undermined (Egan and Kadushin 1995,1997; Davidson, 1990). Egan and Kadushin (1995) make a point that was suggested earlier in this chapter, that the style social workers adopted of working collaboratively within multidisciplinary teams may in fact allow contribution of their own profession to be undermined.

Thompson (2009) provided a reason for this difficulty in identifying a unique role, pointing out that, while a descriptive approach may be helpful it *describing* the range of activities that come under the umbrella of social work, it does not really answer the question of what is social work. He asserts that the picture will be incomplete because it does not include the wider concept of social welfare, and it is also always possible that other activities will be added to the list. If social work is viewed as being embedded within the three levels as discussed earlier, it is not surprising those different studies undertaken in different times and organisations will yield different results, as the social work territory will change depending on the dynamics of the organisation. The personal, therefore, cannot be considered without reference to the cultural and the structural, including what factors may be essentially silencing part of the social work voice.

A good example of the influence of the structural on the cultural and the personal can be seen in the re-emergence of hospital social work in the United States. Hospital social work in the United States of America (USA) has experienced an earlier and more sustained restructuring of health service delivery under the tenets of economic rationalism and managerialism than has occurred in Australia to date. Studies in USA and Canada have found that the emergence of managed care with its linking of professional performance and clinical outcomes to accounting principles has impacted

strongly on how social workers in hospitals view themselves and their role (Globermann, White, Mullings, McKenzie & Davis, 2003). Earlier studies (Globermann et al 1996, 2002) found that during this time of change hospital social workers were forced to examine practice and priorities. They also found a shift in reporting lines, with social workers reporting to nurse managers, were having several negative consequences for social work. Without the support of a social work department social work roles merged with those of other professionals making their contribution unclear to hospital administrators who are concerned with cost cutting (Barth, 2003). Social work also experienced a void in leadership as social work leadership roles were removed. (Globermann et al, 2002). Globermann et al (2002) also noted that despite social workers feeling that program management was impacting negatively on the profession, from the outside social work appeared to have successfully integrated into the new health care environment and the demand for qualified social workers was increasing. One study (Mizrahi and Berger, 2001) found that despite being trained in advocacy and coping with change, social workers rarely used the skills they used to empower clients to empower themselves. Despite this, in a follow up study of their earlier cohort, Globermann et al (2003) found that social work had begun to “find its voice” and was “beginning to seriously embrace its capacity to provide leadership in health care” (Globermann et al, 2003, p.16). Auerbach et al (2007) studied social work’s contribution to timely discharge in an acute care hospital in the USA and found that cases assigned to social workers “involved an array of complex factors beyond the scope of diagnosis alone further confirming the importance of social work in acute care hospitals” (Auerbach et al, 2007, p.18).

These studies of the American experience demonstrate clearly the significance of structural change on practice. However, despite the influence of the structure the hospital social workers in American remain identifiable as social workers. One possibility is that the culture may be the mediator, the filter through which the messages from the structural level are incorporated into the personal. Baines (2006), in interviews with frontline social workers in hospitals, found many constraints imposed by years of managerial restructures. These included losses of social work vision, loss of practice knowledge and the narrowing of skills with the recasting of skills as competencies. Despite this, this study also found that “at least in their talk and their dreams social

workers continue to resist dominant discourses that discourage social obligation” (Baines, 2006, p. 31). She continues to note that “in the face of narrow and miserly approaches to social care, the social workers interviewed for the present study showed that a commitment to social justice has survived premarket restructuring (Baines, 2006, p.31).

This mediation of the cultural level was also demonstrated in my study which shows how participants continue to define themselves by social work values.

What is noticeable is that when looking at a cross section of studies of hospital social work across time it can be seen that that in essence the work done by hospital social workers has not changed. In 1993 Abramson and Mizrafi commented that the “centrality of the discharge planning role to physicians and the financial well-being of the hospital has enhanced the organisational importance of social work’s contribution to patient care” (Abramson & Mizrafi, 1993, p.30). Davis, Milosevic, Baldry and Walsh (2005) also reported similar findings in a qualitative study of the social work role in hospitals that discharge planning was the overall aim of the hospital social workers in their study and the other tasks and roles contributed to this process. Judd and Sheffield (2010) conducted a study to capture the roles and activities of hospital social workers following what they called the era of reengineering and found that “discharge planning activities represent the area in which most respondents spent the greatest percentage of their time” (Judd & Sheffield, 2010 p.863). This would suggest that social work brings something to this task that is valued by the hospital as an institution, that there is something about social work practice in this area that makes it successful. What this actually is, is not readily identified in the literature.

Conclusion

This literature review has explored the issues that surround the practice of social work through the three levels proposed by Thompson (2003). The duality of social work (focus on both the individual and the society, both care and control) makes this a complicated process that sometimes seems impossible to unravel. What the literature does show is that as profession social workers are critical thinkers. They highly aware of the operations of social and political contexts and are able to critically evaluate the

usefulness of such fashions as EBP to social work practice. They are aware that their work can either maintain or challenge the status quo. At the same time the profession is directed by its own professional associations to take what could be seen as the high moral ground, to work to combat social injustices and challenge oppressive systems. This is the stated value base of the profession of social work and therefore viewed as “right”. However, as the analysis of economic rationalism shows, many social decisions are really political decisions and Payne’s explanation of the politics of theory suggests that social work is not immune from this. In this situation it is understandable that individual social workers may become pessimistic and see themselves as failures, questioning whether they have a place at all in such a system.

One possible contributing factor to feelings of negativity is that these debates are sometimes interpreted not as healthy discussions but proof that social work is unable to be clear about itself.

Gibelman (1999) argues that social work is not unique in its search for identity and produces evidence to show that other professions, such as teaching and nursing, have also engaged in debates about identities and boundaries. She suggests that, in fact, social work is “somewhat underrepresented in its expressed concern for identity clarification” (Gibelman, 1999, p.298). She goes on to identify in a similar way to Payne that external forces, including demand generated by the employment market, have shaped, and will continue to shape the definitions of social work. Despite this, she is able to identify themes that reverberate throughout the years with regard to the boundaries of the social work profession.

Despite concerns that social work has failed to clarify its focus and boundaries, it seems that, in fact, there has been a consistent strain of thought regarding the focus of the profession. Encompassed in the person-in-environment framework is the reciprocal relationship among an individual, relevant others and the social environment. The centrality of the client (be it an individual, group, community or society as a whole) and his or her interaction with the environment is echoed in the relationship of the social work profession to the larger society in which it functions (Gibelman, 1999, p.300).

If the social work profession accepts that it must, by its nature, be defined by context, then debates that are sometimes seen as negative can equally be seen as positive and healthy. If social work is, as Thompson suggests, a political entity, it must be, by definition, a contested profession who can engage in robust dialogue.

Dominelli (2004) offers social work a rallying point. She also locates social work within the context of upholding human rights but describes the practice of social work within constraining parameters as being challenging but possible, describing social work practice as having become the art of the possible. By conceptualizing social work within a humanist and liberationist framework she places it “within moral discourses concerned with the realization of social justice in the local, national and international domains” (Dominelli, 2004, p. 9).

The data on the numerical growth of social workers in the public hospitals in Perth shows that social work is not being downsized or marginalised, and information from the USA shows a profession that has, to some extent, recreated itself by reintegrating into the structural changes surrounding it. Studies of the tasks carried out by hospital social workers across time show that what hospital social workers do really has not changed very much. This suggests that social work is able to adapt to context but still remain identifiably social work. If social work writings are regarded as lighthouse beacons, as suggested, then it is possible that the culture, the norms and values of social work, are mediating the structural and the personal.

This literature review is deliberately more broad than deep and sets a context for this study within Thompson’s framework. The focus for my study is the inner circle, the Personal (P), and consists of the purely personal reflections and understandings of each participating social worker. However their responses also indicate their awareness of the influence of both their cultural and structural contexts in defining their work.

CHAPTER THREE - DESIGN OF THE STUDY

In Chapter One I described how I was using a design framework described by Crotty (1998) as the design blueprint for this study. This scaffolding holds my study together and, connects the methods and methodology to the philosophy, a connection which, according to Crotty, is often unclear.

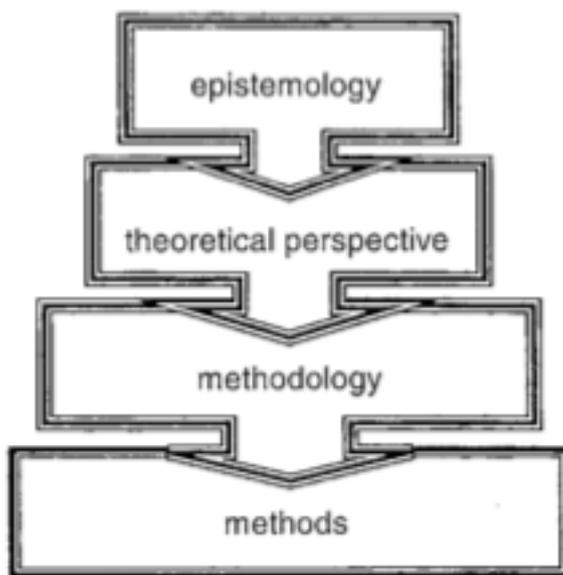


Figure 2: Crotty's framework. Crotty, (1998, p.2).

The two initial pieces of scaffolding my underlying epistemology (constructivism) and my theoretical perspective (critical theory) are described in Chapter One. This chapter describes in detail the last two pieces of scaffolding, specifically the methodology and the method, as well as defining my ethical approach to this research which, because it is based in my own field of practice, has specific ethical considerations.

Methodology: defining constructivist grounded theory

The chosen methodology for this study is grounded theory. The concept of grounded theory first appeared in what history now hails as a methodological landmark study on how hospital staff relate to dying patients (Glaser and Strauss, 1967). The methodology developed by Glaser and Strauss was seen as an acceptable alternative to scientific method as a framework for qualitative research. Grounded theory calls for a ground up approach. The researcher begins with exploration, wide-ranging questions that explore the area being researched, then develops categories generated from the data collected, which he/she then goes on to test by returning to the field. The researcher needs to keep returning to the field until all the categories are *saturated*, meaning that no new information is being uncovered (Creswell, 1998).

The grounded theory methodology developed by Glaser and Strauss is framed in the positivist tradition based on the assumption that there will be an end point to the exploration and that at some stage the researcher will reach a point where he/she will know something that is external to the knower. The methodologies developed by Glaser and Strauss depend on the belief of the existence of an external knowable reality that can be explored and ultimately reduced to a set of categories that have generalized and predictive value over time (Reissman, 1994; Stebbins 2001). Strauss (1987) argued for this position by acknowledging that social situations are complex but claimed that they can be adequately represented by developing many and sufficient concepts and their linkages in order to capture the great deal of variation that characterises the central phenomena being studied. However, grounded theory has evolved a constructivist version which is identified as a methodological style, rather than being a fixed technical methodology. Charmaz (2000, 2011) defined this notion of style by suggesting that grounded theory can be used within a constructivist framework by operating under a different set of assumptions. She suggests that although the original assumptions behind the use of grounded theory were positivist, if you began with a different set of assumptions, for example that reality was constructed, you would still obtain information but it would be more in the form of hypotheses linked to context (Charmaz, 2000). Charmaz sees constructivist grounded theory as a method for the 21st century as it “challenges positivism elements that ignore reflexivity, overlook ethical issues,

disregard issues of representation and do not attend to researchers' agency in constructing and interpreting data" (Charmaz, 2011, p.374). It is noted that social work research has used constructivist grounded theory to develop pieces of work that are useful in informing practice (Abramson & Mizrafi 1994; Pockett 2002; Holdsworth & Tiyce 2012) so it seems useful to use constructivist grounded theory in this study. By adopting Charmez' interpretation of grounded theory I am able to use this methodology while remaining consistent with my epistemology and theoretical framework outlined in Chapter One. In keeping with this, my results are interpreted within their context and offered as hypotheses, not a set of definitive answers.

Method

This section provides a full description of how the study was carried out. As indicated in Chapter One, when outlining how Crotty's framework will be applied (Figure 2, p.8) the method chosen for this study was the McCracken long interview (McCracken, 1988). McCracken describes this method as "one of the most powerful methods in the qualitative armory" (McCracken, 1988, p.9), as it is able to define a field of enquiry while at the same time allowing the interviewees to express themselves without the artificial constraints of fixed questionnaires. The method described below includes questionnaire structure and content, data collection (sampling technique and sample description), and data analysis.

Questionnaire structure

McCracken's method insists on the use of a questionnaire, arguing that the use of a questionnaire, which is not always used in qualitative research, has several functions. Firstly, it allows the interviewer to cover the same material in roughly the same order for each subject, while roughly preserving the conversational context. Secondly, it allows for the planned prompts to be developed prior to the interview and carefully positioned, as it would be very challenging to expect the interviewer to recall consistent prompts during the interviews and allows the interviewer to give complete attention to

the interviewee. The third function of the questionnaire is that it “establishes channels for the direction and scope of discourse” (McCracken, 1988, p.24).

The questionnaire (see Appendix 1 for full questionnaire) used in this study consists of a number of overview questions supported by planned prompts. While use of the questionnaire is designed to impose some level of control, McCracken argues that this does not mitigate the open-ended nature of the qualitative interview, as within each question there is opportunity of unstructured, exploratory responses. The questionnaire serves to give the answers context, which is important in the analysis. He explains why the use of such a questionnaire does not detract from the nature of qualitative research.

It is not the purpose of a fixed interview to abolish the characteristic abundance and “messiness” of qualitative data. Qualitative analysis requires that the interviewer work with substantial chunks of data. Without data of this character it is difficult to see which ideas go together in the mental universe of the respondent, or the “cultural logic” on which the ideas rest. For analytical purposes, it is necessary to capture not just the ideas but also the context in which these ideas occur. The context is, in a manner of speaking, the small amount of seawater that keeps the catch alive (McCracken, 1988, p.25).

This structure was found to be extremely useful in the interviews as it kept the interviews on track exactly as McCracken described and stopped the interviewer pursuing responses that veered into interesting, but probably not relevant, pathways. This did make analysis easier as responses were mostly in the context of the questions asked.

Questionnaire content

The content of the questionnaire was designed around those aspects that were commonly identified in social work texts as defining social work. Thompson’s work (2009) was particularly used as it summarized a lot of what appeared in other social work texts. Based around this content, the overview questions were designed to provide maximum opportunities for the social workers to describe their work, including the

reasons why they actually saw patients, what work they actually did (tasks), and the skills, knowledge and values that supported and informed this work. They were also given an opportunity to identify anything that was unique to social work. There were five questions, three of which were overview questions. Each overview question incorporated a set of prompts to encourage respondents to expand and elaborate on their experiences.

- Question 1 asked about their length of experience in hospital social work to confirm that they met the criteria (three years or more experience) for this study.
- Question 2 was a direct question asking for a description of their work, with prompts asking about tasks, skills, knowledge, values, how they relate to their work environment and what outcomes they are seeking.

The next two questions were designed to obtain more information about all the above areas by approaching the same material in a different way.

- Question 3 asked the social workers how they distinguished themselves from other professional groups in the hospital, with prompts asking about difference in tasks and style of work, differences in values and also differences in perceptions of health and wellness.
- Question 4 asked the social workers to consider what social work contributed to patient care that is unique to the profession, with a prompt that asked them to consider what would happen if there were no social workers in hospitals.
- Question 5 asked for any additional comments they wanted to make.

Issues of reliability and validity are discussed at the end of Chapter Three.

Data collection

Sampling

This was always designed as a small study and it was initially decided to interview six social workers. A level of social work experience was required and this was defined as at least two years full-time social work experience. Age was not used as a variable, but

there was a wide cross-section of the ages of the volunteer subjects and during the data analysis some age differences in opinions were noted and mentioned. All the volunteers for this study were female.

Participant volunteers for this study were sought by sending an email to the heads of department at Royal Perth Hospital and Sir Charles Gardiner Hospital. Volunteers were not sought from Fremantle Hospital as I felt my own role as a senior social worker and manager in this department could influence responses of this group of social workers. I was, however, approached by one social worker who worked at a different site of Fremantle Hospital (Kaleeya Hospital) who had heard about my study and offered to participate. She was included as she met the other criteria and was not, and had never been, supervised by me.

Six volunteers were obtained as a result of these emails. Unfortunately one volunteer had to withdraw after the interviews had commenced due to a family bereavement overseas, and it was decided to use five interviews only due to time constraints. The social workers interviewed for this study were all given pseudonyms (with their approval) for ease of identification. At the beginning of the interview all respondents were asked their approximate age (they could elect not to give this) and how long they have worked as social workers in a hospital setting. The profiles of the 5 social workers who participated in this study are as follows:

Alice was a social worker in her late twenties with approximately five years of social work experience, almost exclusively in hospital settings.

Sarah was a mature social worker with approximately 35 years social work experience, thirty of these years being in hospital settings

Meredith is the youngest of the participants, she reported three and a half years of social work experience in hospital settings.

Kellie reported approximately eleven years social work experience, mostly in hospitals.

Roslyn described herself as a mature-aged social worker, stating that she had worked “on and off” as a social worker in hospitals for fifteen years.

Data was collected via an audio taped interview using the attached questionnaire (see Appendix 1). The taped interviews were transcribed by a qualified medical typist who routinely transcribed from recorded, dictated medical reports. These transcriptions were then analyzed by the researcher. Where there are some small anomalies in the transcriptions (due to occasional volume issues with the tapes and the fact that the transcriber was unfamiliar with social work language), I went back to listen to the tapes to clarify what was actually said. These anomalies, however, do not affect the comprehensibility of the transcribed interviews.

The manner of analysis is described below.

Data analysis

McCracken describes the object of analysis as being “to determine the categories, relationships and assumptions that informs the respondents view of the world and the topic in particular” (McCracken, 1988, p.42). His method involves a five stage process, each representing a higher level of generality.

- Stage 1 separates the interview into “utterances” (p.42) and relationships between utterances are ignored.
- Stage 2 interrelates the utterances to form observations which are further developed according to the evidence in the transcript and to the literature review.
- Stage 3 looks at the interconnection of the second stage observations.
- Stage 4 and stage 5 move through to identifying themes and patterns.

The initial research plan was to follow McCracken’s five stages to analyze the responses from each of the three overview questions and any extra information supplied by question 5.

- The Stage 1 process began with identifying utterances using only content for each interview.

- Stage 2 involved grouping the utterances together in terms of themes identified by the content. This was done on butcher paper with different colours and put up on a wall. The low number of interviews made this technique very effective as it served to differentiate the themes but also keep them all on display at one time.

Once stage 2 of the analysis had been completed it was clear that themes and interrelationships had already emerged and attempts to look for more themes or interrelationships were not revealing any new information. One explanation may be the small number of participants (the examples McCracken gives in his article refer to large groups of participants), or it is also possible that I inadvertently combined stages 2 and 3. As no further information was emerging it was decided to stop the analysis at this point and proceed with the information that had emerged.

Thus stages 3 and 4 were not used and once analysis moved into interpretation I also moved away from McCracken's method as McCracken does not allow for the incorporation of the theoretical perspective into the data analysis. My aim was to approach the analysis from a critical theory perspective it was important that I was able to relate the responses obtained to their context of the hospital setting.

To allow this to occur I turned to Flyvberg's (2001) work. Flyvberg developed methodological guidelines for social science based on an Aristotelian concept of *phronesis* which Flyvberg interprets as reasoned state that goes beyond both analytical, scientific knowledge and technical knowledge and involves values and judgments. The phronetic researcher is able to ask value-rational questions such as where are we going and is this desirable? He also advises including the implications of power, to consider who gains and who loses and by what mechanism. By including value-rational elements in my final analysis In Chapter Six I have been able to relate the information obtained in this very small study to a wider context as set out in the third objective of this study (described in Chapter One).

Ethical Issues

A reality of qualitative research is that the freedom from the artificial constraints imposed by scientific method is itself constrained by concerns which are located within the social context of the research.

The research itself is socially located and (claims to truth) are more likely than not to become part of the problem rather than a means of finding an answer. It is therefore necessary for research never to claim the last word and always to be reflexive about itself as well as the focus of concern ((Schatz & Walker, 1995, p.18).

As the participants of this study were social workers who were at the time working in hospitals at the same time as I was myself, two particular categories of ethical issues were very important – issues around using colleagues as subjects and issues around how findings were presented. At the time I was designing this study I considered the possibility that I may be given information by subjects that I was unable to use, either because it was too personal and would therefore be identifying, or too controversial (and therefore also possibly identifying). Fortunately this did not turn out to be the case.

Colleagues as subjects

Informed consent and confidentiality

Although, as mentioned previous, I did not seek participant volunteers for this study from the hospital in which I worked, I was acquainted with all the participants. Because of this I viewed my position in relation to the participants as being similar to the position of those involved in ethnography – I had a shared professional life with them and would continue to do so after the completion of this study. From the outset of this study I was aware of the same level of respect that an ethnographer must have for his informants, the need to protect (Brewer, 2000). Traditional ethical concerns of research such as informed consent and *do no harm* have arisen out of the positivist tradition

where variables were believed to be controlled and mainly predictable. Informed consent has logically assumed this as a prerequisite position. However qualitative research does not give the researcher the same level of control and therefore questions the validity of informed consent.

For consent to be genuinely informed, the researcher must be able to predict with reasonable certainty the scope and focus of the research. Doing so is a particular concern because, unlike experimental and large-sample research, qualitative enquiry does not aspire to high levels of predictability. Controlled variables and prespecified hypotheses are replaced by flexible planning and emergent themes. It is therefore legitimate to ask if qualitative researchers can inform others when they themselves do not know what twists and turns their work is likely to take (Flinders, 1992, p.102-103).

Using colleagues as participants also changes the meaning of confidentiality. In much of the literature the concepts of *confidentiality* and *anonymity* are used interchangeably. However, anonymity (literally meaning nameless) is not possible here, therefore the issue of confidentiality becomes paramount. Confidentiality is generally understood as an attempt to remove from research records any elements that might indicate the participants' identity (Berg, 2001). In my research this definition was much too simplistic. My relationship with my participants within the context of the research was one of researcher/subject; I also have professional relationships with several of the participants that would be ongoing after the research was completed. Information that I obtain as part of my research, therefore, had to be *confidential to that research*. The AASW Code of Ethics (2010) offered advice on how to manage this.

Social workers will seek to ensure the anonymity and/or confidentiality of research participants and data and discuss them only in limited circumstances for professional purposes. Any identifying information obtained from or about participants during the research process will be treated as confidential (AASW Code of Ethics, 2010, p.37).

Flinders (1992) points out that the use of “detailed portraits and thick descriptions” (p.103) do not protect confidentiality well and sometimes the better the research the more readily others can recognize the participants. In this aspect the fact that I had some prior knowledge of my participants was an advantage as it allowed me to edit out descriptions and quotes that appeared at risk of identifying anybody. In doing this I complied with the Australian Association of Social Workers Code of Ethics 2010 which directs that “social workers will place the interests of research participants above the social workers personal interests or the interests of the research project” (AASW, 2010, p.36).

Presentation of findings.

In situations where research is sensitive or political the researcher must be mindful of use and misuse people may make of a finding (Brewer, 2000). My research involved a relatively small group of subjects in a small, defined profession. It is also possible that my findings could challenge colleagues who do not see issues in the same way. The issue of how to safeguard the use to which research findings are put does not appear to be well documented. The notion of *do no harm* appears to be deemed sufficient. However, some writers, particularly those who adopt a feminist perspective, challenge researchers to do more than this. They require the researcher to conform to codes of behavior that are acceptable to the subjects, not just to the institution mandating the research, and require the researcher to take a positive stance on the roles of compassion, nurturance and caring (Flinders, 1992; Gilligan, 2000). The interdependent nature of the relationship between the researcher and the researched should influence how the findings are presented. In conducting my research and presenting my findings I engaged with the ethics of respect, fairness and caring, rather than simply “doing no harm” I have been mindful of these issues in the design of my study. My choice of the long interview as presented by McCracken had the advantages of allowing the participants to present their views and experiences without extraordinary intrusion by the interviewer (a maximum of two interviews were planned but only one per participant was carried out), and as it was a structured interview with no devices it allows the subjects to be in control of what information they chose to give (McCracken, 1988). In my presentation

of findings I have often used the participants own words, thus trying to incorporate a design that allows the voices of the participants to be presented fairly, not be an end product of researcher manipulation.

Reliability

Reliability is generally about consistency of results over time or across different variables (Alston, 2003). Fook (2001) argues that because qualitative research is contextual it may never be possible to replicate existing studies. In quantitative research reliability is sought via control over variables. Sarantakos (2005) argues that in qualitative research alternative terms, such as credibility, applicability and auditability are used. I recognize that my own study was based in a particular time and a particular location. Use of the questionnaire ensured that I am covering the same territory with all my participants, which gave internal reliability. I believe I have presented my results in a manner that gives transparency to my analysis, thus meeting the criteria for auditability.

Validity

Validity is an integral part of qualitative research although it may also appear under different names, such as credibility, trustworthiness or authenticity (Sarantakos, 2005). The qualitative researcher can ensure validity through their methods of data collection and analysis, such as checking findings with the participants and against the available literature. Alston & Bowles (2003) argue that qualitative research has automatic validity because it represents the world view of the participants. Miles and Huberman (1994) argue that qualitative investigators do not need to demonstrate validity but rather methodological excellence, that is, research performance in a professional, accurate and systematic manner.

The use of the long interview format increases the likelihood on consistency in interviewing. The participants in this study were also given an opportunity to review their answers and provide feedback on the findings. All participants were mailed hard

copies of their own interviews and invited to comment. Two did comment, but only to say they agreed that it was an accurate recording of the interview.

Summary

Chapter Three, using the framework described by Crotty and informed by Thompson in Chapter One, describes the methodology and method of this study, the final two pieces of scaffolding of this research in line with Crotty's framework. It describes the methodology as posited in constructivist grounded theory and then describes how the method was developed using McCracken's long interview technique using three overview questions with prompts. It also describes the shortfalls of using McCracken's analysis and to ensure the aims of the study were met, to be able to contextualize to a social work setting in a hospital, it introduces Flyvberg's work to enable a value-rational dimension to be included in the data analysis. Chapter Three also defines my ethical approach to this study, which is based in my own field of practice and therefore has specific ethical considerations.

Chapter Four presents the findings of this study using the methodology and method described in Chapter Three.

CHAPTER FOUR: PRESENTATION OF FINDINGS

Thompson (2009) points to the difficulties in offering definitions of social work when he suggests that there is no simple answer to the question of ‘what is social work?’ The reason for this, he says, is that “social work is a political entity and so, of course, how it is defined, conceptualized and implemented is therefore a contested matter” (Thompson, 2009, p.12). From the beginning of this study it has been acknowledged that context is central to understanding social work and in this Chapter it is again acknowledged that these findings relate to the hospital context. This Chapter sets out the themes discovered in these interviews by the method described in Chapter Three. As well as setting out the themes this Chapter also showcases the words of the social workers interviewed, how they described themselves as social work professionals, how they distinguished themselves from other health professionals in the hospital setting and what contributions they saw as belonging within the domain of social work. The primary purpose of this chapter is to identify and summarise the key themes. In depth discussion of these themes will occur in Chapter Five.

The interview questions, as described in Chapter Three, were designed to support the social workers to describe their work in terms of how they defined their work and their values, skills and knowledge, and to identify any parts of these that might be unique to the profession of social work. This information was sought in several different ways (see Chapter Three) by three overview questions. Questions 3 and 4, which asked the social workers to describe themselves by comparison with other health professionals, and then by what would be lost by their absence, allowed for greater elaboration of ideas already expressed in question 2. Question 4 provided an unstructured opportunity to provide any additional comments but none of the social workers provided any real additional information in response to this question, stating that they felt that the preceding questions had covered everything. For the purposes of analysis, their responses from the interviews are grouped as follows:

- Doing social work (why social workers see clients and the work they do); and
- Being a social worker (the knowledge, skills and values that shape the social work identity).

The language used in this analysis is the language used by the social workers in this study. They work in hospitals and much of their language reflects their setting. It may be that there are meanings that could be made from this, but this is outside the scope of this study. In particular, the social workers refer to their clients as patients. This is the language of the organisation and I have taken it at face value. For the sake of consistency, clients are referred to as patients throughout the study unless referred to differently in direct quotes. To also contextualize the findings, the term participants, as referred to in the previous Chapters, will now be referred to as social workers.

Doing social work

This section looks at how the social workers in this study defined their work, including why they saw particular patients and what work they undertook. It will begin with a description of how the social workers in this study (identified by their pseudonyms) perceived health and illness. Despite working in an environment where the medical model of health is dominant, health being lack of illness, the social workers took a more social view of health. Their understanding of health, which also recognized psychological, spiritual and social determinants, influences how they work in the hospital setting.

How social workers perceive health and illness

Meredith: *I think that it is the view of my profession in terms of we see health and wellness as a combination of the physical, the spiritual, the psychological, all these aspects, not just the physical medical model. We certainly have different ideas of what it means to be healthy and what it means to have well-being in someone's life.*

Roslyn: *I think our holistic approach and our ability to think holistically has us looking beyond the medical problem.*

Kellie: *I think that certainly what we are looking for is an increase in psychological wellness of a person, not just the fitness of their body. Or particularly with a lot of medical specialties they are looking at a body part, let alone the whole body and not including the psychological aspects of the person. I think there is a big difference.*

Alice: *Sometimes relationships can be unhealthy. I don't think things like relationships and psychological health are necessarily considered to be part of health in this particular context. I don't think there's any room for psychological health.*

Why social workers see patients

The social workers in this study were clear that they saw patients for a purpose, that they had a specific professional role that was consistent with their social view of health. The social workers talked about their patients as people who have an illness that impacts on their functioning, the condition that brought them to hospital where some type of psychosocial adjustment needed to be made. At no time did they describe seeing patients merely because they were ill, there needed to be some other problems, psychological, cognitive or involving mental health or physical adjustment to the illness that had brought the patient to hospital.

Alice: *Patients we see will have a functional disability or a cognitive problem or maybe some type of psychosocial adjustment they need to work on because of their medical problem*

Sarah: *Our job is identifying how their current condition is going to impact on them continuing in their role when they are discharged from hospital.*

Meredith: *My principle role is to undertake psycho social assessments to actually enable people to deal with the impact of the condition on which they have come to hospital.*

Kellie: *The role (in the aged care assessment team) is to see people normally in their own home environment to make an assessment, of looking at what their needs are from a functional and social perspective, looking at the supports they have in place and identifying whether there might be a better way to support them.*

The work that is done by hospital social workers

In line with what was found by Thompson (2009) the social workers found it easier to define themselves by contrasting themselves with other health professionals. Key differences identified were

- Social workers work more in the abstract (such as with systems) while other professionals work in the concrete (diagnosis and treatment)
- Social workers look for outcomes that involve both the patient and their social system whereas other professionals look for more specific outcomes such as recovery from a medical condition or improvement in a particular function such as mobility, and
- Social work was sometimes seen as complementary to other professionals rather than being part of their processes.

All the social workers expressed the belief that other professionals within the hospital tended to focus entirely on the patient whereas social workers focused on the patient and their social system. Other professions within the hospital system would tend to focus on

the patient as being the job whereas for social workers the job was much wider than the patient.

Several key themes emerged in the way the social workers described their work. The task of psychosocial assessment was seen by most as crucial, the assessment being the vehicle by which the social workers identified their role with that particular patient. Other elements of their work that were seen to be defining and important were advocacy and empowerment. The social workers were also asked to contrast themselves to other professions, which drew out another theme – social work was about *how* work was done, rather than *what* was actually done.

Assessment

Four out of five social workers emphasized the psychosocial assessment as a first priority and a defining part of their work. All the social workers talked about the assessment in terms of identifying the needs and goals of the patient but also emphasized that the assessment also included the patient's family or their significant others. Two social workers also included the hospital team's interactions with a patient as being part of the assessment, incorporating relevant hospital staff into the patient system.

Sarah: *We assess by looking at the person in the system in the system, the system including home/family environment, the wider extended family, their work history and also looking at them within the hospital and how, with knowledge from over the years you have some idea of what the likely physical and psychological outcomes are and that informs your discharge plan.*

Meredith: *I see my role is to look at the impact of the condition on that particular individual, their family and their relationships, or likewise what are those relationships in the family, how it that impacting on the condition.*

Alice: *We perform a psychosocial assessment; we speak to the family, to the patient, to the team, to the doctor, so it is a full systems liaison. Hopefully we identify some goals which the patient, the family and hopefully the team work towards.*

Sarah: *I always see the patient as essential part of a system and you are looking at all of that, which I don't believe other allied health people are doing.*

Kellie: *We make an assessment of what their needs are from a functional and social perspective, helping people make decisions about what they want to do.*

Sarah: *We are giving the team the understanding of the person in their environment outside the hospital.*

Meredith: *I think we understand that people don't bring just their bodies to hospital, they bring a multitude of other relationships.*

The importance of the psychosocial assessment as being the foundation for all effective intervention is supported by social work literature, and is summarized by Baldwin and Walker (2009, p. 213).

Individuals do not live in a vacuum, rather they exist within complex systems that include their immediate surroundings, social networks and cultural communities set within a wider social structure.

Baldwin and Walker (2009) also advocate for a systematic approach that allows for the “unique influence and relevance of the immediate environment and interconnecting systems on the individual’s situation; how strengths within them may be mobilized to support positive change, as well as how deficits and problems may be addressed” (p 210).

It appears that literature supports what was being said by the social workers in this study, as all said that they looked at the patient in their social situation, including the patient's current situation of being in hospital, to assess what work needed to be done with that patient.

Social Workers as Advocates

Just as their assessments took a systems approach, so did other parts of the work they did. The social workers saw themselves as advocates for the patient *within the system* which, for different reasons, may not necessarily put the patient's wishes first. Several aspects of this advocacy role were identified.

- Sometimes the role was complementary to the role and focus of others.

Kellie: *I think doctors have an enormous amount on their plates just thinking about the medical needs of a person and I think the role of the social worker is to help them also consider the social aspects.*

However, often the role was advocacy in a hostile system. Most of the social workers stated that when there was a lot of pressure to discharge patients from hospital the medical staff did not want to know about social issues because it might slow down the discharge. The social workers walked a fine line trying to achieve good outcomes for both the hospital and the patients and their families.

Alice: *I think the pressure of the hospital has made it so a lot of them (medical staff) don't want to look for problems because they don't want to solve problems because it's going to take too much time with this patient sitting in a bed that they need to send another patient into.*

Roslyn: *I am talking about pressure on patients to get out (of hospital), the focus on numbers from the overall hierarchy, the emphasis on bed-days. I now*

work predominantly in the area of aged care; there are comments that the elderly are blocking beds, so there is the sense of blaming. The outcomes I look at trying to achieve are the fine line between what the patient's preferred outcome would be and the hospital's preferred outcome.

Meredith: *I think social workers are really powerful in a multidisciplinary role; they are able to influence other practitioners.*

Kellie: *I think we are the human face of the health service. I see the hospital as being like a big sausage factory that people are fed into at one end and churned out through the other and the social workers role is really to keep the sausage machine churning. But we also help explain to families and patients what is happening.*

- Social workers are more likely to look at outcomes that affect the patient's whole life, not just their medical condition.

Meredith: *I think it's about valuing the person, in terms of the entirety of their life, not just their condition.*

Sarah: *It's a positive outcome if the person's placed in a facility that will look after their needs and their family and the significant other people in their lives can come to terms with that as well.*

Facilitating empowerment and self-determination

Although more described than named, the act of empowerment, of trying to give the patients control over their circumstances, was also seen as defining of social work. The example of patients making choices that were perceived as risky was a common theme. The social workers identified that they thought they were more comfortable with

patients taking risks than were other disciplines in the hospital. As social workers they thought it is acceptable for patients to make choices that may not be those recommended by other hospital staff, providing the patient had been given all the information necessary to make the choice. Most of the participating social workers seemed to view the giving of information, which was seen as a social work role, as a means of empowerment. Once patients were empowered in this way it was right for them to make their own choices even if these choices were perceived by others as risky. This work is a product of the advocacy role and supported by the value base articulated by the social workers (discussed further on in Chapter Four).

Sarah: *If you are going to maximize a person's quality of life it often means taking risks, as long as they are calculated risks and the client knows what the calculated risks are.*

Alice: *If someone wants to leave the hospital against medical advice and they've had all the information presented to them, then it's their choice and I'm happy for that to happen. I see my task as informing them and really giving them as much knowledge as I can bring to that person so they can make the right choice for them. It's got nothing to do with what I think; it is what they think, as long as I can give them all the information.*

Meredith: *In this job allowing people's choices is hard because you may see certain risks but in the end people are responsible for their own actions and you actually support them to make the best decisions for themselves.*

Social work as a bridge

McCracken (1988) suggests that interviewees' use of metaphors can give a lot of information. He suggests that initially all metaphors should be treated literally as this can bring about a powerful understanding. The idea of social work as being a bridge or a link came up in all the interviews, presenting pictures of hospital and community or of

patients and other staff being separated by a chasm of some sort, or being two entities without many connections. All the social workers interviewed saw themselves as providing this bridge or link, which was seen as a very important part of the work that social work does. The social workers described themselves as linking or bridging in a number of different ways.

- They bridged gaps between the hospital and the community

Roslyn: *Part of our work is our ability to bridge the gap between the hospital and the community as entities of behalf of our patients.*

Meredith: *The sort of outcomes I am looking for are that people are well emotionally and physically so they can deal with their condition and they are also well equipped in terms of support services so they are not isolated any more.. They are the sort of outcomes that by the time they leave this hospital they are well supported and linked to community services.*

Kellie: *I think the tasks we do are different because they are about linkage to outside services and support.*

- Sometimes they provided linkages between patient's past, present and future. The social worker sees the client as part of a continuum with the past being important to understand the future in terms of how people will cope with illness.

Sarah: *It's really identifying the client's needs and how that fits into their past and pre admission status and how their current condition is going to impact on them continuing in their role past.*

- They may also bridge the gap between what the patient wants and what outcome other hospital staff think they should have.

Alice: *I personally try to accommodate the patient's wishes. They come to hospital, they've had some kind of medical incident, and they know what they would like, what they need. Sometimes what they want isn't what they really need but we try to bridge that gap between what they want and what they need, then put in some kind of plan to hopefully keep all the stakeholders happy.*

Another metaphor, different in structure but similar in intent, that was used by the participants was that of a stepping stone, again used to describe a way of moving across the two seemingly unconnected areas of the patient in hospital and the patient in their social environment. This was considered important not only to assist with discharge planning but also to contribute to the management of the patient in the hospital

Sarah: *But then we go that other stepping stone outside the hospital and then interviewing and spending as much time as necessary to speak to the family and the significant others of all our clients and bringing the information we obtain into the discharge planning with the whole team, not only discharge planning but the management of the patient while they are in hospital. I don't think anybody else sees and spends time in not only looking at the client but in looking at the social system of the patient and it is the social worker's job to bring awareness to the team of what that means in terms of discharge of a particular client.*

These bridge or connection metaphors are powerful and illustrative, and will be used in further discussion in Chapters Five and Six.

Being a social worker

This section is about capturing those things that contribute to making a social worker distinguishable from other health professionals, as stated earlier, the knowledge, skills and values that shape the social work identity.

The knowledge base

The findings in this area were interesting. Thompson (2009) refers to the social work knowledge base as being large and complex, and identifies a number of subsections, including human development, social processes and institutions and interpersonal, group and organisational dynamics. However, a formal knowledge base (including that which was acquired in an academic setting) was not widely identified as being a part of what the social workers in this study saw as their body of knowledge. Only one social worker (Meredith) identified social work knowledge learned “at uni” as being influential. The types of knowledge identified as being important were labeled as informal knowledge about the hospital system, knowledge acquired *over the years* about likely outcomes in certain circumstances, and knowledge of resources. No social worker named specific knowledge as defining of social work, although one social worker (Alice, see below) described an enormous amount of knowledge that she both held and used, but then dismissed it as being less important than some informal knowledge she’d picked up while doing her job. Likewise, Roslyn described a considerable knowledge base then stated that she had acquired this knowledge prior to doing social work. Like Thompson (2009) they also identified knowledge that they shared with other professions but the social workers in this study felt that they used this knowledge in a different way. They described social work as taking a broad, systems-based approach and therefore incorporating knowledge that is specialist to others. While not having the same in depth knowledge of specialist areas as other health professionals, the social workers saw themselves as able to interpret the knowledge of other health professionals as to how it will impact on their client’s psychosocial functioning. The first set of quotes illustrates how the social workers defined their knowledge.

Meredith: *I think you acquire knowledge at uni as you start, and certainly through your prac experience, you start to develop those skills. So whatever area I am working in I try to look for what are the gaps in my knowledge and then how am I going to fill those gaps.*

Alice: *The informal knowledge is the stuff that you get just by working in a hospital, like medical terminology, how systems work, what doctors expect, how doctors work, how nursing staff work, the expectation of the patient flowing through the hospital and what kinds of things might be available to them when they leave the hospital. That's the informal stuff we learn on the job. Then there's the formal knowledge base, what we learned through our education, and I think you do constantly go between two knowledge bases, but it's the informal stuff that gets you through.*

Roslyn: *Actually, pre degree knowledge, like experience, knowledge of the profession, knowledge of the system, the health system itself, knowledge and understanding of human development, and a wider understanding of actual political decisions and an understanding of the impact of these decisions on the day to day task is what is important.*

Kellie: *I think you develop as you go along. There is all the resource knowledge and just the ability to walk into someone's home or pick up the phone and talk to someone and start getting back assessment information quite quickly and putting people at ease to provide assessment is the main thing.*

Kellie: *I have knowledge about my particular area of expertise (aged care) which is very complex and has a lot of meshing between State and Commonwealth and inpatient and outpatient work. I also have knowledge of bigger issues like societal issues of attitudes to aging and the place of older people within society and within families.*

This next group of quotes describes how social workers use the knowledge of others. Several of the participants commented that social workers did this, but did not name the ability to do this as a particular skill owned by social workers.

Sarah: *You can't make an assessment without having some of that knowledge in all those areas, whereas I see occupational therapists and physiotherapists having their interest in those areas, not the total overview that is our responsibility. We need to bring the knowledge together for the rest of the team.*

Sarah: *I think each of the other health groups look at their particular area of interest. We don't have as much detailed knowledge in those areas but we do have a working understanding of how those things are going to impact on the person's ability. You can't make an assessment without having some of that knowledge in those (other) areas whereas I see occupational therapists and physiotherapists having their interest in those areas alone, not the total overview that is our responsibility.*

The skills base

Thompson (2009) perceives the skills base as being supplementary to the knowledge base, the knowledge base gives the social worker information about the situations they face and the skills base gives them a choice of the most appropriate response. Again, the social workers in this study responded to this question in a similar manner to the question about knowledge. The social workers did name skills but did not relate these skills to any knowledge they held or acknowledge that these skills were a significant part of being a social worker. Again, they tended to talk about their skills in terms of what they did rather than naming how the skills enabled them to do their work, and several social workers reflected that they believed they learned their skills on the job, rather than part of an education process. The skills named were assessment skills, communication skills, use of reflective practice and supervision, "generic social work skills" counseling skills, listening skills.

- Kellie: *I think the skill of assessment, sure we had the formal education behind it but you learn to really narrowly target that in a hospital setting.*
- Meredith: *I think I bring a lot of generic social work skills in terms of advocacy, assessment, counseling, resource skills, liaison skills and mediation skills.*
- Alice: *The skills that I would bring to the job, I think, well, I think they are very much developed on site, like communication skills. As a student you don't learn that necessarily, you learn on the job. With communication in a hospital there is so much to consider and we deal with such a big system that you do become strategic in how you communicate.*
- Roslyn: *Our communication, I believe is more finely tuned. I witness that so often in family meetings. Sometimes it is easy to get caught up in the pressure of things but I believe our listening skills are more finely tuned than other professionals.*

The values base

Values proved to be extremely important to these social workers. In the following quote Thompson (2009) describes the power that can be attributed to values.

At its simplest, a value is something we hold dear, something we see as important and worthy of safeguarding. Consequently, values are an important influence on our actions and attitudes – they will encourage us to do certain things and avoid certain others. In this way values are not simply abstract concepts – they are very concrete in the sense that they have a very strong influence over what happens. They are a very strong force in shaping people's behavior and responses to situations. It would therefore be very foolish to underestimate the significance of values in social work (p. 109).

This study demonstrated that for these social workers their values were something they could readily identify and talk about. More importantly, the identified themes suggest that the social workers in this study were more likely to define themselves by their values than by anything else. The values of individualization, self-determination and social justice were seen as particularly important, and these values both guided practice and were significant in defining the part of the social work role involving advocacy for patients.

Meredith: *What is important is valuing people's prior support and respecting them as individuals and respecting their right to self-determination and to make decisions for themselves. That's often hard in this job because you may see certain risks but in the end people are responsible for their own actions and we are actually supporting them to make the best decisions for themselves.*

Alice: *The outcome I look for is that if the patient can identify their need and if it's aligned to the team's identification of the patient's need then we can work together for that outcome to occur. But that's not always the way it happens. If the patient isn't in agreement with the team's idea of what a good outcome is, well, self determination would mean to me that we head towards the patient's decision.*

Meredith: *Professional values I think are things like anti-discriminatory, issues of equity, helping people gain access to what they are entitled to, and I think that's an important part of any social work.*

Kellie: *If there were no social workers I think a lot of people would be dealt with in a way that would trample their rights.*

Alice: *I believe there really is a role for social work and social work is a really important discipline in this hospital for the patient's voice to be heard.*

These social workers also believed that their values did not always match those of the hospital. Thompson (2009) describes dialectical reason, or the need to understand social and other phenomena in dynamic terms, as part of the knowledge base of social work. Despite not naming this as part of their knowledge base the next set of quotes show that the social workers in this study had a good understanding of the power bases and conflicting interests operating in the hospital.

Alice: *If I'm here to advocate for my patient and I'm able to, then that's a win for me, so I'm happy to work in this environment because I'm happy to challenge the institution.*

Sarah: *I am troubled with a situation where you have got your values and they are being challenged all the time because they don't fit with many of the bureaucratic decisions that are made these days. And I am constantly questioning that and standing up and stating what I see as the best outcome for the patient rather than the hospital, and trying to buy time or justify taking time to achieve a good outcome for the patient.*

Alice: *If my values are about self-determination and then there is all this pressure, shouldn't this mean I become more vocal for my patients as the pressure becomes greater?*

Roslyn commented that she thought most staff members in a hospital would give “lip-service” to having similar values to social work; but that the social worker would actually demonstrate these values when called on to do so, even if it meant disagreeing with other staff

Roslyn: *Overall I would say they would probably give lip service to having the same values about patient rights and in many cases we all do have the same values, except perhaps when it comes down to individual cases where patients and families may be in disagreement with the system or*

with medical staff, or other allied health staff and then our patient focus and our advocacy role will have us in a different position, a different role from other members. We will often be the one who will sit on the side of the patient, the family, and separate to medical staff.

Several social workers indicated that social work values were also their own personal values which made these values doubly strong and to an extent merged the professional and the personal selves.

Alice: *If you are reflective and you use your values then I think you are okay. I think you have got to constantly challenge yourself or you can get lost, so I guess that draws on my values. I always come back to social work values and I think they are aligned to some of my own values. I'm very big on patient self-determination.*

Meredith: *I bring to the job my personal values of things like professional integrity. That's one of the things that I think is really important, to be honest and authentic about what I do and to have an honest an authentic relationship with the people I work with. Professional values I think things like anti-discriminatory, issues of equity, and helping people gain access to what they are entitled to, and I think that's an important part of any social work.*

Kellie: *I think that so many of other disciplines bring tools and techniques. I think we bring our human self with a lot of what we have to offer. When we are doing a role that's how you establish rapport with someone, how you get them to trust you and open up to you and being able to have empathy and imagine yourself in their situation is a lot of what helps you do the job.*

One social worker felt there were generational differences in social work values due to different pressures being applied from the organisation.

Sarah: *Everybody talks about the good old days but in broad terms social workers that graduated not even one or two decades ago possibly have a different value system to many of the people who have graduated these days. Well, it is very hard to sit in judgment of other people but I really feel we (older social workers) have a determination to bring about the best even though you have got to fight the bureaucracy, and many of the dictates that come to us from the bureaucracy about what we will do. You know what happened in the past, you knew what was possible in the past and you still strive for those goals because you have seen it happen before and you know that it has been possible, so you continue to fight and strive regardless of what the bureaucracy tells us to do now.*

However, Meredith, a younger social worker, described that she had actually started a social work service in an area where there was none, and sees that the service has been well received and that she is able to make a difference.

Meredith: *I started the social work service here and it's never had a social worker before so certainly it got a mixed response in terms of my presence here. It was really important from the start to really clarify the social work role and build a working relationship with people that I work with. Now it's very much accepted and it probably, with the exception of a very few people, it has been a welcome service definitely. People have seen that it has actually extended the care of the patients.*

It is interesting to note that one social worker saw reflective practice in supervision as important to help keep social work values alive in the organisation.

Alice: *I think a process of using your reflective practice in supervision is important. I think it is easy to take on the values and the systems of the organisation and the informal stuff that is out there. Given that social work isn't the core business around here it would be easy to take all that*

on board and act more like other people in the organisation if you don't question your practice or why you are doing it.

Contrasting social work to other professions

When the social workers compared themselves to other professions the major theme to emerge was that social work was defined by the *way it worked* more so than actual tasks it undertook. The social workers often noted overlapping assessment and shared knowledge with other professional groups but saw the defining characteristic of social work as being that social work brought all this information together, and then worked at dealing with the situation together with the patient and family rather than recommending a course of treatment. That social workers worked backwards from the patient, rather than forwards from a diagnosis was probably a key theme that social workers saw as defining themselves.

Alice: *Other professions always seem to want a diagnosis and they come up with a treatment and work from that kind of model whereas social work, we don't want to diagnose people we want them to tell us what they want.*

Kellie: *I think other disciplines find it a lot easier to draw boxes around what is their territory and what isn't. I think for social work you can't be too restrained in terms of what is your territory. It's just that whole concept of support and information and helping people make decisions based on having all the information they need and coping with situations based on having everything they need is what the social work role is.*

Alice: *Watching someone (a social work student) who has been a nurse trying to shift through to a social work perspective, it took a lot of teaching; the student just went in for the task. I had to keep asking about what they thought the patient was feeling, asking them to come back and tell me*

what the patients were thinking, what they were feeling. It was a very interesting process.

Alice: *We don't want to diagnose people; we want them to tell us what they want, what they need. We then try to accommodate that or perhaps provide information to work through the adjustment phase.*

Meredith: *I think we engage more with the people we work with and see them more as a person. I actually do find that there are fabulous other professions that do that but I think that it is central to our role.*

Alice also pointed out that because social work worked with systems, it could be difficult to show a direct causal relationship between the social work intervention and the outcome, an issue for social work that is also raised in the literature (discussed in Chapter Two)

Alice: I don't think social work is about giving people assessments that turn out a score. I don't think that that is useful in social work, whereas I can see in most other disciplines they definitely can measure the outcome of their work through a scoring system and I think that's the big difference for social work. Someone that has a very good outcome in terms of improved emotional stability it's very hard to say that that's an outcome necessarily of the work you as a social worker have done as there are too many other factors that could be involved.

What would the hospital be like if there were no social workers?

When asked to consider how things would be if they weren't there, the participants unanimously felt that both the hospital and the patients would be worse off without social work.

Issues identified were

- Premature, inadequate or delayed discharges, social work being efficient as well as effective.

Kellie: *I think there would be a lot more pressure for people to go home without a discharge plan. I think there would be a lot more staff time spent by nurses and doctors and other professionals trying to deal with families when they are not coming from a non judgmental, understanding point of view. Often they are trying to tell people what to do. And I think there would be either bad discharges or delays in discharge.*

- People would not be given information that they needed to make informed choices

Sarah: *The patients would not be informed about what action they needed to take, whether it be legal or financial or whatever. All these things help, one hopes, to enable people to be more independent in the longer term.*

- Coordination would be lacking, as this is the social work role.

Sarah: *when it comes to drawing everything together the good team knows to refer to the social worker earlier rather than later and then the social worker co-ordinates all the information available and makes recommendations to the team on management while in the hospital and for future management.*

- Outcomes would not be as good for people because only their medical condition would be looked at.

Meredith: *Social workers often use the words “holistic approach” and I guess that’s the sort of approach I’m looking at I feel we support growth, that other professions are not about growing. I think if we didn’t do that then people would perhaps not have as good outcomes because only their physical conditions being looked at rather than other areas as well.*

- Patients would not have a voice

Alice: *We intercept when medical or nursing or someone starts to dictate what the patient needs. I think we intervene at that point and start talking about the patient’s wishes, so I don’t think the patients would have a voice without social work..*

Summary

This Chapter illustrates that the social workers who participated in this study have a clear and consistent view of themselves, both in terms of who they are and what they do. It also shows that the relationship between identity and role is more circular rather than linear. The social workers saw their identity as very much defined by their values, which then defined their work and how they carried this out. This then reinforced the importance of their values.

The social workers in this study also believed their work to be both valuable and relevant to the organisation. As social workers they believed that health and illness have a social component that must be addressed. This belief was the focus of the psychosocial assessment that was seen as very important, and was also reflected in their statements about the meaning of health and illness. It also influenced how they carried out their work, in that they saw an important part of their role to be an advocate for their

patients' wishes and to work with both the patient and the system to accommodate this. This role was seen as being different from roles of other health professionals and therefore defining of social work. They showed themselves to be aware of their context and believed they could work effectively within it.

The social workers also saw themselves as having a professional identity that was primarily defined by their value base. Their value base was both an anchor and a lighthouse, it informed the work they did and separated them from other health professionals in terms of their values being core to and defining, their practice. The social workers in this study all felt that the hospital would not function as well without social workers because their psychosocial focus added value in terms of care coordination and improved outcomes for patients.

While all these social workers were highly articulate about their work and values, they showed difficulty naming their skills and knowledge base. The social workers all struggled to name a defining social work knowledge base and, probably as a result of this, also struggled to name defining skills, despite having talked at length about how skilful they were in different areas, especially at managing systems. The issues around naming a social work knowledge base have already been discussed in Chapter Three in the discussion on the split between knowing and doing in social work, and will be discussed further in Chapter Five. Sufficient to say here is that knowledge and skills are closely related and it would be difficult to articulate skills without having the knowledge (Thompson, 2009). The social workers could articulately describe their work when they spoke of the doing of social work but seemed to lack the language to name the particular skills they used in this context. The skills they did name seemed to be in abstract from their work. However, the fact that they were able to describe common aspects of their work, the processes they used and a strong, consistent value base suggests that particular knowledge and skills *are* held by the social workers in this study but expressed only through their practice.

Despite these gaps in descriptions of the knowledge and skill base, the fact that the participants could define their profession in a consistent manner, both in terms of work and identity, is important in the context of Chapter Five when their descriptions are aligned to the context supplied by the literature review.

CHAPTER FIVE – DISCUSSION

To discuss and integrate the responses of the social workers in this study I return again to Thompson's model and employ his three levels to show how each level interacts with and influences the other two levels (see Figure 3, Chapter One). This chapter integrates the responses of the social workers and the information provided by the literature review, the model being used to identify and discuss how the social workers in this study saw themselves and their practice within the three levels. The starting point for this chapter will be the outermost level, the structural level (S) and finish with the centre, the personal level (P), which is the focus of this study. The identity of 'hospital social worker' as defined by the participating social workers will be described, beginning with the factors from the first two levels that that contributed to this identity and finishing with their definitions of a a hospital social worker. The data gathered from the interviews described in Chapter Three and presented in Chapter Four will be used for this discussion.

The overarching finding from this study has been that the social workers interviewed were all able to talk about themselves fluently, confidently and at great length. That fact alone was very reassuring for this researcher who harbored a secret, and clearly unfounded, fear that this might not be the case! These social workers confidently knew who they were and what they were about. For them, social work is what they do and they believe they do it well and consistently. They also showed a keen understanding and appreciation of the social context of their work and how this impacted on what they could achieve, and showed clearly that their commitment to their profession was strong in tough times. Their responses were also in line with issues raised in the literature, although the participants themselves did not appear aware of this, as will be seen in considering their responses to questions about their knowledge base.

The Structural Level (S)

As discussed earlier in the literature review, hospital social work is currently operating in a climate of change. The conclusions reached in this study from a review of the literature in Chapter Two were that economic rationalism is the prevailing political system that has had economic consequences, and despite debates about increasing managerial dominance, the medical model was seen to remain dominant in the provision of hospital care. This is despite emerging evidence of the importance of social factors and patient participation in determining good health outcomes.

In this study the social workers were not specifically asked to comment on the impact of either a strong medical model or economic rationalism and managerialism on their work. This was deliberate, as this inclusion was viewed by the researcher as having the potential to encourage the social workers to be negative about their work. (This may have been a false assumption, given how strong and positive the social workers were about their place in and value to the hospital). However, their responses showed an awareness of the impact of the structural issues and a strong professional response to this. This will be discussed later in the Chapter in the section on the interaction between the structural and the cultural, but it is noted here how the social workers were aware of an interaction with their structure. The social workers described their awareness of their structural context at three different levels, the impact of what they saw as a dominant medical model, the impact of the hospital as a system and the influence of economic rationalism. However, as they talked of managing the system on behalf of their clients, they also showed an awareness of political nature of economic rationalism and that they could modify expectations on behalf of their clients. This finding will be discussed again later in the chapter in relation to doing social work.

The impact of economic rationalism

Many of the responses given in this study show how the currently dominant paradigm of economic rationalism is influencing both the work the social workers did and the professional responses they developed. Two groups of responses in particular showed

differences between the context of the system and social work. These were the responses citing empowerment and advocacy for self determination as defining of social work, and the responses to the question on what hospitals would be like if there were no social workers.

Empowerment

For empowerment to be needed implies that there is disempowerment and the social workers in this study seemed to believe that some patients could be disempowered by the system. However, the social workers believed that they were able to intervene to improve outcomes for their patients.

One interesting finding was that there was an age-related difference in responses to how negatively the social workers viewed the current socio-economic context and how effective they saw their intervention to be. The social workers with the most years experience were able to reflect on changes that had happened during their careers in terms of how the changes brought by the replacement of the welfare state with economic rationalism had impacted on their abilities to do their jobs. Their reflections align with such writers and Dominelli and Hugman who (as discussed in Chapter Two) recognize the impact of budgetary constraints and social expectations. Roslyn, who described herself as having worked in a hospital “on and off” for fifteen years, stated the following

Roslyn: *In the latter years, particularly in the last two years with the changes going on in the health system it's become frustrating, extremely difficult at times. It's still rewarding, I find professional social work still very rewarding. The structure in which we work is more difficult than when I started .I am talking about pressure on patients to get out (of hospital), the focus on numbers from the hierarchy, emphasis “bed days”. Because I now work predominantly in the area of aged care, there are comments that the elderly are blocking beds, so the sense of blaming all of that does highlight our social work skills but at the same time adds to the pressure.*

Sarah, who had worked in hospitals for 30 years, saw some differences between social workers who have graduated in recent years and those who graduated one or two decades ago, believing her knowledge of what used to be possible caused her to continue to still strive for these outcomes.

Sarah: Well, it is very hard to sit in judgment of other people but I really feel we have a determination to bring about the best even though you have to fight the bureaucracy, and many of the dictates that come to us from the bureaucracy about what we will do. You know what happened in the past, you knew what was possible in the past and you still strive for these goals because you have seen it happen before and you know what has been possible so you continue to fight and strive regardless of what the bureaucracy tells us to do now.

She also commented that it was very difficult to work in a situation where your values were being challenged all the time.

The 'younger' social workers, however, believed that the system was often willing to accommodate social work values once they were explained, and that social work could make a positive impact on how patients were managed. In response to a question about whether social work was a comfortable fit in her environment, Meredith answered the following:

Meredith: It is comfortable now. I know certainly because I started this social work service here so I certainly it got a mixed response in terms of my presence here so it was really important from the start to really clarify the social work role and build a working relationship with the people that I work with. Now it is very much accepted and it's probably, with the exception of a few people, been a welcome service definitely. People have seen that it has actually extended the care of (patients), so it's been good.

Alice saw the experiences of her older colleagues positively, as showing that things could be done differently and therefore creating hope for change.

Alice: I haven't been a social worker for that long but it seems like from talking to changes and gone through different types of phases so I think that as a social work profession we need to just hang in there, we have to be strong in our values....and keep working hard at getting our voices heard...I think things will get better people who've been around a lot longer that health and social work have had many eventually, I think we just need to stick it out and that's from talking to people who are a bit older and have been around for a bit longer.

As pointed out by MacDonald and Jones (2000), the welfare state that dominated from the 1950s to the 1980s in Australia was more consistent with social work skills and values, so consequently social work flourished in this time. The older social workers who grew up professionally in this time knew how it felt to work in a more supportive social structure, whereas the younger social workers had been socialized into economic rationalism and were more likely to see wins where older social workers saw only losses and struggle. As indicated by the literature, social work as a profession is mandated for both social care and social control (Lonnie, 2008, Dominelli, 2004, Thompson, 2009) and is often “explicitly charged” (Dominelli, 2004,p.3) with improving people’s lives within a context of budgetary restraints, incongruent policy directives and challenges to the legitimacy of state welfare (Hugman, 1991). The social workers in this study acknowledged these difficulties but remained robust.

It was also noted in Chapter Two that there was some ambiguity in the literature between effective and useful social work practice, whether practice is defined as being useful to clients or to the system. The social workers in this study did see themselves as being useful to the system in that they could achieve the goal of discharging patients from the hospital, but they were all also firmly committed to advocating for and empowering their patients and would choose this over advocating for the system if they had to. As Roslyn put it, social workers are the ones who “sit on the side of the patient”. By acting as a bridge between the wants of the patient and the needs of the hospital, the social workers demonstrated that they did not accept economic rationalism as the inevitable driver of all health policy and strove to modify it, albeit at a very micro level, in the interests of their patients.

So what if there were no social workers

From the responses the question about what it would be like if there were no social workers, all the social workers in this study alluded to their ability to modify structural forces in a way that benefited both the patient and the hospital. They all felt that decisions would be made purely based on the patient's medical condition (in line with the medical model), which they understood would mean inadequately planned discharges and poorer outcomes for the patients, but also poorer outcomes for the hospital as by working with the patients and helping them achieve what they needed social workers expedited discharges from hospital that were not only quicker but less likely to break down resulting in the patient being readmitted to hospital.

Identifying a dominant medical model

The social workers all indicated that they saw themselves as having a different focus and different preoccupations from all other health professions and saw themselves as advocates the psycho-social approach to health in a system where medical-type preoccupations dominated, namely that other professionals wanted to diagnose and treat, whereas social workers worked with the patient to achieve the patient's goals. This difference in perspective also showed in the discussion about risk. The social workers would support patients making risky decisions if the patients had all the information, whereas they thought other professions viewed that negatively, seeing it as the patient not maximizing their treatment options. The social workers could also identify that the other health professionals viewed health as essentially physical health, while their view of health was a combination of other aspects. Good health was also good psychological, spiritual and even social health, not just an absence of illness. This broader view of health is more consistent with a social model of health than with the medical model and is another way in which social work in hospitals differs from its structural context. This, however, was seen by some of the social workers as value-adding rather than detracting from social work's ability to contribute to the effectiveness of the patient's treatment by "giving the team the understanding of the person in their

environment outside the hospital” (Sarah). All the participants identified the medical model as being dominant although sometimes individuals from other professions did take broader perspectives. However, as Meredith pointed out, for social work the taking of a psychosocial perspective is core business. The issue of this possibly leading to marginalization is discussed later in this Chapter.

In summary, the social workers in this study were aware of the structural context, dominated by economic rationalism and the medical model, and that it presented challenges to the practice of social work. Despite feeling challenged by the system, the social workers did not appear to feel disempowered. How they used the cultural context to develop their personal identity will be described in the following sections of this Chapter.

The Cultural Level (C)

Given the impact of the structural context described above and the social workers’ relationship with it, in the hospital setting the profession of social work faces challenges in understanding and defining its role and maintaining cultural consistency. Culture was previously defined in Chapter Two as the values and norms of a particular group and also the products it produces. This is what binds the individuals together and gives them a common identity as a separate group. In the literature review it was suggested that the culture appears to mediate or filter impact of the structural on the personal. In the face of the demands being made on them by the hospital system the social workers in this study were able to express a strong and consistent culture. They revealed two key points that appeared to serve as their cultural lighthouses in the hospital. These points, which emerged in some form in all the interviews, showed that the social workers maintained this consistency by how they understood and defined themselves. Firstly they defined themselves by their **practice**, the doing of social work, and secondly they defined themselves by their **values** (being a social worker), as articulated by the social work professional bodies and presented in Chapter Two.

Doing Social Work in a Hospital Setting

“Social work is what social workers do” (Thompson, 2009, p. 14)

Thompson explains this by saying that social work is both a profession and a practice and the social workers in this study agreed with this. They saw themselves as working differently from the other professional groups in the hospital. The first item of social work practice that was identified by all the social workers was the psychosocial assessment. This was seen as being specific to social work and different from other assessments done in the hospital. Secondly, the social workers located their client as the central point of their practice and saw good outcomes as directly relating to what the clients wanted. This is consistent with section 5.2 of the AASW Code of Ethics (2010) which states that social workers will “maintain the best interests of clients as a priority, with regard to the respective interests of others” (AASW, 2010, p.25).

Social work was seen by these social workers as more about how the job is done than what is actually done. While they were able to talk about their work in terms of tasks (for example psychosocial assessment, linking with community services), commonly more time was spent describing how they practiced. This was a critical distinguishing factor that the social workers saw as separating them from other allied health professionals.

This can be summarized as follows

- Social work is about caring rather than curing; and
- Social work is about understanding systems and how to work within these.

The social workers were all very client-focused; their primary focus was the well-being of the client, not the well-being of the system (although as demonstrated in Chapter Four, this was not disregarded). They were able to identify and articulate that this made them different from the other health professionals who worked in the hospital system and also that this difference defined their identity as social workers. What these social workers are *doing* in the hospital has become, for them, the framework of what social

work *is* in the hospital, and part of this includes modifying the system when this is called for.

The social workers all indicated that their strength lay in understanding how the hospital system worked and being skilled in advocating for their clients through this system. They saw themselves as being very good at manipulating the system on behalf of their patients to match individual needs, rather than enacting structural change. This was central to their role. This study was framed within a critical theory perspective and this perspective offers some insights into why the participants may hold this position and why it is useful to them. If the issue of power is regarded as being central, then the positions of the players becomes clearer. The social workers articulated that they are firmly on the side of their patients, and were also able to be useful to the organisation by assisting to discharge patients in a timely manner. By doing this they have claimed territory that is important to functioning of the organisation and developed high level skills to maintain this territory as shown in Chapter Two in the discussion of the enduring role of hospital social workers as discharge planners. One of the social workers (Kellie) did actually articulate that this was a position social work had taken in the organisation, but most of the social workers in this study just saw it as part of the doing of social work.

Kellie: I think what we do; other people could do as well. There is nothing kind of magic that is specifically social work. But I think that there is a role that is social work. I think that we pick up the pieces that other professions don't have the time or the skills to deal with.

This is a powerful position to be in, a power that might not be as well recognized by those occupy or aspire to structurally based positions of power. The US experience (described in Chapter Two) of the evolution of hospital social work in a society highly driven by economic rationalism shows that social workers, given time, can manage to find a niche and thrive in a setting that is driven by these values. They achieved this by providing an expert service in an area that the hospitals values (discharge planning), and arguing that by proving worth in a visible area they can then also achieve other things that may be essentially invisible (Auerbach et al, 2007). This raises several questions.

Can social work overtly align with the values of the corporatized organisation and still pursue a social justice agenda? However, if social workers deliberately and visibly pursue a social justice agenda what would that do to their ability to work effectively in a hospital? If the social work culture becomes too embedded in the structure it may risk losing that culture?

Watson (1997) summarizes this dilemma.

Social workers in hospitals need to make a decision about whether they wish to maintain a place in hospitals pursuing a social justice agenda, facing the risk of reducing their credibility as being of value to the organisation and eventual exclusion: maintain their place and credibility in the hospital by fulfilling the role as prescribed by the hospital which at times is in conflict with a social justice agenda, or departing from hospital locations altogether voluntarily acknowledging that social work's social justice agenda is perceived as irrelevant to the organisation as their interests are so different even though the rhetoric may be the same (Watson, 1997, p.660).

However, the social workers in this study did not identify with this dilemma. They demonstrated a consistent and reasonably clear understanding of their own role, a good understanding of 'the system' in which they worked, and how the two could interact. They expressed the belief that their understanding of systems was the main strength that helped them help their clients and saw this as positive. The social workers in this study reported understanding several systems.

- They understood the social system of the patient, as describes by Sarah.

Sarah: I don't think anybody else sees and spends time not only looking at the patient but also looking at their social system and it is the social worker's job to bring an awareness to the team of what that all means in terms of the discharge of that particular client.

- Kellie also described the importance of understanding how the hospital system worked in order better advocate for her patients.

Kellie: You have to understand where the other professions are coming from as well and be able to work with them and be able to present information to them in a way they find more palatable and will help them understand the the patients and where they are coming from.

- Roslyn also described social work knowledge of the prevailing politics as they related to her work area

Roslyn: We have a wider understanding of the actual political decisions and an understanding of the impact of these decisions on the day to day task. My focus is very much on the elderly and seeing more and more how disadvantaged they are going to become.

Watson (1997) suggests that in order to be effective in a hospital setting social workers need to compromise their social justice agenda. The social workers in this study all took the position that they could be effective for their clients which maintaining their values. The style of social work they have adopted can be understood within Payne's (2005) framework of the politics of social work. They have adopted Payne's individualism-reformism approach, where they are challenging the system on behalf of individual patients, not with intent to achieving large scale social change. Within this position they felt powerful, and the following section shows how they used their social work values to reinforce this position.

Being a social worker in a hospital

The social workers in this study all anchored themselves with the values of the profession. These values were seen as a particularly important lighthouse that guided the work they did (advocacy and empowerment as opposed to treatment). The social

workers could articulate a poor fit between their own values and those of the organisation but despite this felt their contribution to the organisation was both different from other professionals and positive. What was significant here was that when confronted with a challenging work environment all the participants had turned to their professional values as their source of direction. They had very much taken on board the key values of the profession as identified in all the statements of the professional associations and the Social Work Code of Ethics (as discussed in Chapter Two). Unlike other professions, such as nursing, who may be seen as a profession struggling for dominance in the hospital system, social workers did not offer unique skills and knowledge as important and defining of their profession. Whereas writers on nursing practice see nursing as a very strong “practice discipline” (Walker and Avant ,2005), the social workers in this study placed emphasis on their core values, rather than sets of skills, to supported their identity as a group within the hospital and also to provide a connection to the wider professional group. Ife (2008) provides a platform for this in his framing of rights based practice. His contrasts rights based practice to needs based practice, which he describes as “the assessment of needs and then the process of having these needs met” (Ife, 2008, p.26). The social workers in this study described their practice in terms of being rights based, whereas other health professionals took a more needs based approach. Ife (2008) claims that, despite the complexity and ambiguity around the conceptualization of human rights, “a social work practice based on human rights framework can both enrich and contextualize the ideas of needs and justice so that they become more powerful and more useful (Ife, 2008, p.28). This aspect of social work was described by several of the social workers, for example Kellie’s response to the question about what would happen if there were no social workers involved patients losing rights.

Kellie: I think a lot of people would be dealt with in a way that would trample of their rights, their right to have all the information and their right to make decisions.

As argued in Chapter Two, the discourses of economic rationalism are not hegemonic and there is some evidence that the political expressions of the ideologies of economic rationalism are modifiable and not totally dominant. To apply this thinking to the

hospital context, in considering the written policies of hospitals, the mission and value statements do not reflect the financial and administrative aspects of economic rationalism. They talk about care and quality service. It may be that social work, with its ability to understand systems, has inherently recognized that two sets of discourses are operating and has aligned itself with a set of discourses that may not be as loud but are also valued by our society.

The study conducted by Globermann et al (2003) which found a renewed positive feeling in hospital social workers also found that the social workers in their study were increasingly becoming involved in the most complex cases that did not fit well with the managed care models. The social workers in my study also described their client group as patients who required advocacy, patients who were not good patients in terms of what the system expected. It may be that social workers were able to work successfully with these people because of their client centered values, because they worked with the patient rather than demanding that they fit into the system, and because they were skilled negotiators were able to produce outcomes that were acceptable to both parties. What is more significant is that even in a system like the pre-Obama U.S. health care system, which is as close an example of an economic rationalist driven system as any social welfare system in existence, social workers were allowed to spend the time to work with complex clients to obtain good outcomes.

By becoming part of a different set of discourses social work can then be seen as powerful in a Foucaultian sense, holding their power by their operations and their language rather than by the positions they occupy. By describing themselves as operating from their professional values and by identifying that they manipulated the system to work with their patients according to these values, all the social workers illustrated this process. What was problematic in this study was the difficulty the social workers had describing the skills and knowledge they used to achieve these outcomes.

Difficulty defining a knowledge base

All the social workers in this study struggled to define their knowledge base, tending to revert of generalized, non-specific knowledge rather than providing examples of

specific social work knowledge. Most referred to knowledge that was acquired in practice and described it as knowledge of the systems within which they worked and knowledge of how to negotiate these. They did not, however appear to recognize how important or extensive this knowledge was or what skills might be needed to support it. Only one of the social workers mentioned theory knowledge but offered no in-depth discussion.

Two possible explanations for this difficulty are suggested as:

1. There are professional difficulties around how social work defines knowledge; and
2. This problem may be intensified by hospital setting where knowledge is very specifically defined.

Social work definition of knowledge

The difficulty in defining a social work knowledge base is noted in social work literature, with writers disagreeing on the most appropriate form of knowledge base to guide social work practice (Hudson, (1997); Smith, (2004)). Thompson (2009) notes, that social work draws on an extensive knowledge base that often contains knowledge specific to the area in which the social worker is employed, such as health. This type of knowledge was also mentioned by the social workers but again not named as knowledge that social work might hold. Hudson (1997) argues that the criteria for professional knowledge have been largely socially determined and therefore change over time, location and philosophy. The model of professional knowledge she has developed attempts to synthesize these different points of view. She defines professional knowledge as “the culminated information or understanding derived from theory, research practice or experience considered to contribute to the profession’s understanding of its work and that serves as a guide to its practice” (Hudson, 1997, p.37).

This model is a useful framework to consider the social workers’ responses concerning knowledge, as it identifies five main categories of knowledge:- theoretical knowledge, personal knowledge, professional knowledge, practice wisdom, empirical knowledge and procedural knowledge. While the participants struggled to name a knowledge base,

they talked extensively about what Hudson calls “procedural knowledge” without naming it a knowledge that they held. Procedural knowledge is defined as “knowledge about the organisation, legislation or policy context within which social work operates” (Hudson, 1997, p.38) and this is what was highlighted by the social workers as being definitive of who they are as a profession.

Some evidence of this from the data being:

Meredith: *We have an understanding of the medical model and work within that but hopefully we look well beyond because I think we understand that people don't just bring their bodies to hospital, they bring a multitude of other relationships.*

Kellie: *I see hospitals as being like a big sausage factory that people are fed into at one end and churned out through the other and the social worker's role is really to help the system, keep the sausage machine churning. But we also help explain to families and patients what is happening and why things are the way they are.*

The social workers were able to describe what they did and how they worked, without being able to attribute this to what can be seen to be, using Hudson's model, a solid base of procedural knowledge. Sarah, for example, acknowledged that social workers had knowledge of other people's work areas but then did not acknowledge that it was her own particular knowledge base that allowed her to take from others and put together to form a specific social work assessment.

Sarah: *I think each of the other health groups look at their particular areas of interest. We don't have as much detailed knowledge in these areas but we do have a working understanding of how these things are going to impact on the person's ability and what they need in the future.*

One possible interpretation of this finding is that the participants lacked the language (such as Hudson's model) to describe what they did in terms of a knowledge base. This may be an issue that needs to be addressed by schools of social work and also as part of

ongoing practice development. A model such as Hudson's can be more easily related to practice and therefore more helpful in assisting practitioners articulate a knowledge base

Medical definition of knowledge

A second possible reason is that the hospital context poses an extra challenge for social workers trying to describe a credible knowledge base. The definition of knowledge in health is strongly influenced by Cochrane's 1972 seminal work on overwhelming importance evidence in the production of knowledge, with hierarchical levels of certainly headed by the randomized double blind trial. The randomized double blind trial remains the gold standard by which all other evidence is judged, and anything less than that is regarded poorly. Faced with this overwhelming dominant paradigm, social work continually has to make decisions around its own construction of knowledge. The difficulties that the use of evidence based practice produces for social work was discussed in Chapter Two, with the conclusion that EBP can be used to legitimize social work activity in the hospital setting in terms of meeting the organisational goals but it does not produce social work knowledge.

MacDonald (2003) employed a sociological construct called the professional project to define the process of the debates around knowledge. The professional project was defined as "the activities undertaken and the characteristics projected by those wishing to propel the idea that an activity called social work exists (and still exists) and has the characteristics of a modern profession" (MacDonald, 2003, p.126). She argued that social work continues to reflect the optimism of the twentieth century welfare state, that improvement in general human well-being was both possible and important. However, as this thinking is being taken over by economic rationalism and managerial thinking, social work is also being destabilized and marginalised. Using the example of evidence-based practice she further suggested that as social work sees itself as marginalised it has responded by presenting itself and its knowledge base in a manner compatible with the economic rationalist agenda. In the face of the debates around what is knowledge, it appears that the social workers in this study have chosen to opt out of the whole debate by not really considering a defined knowledge base important. Although this is a very

small sample, the fact that all the social workers gave similar responses suggests that this might be common to many hospital social workers, suggesting that debates around knowledge make for robust intellectual considerations but may not be helpful to practitioners. As a substitute for this they have returned to their value base and hold this as defining their profession. While this strategy appears to be very successful for these social workers, overall it may be risky in the current climate. It also closes a pathway for practising social workers to express their skills and knowledge (as other professions do) and is therefore potentially devaluing of the profession. Knowledge is part of the cultural level identified by the professional bodies, but it appears that ownership of specific professional-based knowledge is not yet part of the social work identity at the personal level for these participants. This will be discussed further in the following section, which deals with what is really the focus point of this study, the hospital social work identity.

To summarize, for the social workers in this study the cultural level (C) can be seen as mediating between the structural (S) and the personal (P) described below. The social workers were aware of their structural context (predominantly economic rationalism and the medical model), but rather than challenging the system they turned to their professional values and developed a role as patient advocates, while using extensive skills in understanding and managing systems to adapt, rather than change, the system to accommodate individual patients. However, despite describing these skills as processes and implying an underlying knowledge base, none of these social workers could explicitly name their skills and knowledge. Possible implications of this will be further discussed on Chapter Six.

The personal level (P) - builders of bridges, a social work identity?

The personal level represents the essence of who these participants see themselves to be. It is shaped by the influences of both the structural and cultural levels, but also influences outwards on both these levels.

As identified by McCracken (1988) the metaphor is a powerful communication tool, and the metaphor that emerged most strongly across the interviews was one relating to connection such as the bridge, the stepping stone, the link between the hospital and the outside world.

From the earliest days of hospital social work the bridge metaphor has been used to describe the work done by social workers. Fort Cowles (2003) quotes Dr Richard Cabot, who is believed to have appointed the first hospital social worker in the USA in 1905, as describing the social worker “as a liaison or bridge between the hospital and the social environment and the community resources of the patient” (Fort Cowles, 2003, p.5). The social workers who participated in this study described themselves as builders of bridges. Three different bridges built by social workers can be identified from this study.

The first bridge they build a bridge is between two different environments of their clients, their client who is called ‘the patient’ and who is in hospital, and their client who also lives in the society outside the hospital. This bridge could be imagined to look like a bridge, a solid construction often built of community services and supported by other social work skills such as adjustment counseling, which allows the patients to cross from the hospital back to their lives. It is the bridge that is described in detail by the social workers and seen as defining their purpose. Interesting, a visual presentation of social work used by the AASW in a poster shows people (presumably social workers) building bridge-like structures across a chasm.

This bridge is also very recognizable in the literature as the task associated with discharge planning which, as argued in Chapter Two, has remained the domain of hospital social workers for decades. Judd and Sheffield (2010) concluded from a range of studies, including their own, that throughout history social workers have been a vital force within the hospital system and continue to maintain pivotal roles associated with discharge planning. Despite efforts to minimize and compartmentalize discharge planning activities “it continues to be recognized as a complex feat requiring a professional level of knowledge and skill” (Judd & Sheffield, 2010, p.868).

As well as being recognizable, there is growing evidence that this bridge contributing to curtailing the increasing cost of health care. Shier, Ginsberg, Howell, Volland & Golden

(2013) cite a number of studies where lack of social support has led to poor health outcomes and conclude that “emerging research points to social and environmental factors such as limited access to care, poor functional status and lack of social support as drivers of unplanned hospital admissions” (Shier et al, 2013, section 2, para 4).

The second bridge is somewhat less visible but was readily identified by the social workers in this study as the bridge of understanding. This bridge connects the patients’ realities back to the other hospital staff so they can become more engaged in working with the patients, rather than directing what will happen. Sarah provided a good description of this bridge or (as she called it) stepping stone.

Sarah: I spend time with the client finding out from them what their previous experiences have been. How the current situation has impacted on them and what their expectations are of the future and trying to goal set with them. But then we go that other stepping stone outside the hospital and then interviewing and spending as much time as necessary to speak to the family and the significant others of all our clients and bringing them into the discharge planning with the whole team. Not only discharge planning but the management of the patients while they are in hospital. I don’t think anybody else sees and spends time in not only looking at the client but looking at the social system of the patient and it is the social workers job to bring an awareness to the team of what it all means in terms of discharge of a particular client.

The building of this bridge is usually named in the literature as being part of the social work role of advocacy and has the social work value base as its foundation, demonstrating how the structural and the cultural influence the personal. Like the first bridge, this bridge is also beginning to find credibility beyond the bounds of social work practice. In 2001 the Institute of Medicine in the United States released a report that suggested, among other things, that patient centered care and collaborative health practices could lead to improvements in both health outcomes and patient satisfaction. Zimmerman and Dabelko (2007) noted that social workers were “skilled professionals able to advocate for the inclusion of the patient and the family member perspective

across hospital operations” (Zimmerman & Dabelko, 2007, p.43), and further suggested that social workers should, in fact, take a role in leading this change in practice across the wider hospital.

The third bridge is less well described by the social workers, more implied than explicitly defined, a theme that comes through all the interviews. This bridge is a connection between paradigms and reflects my earlier comments about social work maybe being part of a different set of discourses to those that are dominant. As discussed earlier in this Chapter, the hospital is a part of the health care system operating in the prevailing socio-economic system, whereas the social workers are operating within the values of their profession. Social Work is a very small occupational group when compared to doctors and nurses but, as demonstrated in Chapter One, has maintained numerical parity. Social work appears to operate in different territory, mainly that social work is charged with, and accepts, the upholding of human rights (Ife, 2008; Dominelli 2004). While what actually constitutes these rights is a contested area, the value itself has some universality. Human rights are upheld in the constitutions of all democracies and are defended strongly when seen to be violated (Dominelli, 2004). Social work values, therefore, are unlikely to be explicitly denied by an organisation such as a public hospital. The challenge for social work would be to “engage with the uncertain and fraught worlds clients inhabit, alongside meeting the demands of those who provide the resources necessary for pursuing the objective of social justice in the daily lives of the socially excluded” (Dominelli, 2004, p. 8). This is the third bridge, the one that allows connection between the loudly spoken rhetoric of the more dominant paradigm of economic rationalism and the more softly spoken values around human rights and social justice that may well still underpin human existence. This bridge that these social workers appear to be building between two paradigms was more implicit than explicit in that they did not describe this as one of their bridges. However, their responses showed that they were aware of difficulties they faced in the hospital system but still believed that they could achieve outcomes for the patient and still be relevant to the system while at the same time maintaining their social work values. Meredith summed this up well.

Meredith: *I started the social work service here and it's never had a social worker before so certainly it got a mixed response in terms of my presence here so it was really important from the start to really clarify the social work role and build a working relationship with the people that I work with. Now it's very much accepted and it's probably, with the exception of a few people, it has been a welcome service definitely. People have seen that it has actually extended the care for women antenatally. So it's been good. But I think social workers are really powerful in the multidisciplinary team. They need to be able to influence other practitioners and I've certainly seen a change in some of the nurses and some of the doctors here, in building a really good relationship with them and with them respecting the work that you do. Now ...their practice has been influenced, or at least they're making appropriate referrals, so that person now gets the assistance in those areas that they're (doctors and nurses) not dealing with. So I think we are very powerful to influence those systems and those relationships.*

However, despite feeling positive about themselves and their contribution the participants still felt different from others in the organisation. Alice described some of this difference as expectations of outcome.

Alice: *Once again, I think it's about valuing the person and wanting better outcomes for that person, I think, in terms of the entirety of their life, not just their condition.*

By working within a different set of discourses that are quieter but still valued social workers can be seen to be holding their power by their operations and their language rather than by the positions they occupy. However, the social workers in this study did not explicitly understand this, which is also similar to their difficulty describing a knowledge base. To them their social work identity was practice (building bridges) and their values. While this strategy appears to be very successful for the social workers in this study, it may be a risky way forward in an economic rationalist dominated climate, where at any time social work may be called on to justify its existence. It also closes a pathway for practising social workers to express their skills and knowledge (as other

professions do) which is potentially devaluing to the profession. As stated earlier in this chapter, knowledge is a part of the cultural lighthouse from the social work professional bodies as much as values, but these social workers have chosen only to incorporate the values into their professional identities and appear to be completely ignoring the knowledge base, relying instead on practice wisdom.

A bridge yet to be built

In addition to the three bridges already discussed, it would appear then, that there is a fourth bridge which has emerged in this study as a need rather than something already in existence. This is a bridge that needs to allow easy access between those who practice social work and those who speak for the profession as a whole and articulate its purpose at an organisational level, a professional level and an academic level.

The use of a grounded theory as the theoretical perspective for this study has proven to be powerful in allowing the hearing of voices of those who may not necessarily be heard at an organisational level, and what they have said has been very reassuring. There were, however, some gaps, particularly around their articulation of skills and knowledge. While this did not seem to impact negatively of any of these social workers as individuals, it may lead to lost opportunities for social work to carry their practices forward in the organisation, particularly, as identified earlier in this Chapter, there is evidence to support that the social work practices represented by the first two bridges are more valuable to the hospital system than the current medical model recognizes. By missing opportunities to showcase their skills and knowledge social work are also missing opportunities to build strong bridges between the discourses, bridges that social work is possibly the only profession able to build because it is the only profession that truly understands both sets of discourses.

Summary: being a social worker and doing social work in a hospital

The social workers in this study showed very strong awareness of the hospital as a system. In describing their work they all spoke of doing an assessment, which was

described as assessing the patient as part of a number of systems, including the hospital system. For example, in her interview Alice indicated that she performed an assessment that encompassed the patient, the family, the doctor, and the whole treating team. She indicated that each system could have different goals and the social work role was to “hopefully” identify goals which all systems could work towards.

One point that was evidenced strongly in all the interviews was that social work held expertise in understanding and managing systems. The social workers in this study regarded managing systems as an integral part of their everyday work and also defining of social work in complex organisations such as hospitals. However, despite being clear about what they were doing, this ability to work within and across systems was not named as either a significant skill or part of a specialized knowledge base, as discussed earlier in this Chapter.

Hospitals are good examples of the operations of structural power. Most disciplines within hospitals are organized hierarchically and directions are passed downwards. The participants in this study are not in positions of power structurally terms of the decision making, but do regard themselves as influential. They argue that that do this because they understand systems and can navigate through them. From a critical theory perspective it is possible to see that social work as a profession is under pressure to become part of the mainstream definitions of knowledge (MacDonald 2003). The pressure to adopt this stance in hospitals is very strong and social work as a profession has tried to go down this pathway. However, the viewpoints around such matters as evidence based practice in social work are highly contested and maybe right now are not providing a good lighthouse for practising social workers. The social workers who participated in this study have returned firmly to the values of the profession as expressed by the professional associations worldwide. These values anchor them in a common professional identity and give them a common purpose. This has allowed these participants to sidestep the debates about professional knowledge and evidence of achievement. By defining themselves by their professional values, they have then proceeded to develop strategies to promote these values within the organisation by practising them in their daily work. That they feel successful in doing this is, to them, evidence enough that they are doing a good job.

The social workers in this study could clearly articulate their value to individual clients and their ability to influence the system and the team or patient level. They could also describe how the dominant discourses of the organisation impacted on their practice, but were either unwilling or uninterested in looking at how they impacted on the wider organisation. A hypothesis is that social work may be powerful at the client level but not at the organisational level, so by dealing only with this level the social workers were protecting themselves from feeling powerless or irrelevant. The question from this is does this make social work vulnerable. This will be discussed in the next chapter, but the difficulty demonstrated by these social workers in describing their skill and knowledge base does show a large gap between the doing of social work and the knowledge about social work, hence the need for another bridge.

CHAPTER SIX – CONCLUSION

As discussed in the preamble, this study grew out of my own need to understand what was happening to my profession at the present time. Using the framework described by Crotty (1998), as the aim of this study was to articulate how practising hospital social workers defined their identity and what factors contributed to this identity, the study was supported by four elements of scaffolding, a constructivist epistemology and a critical theory theoretical perspective that allowed context to be considered as an influential factor, and a grounded theory methodology that privileged the voices of social workers currently practising in the field, Use of the method of the long interview (McCracken 1988) allowed the social workers freedom to express their opinions and ideas while maintaining consistency across interviews. The interview questions were structured to obtain as much information as possible about the work carried out by the social workers who participated in this study and the values, skills and knowledge that underpinned this work to fulfill the aim of the study outlined in Chapter One. From the rich material that has been presented, the following conclusions about the nature of hospital social work have been reached.

Findings of the study

Social Work is still both relevant and valuable to hospitals.

These social workers in this study believed themselves to be still relevant in their hospital settings and they were positive about their ongoing relevance. For them social work in hospitals is not an underground movement, nor is it especially under threat any more so than other professions (that is to say, the threats come from across-the-board downsizing rather than profession specific targeted cuts due to irrelevance). For the most part these social workers believed they had a valuable role to offer to the

organisation and as practising social workers were able to feel positive about that role. They were able to articulate the reasons for the work they did –both to advocate for individual clients within the system and also to educate other professionals in the system to their perspective. They weren't, however, trying to change the system based on big picture or conceptual thinking, they were concentrating on trying to achieve the best outcome for each particular patient.

The social work identity is contextual

This study has demonstrated that Thompson's model (Thompson, 2003) can be used to show how social workers' personal identity can be contextually embedded in both the structure and the culture of the wider society. The literature pertaining to hospital social work, as discussed in Chapter Two, has, over many years, tried unsuccessfully to identify a unique social work role that will allow the social work profession to claim unique territory (and the power associated with this unique territory) within the hospital system. It may be however, that structurally social work will never hold positions of power within the hospital if they adhere to the values of their profession rather than the dominant values of the organisation, specifically the bio-medical model of care, economic rationalism and managerialism. The professional project as described by MacDonald (2003) offers an explanation for the social work profession's continual quest to make itself relevant by trying to make itself look like other professions. The social workers in this study did not express the need to try to do this and believed that they hold their power in a different way which allows them to, at the same time, uphold their professional values. They expressed that their power lay in their ability to understand and negotiate systems. They also described the workings of a knowledge and skill base that is different from other professional groups within the hospital (although they were unable to put names to this). It is also clear that the pessimistic concerns about alienation and irrelevancy in the social work writings of the late 1990s and early 2000s were not shared by the social workers in this study. For them, the cultural level served to mediate the structural level and gave them their frame of reference. For them, *being* social workers anchored them in the values of the profession and gave both the direction and purpose to their work and also a cohesive identity. They

defined their own role to suit their own purpose; they weren't defined by an externally constructed role to suit the agency purpose. It was being a social worker that was important and their practice, the doing of social work, was their expression of this. Social work is what social workers do. It is a valid contribution to the profession as a whole, that practising social workers have found a way to remain positive and relevant in challenging times.

Social Workers can be seen as builders of bridges

At the personal level the social workers saw themselves as builders of bridges. This metaphor brings together both the primary social work role in many large teaching hospitals (discharge planning) and the processes associated with this role as identified in the literature. The bridges that they identified were those which connected their patients from the hospital back to their world outside the hospital and to the services and resources they required, and also the bridge of understanding between their patients' realities and the needs of the hospital system. By working the way they did they also implicitly bridged two discourses, the dominant discourses of the medical model, managerialism and economic rationalism and the quieter discourses around individual worth and dignity that allow them to assist people who do not fare well under the dominant discourses.

Locating this study in its context

As described in Chapter One the theoretical perspective informing this study is critical theory. In keeping with this perspective I will now examine these findings within their context. That social work has continued to operate in and be relevant to the changing hospital context suggests that the most important characteristic of hospital-based social work is not its ability to define a unique role or occupy territory, but its ability to adapt to the changes while still maintain its identity. The social workers in this study all appeared to have done this, and while this is a very small study, the fact that their responses were consistent with each other, and also consistent with responses obtained

in other studies cited in the literature review in Chapter Two, allows for this proposition to be considered in a wider context. To do this I will return to the work of Flyvberg (2001) that allows the value-rational questions to be asked, particularly in relation to power and who wins and who loses. As this study grew out a personal need to understand how the changing context was affecting the current and future relevance of social work in the hospital setting, a stated objective was to identify from this study what may be helpful in resolving such dilemmas and moving forward. Two dilemmas were identified.

Dilemma 1: This dilemma was the concern expressed both in discussions with colleagues and in the literature that social work in hospitals was under threat. From this study it does not appear that hospital based social work is particularly under threat as the social workers themselves could articulate their relevance. Furthermore, in Chapter One evidence was presented that suggested that there is a steady growth in numbers of hospital social workers in Perth which is comparable to other professions such as nursing. A reasonable conclusion would be that there is no threat and the social workers in this study firmly believed they made a difference to how patients were managed in the hospital that lead to better outcomes for both the patient and the hospital. It therefore appears that both the hospital social workers and the organisation are winners, but does this mean the same thing for the wider profession of social work? Social work as a whole profession must continue to be robust in its capacity to cope with many types of ongoing changes otherwise the profession may become fragmented and no longer produce a strong culture to be used as a reference point. For example, moves towards interprofessional education and interprofessional practice pose challenges for both social work educators and practitioners. Pockett (2011) notes that social work is well placed to participate in interprofessional education as theoretical underpinnings of social work are compatible with the theoretical underpinnings of interprofessional education. However, she also states that the “challenge for social work educators is to teach students to link the theoretical underpinnings of practice to the workplace situation” (Pockett, 2011, p.218). Social work in the workplace may become more vulnerable if the profession as a whole cannot articulate a profession-specific knowledge base, both

to be able to demonstrate effectiveness and to undertake research. Hudson (1997) provides a succinct summary of this proposition.

It is not enough for social workers to rely upon their professional values, intuition or practice wisdom alone. Skilful and effective professional practice requires social workers to be knowledgeable about research and theories applicable to a given area of practice or problem in order to make informed choices about the most effective course of action.

Perhaps, educational institutions, social work organisations, and professional journals need to re-examine and re-emphasize the place of knowledge in social work practice and provide greater opportunities for social workers to develop a critical professional culture by providing greater encouragement and support for practitioners to undertake social work research in the area of their expertise (Hudson, 1997, p. 44).

The social workers who participated in this study were confidently able to answer questions about their practice within the hospital. They were operating from a client-centered value base to achieve the outcomes their clients wanted. They achieved this by working with the clients but also with the system and measured their success in terms of what they could achieve for their clients. As individuals they won and so did the organisation, as they were confident in their role, and the organisation also benefited because the social workers were also aware of the needs of the organisation and strove to meet those too. However, according to writers such as Hudson and to Pockett this may not be enough and there still may be some risk to the profession if current practices are maintained.

Dilemma 2: This dilemma is that that social work will become irrelevant through being marginalised. The social workers in this study expressed feelings of difference but not of being marginalised, leading to the proposition that social work is not a marginalised profession in hospitals, rather it operates within a set of discourses around human value and human rights that, as proposed by Dominelli (2004) most democratic societies still hold in high regard and which become more visibly defended when challenged. Being able to bridge discourses may be the skill that defines social work more than any other but it was not identified by the participants nor is it specifically evident in the literature. Currently hospitals allow social workers to continue to work as they do because that

work is valuable to the organisation. However, if a time comes when the doing of social work is not enough, social work as a profession may struggle to maintain its presence as a professional entity. Furthermore, although having the skills to lead changes that may challenge a traditional medical model (Zimmermann & Dalbelko 2007), by not recognizing and promoting these skills social work may miss opportunities to promote what are traditionally social work values into the organisation.

Therefore, a fourth bridge was identified in Chapter Five. This is a new bridge that needs to be built, one that connects those who produce knowledge to those who use this knowledge to practice. The social workers in this study have incorporated the values of their profession, but not the knowledge base of their profession, into their professional selves. This has been identified over many years as problematic for the profession as a whole (Munroe, 1998 Hudson, 1997, Pockett, 2011). This new bridge connecting practising social workers to their knowledge and skill base needs also to be a two-way bridge, as currently practitioners do not appear to be engaging in discussions about knowledge, possibly avoiding the whole issue and preferring to work only with values which are largely not contested. It does not appear that social work knowledge is readily accessible to practitioners nor are practitioners actively seeking to engage with knowledge. This study suggests that social workers in the field do have something to say that can contribute to the profession as a whole.

For me, the findings of this study reflected the crisis of identity discussed in the preamble. What I found was that practising social workers were positive and confident in their role and optimistic about their future, which is how I feel when practising in the front line. However, when faced with the struggle the participating social workers showed when talking about skills and knowledge I immediately felt concerned, as my experience tells me that this difficulty is not limited to the five social workers in this study. I now understand this crisis of identity better and can see a way forward for myself to manage this better and make small changes in staff professional development in my own hospital.

Finally, because an objective of this study is to hear the voices of practising social workers, I would like to finish with these voices.

When asked to comment at the end of the interview on anything else they would like to add, responders had different things to say, maybe reflecting on their own social work journey.

Some were a little cautionary.

Alice: I think we're on the right track getting our voice heard. It's interesting that we are becoming an "allied health" group and I think that because no allied health profession is core business it is probably a good idea to have safety in numbers, to have a bit more power as a group rather than individual professions...I can see it heading that way more and more and I guess that's okay as long as one profession doesn't drown out the voices of the others.

Sarah: I have been a social worker all these years and I have always been proud to be a social worker. I have really enjoyed the opportunity to be a social worker but I think social work is under enormous pressure these days because of the number of the aging population, huge pressure because of the amount of drug and alcohol abuse that is within the community which leads to big increase in psychiatric illness. And I just feel that there are not the resources in the community to support the number of people needing ongoing support. So I fear for what is going to happen to many people.

Others embraced the positive and felt confident about the future.

Meredith: I think it is a really unique environment to be working in, the hospital especially, I think it has been really lovely because I have been allowed to build good relationships with the people that I work with and I feel that we are powerful people and I feel as though we have the ability in very small ways and sometimes in larger ways to impact positively on someone's life and that impact may be now or may be in the future, but there is certainly in the

area I work is potential and is fantastic where people are considering making big changes to their life for the better and I think that's a very privileged position to be in.

Kellie: I remember when I finished (SW practicum in a hospital) thinking "oh well, that profession is not going to be around for long, there is no point in planning to be a hospital social worker". I really felt that it was something that was going to disappear. I felt that the whole emphasis which is still worse than it ever was but the whole evidence-based practice kind of perspective, there is no way that social workers can work from evidence based perspective I don't feel. So from that point of view I felt at the time that we are quite vulnerable within the system and the O.T. s and the nurses were building themselves up and sort of cutting across into social work territory and I guess at that time I kind of thought that what I was doing wasn't that special and that probably anyone else could have done it. But as time has gone on you have got to have the interest, it's not just being able to do it. Its having the interest and care for people to be able to do the social work role that makes us. I think we are going to be here for some time.

"I think we are going to be here for some time" seems a fitting note on which to conclude a study that mainly reflected optimism. Despite some challenges being pointed to by this study, and despite this being a very small study, the consistency and optimism of these social workers speaks well for the continued value and relevance of hospital-based social work.

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Interview Questions

1. How long have you worked as a social worker in a hospital setting?

2. As a hospital social worker, how do you describe your work?

Prompts

- what tasks do you do
- what knowledge do you bring to the work
- what skills do you bring to the work
- what values do you bring to the work
- how do you relate to your work environment
- what sort of outcomes do you look for

3. As a social worker, how do you distinguish yourself and your profession from other members of a multidisciplinary team?

Prompts

- Differences between self and other allied health
- Differences between self and nursing staff
- Differences between self and medical staff
- Differences in work (tasks and style)
- Differences in values
- Differences in types of assessments undertaken
- Differences in understandings of concepts of health and wellness.

4. What do you think Social Work contributes to patient care that is unique to the profession?

Prompt

- What do you think would happen to patient care if there were no social workers in hospitals

5. Is there anything else you would like to say?

Appendix 2

Information Letter to Participants

Dear

I am a social worker currently conducting research as part of a Masters by research degree at Edith Cowan University. This research is titled “**Social work is what social workers do: a study of hospital social workers’ understanding of their work and their professional identity**”. The aim of this study is to articulate the nature of hospital social work as it is described by those currently practising it. I am seeking to interview social workers who have worked in public teaching hospitals for at least three years. This research has the approval of the Human Research Ethics Committee at Edith Cowan University.

Participation will involve taking part in 2 interviews of up to 1 hour each. Interviews will take place at a time and venue nominated by the participant, I am happy to come to you. After the first interview a transcript of the interview will be given to you and subsequent interviews will be for the purpose of clarifying or expanding on this interview.. These interviews will be semi-structured. While there are some issues I want to explore I am most interested in your understanding of the role and purpose of social work in hospitals, particularly in terms of what social work uniquely contributes.

I am also seeking your permission to audiotape these interviews. Each interview will be transcribed and given back to you to check prior to any data analysis. There will also be opportunities for you to have input at the analysis stage if you so wish. All aggregated data will be de-identified and any quotes will only be used with your permission. All tapes will be destroyed after the examination of the thesis and all other information held either electronically or in hard copy form will be destroyed after 5 years.

I am particularly aware of the need to protect the confidentiality of all participants. While this study is being conducted I will be the only person who knows the identity of

participants. Transcribing of interviews will be done by a professional transcriber with no connection to either the social work profession or any hospitals. All transcribed interviews and aggregated data will be de-identified.

During the time this research is being conducted all information including data will be securely stored in my home office. The completed research and data will be kept for a period of five years and stored at Edith Cowan University, Bunbury.

Participation in this study is entirely voluntary. If you decline to answer any questions or choose to withdraw from the study, confidentiality will be maintained without any prejudice.

Should you wish to discuss this further my contact details are:-

Chris Perriam

Telephone: 040 301 6015

Email: cperriam@hotmail.com

My supervisor for this research is Dr Dyann Ross, Senior Lecturer in Social Work at ECU Bunbury. Her contact phone number is 9780 7743 and her email contact is d.ross@ecu.edu.au .

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact the following person:-

Research Ethics Officer,

Edith Cowan University,

100 Joondalup Dr,

Joondalup WA 6027

Ph 63042170

With thanks

Chris Perriam

INFORMED CONSENT

Research Title Social Work is what social workers do: a study of hospital social workers understanding of their work and their professional identity

Researcher: Chris Perriam, Masters Student, Edith Cowan University
Ph: 040 301 6015
Email: cperriam@hotmail.com

Supervisor: Dr Dyann Ross, Senior Lecturer, School of Social Work, Edith Cowan University, Bunbury
Ph: 9770 7743
Email: d.ross@ecu.edu.au

I _____
freely agree to participate as an interviewee in the above research. I have been given the Information Letter explaining this study and I have read and understood the information provided and been given any supplementary information requested.

I understand that I can contact either person listed above if I have further questions.

I understand that that my participation in this research will involve taking part in a semi structured interview on the above topic, and subsequent interviews as required to clarify information provided by me in this interview.

I understand that the information provided will be used only for the purpose of this study.

I understand that strict confidentiality will be maintained throughout the study, that my identity will be known only to the researcher and not disclosed to any other person without my consent.

I understand that I may decline to answer any questions or withdraw from the study at any time.

I give permission for interviews to be audiotaped on the understanding that only the researcher will have access to this and all transcriptions and aggregated data will be de-identified.

Signature _____

Print name _____

Date _____