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MEDICAL SOCIAL WORKERS: CLINICIANS OR CLERKS?

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<u>Title</u>

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<u>Abstract</u>

Medical social workers have the training and clinical skills to treat patients with psychosocial problems. Yet in health care settings, medical social workers are not expected to perform as clinicians, but rather as functionaries who carry out a variety of tasks that have no relationship to clinical care. As a result, the clinical role of the medical social worker is eroded, leading to professional stagnation. Due to confusion over what social workers are expected to do, the subordinate role of social work within the health care delivery system, and the lack of treatment modalities specifically unique to the social work profession, upgrading the role of the medical social worker and preserving medical social work services as a viable and recognizable clinical specialty will be daunting and challenging task. Ultimately, the question is: does clinical social work have a credible role in the health care field?

Text

Medical social workers have much to offer as clinicians in the field of health care. Yet they routinely perform duties that are not commensurate with their education, training or skills. Why has this happened? Can social workers perform effectively under these circumstances? Do social workers even belong in the health care field?

Social work services in the health care field is mandated by Federal law (Mizrahi, 1992, page 89) and required by the Joint Commission on the Accreditation of Hospitals (Estes, 1984, page 24). As a result, most hospitals now employ social work staff. In 1997, 84.7 percent of the hospitals in the United States provided social work services (Hospital Statistics, 1999). In 1905 Massachusetts General Hospital became the first hospital to employ social workers (Bracht, 1978, page 11).

Medical social workers can provide a wide range of clinical services. These clinical services include discharge planning, counseling and support, assisting with decision-making, patient and family education, assisting with obtaining benefits, facilitating access to community resources, resolving behavioral problems which interfere with patient care, risk management, and consultation around behavioral and emotional issues (Berkman, 1996, page 544).

Given this impressive array of clinical services that medical social workers can, and do, provide, and the widespread employment of social workers throughout the health care industry (Bracht, 1978, page 5), the

clinical role of the medical social worker should be firmly established.

Yet this is not the case. Instead of being allowed to perform as clinicians,

medical social workers perform as clerks, resulting in professional

stagnation which in turn erodes the credibility of the medical social worker

as a member of the interdisciplinary treatment team and calls into question

the status of social work as a bona fide profession.

This is not a new problem. Known in England as almoners, from the

word "almoner," the title of the officials in 13th cenurty France who

distributed alms to the poor (The New Encyclopedia Britannica, Vol. 1,

1997, page 289), medical social workers historically have been expected to

perform a myriad of tasks that have nothing to do with clinical work. In

1937, the United Hospital Fund reported that

> Some [medical social work] departments have been
> regarded as general utilities to which was assigned
> any job that did not seem to fit logically into the rest
> of the hospital's organization, irrespective of its
> bearing on social study and treatment (The United
> Hospital Fund, 1937, page 560).

Some of the numerous tasks that medical social workers performed

included: indiscriminant mass relief work (milk, food, clothes, ice, coal,

etc.), obtaining blood donors, obtaining permissions for autopsies,

providing information about the operation of the hospital, and "a vast

number of other duties" that lacked "any logical relationship to medical

social service" (The United Hospital Fund, 1937, page 560). The United

Hospital Fund also reported that the "practice of [medical] social case

work" was "exacting and exhausting" and that the social caseworkers

were "fatigued by overwork," "tired," and "harassed" (The United Hospital Fund, 1937, page 580).

The dichotomy between what medical social workers could offer and the duties that medical social workers were expected to perform was most apparent in the area of discharge planning. Although a clinical service, discharge planning was considered an activity that did not warrant full professional status (NASW, Encyclopedia, 1997, page 2286). Yet this was the one clinical function that health care organizations wanted medical social workers to perform. Carol Bailey Germaine writes:

> In many health care settings, discharge planning came to be relegated to social workers with less than graduate education, on the assumption that it required less knowledge and skill than did the counseling function. In hospitals the redefinition of the social work function was rarely congruent with the expectations and perceptions of physicians, patients, and hospital administration, who placed greater value on the social worker's help in developing sound discharge plans than on psychologically oriented counseling (Germaine, 1984, pages 171-172).

Since the 1930s, medical social work has undergone little, if any, Change. Germaine's words hold true today. Physicians, patients, and hospital administration still place greater value on the social worker's help in developing sound discharge plans than on psychologically oriented counseling (Cowles and Lefcowitz, 1992, pages 57, 58, 63). In accordance with this expectation, and consistent with the generalist social work theoretical practice model emphasizing case management, "the link between the client and the service delivery system" (NASW Case

Management, 1992, page 22), medical social work departments today distribute clothing, issue carfare, arrange transportation, provide community liaison service, order medical equipment, and request home care service (Bracht, 1978, page 138; Furstenburg, 1984, pages 48-52). Medical social workers even arrange for the delivery of reading material to Inpatients from the patient library, write letters at the request of patients and their families verifying the patient's hospitalization, and obtain television service for indigent patients free-of-charge. There are 29 possible resources that social workers can use to facilitate service delivery (Furstenburg, 1984, pages 45-47). To provide these services, the medical social worker, who, as a case manager, is "expected to be ready to perform whatever role it takes to ensure that their clients receive appropriate, coordinated, and continuous care" (Rubin, 1992, page 10), must be proficient in the use of a telephone and a fax machine, and in making sure that medical documents are properly completed and expeditiously processed. Although case management is an important service, and requires knowledge of community resources and bureaucratic organization and an ability to communicate effectively by telephone and fax, this task does not require any formal clinical training. NASW reported that "Within the past 10 years, policymakers have appropriated case management tasks and assigned them to nonprofessionals in the interest of cost containment" (NASW, Case Management, 1992, page 21).

Within the hospital setting, the primary function of the medical social

worker is to facilitate the discharge of the patients from the hospital. To perform this task, the medical social worker participates as a member of a multidisciplinary team, which is headed by the doctor who is ultimately responsible for all facets of the patient's discharge. The interdisciplinary collaboration associated with the multidisciplinary team approach reveals the unequal relationship between the physician and the medical social worker, and reinforces the medical social worker's subordinate role in the discharge planning process.

The medical social can diagnose the patient's social problems and offer certain clinical recommendations which a physician may, but is not obligated to, take into consideration or incorporate when developing a treatment plan. The reverse, however, is not the case. For instance, if a physician orders home care services for a patient, the medical social worker is duty-bound to implement that plan. But if the medical social worker makes the same recommendation, the physician has the discretionary authority to reject the recommendation. If the doctor rejects the medical social worker's recommendation, the medical social worker is left with little recourse except to either 1. dispute the physician's decision and thereby be accused of being argumentative, presumptuous, obstructionist, "making waves," and wanting to cause an unnecessary delay in the discharge for which the medical social worker will bear full blame or 2. acquiesce with the physician's decision, even if it places the patient at risk, thereby forfeiting professional integrity, ignoring ethical

considerations and foregoing independent action in favor of the more

politically expedient and non-confrontational option of "buckling

under," "going along with the program," and avoiding responsibility by

rationalizing that "it's the doctor's decision, not mine." In either case, the

physician, as the dominant member of the interdisciplinary treatment team

(Abramson and Mizrahi, 1996, page 271), has the final say. Terry Mizrahi

writes:

> Medical and psychiatric settings are still
> controlled by physicians and heavily influenced
> by nurses and psychologists. Obtaining
> recognition of professional social work services
> as an integral and equal part of health and
> mental health teams remains a challenge (Mizrahi,
> 1992, page 87).

For example, in one vignette, a medical doctor unilaterally decides to

discharge a 62 year old female patient to home, completely ignoring the

medical social worker's plan to place the patient, who was incontinent and

in restraints, in a nursing home (Dziegielewski, 1998, pages 4-6).

For the medical staff, interdisciplinary collaboration is an intrusive

challenge to the physician's competence and authority (Abramson and

Mizrahi, 1996, page 279). Robert Dingwall writes:

> The doctors we have encountered tend to
> be rather dismissive about the value of case
> conferences and to regard them as a waste of
> time…. Given the assumptions of professional
> dominance, then it is a waste of time discussing
> decisions which a doctor has already made. It
> is simply a matter for others to execute (Dingwall,
> page 89).

Dr. Richard Cabot, the physician who in 1905 founded the first hospital

based social work department in the United States, said:

> Unless the doctor has already acquired the
> "social point of view" … he will think that the
> social worker is trying to teach him how to do his
> work whenever she does what he didn't and
> couldn't do before. Naturally, he will resent this
> indignantly (Bracht, 1978, page 10).

Differences between the medical and social work professions

seem to be irreconcilable. The Seeholm Report in Britain noted

> the more fundamental sources of the difference
> between medicine and social work in the
> contrasting developments of the two professions.
> The social workers' emphasis is on the patients
> gaining understanding of their situation and on
> the acquisition of personal insight and empathy
> on the part of the social workers. Medicine on the
> other hand is concerned with refining its
> objectivity and technology …. These two
> approaches are as different as they are obviously
> complimentary (Bracht, 1978, page 10).

Considered as interlopers who could not relate to physicians, it is

not surprising that some health care facilities did not want to employ social

workers. During the 1930s, some hospital administrators were convinced

that the introduction of social workers would lead to the expansion of

charity care in their facilities. Others felt that attending to the social needs

of the patients was a job for city agencies. And others believed that their

institutions already had the resources, such as members of religious

orders, auxiliary committees, and nursing personnel, who could attend to

the social needs of the patients (The United Hospital Fund, 1937, page 542).

Although fallacious, these beliefs were reinforced by the nebulous

nature of social work itself. Nobody knew what kind of services medical

social workers were actually qualified to provide. In 1915 Abraham Flexner said that social work was not a profession because it lacked "an educationally communicable technique (NASW, Encyclopedia, Vol. 3, page 2285). Nor did a medical social worker require any special training or credentials. During the winter of 1935-1936, about 66 percent of the hospital social workers in New York City were nurses (The United Hospital Fund, 1937, page 569). Out of 123 social workers employed by the New York City Department of Hospitals, one had graduated from a school of social work (The United Hospital Fund, 1937, page 570).

Starting in the 1990s, efforts to remove clinical social workers from health care settings have intensified. Social workers have been stigmatized for advocating on behalf of the poor, nonpaying patients who are considered financial burdens (Ross, 1993, pages 243-244). Illinois and Texas attempted, unsuccessfully, to eliminate mandates for the social work degree (Mizrahi, 1992, page 88). In New York State, NASW reported, the Governor's Office of Regulatory Reform (ORR) "refused to approve a proposal that would have required social work departments in urban hospitals to be headed by MSWs" (NASW News, July 1999). Referring to the ORR, Gerald Beallor, of the New York City Chapter of NASW, said: "It … removes jobs from social work" (NASW News, July 1999). Legal efforts to declare the ORR unconstitutional failed. That BSW and MSW social workers perform the same duties (Kadushin and Kulys, 1995; Levin and Herbert, 1997, page 27) have lent credence to these efforts to eliminate

social work positions.

One particularly vexing problem for the social work profession is that medical social work still lacks a well-defined clinical role. In the hospital, auxiliary committees provide charity to help indigent patients and physicians, psychologists, staff nurses, nurse clinicians, case managers and chaplains provide counseling, an important clinical service that other health care professionals in addition to social workers are able to provide. Sophie F. Dziegielewski writes: "Often the roles that social workers perform overlap with those of other disciplines. For example, today nurses are often asked to run therapeutic support groups in the health care setting" (Dziegielewski, 1998, page 9). In a survey of physicians and nurses,

> Only 1.1 percent of physicians and 1.5 percent of
> nurses believed that assessing emotional
> problems of patients belongs to social work, and
> only 6.3 percent of physicians and 8.9 percent of
> nurses believed that helping find solutions to
> those problems belongs to social work (Cowles
> and Lefcowitz, 1992, page 60).

Even discharge planning, that one clinical function most closely associated with social work, is not the exclusive responsibility of the social work department (Berger *et al*, 1996, page 172). If a patient has a mental health problem, a primary care physician will refer the case not to a social worker but to a psychiatrist or a psychologist (Steinberg, 1997, page 213). In several states action has been taken to deny social workers the right to use psychological tests (O'Neill, 1999). The NYC-NASW Think Tank reported

that "Efforts that once constituted social work services are being peeled away" (NASW, <u>Currents</u>, 1999). Lay persons can perform as helpers too (Whitaker and Tracy, 1989, page 13).

Lacking a specific clinical role, social workers are at risk of losing their professional identity. In a survey of medical social workers, concerns were expressed

> about role changes, loss of control over decisions
> regarding the social work role, and lack of
> understanding of the social work role among
> program staff … in all interviews. Respondents
> expressed concern about the opportunity for
> other disciplines to participate in setting priorities
> for social workers and concern that the
> boundaries between social and other disciplines
> could be breached. They spoke about the fear
> that their roles would be watered down and that
> other disciplines would usurp their counseling
> role or expect them to perform tasks social
> workers associate with other disciplines
> (Globerman *et al*, 1996, page 182).

These concerns reflect the social workers' deep awareness that they are in competition with other health care professionals for jobs (Gibelman, 1999, page 305).

Defending and justifying the clinical role of medical social work is made more difficult by the confusion, both within and outside of the social work profession, over the actual function of a social worker. E. R. Tolson writes: "There is considerable confusion in the minds of the public about what a social worker is" (Tolson, 1994, page 134.) Noel and Rita Timms write: "It is surprisingly difficult to define 'social work' or even to describe what social workers do" (Timms, 1977, page 33). Margaret Gibelman writes

of the expansive and expanding boundaries of
social work, and the difficulty in providing
succinct, encapsulated descriptions of a complex
and multifaceted profession (Gibelman, 1999,
page 301).

Further complicating efforts to arrive at a precise description of

social work's clinical role is the lack of consensus over what is meant by

the term "professional social worker." Terry Mizrahi writes:

The profession still struggles with it own
definition of standards and requirements for who
is or should be a "professional," "qualified," and
 "autonomous" social worker (Mizrahi, Health and
Social Work, 1992, page 88).

Efforts to upgrade the clinical role of the medical social worker will

not be easy. In addition to the need for the social work profession to

develop a concise definition for the term "social worker" and a simple,

straightforward description of what a social worker does, several other

obstacles have to be overcome. First, as non-physicians, medical social

workers do not practice medicine (NASW, letter, 1999), and therefore do not

have primary responsibility for the medical management of cases in the

health care setting. Second, as employees (Gibelman, 1999, page 303),

medical social workers do not set the rules governing the conditions of

their employment. Third, as health care facilities continue to cut costs by

decreasing inpatient lengths of stay (Cjeka, 1999, pages 57-58), the focus

on discharge planning is increasing (Ross, 1993, page 246), thereby

placing further demands on medical social workers to provide even more

"low skill" services (Kadushin and Kulys, 1995, page 174). Fourth, clinical

social workers are already being replaced by less qualified and lower-paid

para-professional surrogates (NASW, Currents, 1999). This trend has

already led to erosion in the level of service. The NYC-NASW Think Tank

found that

> Social Work is reduced to a pattern of expansion
> of paperwork, diminishment of direct service, and
> therefore a diminishment of skill and lower wages.
> The trend over the past 20 years has been
> to hire people with bachelors and associate
> degrees instead of MSWs (NASW, 1999).

In the health care field, the role of the social worker has been reduced to

clearing the beds and moving out bodies (Kadushin and Kulys, 1995, page

174).

The social work profession has a long and honorable tradition of

service to the poor. Institutions such as Hull House and the Henry Street

Settlement became world famous, and Jane Addams, who was awarded the

Nobel Peace Prize in 1931, and Lillian Wald, who founded the Visiting

Nurse Service, became icons synonymous with leadership, innovation and

clarity of purpose. Unlike medical social workers, who as employees are

constrained from defining and determining their role in the workplace, and

as wage earners do not want to jeopardize their jobs, Jane Addams and

Lillian Wald developed their own programs which allowed them wide

latitude to affect far-reaching and meaningful social change (Addams,

1938; Feuerlicht, 1970; James, 1981; Siegel, 1983). Paul H. Stuart writes:

"Settlement house residents were pioneers in research and social action

(Stuart, 1999, page 336).

This outstanding tradition of excellent and meaningful service can be replicated in medical social work. To accomplish this, medical social workers must assert their professional status and expand their clinical role, with emphasis on those areas of clinical practice that are directly relevant to the needs of the patients and at the same time applicable to achieving organizational objectives. Further, medical social workers must initiate, facilitate and maintain an ongoing dialogue with other professional disciplines and with hospital administrators and managers in order to 1. instill and reinforce a greater awareness, understanding, acceptance, and appreciation of the role of the medical social worker as an important and valuable member of the clinical team; 2. promote and project a positive image of the medical social worker as dynamic and proactive clinical leader; and 3. actively refute and categorically reject the stereotypical impression of the medical social worker as a mere bureaucratic functionary with nothing to offer clinically or substantively except to process forms and thereby make the physician's job easier (Berkman, 1996, page 545).

Licensure of social workers in many states has further legitimized social work's rightful claim for full and unconditional inclusion in the community of clinical treatment providers, but more needs to be done to ensure that the legal recognition of clinical competence that licensure affords gets translated into practical action at the workplace. Such action, in the form of expanded clinical responsibilities, will result in higher quality service for the patients, greater job satisfaction for the social work staff,

enhanced feelings of pride in being a social worker, and preservation and

expansion of the social work role in the health care field.

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