THE KNOWLEDGE, SKILLS, AND PERSONAL CHARACTERISTICS
OF AN EFFECTIVE MEDICAL SOCIAL WORKER IN A HOSPITAL SETTING

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OF AN EFFECTIVE MEDICAL SOCIAL WORKER IN A HOSPITAL SETTING

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Division of Social Work
Abstract

of

THE KNOWLEDGE, SKILLS, AND PERSONAL CHARACTERISTICS
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This mixed method of qualitative and quantitative study explores the knowledge, skills, and personal characteristics of an effective medical social worker in a hospital setting. Likewise, it also examines current hospital culture and its effects on social work practice. This study aimed to provide a learning tool for new social workers or an added resource for experienced medical social workers in the hospital setting. Such tool will aid in the articulation of social work roles to other professionals and patients. The researcher gathered data through an online survey of 30 medical social workers and interns who practiced in a hospital setting. Snowball sampling method was then employed in selecting the participants. Analysis of the findings was grouped under the main themes noted above to prepare medical social workers in assuming specific functions, roles, and responsibilities in a hospital setting. While most findings aligned with the review of literature, the study indicated that knowledge of medical terminology, clear understanding of the hospital and organizational systems, and effective case management were considered major elements of learning in social work.
Specific findings of this study showed that a knowledge of end-of-life issues and the ability to work collaboratively and flexibly with other professionals facilitate short-term interventions and establishes rapport quickly with patients was essential. Lastly, through higher and continuing education, the medical social worker will help in clarifying his/her distinct role in healing patients in the hospital setting.

_____________________, Committee Chair
Susan Eggman, Ph.D., M.S.W.

_____________________
Date
DEDICATION

I dedicate this project to my grandmother Elizabeth, my mother Kristina and Janet, the strongest women I will ever know. Your guidance, love and strength have been a constant in my life. None of this would be possible without you. I love you all!
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Chapter 1

THE PROBLEM

Introduction

As a graduate student looking toward my future career, I have begun to narrow specific areas of practice into that which I enjoy and believe I can be of greatest service. Having previous experiences working in the medical field, I find enjoyment in the fast-paced, ever-changing environment, which serves a diverse client population. My experience and interest in health care led me to an internship in a hospital setting. Despite my interest in health care, coming into a hospital was intimidating because of the specific skills and knowledge base needed to work effectively with the patients and their families. Working in this type of environment can be exciting as well. However, hospital social workers must learn to be flexible in their roles inasmuch as the hospital setting continues to transform.

As a new social worker hoping to make a career in the hospital setting, I find it important to have a major understanding of the knowledge needed to be effective, the skills necessary to serve my clients best and the specific, innate or learned, characteristics, which are helpful in providing social services. This study aims to explore in performing comprehensively the nature of hospital social work, and after analyzing all the materials, to provide myself and other social workers interested in hospital social work a broad understanding of the knowledge, skills, and characteristics needed for effective practice. The results of this study could serve as a helpful learning tool or an added resource for social workers in the hospital setting.
Furthermore, there appears to be confusion as to the role of a hospital social worker. This research study attempts to clarify the specific functions and responsibilities of the concerned social worker. The multiple reasons behind this lack of role clarity are discussed in depth throughout this study. As hospitals change, social work roles change; hence, the need to understand the present roles better is imperative. It is essential that social workers clearly define their roles and value to the public and other professionals in order to stay viable in a hospital setting (Back, 2000; Davis, 2004; Globerman, 1999; Nilsson, Ryan, Miller, 2007; Silverman, 2008). Otherwise, without a clear picture of their role in a hospital setting, social work will be devalued.

**Background of the Problem**

Dr. Richard Cabot and the social worker Ida Canon started social services in the hospital setting in 1914, at Massachusetts General Hospital (Dhooper, 1997; Gregorian, 2005; Massachusetts General Hospital (MGH); Praglin, 2007). Since then, hospitals have started to employ a large number of social workers. Dr. Cabot believed that effective medical treatment encompassed an absolute diagnosis of the patient. The absolute diagnosis included a complete assessment of the patient's home, family, employment, environmental factors, and the psychological factors (Dhooper, 1997). Social work has been highly valued over the last century, as the healthcare industry has evolved. However, as hospitals change and progress, social service departments must also adjust in order to remain viable assets to the healthcare setting. There has always been a relationship between trends that occurred in hospital social work practice and events in the rest of the field (Pockett, 2002). Due to the risk of psychosocial problems
among patients, hospital management took the responsibility of dealing with these problems, for as long as the patient stays within the hospital setting (Auslander, 2000).

The information available to social workers regarding their specific role in a hospital setting is minimal and often unclear. In effect, role confusion has occurred in hospital social work for decades (Cowles, & Lefcowitz, 1992). The continuous changes in the hospital environment further compounded the role confusion. Hospital restructuring and the evolution of managed care have caused the greatest changes in hospitals, thus leading to the modification of social work roles (Berger et al., 1996; Davis, 2004; Globerman, 1999; Schneider, Hyer, & Luptak, 2000). With the constant changes taking place, clarifying social work expectations becomes difficult.

The lack of role clarity also causes confusion on the working relationships between nurses and social workers. This role ambiguity increasingly stems from the lack of clarity on the specific function of a social worker, thus making the social workers more vulnerable to an eventual loss of position (Davis, 2004; Hebert, Copeland, Schulz, Amato, & Arnold, 2008; Mizrahi & Berger, 2001). In order for social workers to show their viability and necessity in a hospital setting, they must have a clear understanding of their role (Back, 2000; Davis, 2004; Globerman, 1999; Nilsson, Ryan, & Miller, 2007; Silverman, 2008).

Specific characteristics, skill sets, and a solid knowledge base are essential for medical social workers to aid them in understanding their own role. Understanding and articulating their roles, will also help in keeping hospital social workers valued as respected members of the interdisciplinary team.
Statement of the Research Problem

Although there is an abundance of literature and numerous studies on the different aspects of medical social work in hospitals, only a negligible number of studies have compiled the information as guides for best practice. Specifically, there is a lack of research materials, which depict the knowledge, skills, and personal characteristics needed for this specific field.

Purpose of the Study

The primary purpose of this study is to explore specific knowledge, skills, and personal characteristics that are necessary for best practice in a hospital setting. This researcher is hopeful that an in-depth exploration will offer new medical social workers a learning tool and give experienced social workers an added resource, which is valuable to their career. As noted on numerous occasions, as healthcare changes the role of social worker must change to adapt. This study hopes to provide the most current information as a guide, useful in practice immediately.

The secondary purpose of this study is to provide medical social workers with current information on best practices and roles, which they can articulate, to other allied professionals and clients. Social workers in the hospital setting are criticized because they lack the ability to communicate their roles and show their value. The lack of articulation comes from a lack of understanding of roles and the multitude of roles, which social workers acquire. This study will give an overview of knowledge, skills, and characteristics that are easily expressed to others.
Theoretical Framework

The theoretical framework most appropriate for this study is role theory. Role theory asserts that behavior is based on social position (Hindin, 2007). The role that an individual may hold can help shape his or her behavior and how one expects others to behave. According to Payne (2005), role theory has a long history in social work, because it focuses on our interaction with others and how their reactions cause us to respond in characteristic ways. Each position has a role associated with it, and our roles effect how we manage change. Role theory is valuable in that it facilitates an understanding of how certain human behaviors are caused by role conflicts and ambiguities.

The research problem has a direct correlation with role theory on numerous levels. A critical aspect of role theory as it applies to social workers is to have an understanding of the influence of professional roles and its implications on socialization, specific settings, status and hierarchy (Bronstein, 2003). Understanding the knowledge, skills and characteristics of a medical social worker will aid in an understanding of the role in a hospital setting, which will set behavior expectations as well as give a guide for interactions with clients and other professionals. Role theory is also associated with conflict and ambiguity, which is a present problem in hospital social work. Social work roles and nursing roles are often ambiguous and conflicted. Hospital environments are also ever changing and role theory asserts that an understanding of our position will coincide with how we manage change. Essentially, if
medical social workers have a clear picture of their role, they will respond better to change.

**Definition of Terms**

Allied health professionals- health professionals distinct from medicine and nursing that work in teams to make the healthcare system function by providing a wide range of direct patient care and support services.

Evidence-based practice- using the best scientific evidence available in deciding how to intervene with individuals, families, groups or communities.

Health professionals- a qualified person who delivers proper healthcare in a systematic way, professionally to any individual in need of health care services.

Health care providers- may refer to a health professional or an organization that provides services of the health professional.

Hospital restructuring/reengineering- refers to a set of organizational interventions designed to increase efficiency by examining the organization from the “bottom up” and collapsing, blending or streamlining redundant programs, departments, jobs and processes.

Managed care- a generic term for organized system of care – usually with precertification requirements, a limited network of providers and a risk-based payment that provides health care. Health maintenance (HMO’s) and preferred provider organizations (PPO’s) are examples. The goal of managed care is to reduce cost and improve quality of care.
Medical/Hospital social worker - social workers who typically work in hospitals, skilled nursing facilities, or hospice, have a graduate degree and work with patients and families to assess their psychosocial functioning and assess their needs. Medical social workers usually work in interdisciplinary team with professionals of other disciplines.

Assumptions

This study assumes that all hospitals differ in the knowledge and skills necessary to work in that specific setting. In addition, lacking specific characteristics does not make the assumption that you will make an ineffective hospital social worker. However, this study will give a broad range of knowledge, skills and characteristics which can be used according to specific roles in specific hospital settings.

This study does not assume that all hospital social workers have a lack of information regarding the necessary skills and knowledge to be effective. Furthermore, not all hospital setting struggle with the ability to define their role or have role ambiguity.

Lastly, the reader should not assume that all skills, knowledge and characteristics would be included in this study. The best practices found by this researcher to be most prominent in the literature and the present study will be used. It is not assumed that other best practices do not exist, however they may not be included in this study.

Justifications

This study will provide a clear and concise understanding of knowledge, skills, and characteristics for social workers in a medical setting or those who are
contemplating a career in hospital social work. In addition, this study will help clarify the roles of a hospital social worker, providing them a voice, so they may clearly express their roles, values and contributions to the hospital setting.

Limitations

This research was conducted in a specific area of Northern, California. Therefore, the research cannot be generalized or applied to another geographical area. Because hospitals are constantly changing it is difficult to determine the length of time that this research will be valid. The research is also subjective, depending on the hospital and professional experiences of the social workers, which is important to note when reviewing the study. Lastly, this is a small sample of medical social workers.

Summary

This introductory chapter outlined the purpose of this study, which is to explore the knowledge, skills and characteristics of an effective medical social worker, while also exploring current information on social work in a hospital setting, which can be articulated to other allied professionals and patients. In addition, a brief background of medical social work was provided, as well as the limitations to this study. The next chapter broadens the base towards understanding medical social work, through a pertinent review of the literature on the given topic.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

The current health care climate, which is ever changing and focused on giving the most cost effective patient care, has molded hospital social work into its present form. In order for social work to remain an asset in the hospital setting it is pertinent that social workers understand and apply specific knowledge and skills as well as posses certain personal characteristics, which will guide effective practice. This review of the literature begins with the history of social work in the hospital setting and discusses briefly the exponential growth throughout the last hundred years. Following the history, will be the first major theme of specific knowledge, which will be followed by the second theme of skills and conclude with personal characteristics of an effective hospital social worker.

History

Hospitals and the professionals who would later be known as social workers crossed paths dating back as early as the 1700’s when hospitals in the United States were known as almshouses for the underprivileged (Fort Cowles, 2003). During the mid 1800’s when social work began to emerge, workers were immediately faced with health-related problems and roles such as case management, which would later be an integral part of medical social work in hospitals (Fort Cowles, 2003; Greene, 2006). Dr. Richard Cabot, a physician at Massachusetts General Hospital, hired the first social
worker in 1905 to provide social work services in clinics (Dhooper, 1997; Kitchen & Brook, 2005; Massachusetts General Hospital (MGH), n.d).

In 1906, Dr. Cabot met a nurse named Ida Cannon and hired her to assist him in organizing the first hospital social service department in the United States (MGH, n.d; Praglin, 2007). Dr. Cabot presented the notion that although patients were away from home, sick in the hospital, they were never separated from personal problems, which required social service interventions. Dr. Cabot believed that effective medical treatment encompassed an absolute diagnosis, which included an assessment complete with background on home, family, work, problems and environmental factors (Dhooper, 1997). He expected the role of social worker to help bridge the gap between the hospital environment and a patient’s home environment, in order to eradicate barriers to effective medical treatment (Beder, 2006). Many of the first social service workers were nurses, such as Ida Cannon; however, Ms. Cannon found that nursing skills were insufficient and enrolled in social work school (Dziegielewski, 1998; MGH, n.d). After her schooling was complete, Ms. Cannon went to work at Massachusetts General Hospital as a permanent staff and by 1914 she and Dr. Cabot had established the first Social Service Department in a hospital (Dhooper, 1997; Gregorian, 2005; MGH, n.d.; Praglin, 2007).

Early hospital social work focused on assessing the impact of disease and illness on families and patients, as well as the impact of environmental factors on health (Holliman, Dziegielewsk & Datta 2001; Gregorian, 2005). Social workers were used as educators of families and physicians. From the beginning, hospital social work was
interdisciplinary, used a method of casework and linked the person, environment and institution through a generalist approach (Holliman et al; MGH n.d; Praglin, 2007).

Hospital social work began rapidly growing within a decade of the first inception, starting with one social worker in the early part of the century and growing to 100 hospital social work departments by 1913 (Beder, 2006). By 1924, there were 420 social service departments in U.S hospitals (Praglin, 2007). Social work continued to grow, and in 2000, an annual survey of the American Hospital Association found that of the 4,856 reporting hospitals 86% had social work services (Fort Cowles, 2003).

Throughout history and through growth, hospital social work has formed a wide range of principles, interventions, strategies, techniques and theoretical perspectives, while reacting to a changing environment (Dhooper, 1997). Numerous aspects of hospital social work have remained the same, while others aspects have drastically changed. Health care has been in a state of instability for the last few decades and as the health care system changes, so does the roles of social work.

Knowledge

Knowledge is an extremely broad term and conceptualized in many ways. A study by Bjorkenheim (2007) published in Social Work in Health Care explored issues of knowledge and competence in health social work, based on the results of group interviews and surveys of 583 social workers, 110 who worked in the public health sector. One component of the study asked participants to define knowledge, giving them free range to conceptualize knowledge in whatever way they wished. The participating social workers defined knowledge in many different ways. Some of their
conceptualizations are as follows: knowledge is what you learn from education, 
knowing how society functions, theory, concepts, terminology, social work methods 
and legislation to name a few. This study of Bjorkenheim demonstrates that knowledge 
is viewed in many contexts. A specific knowledge base is relevant to social work 
practice; however, there is also specialized knowledge necessary depending on the 
practice setting. The following section will focus on reviewing the literature containing 
knowledge, which is found to be applicable for social workers in the hospital setting

**Managed Care**

Hospital social work has evolved over the last century, seeing the greatest 
change in the last thirty years. Davis (2004) asserts that in the United States, health care 
continues to endure major changes and the inception of managed care has eternally 
changed the health care system. Managed care is defined as, “a method of coordinating 
and delivering health care through a range of provider networks, such as the traditional 
health maintenance organizations (HMO), a preferred provider organization (PPO), a 
point-of-service contract, or a self-insured managed-care (SIMC) system. These 
programs operate with primary care physicians, who provide most services and screen 
referrals to other providers” (Rehr, Rosenberg, & Blumenfield, 1998, p.154). Managed 
care emerged due to the need to control health costs and as a way to regulate access to 
health (Beder, 2006; Berger, 2000; Dhooper, 1997; Fort Cowles, 2003). It is suggested 
that fee for service was changed to managed care in order to slow the growth of health 
care cost and promote efficiency (Schneider, Hyer, & Luptak, 2000). The evolution of
health care into contracted services brought about competition and a profit driven market.

Managed care is the new normal in hospital care, which makes an understanding of the systems, critical to social workers. A study found in Social Work in Healthcare by Bronstein, Kovacs and Vega (2007) assessing the fit between social work education and practice asked the question, "If you were to advise social work educators on how best to prepare social workers for practice in a health care setting, what knowledge and skills would you encourage them to teach?" (p. 66). Managed care was the second most popular response, second only to teamwork. The study used both qualitative and quantitative methods to elicit information from 179 randomly selected NASW members, who identified healthcare as their primary practice area.

The Society for Social Work Administrators in Health Care and NASW collaborated on a national research project to study the changes in hospitals and how those changes are impacting social work (Berger et al. 1996). A random sample of 340 hospitals, which listed social work as a service provided, was taken from a membership list of the American Hospital Association. Eighty percent of those who responded indicate they had a social work degree. An exploratory and descriptive survey was used. Among numerous findings, the study noted that due to the healthcare system now cemented in managed care, social workers need to increase their knowledge and understanding of the system in order to increase their capabilities and help shape their roles in the health care environment (Berger et al.). Schneider, Hyer and Luptak (2000) add that included in an understanding of the structure of managed care is an
understanding of the reimbursement of social work services, speaking in a common language of organizations and knowing what can be done ethically to increase profitability. Some of these terms and ideas are not necessarily those often heard in social services. However, in a managed care environment, it is imperative to work alongside the system in order to achieve results.

Aside from a working knowledge of the managed care system, it is also important for social workers to be aware of the ways managed care has affected social work and its implications on social work practice. Due to cost-containment, ethical issues have increased in hospital social work (Beder, 2006; Berger, 2000; Galambos, 1999). Managed care companies insist on access to client records, potentially compromising confidentiality, as well as place limits on treatment and discharge patients before social workers believe they are ready (Beder, 2006). Berger (2000) adds that the profit motive behind health care may be one of the greatest challenges to ethics, yet social workers have a responsibility to their clients and to their employers. Social workers have the responsibility to educate their employers in regards to ethical obligations and that in times of conflict they should choose to advocate for their clients best interest (Galambos, 1999). This is a constant struggle in managed care. Systems of managed care have also brought about greater accountability, making evidence-based practice significant, in order to assess the impact of managed care on clients and health care in general (Beder, 2006).
Medical Field

Medical terminology, hospital politics, restructuring and insurance knowledge are all important elements in the medical field. Literature as regards hospital social work only minimally touches on these aspects. According to Dziegielewski (1998), social workers in the medical field are at a great disadvantage if they are unable to understand and use medical terminology. An editorial found in Hospital Topics by Ney (1998) which analyzed how the Case Manager Society of America defines case management and the skills needed for good case management explained that hospital procedures, system of care, as well as corporate trends and legislation that applies to the medical field and affects patients is relevant knowledge. Kelly (1998) adds that understanding current politics is important in advocating for medically impoverished populations.

The Society for Social Work Administrators in Health Care and NASW collaborated on a national study on the changes affecting social work services in hospitals (Berger et al., 1996). Among other findings, the study made clear that trends in healthcare are continuously changing, making an up-to-date knowledge critical. Other studies show that preparation for social work practice includes knowledge regarding accreditation and business-related content, health outcomes, health care financing and reform, as well as knowledge of Medicare, Medicaid and other insurance (Bronstein, Kovacs, & Vega, 2007). Gregorian (2005) adds that educating yourself about hospital management will also be empowering.
Theoretical Perspective

Theory is the basis of most social work intervention. Social workers use theory to guide practice and require an understanding of theory to create effective interventions. There are common theories that are utilized across social work arenas and there are theories, which have a distinct use in a specific setting. The following section will discuss theories used in a medical setting.

The biopsychosocial approach is the core of social work practice. Dhooper (1997) asserts that this framework governs the way we perceive our clients, our work and create interventions. This approach, which considers clients biological and medical characteristics, psychological aspects and social environment, is the foundation of all health care services in hospital social work (Beder, 2006; Cowles, 2003; Dziegielewski, 1998; Fort Cowles, 2003; Rehr, Rosenberg, & Blumenfield, 1998). Knowledge of the biopsychosocial aspects of death and dying are also essential (Gwyther et al., 2005). A study on the fit between social work education and practice found that social workers used their knowledge of the biopsychosocial perspective more than any other theory and more than any other department (non-social work) (Bronstein, Kovacs, & Vega, 2007). Research findings support the value of a biopsychosocial approach to guide healthcare for the patient (Frankel, Quill, & McDaniel, 2003; Kaslow et al., 2007). A study found in Professional Psychology: Research and Practice, provided research evidence for the effectiveness of “healthcare for the whole person,” which is an integrative biopsychosocial approach (Kaslow et. al., 2007). The research noted that collaborative
and interdisciplinary healthcare must address the patient’s biology, psychology and social environment for the best patient outcome.

Person-in-environment perspective is closely related to biospsychosocial perspective. Beder (2006) stresses the importance of understanding the person-in-environment perspective for social workers in hospital settings in order to understand what a patient is dealing with after leaving the hospital, such as who will take care of them, what supports they have and community resources. This framework considers both outside influences and personal factors (Weick, 2000). It is important to orient collaborators, clients, families and organizations to the person-in-environment perspective in order to present a clear picture of the scope of social services, as well as present a clear picture of understanding the client and how their environment may affect their medical issues (Beder; Cowles, & Lefcowitz 1992; Weick, 2000).

Research confirms that systems theory and ecological perspective are other key theories that are an important knowledge base for social work interventions, especially in short-term interventions (Gibbons & Plath, 2006; Greene, 2006; Kitchen & Brook, 2005). Systems model is particularly appropriate, because the way in which a person interacts with their family, environments, neighbors and community are key to their functioning, as well as provide insight into how they can be aided to function better (Greene, 2006). Johnson and Grant (2005) describe systems theory and ecological perspective as one connected ecological systems perspective, giving a framework for understanding person and environmental relationships.
Over the last decade, according to Johnson and Grant (2005) the strengths perspective has become the foundation for social work practice. They describe the strengths perspective as believing that people have the power and resiliency within themselves to overcome their own problems by focusing on their strengths. Literature explains specific areas of hospital social work where strengths perspective is useful. In two separate qualitative studies found in Social Work in Healthcare by Gibbons and Plath (2006, 2009) strengths perspective was noted as a needed tool in single session work. These studies were separated into a client's perspective and a social workers perspective. Pockett’s (2006) study found in Social Work in Health, which looked at the role of social work in a hospital disaster response team concurred with the findings of Gibbons and Plath. An additional study found in The Journal of Human Behavior, by Greene (2006) which describes the case management process, also concurred with the previous findings that strengths perspective is a needed tool.

Aside from the easily identified theories in social work, two other theories critical and biomedical also emerged in a review of the literature. Giles (2009) looked at critical theory and how health equality in hospital practice caused challenges for social work. Critical theory has given social workers the framework to raise questions about social justice and access to resources in healthcare, while promoting social action. The biomedical approach is the dominant model for understanding disease, without any emphasis on social behavior (Dziegielewski, 1998). Although social workers often criticize the biomedical model, it is important to understand, due to its use in hospitals and by other medical professionals (Dziegielewski, 1998; Giles, 2009; Payne, 2005).
Lastly, crisis theory is prominent in medical social work due to its use as a short-term intervention. A review of the literature on crisis theory will be included in the section of skills under intervention.

**Ethics**

Ethics are fundamental to social work practice. Ethical dilemmas and their implications in managed care have been reviewed in a previous section. However, ethical deliberations also occur in an organizational setting with a multidisciplinary team. Dodd and Jansson (2004) explain that recent literature discusses how social workers have the skills to express value in ethical deliberations; however, literature assumes social workers are easily allowed in these deliberations and their input is valued. A descriptive study of hospital-based social workers found that social workers witnessed about 46.3 ethical dilemmas in a two-month period and participated in only 37.1 of ethical deliberations (Dodd & Jansson, 2004). In addition, the study found that social work ethics education made social workers aware of ethical issues and gave them a desire to participate, yet the desire did not heed greater participation. The implications of this study are extremely pertinent to medical social workers. There is a power dynamic, which often puts the physicians in the role of power. Social workers need to have confidence in their knowledge and skill, using their power and assertiveness, for the good of their client.

**Evidence-Based Practice and Practice Evaluation**

In reviewing the literature regarding evidence-based practice and evaluation, two issues emerged. First, there is the significance of evidence-based practice to better
serve clients, using tested methods. Second, evaluation, which explores the effectiveness of interventions and social work, in general, is imperative for social workers to illustrate their value in a hospital environment (Davis, 2004; Egan, 2010; Gambrill, 2001; Globerman, 1999; Fielding, Crawford, Leitmann, & Anderson, 2009; Kossman, Lamb, O'brien, Predmore, & Prescher, 2006; O'brien, & Stewart, 2009; Rosen, 2003; Zlotnik, & Galambos, 2004).

David Sackett, known as the father of the evidence-based movement, stated that evidence-based practice is, “the conscientious, explicit and judicious use of current best evidence in making the decision about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Zlotnik, & Galambos, 2004, p. 259). In order for social work practice to be touted effective, knowledge, which is corroborated through scientific evidence, must be acquired (Davis, 2004; Fielding, Crawford, Leitmann, & Anderson, 2009). In addition, Davis adds that evidence-based interventions have become the standard for social work in healthcare. Gambrill (2001) urges social workers in the medical field to employ evidence-based practice due to the transparency, which can visibly describe services and outcomes. A plethora of literature agrees that a focus of evidence-based practice in healthcare is pertinent when focusing on the best interests of the client (Davis, 2004; Egan, 2010 Fielding et al., 2009; Rosen, 2003; Zlotnik & Galambos, 2004). It is noted by Bjorkenheim (2007), that social workers believe that research helps them find new perspectives and structures their thoughts.
Aside from evidence-based practice as a tool for the most effective interventions for clients, evaluation is used as a way to measure the value and importance of social work in hospitals, as well as patient satisfaction. Globerman (1999) contends that both qualitative and quantitative evaluation must be used to critically assess social work practice. Medicare and Medicaid services require some form of patient satisfaction measurement for any facility that receives funding, which is an added reason for evaluation (O’Brien, & Stewart, 2009).

Little has been researched and published on measuring the efficacy of services provided by social workers in the hospital setting, and the lack of empirical data has shown to have lead to a decrease in medical social work staffing and even the elimination of departments (Kossman, Lamb, O’Brien, Predmore, & Prescher, 2006). In response to the decrease in medical social workers and the lack of data presenting the value of social work, the Mayo Clinic in Minnesota used their computer application called MedSoc to gather information on cases and measure social work productivity through this program (Kossman, et al.). The findings of the Mayo study, led to improved communication and a 38% staff increase, for the reason that value and productivity were documented.

Another related study, found in Social Work in Health Care, by O’Brien and Stewart (2009) measured patient satisfaction by surveying nurses. The social service department of a large Midwestern hospital faced a dilemma when trying to complete program evaluation. Certain institution guidelines and a low response rate to patient satisfactions surveys, led professionals to explore alternative information-gathering
methods. Due to the nurses having an understanding of social worker roles, they were able to compare patient satisfaction with social work roles. Because this approach to measuring patient satisfaction was never used prior, the hospital had a 12 months pilot study, which included 41 social workers. A total of 2,193 surveys were given to nurses, with 1,007 returned for a 46% return rate. The pilot study demonstrated the ability of social workers and nurses to collaborate, with a 90% satisfaction rating. It also demonstrated that nursing colleagues could provide accurate measurement of patient satisfaction in a hospital setting. This study gives an added way to evaluate practice and can be used in other settings.

The previous two studies were touched upon, particularly because they give examples of measuring services and values. In order for social work to remain viable and survive in the current health care climate, they must show their cost effectiveness through evaluation and research evidence (Fort Cowles, 2003; Keigher, 2000). By understanding different research studies and methods, social workers add value to their role in a hospital setting and can negotiate their position (Davis, 2004). In addition, Zlotnik and Galambos (2004) stress the need for evidence-based practice, while asserting that research is here to stay and social work practitioners have a responsibility to develop and test interventions, as well as support program evaluations.

**Ability to Define and Articulate Social Work Roles and Their Value to the Hospital Setting**

In recurring themes in a review of the literature, the need for social workers to know their roles and have the ability to articulate those roles and the value they bring to
the health care setting is clear (Back, 2000; Cowles, & Lefcowitz, 1995, 1992; Craig 2007; Davis, 2004; Globerman, 1999; Gregorian, 2005; Hebert, Copeland, Schulz, Amato, & Arnold, 2008; Keigher, 2000; Mizrahi, & Berger, 2001; Nilsson, Ryan, & Miller, 2007; Silverman, 2008; Weick, 2000). Mizrahi and Berger (2001) assert that social work has been criticized on occasions for its lack of ability to clearly express their contribution to a hospital. Gregorian (2005) adds that we struggle to establish credibility. In the current healthcare climate of restructuring, downsizing and managed care, articulating roles and values is detrimental to the staying power of hospital social workers.

A large challenge for social work starts with articulating their role to allied health professionals, such as doctors and nurses. Cowles and Lefcowitz (1992) conducted a study twenty years ago on social workers perception of their roles, compared to doctors and nurses. Almost 500 physicians, nurses and social workers associated with four hospitals participated in a mailed questionnaire survey. The study found that doctors and nurses often agreed on social work roles, however the responses between them and social workers, were repeatedly different. Aside from the previous results, they also found that social workers presented a vague image of their profession to collaborators. A few years later a follow-up study was completed which stressed that social workers had a great opportunity to demonstrate the advantages of social work in hospitals, and if they do not, they will continue to experience a lack of role clarity when interacting with other allied professionals (Cowles, & Lefcowitz, 1995). Unfortunately,
there is still confusion from other professionals as to the role of social workers (Davis, 2004).

It is also apparent that the role of social worker and nurse in the hospital setting has blurred causing role ambiguity (Davis, 2004; Hebert, Copeland, Schulz, Amato, & Arnold, 2008; Mizrahi, & Abramson, 2000). One specific study found in Social Work in Healthcare by Davis (2004) reviewed current literature over a 10-year period, in order to assess the effectiveness of hospital social work in implementing intervention-based research. Forty-four peer-reviewed journals, 19 of which were qualitative articles and 25 of which were quantitative, were identified for inclusion. These studies revealed a role blurring and role conflict between nurses and social workers. A study found in Social Work by Mizrahi and Berger (2005), using an exploratory – descriptive survey design, drawing on a stratified random sample of 750 hospitals that yielded 340 surveyed social workers, which examined the response of social work administrators to the changes occurring throughout hospitals has similar findings to the previous study. However, they strongly cautioned that if nurses are perceived as able to accomplish social work tasks and replace social work, there could be a loss of position.

It is imperative that social workers clearly define their roles and values to the public and other professionals in order to stay viable in a hospital setting (Back, 2000; Davis, 2004; Globerman, 1999; Nilsson, Ryan, & Miller, 2007; Silverman, 2008). Social workers need to believe in themselves and their own self worth in order to articulate their worth to others and advocate for expanding roles (Davis, 2004; Globerman, 1999; Hebert et al., 2008; Keigher, 2000; Weick, 2000). The occupation
can be timid when it comes to the good work they do and feel it inappropriate to market their skills. However, the profession, especially in a hospital setting, cannot afford the unassuming nature and must market themselves and their cost-benefit, or risk becoming obsolete (Globerman, 1999; Mizrahi, & Berger, 2005; Silverman, 2008).

There are differing ideas as to the best way to present the roles of a social worker, while also marketing the many facets and importance of the profession. Presenting roles through personal narratives is one avenue (Craig; 2007; Grobman, 1999; Weick, 2000). Grobman (1999) compiled 50 real life stories of social workers in a wide variety of settings using first person narratives. Grobman chose to compile narratives for the reason that social work is hard to articulate due to the variety and argues that the best way to convey a sense of the profession is through personal stories of the day-to-day lives of real social workers. Craig’s (2007) own personal narrative found in Qualitative Social Work, asserts that social workers use narratives daily with clients, however do not often use this gift to tell their own story. For hospital social workers, it is especially important to find interesting ways to express an understanding of our roles and the uniqueness that we bring to setting. The use of personal stories is an innovative way to distinguish us from other professions and bring light to our worth and importance in the ever-changing hospital setting. In the words of Ann Weick (2000, p. 402), “If we can find our courage, we may be finally free to do, teach and write about the essential aspects of social work. It would make me proud to know that the profession has at last found its own voice.”
Skills

A review of knowledge has now led to skills, which in essence is putting much
of the acquired knowledge into action. The specific skills associated with social work in
general are expansive and can greatly differ depending on the practice setting. Skills as
a theme will provide the most recent literature, which describes the skills found to be
essential in hospital social work overall. This literature review will not cover precisely
every skill which may become present in the hospital setting. Skills can change
depending on the hospital structure and the community needs. The groundwork for
effective practice will be reviewed.

Case Management

Throughout this literature review, it has become clear that many of the tasks
assigned to social work are intertwined with managed care. Case management is no
different. Keigher (2000) explains that the importance of case management is directly
related to health care reimbursement, which has one goal; containing cost. Ney (1998)
adds that case management also strives for positive health care results, while focusing
on cost containment. Case management is an umbrella term, which covers the tasks of
social worker throughout their work with clients. The following section will review the
literature on the different aspects of case management, including discharge planning.
Case management in the hospital setting is accomplished in a short time period, due to
managed care and short patient stays.

Dhooper (1997) explains that the concept of case management is evolving and
can differ depending on the client group, setting and situation. The basics to case
management however include assessing needs, identify and planning services, linkage, advocating, coordinating, monitoring, evaluating the process and result as well as emotional support and counseling. According to Ney (1998), effective case management occurs when a patient’s wellness is achieved through identification of the patients needs throughout their care, through advocacy, education and identification of resources. In addition, a meticulous understanding of services available in the community and understanding the hospital system is vital. Above all, the role of case manager is to be the communication link between client, doctor, allied medical professionals and the family to assure that correct information is conveyed. Greene (2006) identifies case management roles as outreach, information and referral, assessment, linkages and evaluation of services. Ozarin, as cited by Green identifies responsibility, continuity, and accountability as key elements to success in case management. Vourlekis and Ell (2007) add that effective case management should be individualized, patient-centered, addressing health circumstances and barriers. Case management protocols and interventions should include education, psychosocial support, tactics that empower patients to manage their own health and exploration of adequate resources.

Keigher (2000) and Greene (2006) identify two forms of case management, the client-driven model and the provider-driven model. The client-driven model focuses on the client’s strengths, giving the client the power to identify his or her own needs and give course to their own health plan. Assessment, linkage to social services, monitoring client progress, and working on the attainment of goals and developing social networks.
reciprocally between client and case manager are the focus of client-driven case management. Provider-driven models, in contrast, focus on cost-containment and offering services only which are contained in a client’s health plan and at a set cost. Provider-driven models focus on identifying problems, on making referrals, and on ensuring patients’ adherence to a treatment plan. Attention is also paid to behavior and functioning of the client and family interaction. Enforcing limits and patient compliance is another goal of this model. Hospitals are driven by managed care, which focuses on cost containment, making the provider-driven model the form of hospital case management. Ney (1998) explains that this model is uncomfortable for social workers because they are caught between advocating for the client and doing their job.

Discharge planning is known as the primary function of a social worker in the hospital setting (Cowles, & Lefcowitz, 1995; Gregorian, 2005; Holliman, Dziegielewski, & Datta, 2001; Mizrahi, & Berger, 2001; Zimmerman, & Dabelko, 2007). The American Hospital Association defines discharge planning as “any activity or set of activities that facilitates the transition of the patient from one environment to another” (Rehr, Rosenberg, & Blumefield, 1998). In 1986, The Omnibus Reconciliation Act made discharge planning a condition of hospital participation in any Medicare program (Dhooper, 1997). The Joint Commission on Accreditation of Health Care Organizations and the Professionals Standards Review Organization also requires discharge planning.

Discharge planning seems like the end game of the case management process and it is, in the sense that the tasks parallel one another; however, discharge planning is
occurring from patient admission throughout their stay (Dhooper, 1997). The roles associated with discharge planning are as numerous as those of a case manager and differ depending on the setting. Zimmerman and Debelko (2007) assert that while crisis intervention, screening and counseling are important, the social worker job of financial arrangements and arranging transfers has become a focus. An analysis of 24 central skills and tasks of a discharge planner found that assessment, communication, counseling, coordination and referral were the tasks most performed (Holliman, Dziegielewski, & Datta, 2001). The previous study also found that communication and skills training, knowledge of community resources, social assessment skills, field experience and receiving continuing education were needed to effectively carry out discharge planning. Rehr, Rosenberg, and Blumefield, (1998) focus on the case management approach to discharge planning which requires the ability to evaluate risk factors in aftercare, augment support of families and access support from community resources. The role of social worker does not end once the patient is discharged. Proper discharge planning includes follow-up services (Dziegielewski, 1998).

Discharge planning has its own specific challenges. The cost containment aspect of healthcare has pushed patient stays as short as possible, often pushing clients out before they are physically, mentally or environmentally ready (Beder 2006; Dziegielewski, 1998; Fort Cowles, 2003). In many cases, the obligation to the hospital and the patients’ need are conflicting (Dhooper, 1997) Not only are social workers responsible for facilitating the discharge they are also responsible for providing
oversight for other team members to assure the client is getting the appropriate services
(Dziegielewski, 1998).

**Collaboration and Teamwork**

A review of the literature found collaboration and teamwork tremendously
imperative in a hospital setting (Abramson, & Mizrahi, 1996; Bjorkenheim, 2007;
Bronstein, 2003; Bronstein, Kovacs, & Vega; Cohen, & Gagin, 2005; Cowles, &
Lefcowitz, 1992; Davis, 2004; Fort Cowles, 2003; Gregorian, 2005; Kitchen, & Brook,
2005; Mizrahi, & Abramson, 2000; Rehr, Rosenberg, & Blumenfield, 1998;
Zimmerman, & Dabelko, 2007). Collaboration is when members of a medical team that
include physicians, nurses, social workers, physical therapist, psychiatrist, nutritionist
among others, work as a team with multiple forms of knowledge and skills to best serve
the patient and their family (Beder, 2006).

Abramson and Mizrahi (1996) conducted a study, published in Social Work,
which looked at the positive and negative experiences of social work and physician
collaboration. The qualitative study used a nonrandom sample of 51 physicians and 54
social workers from 12 New England area hospitals. Each participant was given a pre-
coded list of factors that contributed to positive or negative collaboration. The study
showed that social workers place more importance on collaboration, however
communication was agreed to be a universal aspect of collaboration. In addition, the
study found that collaboration in healthcare is becoming more important due to
managed care, cutbacks and the emphasis on non-duplication of services through
referral, networking and coordination. Proficient health care delivery will increasingly
depend on the capability of health care providers and professionals to collaborate for the best service to patients.

The economic climate and trends in social problems have made effectively serving clients impossible without collaboration (Abramson, & Mizrahi, 1996; Bronstein, 2003; Rehr, Rosenberg, & Blumenfield, 1998). Kitchen and Brooks (2005) refer to the complexity of cases as to why collaboration has become a necessity. Collaborating with other professionals gives a better understanding of the client’s needs and resources, while giving a range of professionals for problem solving (Abramson, & Mizrahi, 1996). Zimmerman and Dabelko (2007) explain that shared models of patient care create partnerships among patient’s, families and health care providers through the sharing of task, which include; planning, delivery and evaluation of health services. In order to collaborate effectively, there must be a high degree of cooperation and belief that you have something to contribute (Rehr, Rosenberg, & Blumenfield, 1998).

Aside from collaboration serving the client, it can also be useful for collaborators. Collaborating with other professionals gives a chance for learning and acquiring knowledge of a different expertise (Abramson, & Mizrahi, 1996; Bjorkenheim, 2007). A study found in Social Work by Bronstein (2003) used multidisciplinary theoretical literature and conceptual and research pieces from social work literature to support the development of A Model for Interdisciplinary Collaboration. The suggested model by Bronstein has two parts. Part 1 consists of five components that represent collaboration between social workers and other professionals, which are interdependence, newly created professional activities,
flexibility, collective ownership of goals and reflection on process. Part 2 of the model, consists of four influences on collaboration: professional role, structural characteristics, personal characteristics and a history of collaboration. This model is intended as a framework for effective collaboration. Bronstein also highlights in the framework that knowledge and expertise from other occupations amplify creativity, in a world with complex problems. Even if your collaborator is of the same profession, acknowledging their expertise is useful. Social workers generally believe that informal discussion with one another is helpful in problem solving (Bjorkenheim, 2007).

Bronstein, Kovacs, and Vega (2007) studied the fit between social work education and practice, using 179 randomly selected NASW members, as well as qualitative and quantitative methods. The open-ended question which asked, If you were to advise social work educators on how best to prepare social workers for practice in a health care setting, what knowledge and skills would you encourage them to teach, teamwork was the number one theme, with 49 respondents citing it’s importance. Teamwork included communication with other colleagues, knowledge of other disciplines training and teambuilding. There has been a shift away from hierarchal models and team models have come to the forefront (Kitchen, & Brooks, 2005). Dziegielewski (1998) stresses that a team effort is expected of social workers in a health care setting.

Conflict in collaboration is inevitable, when people come from different education backgrounds and encompass different roles. Having a clear understanding of your own role in the team is crucial (Abramson, & Mizrahi, 1996; Bronstein, Kovacs, &
Vega, 2007). According to Cowles and Lefcowitz (1992), role conflicts between social workers and other health professionals have appeared in the literature since the mid-1950's. Role conflict, role blurring, and a lack of understanding as to the roles of a social worker continue to pose problems in collaboration (Abramson, & Mizrahi, 2004; Bronstein, 2003; Davis, 2004). Although collaborator roles are different, they should be seen as equal. However, it is questionable whether the medical social worker is ever seen as being equal, with the dominance and often lack of acceptance by physicians, causing hostility (Abramson, & Mizrahi, 2004; Crabtree, 2010). There is a pecking order in hospitals, and social workers are rarely at the top (Gregorian, 2005).

Collaboration is important; however building positive relationships with other professionals is equally important (Bronstein, Kovacs, & Vega, 2007; Gregorian, 2005). An editorial found in Social Work in Health Care, which draws upon Gregorian’s twenty-year career in hospital social work explains that relationships between social work staff, physicians, nurses and hospital leadership which are characterized by mutual respect, generally garner more recognition and support for the social work department goals. In addition, an exploratory study, using a small sample size of twenty five social workers, found in Social Work in Health Care by Cohen and Gagin (2005) which focused on skill-development training alleviating burnout, found that peer-support was positively related to lower emotional fatigue. Collaboration and teamwork can be beneficial to clients although it is not without challenges. The goal of collaboration is to bring people of different professions together for the need of the patient; however, different professions bring different values, skills and educational orientation, which
poses difficulty at times (Beder, 2006). Mizrahi and Abramson (2000) conducted a study that evaluated the experience of collaboration between social work and physicians. The study found that social workers were less satisfied with collaboration than physicians. In order to improve patient care, social work should advocate for more positive collaboration in the hospital setting, which allows for a more holistic medical approach (Kitchen, & Brooks, 2005; Zimmerman, & Dabelko, 2007). Gregorian (2005) agrees and adds that social workers must always partake in a balancing act of advocating for their profession, while not being excessively aggressive and being flexible when resolving conflict. Successful teamwork should consistently recognize and manage tension (Abramson, & Mizrahi, 1996). Furthermore, it is important to acknowledge that although social workers use the skills of collaboration, they report needing further education and development in this area (Bronstein, Kovacs, & Vega, 2007). However, Bronstein et al. (2007) point out that education on group work, which is taught in all social work schooling, is a great tool for collaboration.

**Short-Term Interventions**

It became apparent in the research, that short-term interventions are crucial in hospital social work, due to the short period of time often spent with the client. A short list of interventions were touched upon including solution-focused and task centered, however the majority of the literature points to brief interventions such as crisis intervention and the increasingly popular single session contacts. The latter, includes solution-focused, task-centered and crisis intervention in brief sessions.
Crisis intervention is a large part of social work education, all social workers have acquired knowledge of crisis intervention, and the stages associated. Hospitals provide the ideal setting to intervene with client’s in crisis. Crisis intervention addresses severe problem situations and can facilitate a client’s discovery of coping methods to face the problem, which has caused a crisis (Dziegielewski, 1998). Assessment in crisis intervention is quick and focused in here-and–now, while evaluating the nature of the crisis, recognizing priority concerns and developing goals (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010).

Skills in providing crisis intervention are necessary and repeatedly used in hospital social work (Auerbach, & Mason, 2010; Dhooper, 1997; Dziegielewski, 1998; Gregorian, 2005; Kotrla, 2005; Pockett, 2006; Zimmerman, & Dabelko, 2007).

Bronstein, Kovacs, and Vega’s (2007) study on the fit between social work education and health care practice found that crisis intervention was the third most important skill practitioners felt they needed to be acquainted, in order to feel prepared for practice in health care. The same study found that respondents reported frequent use of crisis intervention skills, more than those in non-social work departments did. Specific departments, which use crisis intervention more frequently, were also noted. Oncology departments identify crisis intervention as the most highly utilized service in cancer centers (Zimmerman, & Dabelko, 2007). Social work skills of crisis intervention are highly utilized in disaster circumstances as well as in emergency rooms (Pockett, 2006).

The pressure to increase efficiency, decrease length of stay, and contain cost has been a factor influencing single session contacts in the hospital setting (Gibbons, &
Plath 2009; Gibbs, 2001). However, Gibbons and Plath (2006) argue that single session contacts have always held a valuable place in social work practice. Single-session work encompasses many different interventions, which include crisis intervention, task centered and brief-solution focused. In a range of situations, it may be suitable to engage in single sessions with a client in order to deal with an abrupt crisis, present information, make an assessment quickly and skillfully, and connect to resources or simply because that is the client’s preference (Gregorian, 2005; Kotrla, 2005; Squires, & Kramaric-Trojak, 2003). Gibbons and Plath (2006) set up focus groups facilitated by researchers to explore the thoughts of social workers on single session work. They concluded that social workers found single session work common and appropriate; however, it was intense, because it often occurred during a crisis. Social workers have to engage, establish rapport, assess, provide information, validate, and challenge beliefs and behavior, as well as counsel, all in a limited time frame. Swift assessments, counseling and crisis intervention in a single session, take critical assessment and intervention proficiency within the person-in-environment framework (Kotrla, 2005). Focus groups also found single-sessions were effective and appropriate in the emergency room (Auerbach, & Mason, 2010).

Gibbons and Plath (2009) later studied the experiences of clients in single session practice and found that interviews indicated effective social work involves appealing to client at a personal level, demonstrating knowledge and capability, as well as listening in a tolerant manner. Understanding the client’s life adjustments and advocating were also identified as pertinent skills in single session work. Single session
work is every skill and knowledge that social workers have acquired, used in a short period and takes tremendous confidence. Gregorian (2005) asserts that one of the best aspects of hospital social work in the ability to make a difference in one short encounter. Social workers should use their skills and incorporate brief interventions into their practice, especially in time-limited situations (Gibbons, & Plath, 2006, 2009; Kotrla, 2005).

**Continued Education**

The profession of social work must continue to find ways to strengthen practice and continue education post-graduation in order to improve their professional practice (Nilsson, Ryan, & Miller, 2007). Nilsson et al. also advises social workers to become involved with professional associations or unions, attend conferences and training and read professional journals to assist with continued education throughout practice. Gregorian (2005) emphasizes that continued education which fosters constant change, such as refocusing on a new project, partaking in research, writing an article, or working on a committee can help avoid burnout in a hospital setting.

A qualitative and exploratory study found in Social Work in Health Care by Pockett (2002), used primary and secondary data to explore social workers “tolerance” of a hospital setting as a reason for staying employed in a hospital. The study found that continuing education provided by the employer was important for positive tolerance and beneficial for decreasing burnout. In a separate study by Cohen and Gagan (2005) that used The Maslach Burnout Inventory to measure burnout of 25 social workers in a large medical center found similar results. As part of the latter study, participants attended
development-training programs, which provided regular individual supervision and the participants regularly attended conferences and courses, which decreased burnout and increased the perception of peer support. The study also noted that skill-development programs could improve a professional's abilities and promote self-efficacy in their work. Bjorkenheim (2007) emphasizes that social workers in health care rely much more on in-service continued education than do social workers in other community social services.

Continued education in end-of-life issues is also noted in the literature (Back, 2000; Hebert, Copeland, Schultz, Amato, & Arnold, 2008). A study found in the Journal of Palliative Care, in which a nation wide survey of social workers caring for people during the end-of-life was conducted and illustrated two noteworthy barriers in their work: lack of suitable preparation at the Master’s level and diminutive continuing education (Back). A separate study reported in the Journal of Social Work in End-of Life & Palliative Care conducted through focus groups and semi-structured interviews with caregivers of terminally ill patients, found that hospital social workers were found to be less than helpful in preparing caregivers for death (Hebert et. al., 2008). Social work competencies such as knowledge of the biopsychosocial aspects of dying, as well as the expertise in the spiritual needs of clients make them perfect to assist caregivers in end-of-life care (Gwyther et al., 2005). More education, training projects, research, and social workers committed to end-of life care are necessary in this field of expertise.

Continued education should focus on end-of-life care with the client, as well as the
caregiver and establish how to overcome the obstacles, which seem to thwart social workers from preparing caregivers for the death of family and friends.

**Leadership and Supervision**

Leadership skills have become increasingly coveted in medical social work, as hospital restructuring has threatened social work departments. The constant need to justify capabilities and social work roles in a hospital requires leadership. Leadership is about setting principles, direction, and a vision for a work environment. However, it is different from management which focuses on getting the work done (Mizrahi, & Berger, 2001). A need for increased visibility within institutions has led social work leaders to urge that social workers take on more leadership positions, which include decision-making and collaboration (Gregorian, 2005; Mizrahi, & Berger, 2001). Persevering and supporting certain programs in times of change makes leadership more important now than ever, as well as responding to the social, cultural, economic and political forces (Mizrahi, & Berger 2005; Rank, & Hutchison, 2000).

Medical social workers are well positioned to play a leadership role in collaboration due to the use of empowerment approach and proactive roles with clients (Mizrahi, & Berger, 2005; Zimmerman, & Debelko, 2007). A research study found that leadership qualities in a director influenced performance priorities in hospital social work departments and were most influential in the area of service quality (Ezell, Menefee, & Patti, 1997). In essence, having positive leadership qualities puts a priority on the quality of care to clients.
Rank and Hutchison's (2000) research found that social work leaders identified five fundamentals to leadership: communication, values and ethics, empowerment, pro-action and vision. They also found that due to the values of the profession, which include concern for others, systems perspective, concern for public representation, participatory management approach and inclusiveness, social workers were faced with challenges that do not effect other professions. Again, leaders must be at the forefront of displaying there cost-effectiveness to ensure support for social service programs (Rehr, Rosenberg, & Blumenfield, 1997).

Mizrahi and Berger (2001) explain that leadership is about being creative and optimistic, while developing new approaches that best serve the client as well as co-workers. In their study of leadership in a changing health care environment, they outlined five skills necessary for leadership in the present health care system:

1. Understanding and correctly interpreting an environment.
2. Restructure your own environment, before non-social workers do it for you.
3. In order to preserve strengths in your department, focus on effective, acknowledged and valued programs.
4. Create new, efficient programs, through income sources acquired through grant writing.
5. Create and nurture partnerships with the community.

Supervision can be viewed in two ways, namely, clinical supervision, which aims to improve skills and client service, and administration supervision, which focuses on responsibility (Berger, & Mizrahi, 2001). The present focus is on supervision that
improves skills and confidence. Clinicians who provide supervision need to have the skills of leadership, conflict resolution, effectual communication, as well as feedback and group dynamics. Gregorian (2005) defines supervision as a process where clinicians can discuss complex cases, recognize issues of counter-transference and acquire skills, which will aide in better understanding the impact that institutions have on clients and practice. Social workers willingness to make use of supervision can aide them in flourishing practice, development, and growth in the hospital environment. It is important to note that Silverman (2008) argues that there is a lack of institutional-based, mentors for social work leaders in healthcare; however, literature discusses mentorship as a predictor for career advancement.

As with everything else in health care, economic and political factors play a role in social work supervision. Restructuring reduces management positions, which leaves less qualified individuals as supervisors (Berger, & Mizrahi, 2001; Dziegielewski, 1998). However, a study found that the majority of social workers are receiving clinical supervision from another social worker in the hospital setting. Yet, the study concludes that there has been a growth of supervision by non-social workers, which is disconcerting for practitioners and leaders. If the present healthcare environment continues, supervision will become a luxury, which suggests that social workers need to take on more leadership roles that produce productive and effective supervision.

Characteristics

A characteristic of an entity is defined as a feature or quality that makes someone or something recognizable. Specific personal characteristics have shown to be
useful assets in hospital social work. Many personal characteristics are innate however others can be learned. A study found in Social Work in Health Care by Holliman, Dziegielewsk & Datta (2001) which looked at social work practice in discharge planning, noted that some respondents found personality characteristics to be a more important requirements, then specific skills and training. The following section will rely on some studies, as well as anecdotal and personal opinions found throughout a review of the literature.

Creativity

Creativity and social work go hand in hand, as often social workers must find creative ways to serve a client in the best way. Creativity is perceived as a necessary characteristic for medical social workers in a hospital setting (Bronstein, 2003; Giles, 2009; Globerman, White, Mullings, & Davies, 2003; Gregorian, 2005; Mizrahi & Berger 2001; Ney, 1998; Weick, 2000). An editorial in Hospital Topics by Ney (1998) which focused on case management and the reasons social workers make good case managers, expressed that perhaps the most essential skill and the hardest to teach is creativity. Especially in the role of case manager, it is important to use creativity to obtain the necessary and cost-effective services for patients (Ney, 1998). The study of Globerman and his confreres (2005), which focused on thriving in program management environments, found that respondents accounted creativity as a strategy for enhancing their role. In addition, Giles editorial found in International Social Work on the challenges of health equality in hospital social work noted that creativity is needed to work on the details of making a difference in health equality.
Effective Communication Skills

Communication, not only with patients, but also with everyone connected to the patient's care is essential for positive outcomes (Abramson, & Mizrahi, 1996; Bjorkenheim, 2007; Bronstein, 2003; Ney, 1998; Van Wormer, & Boes, 1997; Zimmerman, & Dabelko, 2007). A study in Social Work in Health Care by Bjorkenheim (2007) which focused on knowledge, and social work noted that effective communication with colleagues was crucial to knowledge building. The study, based on the results of surveys and focus group interviews among social workers, found that social workers think that discussion with co-workers is a great problem-solving method. In addition, the study by Zimmerman and Dabelko (2007), which presented strategies for patient and family centered care, noted excellent communication skills are an essential tool for providing patient- and family centered care. Ney (1998) concurs with the previous study, noting that good communication is necessary between professionals, yet also crucial between everyone connected to the patient. Furthermore, communication is noted as a necessary characteristic for good collaboration (Abramson, & Mizrahi, 1996; Bronstein, 2003).

Flexibility and Adaptability

Flexibility is referenced in numerous studies pertaining to social work in hospitals (Berkman et al., 1996; Bronstein, 2003; Bronstein, Kovacs, & Vega, 2007; Globerman, White, Mullings, & Davies, 2003; Nilsson, Ryan, & Miller, 2007; O’Brien, & Stewart, 2009; Pockett, 2006; Silverman, 2008; Zimmerman, & Dabelko, 2007). Bronstein (2003) defines flexibility as the ability to attain productive compromise in the
face of disagreement, as well as the ability to adjust roles and respond creatively to any situation. Flexibility and adaptability are essential in hospital social work (Bronstein, Kovacs, & Vega, 2007). In her research to create a model of interdisciplinary collaboration, Bronstein (2003) found flexibility to be one of the components of interdisciplinary collaboration that consistently appeared. A study in Social Work in Health Care by Zimmerman and Debelko (2007) outlined specific strategies for medical social workers to integrate patients and families into the planning and delivery of health care in order to provide better patient-centered care. The study noted that flexibility and quick thinking were necessary in order to accommodate the special requests and circumstances of patients and hospital policy. Another study, found in Social Work in Health Care by Globerman and his conferees (2007) which examined ways that social workers thrive in program management environments, found flexibility was one reported strategy to preserve and enhance their role. O'Brian and Stewart (2009) measured satisfaction of social work service through nurses reporting and found that a willingness to be flexible in meeting patients needs was linked to patient satisfaction.

**Good Listener and Empathetic**

An article by Gibbons and Plath (2009) found in Social Work in Health Care reports on a qualitative study of client’s experience with short-term single session work. The study found that from a patient’s perspective listening and empathy were important characteristics for a social worker to possess, especially for short-term interventions. The ability of the social worker to listen and portray empathy influenced the patient’s view of the social worker. In a similar study found in Social Work in Health Care, by
O'Brien and Stewart (2009) that measured patient satisfaction in social work services, addressed the point that a social workers willingness to listen to patients needs was fundamental in patient satisfaction. An article in Hospital Topics by Ney (1998) noted that that good listening is especially necessary in case management, as it is important to listen well enough to hear what is not being said and concerns not being voiced by patients and their families.

Humor

A definition of humor is that it is an outlook that exists apart from laughter and a way to express many feelings, including frustration, hostility, anger, and even joy (Van Wormer, & Boes, 1997). Numerous editorials and studies have found that a sense of humor is crucial to help social workers thrive, as well as survive in a healthcare setting (Bronstein, Kovacs, & Vega, 2007; Gregorian, 2005; Holliman, Dziegielewski, & Datta, 2001; Pollio, 1995; Van Wormer, & Boes, 1997; Weick, 2000). Van Wormer and Boes (1997) studied humor in the emergency room of a large city hospital. They found that a sense of humor was necessary to fight the struggle against burnout, can provide a sense of catharsis and lead to greater and longer job satisfaction. In essence, social workers should not take themselves and their work so seriously. The study also noted that social work literature on practice, mentions little about humor, with a focus on professionalism, code of ethics and self-discipline, however social work education should teach the value of humor as a coping mechanism and intervention tool. A study found in Families in Society: The Journal of Contemporary Human Services by Pollio (1995) analyzed possible outcomes for humor in particular practice situations. Humor in
crisis intervention was found to be useful in generating movement in a therapeutic situation and was considered low risk for practitioner and client.

**Patience**

Patience is a key characteristic in social work (Bronstein, Kovacs, & Vega, 2007; Gregorian, 2005; Holliman, Dziegielewsk, & Datta, 2001; Wieck, 2000). Weick (2000) who is a dean and professor at the School of Social Welfare at the University of Kansas wrote an essay on the Hidden Voices of Social Work, noting that patience is a hallmark of the social work profession in general. In addition, Gregorian (2005) wrote an article for Social Work in Health Care, which she drew upon her twenty-year career in hospital social work to provide a glimpse of the clinical role in a hospital. Her experience brought her to deem patience and perseverance essential. A study found in Social Work in Healthcare, by Holliman, Dziegielewsk, and Datta (2001) found that successful discharge planning required the characteristic of patience. In this study, 178 discharge planners from 58 hospitals in Alabama were surveyed using closed-ended and open-ended questions. Some discharge planners noted that personal characteristics, such as patience were more important than skills and training. Another study referenced numerous times throughout this literature review, which looked at the fit between social work education and practice, found that in the open-ended question "Is there anything else you would like to tell us?", the characteristic of patience was mentioned to help social workers thrive (Bronstein et al., 2007, 67).
Regulate Emotions

A qualitative study of 47 medical social workers found in Social Work in Health Care by Nelson and Merighi (2002) which examined how several ecological aspects of medical social work effected social worker emotional well-being, noted that social workers must be highly skilled in managing their emotions in order to effectively mediate in crisis situations, which can create emotional circumstances. However, they added that self-control might also be harmful, because their positions require emotional accessibility on a regular basis, which can lead to emotional exhaustion. Without the ability to manage emotions social workers run the risk of taking on client’s pain and becoming emotionally depleted (Gregorian, 2005). The ability to regulate emotions as well as to release the emotions is essential.

Self-Determination and Honesty

A qualitative study found in Social Work in Health Care by Gibbons and Plath (2006) explored single session contacts in hospital social work. The data was obtained via focus groups with hospital social workers. The study found that self-determination and honesty came up consistently in the focus groups. Participants considered self-determination and honesty distinctive to social work and found that having these characteristics aided in establishing rapport and trust quickly, which is crucial in short-term interventions. Holliman, Dziegielewski, and Datta (2001) found similar results in their study of 178 discharge planners from 58 hospitals, which used open and closed-ended questions to elicit information on the roles and tasks of a discharge planner. Self-
determination and honesty were noted essential characteristic in good discharge planners.

Tolerance

Tolerance is defined as the capacity to accept others views and way of living as well the ability to endure without damage (Pockett, 2002). Pockett points out that a tolerant person has the qualities of broad mindedness, forbearance, open-mindedness, endurance, fortitude, hardiness, reliance, toughness and staying power. A study found in Social Work in Health Care by Pockett used the characteristic of tolerance to explain the staying power of social workers in a hospital setting. She completed her study in over two decades. It involved in-depth qualitative interviews with nineteen social workers from two teaching hospitals. The study found that positive tolerance correlated with a social worker’s capacity to stay in the hospital setting. In addition, the study found that a high degree of self-actualization had a positive effect on tolerance.

Self-Actualization

Social workers who succeed and enjoy hospitals are self-actualized, meaning they have the ability to successfully develop and use personal talents and abilities (Pockett, 2002; Gregorian, 2005). Self-actualized practitioners are open to new experiences, open to learning and change, reflective and willing to examine their own responses to environmental challenges, as well as expect to succeed (Pockett, 2002).

Summary

The preceding literature review began with a history of medical social work, where it was discovered that medical social work was started by Dr. Richard Cabot and
Ida Cannon, at Massachusetts general hospital in 1914. Following the history, specific knowledge was reviewed, which was found to include managed care, the medical field, theoretical perspectives, evidence-based research and practice evaluation, as well as the ability to define and articulate social work roles their value. An exploration of knowledge was followed by a review of essential skills, which included case management, collaboration and teamwork, short-term interventions, leadership and supervision, as well as continued education. Lastly, a plethora of characteristics were explored including creativity, effective communication skills, flexibility and adaptability, good listening skills and empathy, humor, patience, regulation of emotions, self-determination and honesty, self-actualization and tolerance. This extensive review of the literature was in preparation of the present study, which will coincide with the findings of this literature review. The following chapter will discuss in depth the methodology of the present study.
Chapter 3

METHODOLOGY

Introduction

The following chapter will discuss the methods used to conduct this research. Methodology will include the study design, sampling procedures, data collection procedures, instruments used and data analysis. There will be a separate section explaining the protocol for the Protection of Human Subjects. This researcher will also discuss procedures taken to reduce risk and provide privacy and confidentiality to the participants.

Study Design

The unit of analysis for this study is medical social workers and social work interns who practice in a hospital setting. A mixed method of qualitative and quantitative data measures was used. Quantitative data analysis was measured through nominal, interval and ratio measures. Qualitative data analysis was measured through open-ended questions, which allowed participants to share narratives and offer additional input. Data gathering took place through surveys sent via email to participants with the use of an online survey program called SurveyMonkey. This was a one-time survey with no follow-up. A non-probability snowball sampling method was used to elicit the participation of medical social workers in Northern California. The sample size was 30 medical social workers and social work interns. The sampling design and size were chosen for this study due to the accessibility and the need to acquire a broad range of participants whom work in varying hospital structures.
Measurement Instrument

The measurement instrument used was a survey distributed online through SurveyMonkey. SurveyMonkey uses Secure Sockets Layer (SSL), which is http encryption technologies to protect user’s information using both server authentication and data encryption, ensuring that user data is safe, secure and available to only authorized individuals. This researcher aimed to create an instrument that was low risk and conscientious of the valuable time of social workers. The survey consisted of 17 closed and open-ended questions. Consent to partake in the research was the first question, which was the only question participants were required to answer. Five questions elicited specific demographic information. Following demographics, were five closed-ended, multiple choice questions and five open-ended narrative and descriptive questions which elicited information on the knowledge, skills and personal characteristics of medical social workers in the hospital setting, as well as information on ethics, hospital restructuring and role articulation. The last question gave the participants a chance to give any feedback, which they felt pertained to the topic. All questions were experience and opinion based. No question, excluding the first required an answer. There was minimal risk of discomfort or harm.

Sampling Procedures

The participants of this study were chosen through non-probability snowball sampling. Enrollment was not anonymous, but responses were. This researcher solicited personally known medical social workers to participate in the study and help locate other potential participants. After compiling email addresses of perspective participants,
this researcher sent a cover letter, explaining the research study and informed consent. In accordance with SurveyMonkeys anti-spam policy, all participants must consent to receiving communication, before their email is used. Therefore, perspective participants must have given the researcher verbal or written consent, before their email was linked to the online survey. Any participant who did not give consent to use their email address was excluded from the sample. Informed consent was also obtained through the survey.

**Data Collection Procedures**

After the participant consented to receiving an online survey, they were added to the sample pool. During the first week of January 2011, data collection began. The participant received a second email, which gave simple directions for the survey and invited them to complete the survey at a suitable time. The invitation email contained a link, which the participant simply clicked upon, sending them straight to the first page of the survey. The first question of the survey stating, “I give my consent to participate in this survey” must be checked “Yes” for the participant to continue. Participants were given roughly one month to respond to the survey. Approximately two weeks after the first invitation, a reminder was sent to all participants. Subsequent reminders were sent and the time frame was extended due to low response rates. Data collection was complete after a five-week period and data analysis began.

**Data Analysis**

Data collected through online surveys were analyzed through SurveyMonkey, where this researcher was able to use varying functions to analyze the data according to the uses for this study.
Human Subjects

An important element considered in this study was the protection of human subjects. Human subjects are the participants of this research. After having decided the topic for this study and the intended human subjects, this researcher presented an application for approval of human subjects to the Division of Social Work's Human Subject Review Committee at California State University Sacramento. The committee reviewed and approved the application to involve minimal risk to the participant.

In order to assure voluntary participation, this study had two levels of consent. First, the participants had to give verbal or written consent to receive a survey via their email. Following consent to receive the survey, participants had to consent a second time, in order to complete the online survey. Participants were informed in a cover letter that they could skip any question, excluding the first and quit the survey at any time, having their data eliminated. Any participant, who decided not to participate, was immediately removed from the sample pool. Confidentiality was assured through blocked email addresses. Participants completed surveys were submitted with no identifying information and no identifiable email address, making their responses anonymous and protecting their privacy. In addition, this researcher is the only individual who had access to the survey results. Access was protected through a user name and password, only the researcher was privy too.

Summary

This chapter of the research study presented the methods used in identifying the topic and the selection of the participants with the approval of the human subjects by
the Division of Social Work’s Review Committee. In the next chapter, the findings from the qualitative and quantitative data measures will be presented and analyzed.
Chapter 4

FINDINGS

Introduction

This chapter presents the findings on the knowledge, skills and personal characteristics of an effective medical social worker in a hospital setting, as well as additional findings, pertinent to medical social work. As stated in the previous section, the research findings are a result of a survey sent to 30 medical social workers and interns in a hospital setting via email. The online survey company SurveyMonkey distributed the survey and all of the findings were analyzed through SurveyMonkey. A mixed method of qualitative and quantitative data measures was used. Quantitative data analysis was measured through nominal, interval and ratio measures. Qualitative data analysis was measured through open-ended questions, which allowed participants to share narratives and offer additional input. The research survey contained demographic information, closed-ended and open-ended questions, which were analyzed as follows. The first section presents demographic information elicited from quantitative closed-ended questions. The second section will discuss specific findings on knowledge, skills and personal characteristics, also elicited from quantitative closed-ended questions. Lastly, additional qualitative data taken from open-ended questions, which strive to elicit pertinent in-depth information on hospital social work, will be analyzed.
Demographics

Of the 30 medical social workers sent the survey via email, 22 responded within the five-week research period, yielding a 73% return rate. Approximately 82% were women and 18% were men. Twenty three percent of the respondents were 2nd year MSW interns and the remainder were MSW’s. No respondents held a PhD. Fifty seven percent of the respondents were Licensed Clinical Social Workers. The age range of respondents varied. The most prominent age ranges were between 20-30 and 51-60, both representing about 32%. However, five of the seven age 20-30 were MSW Interns. Ages 31-40 represented about 14% and 41-50 about 18%. Sixty one to seventy made up the remaining respondents, at about 5%. Fifty five percent have been practicing social work in a hospital setting for over five years, while 13% have been in a hospital setting for over 25 years.

Specific Findings

Knowledge

Respondents were given twelve choices in the category of knowledge. They could choose all knowledge that they felt was pertinent in effective hospital social work. Of the twelve choices, knowledge of ethical dilemma’s, cultural diversity, community resources, vulnerable populations, and end-of life issues had an 100% agreement rate from all respondents as being essential knowledge for hospital social work. Knowledge of insurance was found as essential by 95% of respondents and 86% felt that an understanding of medical terminology was pertinent. About three quarters of respondents believe knowledge of evidence-based research was necessary and
interestingly enough, knowledge of managed care was only seen as necessary by 59% of respondents. Half of respondents felt group dynamics were essential knowledge. The question had a section for other and two respondents noted that a knowledge of hospital culture and disease related information were also important.

About 64% of respondents found a knowledge of theory necessary for effective practice. In a separate question, respondents were asked what theoretical perspectives guide hospital social work. All of the respondents believed that biopsychosocial perspective guided hospital social work. Strengths perspective, crisis intervention and family systems theory were viewed to guide hospital social work by more than 90% of respondents. Eighty six percent of respondents felt person-in -environment perspective guided social work, while about 55% thought bio-medical perspective guided their practice. General systems and ecological perspective were found by only 40% and 46% respectively as guiding hospital social work. A lesser-known critical perspective yielded a 36% response rate. This question also had an option for other and one respondent noted that humanistic perspective was essential in hospital social work.

Skills

The question eliciting information on necessary skills for effective practice, gave respondents nine skill choices and again they could choose as many as they found pertinent, leaving a section for other as well. Each respondent believed that the skills of collaboration and teamwork, as well as short-term intervention were essential. Case management skills and discharge planning were viewed by 86% and 82% respectively as necessary. Seventy three percent of respondents experienced leadership skills and
continued education as a necessity. Only 45% believed that supervision skills were necessary and of that 45%, seventy percent had been in a hospital setting for less than five years and 90% less than ten years. Thirty-six percent deem educator skills necessary. Less than 10%, only two respondents considered fundraising necessary.

In a review of the literature, it became apparent that many hospital social work tasks are contained under the umbrella term of case management. Therefore, one question asked participants to choose from fourteen case management tasks, which they found essential for effective case management. Again, they could choose as many as they felt compelled and there was a section for other. All respondents agreed that assessment, referral and communication with families were essential for effective case management. Communication with other professionals, resource management and psychosocial support were found essential by 96% of respondents. Discharge planning, linkage and advocating yielded 90% of respondents. Eighty six percent of respondent’s experience that empowering patients to manage their own health care was vital, while 77% thought consultation was necessary. Monitoring and evaluating the process and result were considered less essential with 55% and 41% respectively. Rounding out the tasks, only 46% of respondents thought that outreach was essential for effective case management.

**Characteristics**

The final closed-ended question, solicited information about essential characteristics for effective practice in the hospital setting. Respondents had twenty-four choices. All characteristics were taken from a review of the literature. Out of 24
choices, three yielded 100% of the respondents; flexibility, good multi-tasker and the ability to establish rapport quickly. Ninety percent of respondents found that humor, empathy, being a good listener and communicator, as well as accountability were essential. About 85% of respondents deemed adaptability, the ability to regulate emotions and good time management skills vital. Patience and strong boundaries were close behind with 82%. Seventy seven percent of respondents found honesty, responsibility and the characteristic of self-discipline essential, closely followed by proactive, with 73%. Self-determination and creativity were viewed as critical by 68% of respondents and tolerance by 64%. Instinctual and having a "tuff skin," yielded about 60% of a response rate, while positive self-esteem was barely viewed as essential by half of the respondents. Lastly, merely 27% of respondents felt that self-actualization was an essential characteristic.

Additional Qualitative Data

In order to elicit further, in-depth information on hospital social work culture, six open-ended questions were included in the survey. Each question stemmed from the researchers interest in collecting data on specific interventions frequently used, the effects of restructuring and downsizing on social services and ethical issues, as well as role clarity and assessing what medical social workers feel is the best way to prepare social workers to work in a hospital setting. In addition, the last question gave social workers a place to provide additional information that they felt essential for hospital social work.
Specific Interventions

Question #12 asked "What specific Interventions do you regularly use?" The answers varied however; there were themes, as well as outliers. Some form of crisis intervention or crisis stabilization was named by about 45% of those who answered the question as being a regularly used intervention. Resource referrals were also regularly used interventions yielding 45% of respondents. Providing psychosocial assessments for a wide variety of populations was another theme. Five of the respondents who answered the question, noted that motivational interviewing was regularly used. One respondent stated, "I use motivational interviewing to determine an intervention." Brief supportive counseling, as well as grief and loss counseling was noted by 32% of respondents as a regularly used intervention. Other themes included discharge planning, problem solving, family meetings and mandated reporting. Aside from common themes, one respondent's states, "prochaska's model of change" as a regularly used intervention. Two respondents noted using cognitive behavioral therapy and one noted solution focused approach. In addition, one respondent stated using "confrontation," as an intervention.

Role Clarity

Much of the literature surrounding hospital social work discusses the fact that social workers have difficulty articulating their roles in the hospital setting, therefore question number #13 asked social workers if they found this to be true and if so, why. Sixty four percent of respondents found this to be true, while 31% found this untrue in their setting and one respondent was on the fence, saying "somewhat".
Of the respondents who consider their role hard to articulate, it was overwhelmingly because hospital social workers have a broad scope of work, which changes on a daily basis to meet the needs of the hospital. Some of the social workers' responses are as follows. "Yes, because hospital social workers do so many different things. It is hard to explain all the things we do". "I do have a hard time articulating my role in the hospital to people who ask. I think it is because my role is different from day to day, from patient to patient. I may be providing substance abuse counseling one hour and helping to facilitate an adoption the next, all while supporting a family who is grieving the recent loss of a loved one. I do not have one job, I have many!" Many of the other responses echo these sentiments. In addition, one respondent stated, "Yes. Particularly with new graduates. Often, they have not found their place and clinical style, so want to be accepted as part of the healthcare team and be seen as helpful. This often leads to newer graduates taking on inappropriate tasks and at times, demonstrating poor boundaries. Thus, clinical supervision is of the utmost importance." Another linked role clarity to the perception of our patients. "I feel that patients tend to have a negative view of social workers based on an inaccurate assumption that social workers are there to scrutinize the patient for their actions. Therefore, it is extremely important that we as social workers articulate our role to the community, as well as hospital staff and hopefully our work with patients will educate them to the true role of social workers."

Conversely, 31% of respondents did not have a hard time articulating their roles. Some social workers noted, "Not at all, my boundaries are very clearly set by my job
description, my professional ethics and by a collaborative effort amongst the colleagues and ancillary colleges.” Others suggested, “We are very established in the interdisciplinary team.” In addition, 23% of respondents expressed that their role is often confused and blurred with the nursing case manager role. One respondent stated, “No, I feel our role is quite clear. However, it often gets confused with the Nurse Case Manager role by other disciplines.” Another stated, “Other disciplines, in particular physicians, have some difficulty differentiating social workers and case managers—understandably as there is a lot of overlap in the scope of practice.”

Hospital Restructuring and Downsizing

Question #14 aimed to elicit information on how hospital restructuring and downsizing has effected social work departments. About 60% of respondents noted that hospital restructuring and downsizing has effected the social work departments in their settings. Some expressed loosing positions, “We are extremely short-staffed, had many lay offs last year. It affects moral and team relationships.” “We have lost a part-time worker and a full time position was made part-time” and “less per diem coverage.” Others noted a change in role. “Our referrals have increased, but in order to justify another social worker, we had to accept an assignment of 50% discharge planner responsibility,” and “Case management Department is using social workers to help out case managers.” Another theme apparent is that there is a greater number of referral and less social work staff, therefore social workers must work harder, be more proficient and fewer patients are served. One respondent stated, “Reality is that with fewer social work hours, fewer patients receive social work assistance during their
hospital stay". Another state's "We are asked to do more with less." Other respondents noted that morale and team relationships are affected by the increasing stress. In summery, "With a focus on the bottom line, it has become increasingly important to be able to identify the value of social work intervention in the hospital setting." Of those who did not feel that downsizing has affected their setting, one noted the use of MSW interns and another noted, "The hospital hasn't downsized, they haven't adjusted to the increased needs of their patient's."

Conflict Between NASW Code of Ethics and Practice in a Hospital Setting

Question #15 asked, "Do you find there to be conflict in adhering to the NASW Code of Ethics, while also working in a hospital setting? Of the twenty-two respondents, about forty percent did not have conflict adhering to the NASW Code of Ethics while practicing in hospital. One respondent who answered no, stated "I feel social workers are very involved in ethics, can bring ethical issues to the attention of staff and the ethics committee." Another noted, "I have not experienced a conflict in how I interact with my patients, but other professions may not always act in accordance with our values. It is important to advocate for the patients at that time." Of those who felt conflict between NASW Code of Ethics and hospital work the most common themes dealt with issues surrounding length of stay and discharging patients before they are ready, as well as adhering to the NASW Code of Ethics- the dignity and worth of a human being. One respondent explained, "The most challenging conflict is with adhering to the NASW Code of Ethics- the dignity and worth of a human being. The human being is considered a statistical piece of data which drives LOS (length of
stay).” In addition, 32% of respondents cited Bioethics meetings and consulting with supervisors as means to addressing ethical dilemmas. “Occasionally there are cases that present to be of ethical dilemmas; however the members of the Bioethics Committee would involve all the key personnel's (MD's, RN's, Social Workers, etc.) to partake in finding the best outcomes for patient's well-being. The Social Workers would adhere to the NASW Code of Ethics throughout this process.” Other ethical conflicts noted by respondents included confidentiality, interpreter use and the difficulty of doctors, nurses and case managers honoring a patient’s right to self-determination.

Best Preparation for Practice in the Hospital Setting

Question #16 asked, “If you were to advise social work educators on how best to prepare social workers for practice in a hospital setting, what knowledge and skills would you encourage them to teach?” The responses for this question were quite in-depth and varied. Thirty two percent of respondents noted that medical terminology and an understanding of hospital and organizational systems were needed for preparation. One of those respondents suggested, “I would highly recommend having a current medical social worker teaching the class, in order to be able to provide practical knowledge.” The second most common response with 27% response rate was some form of crisis intervention that is needed “to deal with immediate medical crisis. Coping with intense emotional life and death situations.” Twenty three percent of the respondents stated that preparation in end-of-life issues and grief and loss were essential. One respondent noted, “I would have liked a stronger background in grief and loss intervention”. Flexibility, teamwork and good communication skills, as well as
assessment skills in brief contact, the ability to establish rapport quickly and knowledge of chemical dependency were the fourth most popular responses to this question, with a thirteen percent response rate each. Three respondents felt that good internships in health care settings were also vital for the learning experience. One respondent noted, “So much can’t be taught-like how to be calm and unemotional during codes and deaths can only be developed by doing the work. Good internships with a skilled supervisor is imperative”.

The last question gave respondents a space to note anything that they believe is essential for effective practice in a hospital setting. Sixteen of the twenty-two respondents answered this question. Because the answers are extremely varied, I will quote some responses, which have yet to be touched upon in the earlier findings. It is essential “to encourage consistent limit setting in a setting with a large staff ratio to patient and family” and “Cultural competency in dealing with patients and families.” “I think you have to have a passion for this work, a sense of humor, and learn to take care of yourself so there is balance in your life” and “The ability to say I can’t do everything.” In addition, one respondent noted, “be willing to challenge professionals, such as MD’s and RN’s in the best interest of patient advocacy” and another responded “good mentors”. In conclusion, “Practice self care” and “Laughter is the best medicine.”

Summary

Overall, the findings reveal numerous themes on what knowledge, skills and personal characteristics are essential for effective practice in a hospital setting. The
findings also reveal some differences, which in all probability are due to the specific setting in which the respondents practice. The specific findings found that knowledge of ethical dilemmas, cultural diversity, community resources, vulnerable populations, and all respondents viewed end-of life issues as essential. However, in an era of managed care, only 59% of respondents found an understanding of the managed care system to be important. Knowledge of theory was viewed as essential by only 64% of respondents. The findings reveal that biopsychosocial perspective guided all respondents work in the hospital setting. Strengths perspective, crisis intervention and family systems theory were viewed to guide hospital social work by more than 90% of respondents.

The specific findings regarding skills essential for effective practice discovered that all respondent believed that the skills of collaboration and teamwork, in addition to short-term intervention were essential. However, only 45% believed that supervision skills were necessary and of that 45%, seventy percent had been in a hospital setting for less than five years and 90% less than ten years. Under the umbrella term of case management, all respondents agreed that assessment, referral and communication with families were essential for effective case management. All but one respondent found communication with other professionals, resource management and psychosocial support essential. Conversely, only 46% of respondents thought that outreach was essential for effective case management.

The specific findings regarding characteristics found that out of 24 choices, three yielded 100% of the respondents; flexibility, good multi-tasker and the ability to
establish rapport quickly. Ninety percent of respondents found that humor, empathy, being a good listener and communicator, as well as accountability were essential. Less respondents felt that self-actualization was an essential characteristic, with a merely 27% agreement.

Additional findings revealed that crisis intervention and resource referrals were the most used intervention in a hospital setting. Less used interventions included “prochaska model of change,” cognitive behavioral therapy, solution focused approach and “confrontation,” as an intervention. Of the respondents who consider their role hard to articulate, it was overwhelmingly because hospital social workers have a broad scope of work, which changes on a daily basis to meet the needs of the hospital. Other additional findings noted that hospital restructuring and downsizing has affected 60% of the respondents, which has caused a loss of positions, additional functions for social workers and less clients being served. About 60% of those who felt conflict between NASW Code of Ethics and hospital work, the most common themes dealt with issues surrounding length of stay and discharging patients before they are ready, as well as adhering to the NASW Code of Ethics- the dignity and worth of a human being.

Lastly, in addition to the previous findings the respondents noted what knowledge and skills they would encourage social work educators to teach, in order to prepare social workers for practice in a hospital setting. Thirty two percent of respondents noted that medical terminology and an understanding of hospital and organizational systems were needed for preparation. One finding, extremely pertinent to
this study was that three respondents believed that good internships in health care settings were also vital for the learning experience.

The following chapter will recap and summarize the major findings of this study. This researcher will compare and contrast the outcomes of this study with the review of the literature found in chapter 2. Additional observations that materialized throughout the study and recommendations for further research which also be discussed.
Chapter 5

CONCLUSIONS, RECOMMENDATIONS, SUMMARY

Introduction

This final chapter discusses the conclusions of the study and their relevance to social work practice. The major findings on the knowledge, skills, and personal characteristics of an effective medical social worker in a hospital setting and how they compare and contrast with the literature review in chapter 2 will be explored and summarized. The researcher’s personal opinions regarding the study will also be presented, as well as specific observations that emerged. Lastly, the researcher will describe practical uses for this research project and advice for expanding the research project.

Findings

This research study evolved from the researcher’s interest in medical social work and a hope to provide new social workers interested in a medical social work and veteran medical social workers a current guide for best practices. The study began with a comprehensive exploration of the research through literature and progressed to a real life study of medical social workers in a hospital setting. Throughout the process, many aspects of the literature and present study were found to concur, while other aspects differed.

In the category of knowledge, starting with theory, the biopsychosocial perspective was found in the literature and the present study to be an essential aspect of medical social work. Literature, as well as the present study named the biopsychosocial
perspective as most used in a hospital setting. Knowledge of family systems theory, crisis theory and strengths perspective were essential, as well. Knowledge of ethical dilemmas and evidence-based research were also important in literature and the study.

A review of the literature found knowledge of the managed care system essential for effective practice; however, the present study found that only about 60% of respondents consider knowledge of managed care to be essential. The discrepancy may be due to a lack of understanding as to what managed care is, and how it affects social workers and their clients. Literature regarding an understanding of the medical field and medical terminology was minimal, however the present study found that over 85% of respondents found knowledge of medical terminology to be essential. Furthermore, in the open-ended question which asked “If you were to advise social work educators on how best to prepare social workers for practice in a hospital setting, what knowledge and skills would you encourage them to teach?”, thirty two percent of respondents noted that medical terminology and an understanding of hospital and organizational systems were needed for preparation. This was the most common response.

This researcher grappled with the inclusion or exclusion of a review of literature regarding knowledge of cultural diversity due to the minimal amount of research found that primarily discussed cultural diversity in a hospital setting. This researcher excluded knowledge of cultural diversity from the literature review; however, she included cultural diversity in the research study for further exploration. All respondents agreed upon cultural diversity as essential knowledge for effective practice in a hospital setting. One hypothesis for the discrepancy between literature and research is the assumption
that cultural diversity is pertinent knowledge for all social workers and should be assumed important in all practice settings.

In the category of essential skills, all respondents in the present study, which coincided with the literature review, agreed upon collaboration and teamwork, as well as short-term interventions, as necessary skills for effective practice. The literature review explains that discharge planning is the primary function of a hospital social worker, however only about 82% of respondents from the present study found discharge planning skills essential. In addition, 86% of respondents found case management to be an essential skill. Throughout this study, it has become apparent that hospitals employ case managers and social workers. Depending on the setting, case manages are usually nurses and have the role of discharge planning. Therefore, there is role confusion, which can lead to difficulty in articulating roles. However, the umbrella term of case management contains many roles of a social worker. Case management roles, which were revealed in a review of the literature and the present study, coincided on most levels. The most important being assessment, communication with families, referral, advocating, linkage, psychosocial support, resource management, collaboration with other professionals and discharge planning.

The findings in the present study and the literature review surrounding leadership and supervision are somewhat disconcerting. Literature discusses leadership skills as coveted in an era of managed care and hospital restructuring, while also concluding that there has been a growth in supervision by non-social workers. The present study found that about 70% of respondents believe that leadership skills which
set principles, direction and a vision for a work environment, are necessary for effective practice and 45% found supervision skills to be a necessity. Of that 45%, seventy percent had been in a hospital setting for less than five years and 90% less than ten years. Those who no longer need supervision due to experience, find it a non-essential skill. However, social workers providing supervision are a needed aspect in the hospital setting, now more than ever.

The inability to articulate social work roles was present in the literature review and present study. The literature makes clear that in the current health care climate of restructuring, downsizing and managed care, articulating roles and values is detrimental to the staying power of hospital social workers. The present study found that 64% of respondents found articulating their role to be difficult and it was overwhelming because hospital social workers have a broad scope of work, which changes on a daily basis to meet the needs of the hospital.

The facet of the study, which explored characteristics, yielded a plethora of responses. One study noted that some respondents found personality characteristics to be more important requirements, than specific skills and training. A review of the literature was limited to characteristics, which were found to be common, although the present study gave respondents more choices than were reviewed in the literature. The literature review and present study were comparable in responses, yet there were a few major contrasts. Creativity was found to be one of the most essential characteristics in the literature review. However, the present study found that only 68% of respondents agreed. In addition, self-actualization yielded only 27% of a response rate in the current
study, yet was determined important in a review of the literature. This researcher believes there is confusion as to the definition of self-actualization.

This researcher found the information on the topic of knowledge and skills regarding end-of-life to be an especially significant finding in this study. A review of the literature found minimal information on end-of-life knowledge and skills in the hospital setting. The minimal literature that is available discussed that social workers have a lack of suitable preparation at the master’s level and not enough continuing education. In addition, one study found that social workers were less than helpful in preparing caregivers for end-of-life. However, in the present study, all participants agreed that knowledge regarding end-of-life issues is essential for work in the hospital setting. Brief supportive counseling, as well as grief and loss counseling, was noted by 32% of respondents as a regularly used intervention. Respondents also noted that they would like a better background in grief and loss. As an intern in a hospital setting, this researcher has had first had experience with this dilemma. There is little education on end-of-life issues in school as well as in the hospital setting. More education surrounding end-of-life is needed during graduate level study, continued education and on the job.

Lastly, it became apparent throughout this study that more education is needed in the area of medical social work. Education provided in master’s level training, as well as on the job and continued education is essential to prepare social workers. Hospitals provide social services to all populations, with a multitude of needs; therefore, well-trained professionals are essential. Classes dedicated to medical social work
offered in school and added internships in the hospital setting are just two of the recommendations offered by participants of the study. Without proper training, hospital social workers will be viewed as non-essential, and therefore, easily dispensable.

Social Work Practice Recommendations

The present study aimed to explore the knowledge, skills and personal characteristics of an effective medical social worker, which can be used as a current guide for practice in the field. This research study can be put to practical use immediately to assist medical social workers in understanding their role in the hospital setting, while also giving them the ability to articulate that role to other professionals and clients.

As well as providing a guide to best practice, this research study explored the current hospital culture and its effects on social workers, which has a practical application in educating medical social workers. Understanding the current hospital culture and the affects it has on social workers and social service departments will better prepare medical social workers for practice in this setting. They will have the ability to show their value and leadership skills through education of the hospital culture and their specific roles and responsibilities. In addition, understanding hospital culture will assist social workers in working with, and not against the hospital structure, to provide better patient outcomes. Knowledge is definitely power in a hospital setting.

Future Research Recommendations

The present study involved a limited scope, using a limited number of medical social workers and interns from a minimal radius in Northern California. Increasing the
study to include more participants from a larger geographical area would be a good way to expand this research project. Including the hospital setting in which the participants practice would also expand the research and attempt to explore how the setting affects the knowledge, skills and characteristics needed for effective practice. Hospital environments are ever changing, therefore a research study of this kind completed every five years would allow for an up-to-date guide on the roles of medical social workers.

In addition, a new survey, which expands on aspects of medical social work, which were found to be pertinent in the present study, yet not included in the review of the literature or present survey. The qualitative data acquired in this research was the most useful data in understanding the real experiences of medical social workers. Therefore, this researcher advises an entirely qualitative study, which will provide in-depth and expansive information on the topic, by eliciting information from medical social workers through one-on-one interviews. Giving participant the ability to provide personal stories and real-life experiences, provides an understanding of the topic that is not possible with closed-ended questions used in a quantitative study.

**Researcher Experience**

The process of completing a project, which included an in-depth literature review and complete study with human subjects, was a large undertaking, which was overwhelming at times. Yet, now to have a completed project, this researcher feels a sense of accomplishment. Throughout this process, this researcher has gained a tremendous amount of knowledge surrounding hospital social work, which has provided a better understanding of the setting in which I hope to make a career. In addition, this
reapser takes away a better understanding of the research process, which is essential in social work.

Summary

Throughout this research study, there has been expansive information acquired surrounding medical social work. What started as the researchers' interest in exploring the knowledge, skills and personal characteristics of a medical social worker in order to best prepare for a career in medical social work, turned into an expansive and thorough exploration of hospital social work, as well as hospital culture and the effects of the ever-changing hospital environment on social work practitioners. Many conclusions were gathered and the information acquired can be used as a guide for medical social workers, as well as provide education into the hospital culture. After the completed literature exploration and research study, this researcher's hope is that the information on the many facets of medical social work in a hospital setting will assist in educating and preparing social workers for practice in a hospital setting. Education and the ability to fill the social work role in a hospital setting is crucial to the viability of hospital social work.
APPENDIX A

Informed Consent Form
Prospective Participants:

My name is Renee Gregg and I am a graduate student at Sacramento State University, pursuing a master’s degree in social work. I am currently working on my thesis/project. The purpose of my research is to explore the knowledge, skills and personal characteristics of an effective medical social worker in the hospital setting. I would greatly appreciate your participation in my research.

This research study is considered “minimal risk” and your participation is completely voluntary. The study will be done via on-line survey and will include a total of 17 multiple choice and open-ended questions, which are experience and opinion based. I attempted to keep the survey as short as possible, knowing that spare time is often in short supply. You may skip any questions if you feel uncomfortable and may opt out of the survey at any time and your data will be eliminated.

In the interest of avoiding any conflict of interest, as I may personally know participants, all email addresses will be blocked in the results; therefore your survey responses will be anonymous. The specific hospital in which you work will not be named or used in the study whatsoever.

There will be no compensation offered for your participation. Your survey responses will be kept confidential to the degree permitted by the technology used. However, no absolute guarantees can be given for the confidentiality of electronic data. If you complete the anonymous survey and submit it, the researcher will be unable to remove anonymous data from the database should you wish to withdraw it.

The survey will be sent through an invitation email, which will include a link that will take you directly to the survey. Per SurveyMonkey Spam Policy, which is the on-line survey site, in order for this researcher to use any participants email address, I must have prior consent for communication. Therefore, if I have not previously received written or verbal consent to send you the survey, a simple response email that states “Yes,” will be greatly appreciated. Once the consent to use your email is received, the survey invitation will be sent. If consent has previously been received, an invitation email will follow this cover letter within two days. The first question on the survey must be checked “YES,” giving your consent to participate in the survey.

If your participation in this research causes you any emotional harm you are urged to contact the researcher who can provide further resources, or contact your local mental health agency. Sacramento County Mental Health Services Adult Access Team (916) 875-1055
Solano County Mental Health Services Access Unit (800) 547-0495
Contra Costa County Mental Health Services (888) 678-7277
Additionally, your agency may also provide counseling you can access through an Employee Assistance Program (EAP).

Concerns or questions regarding any aspect of your participation may be directed to my email @ reneegregg@yahoo.com or you may call me at (510) 334-5920. This research is being supervised by Dr. Susan Eggman, Associate Professor in the Division of Social Work at Sacramento State University (916-278-7182), eggmans@csus.edu. You may also contact her with any issues or concerns about this project.

Thank you for your time and I appreciate your participation.
Appendix B

Survey Questions for Medical Social Workers
1. I give my consent to participate in this survey (must be answered to continue).

_______ Yes

2. What is your gender?

_______ Male
_______ Female

3. What is your education level?

_______ BSW
_______ MSW Intern
_______ MSW
_______ PhD

4. Are you a Licensed Clinical Social Worker?

_______ Yes
_______ No

5. What is your age group?

_______ 20 to 30
_______ 31 to 40
_______ 41 to 50
_______ 51 to 60
_______ 61 to 70
_______ over 70

6. How many years total, have you worked in a hospital setting? (Do not need to be consecutive.)

_______ less than 5 years
_______ 5 to 10 years
_______ 11 to 15 years
_______ 16 to 20 years
_______ 21 to 25 years
_____ over 25 years

7. In your experience, knowledge of the following is necessary for effective practice in the hospital setting… (Check all that apply.)

_____ Managed Care
_____ Medical Terminology
_____ Insurance
_____ Relevant Policies
_____ Ethical Dilemmas and Protocols
_____ Evidence- Bases Research
_____ Theory
_____ Cultural Diversity
_____ Community Resources
_____ Vulnerable Populations
_____ Group Dynamics
_____ End-of- Life Issues

8. In your experience, what theoretical perspectives guide hospital social work? (Check all that apply)

_____ Biopsychosocial
_____ Person-in- Environment
_____ General Systems
_____ Family Systems
_____ Ecological
_____ Crisis
_____ Strengths
_____ Critical
_____ Bio-Medical

9. In your experience, the following skills are necessary for effective practice… (Check all that apply)

_____ Case Management
_____ Discharge Planning
_____ Leadership
_____ Supervision
_____ Collaboration/ Teamwork
_____ Short-Term Intervention
_____ Continued Education
_____ Educator
Fundraising

10. Check all tasks that are essential for effective case management.

- Assessment
- Outreach
- Referral
- Advocate
- Consult
- Linkage
- Monitoring
- Evaluating the Process and Result
- Psychosocial Support
- Resource Management
- Communication with Families
- Communication with Allied Professionals
- Empowering Patients to Manage Their Own Health Care
- Discharge Planning

11. What personal characteristics do you find essential for effective practice in a hospital setting? (Check all that apply)

- Humor
- Self-Determination
- Honesty
- Flexibility
- Adaptability
- Patience
- Communication Skills
- Self-Actualization
- Empathy
- Good Listener
- “Tuff Skin”
- Positive Self-Esteem
- Ability to Regulate Emotions
- Creativity
- Tolerance
- Good Time Management
- Strong Boundaries
- Ability to Establish Rapport Quickly
- Self-Disciplined
12. What specific interventions do you regularly use?

13. A reoccurring theme in the literature surrounding hospital social work is that social workers have a hard time articulating their roles in the hospital setting. Do you find this to be true? Why?

14. How has hospital restructuring and downsizing effected to social work department in your setting?

15. Do you find there to be conflict in adhering to the NASW Code of Ethics, while also practicing in a hospital setting? If so, how do you deal with these ethical dilemmas?

16. If you were to advise social work educator on how best to prepare social workers for practice in a hospital setting, what knowledge and skills would you encourage them to each?

17. Is there anything else that you believe is essential for effective practice in a hospital setting?
APPENDIX C

Approval by the Committee for the Protection of Human Subjects from the Division of Social Work
TO: Renee Gregg  
FROM: Committee for the Protection of Human Subjects  
Date: January 3, 2011  

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, "What are the knowledge, skills and personal characteristics of an effective medical social worker in a hospital setting?"

_X_ approved as _____EXEMPT  ____ NO RISK  _X_ MINIMAL RISK.

Your human subjects approval number is: 10-11-067. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Jude Antonyappan, Maria Dinis, David Demetral, Susan Eggman, Serge Lee, Kisun Nam, Maura O'Keefe, Sue Taylor, Santos Torres

Cc: Dr. Susan Eggman
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