Hospital Social Work

Dr Dan Burrows

Cardiff University

burrowsdr1@cardiff.ac.uk

Hospital Social Work Origins: The Lady Almoner

Almoner posts were created to assess hospital patients' eligibility for free care – first in 1895

The role was quickly expanded to assisting doctors to understand the social causes underlying disease and to remedying such causes

Aim to ensure that patient could get the most possible benefit from medical treatment

'Social Diagnosis' (Richmond, 1917)

First branch of social work to have a professional association

Influence within Medicine

Trend of sanitoria and convalescent homes in early 20th Century linked to influence of almoners

Mid-20th Century: Almoners/medical social workers given an active role in medical training

Claimed a role in treating illnesses with a strong social impact – e.g. STD epidemics after WW2

Successful resistance to being registered as 'Professions Auxiliary to Medicine'

Professional qualification recognised for practice

Waning Professional Power

Creation of NHS brought about new public health professional roles which undermined place of medical social work

Genericisation and creation of BASW diminished prestige within the social work profession

Community Care reforms under Thatcher/Major – social workers as brokers of services

‘Modernisation’ – Managerialism and bureaucratic control of social workers

Diminishing resources

Modern Hospital Social Work

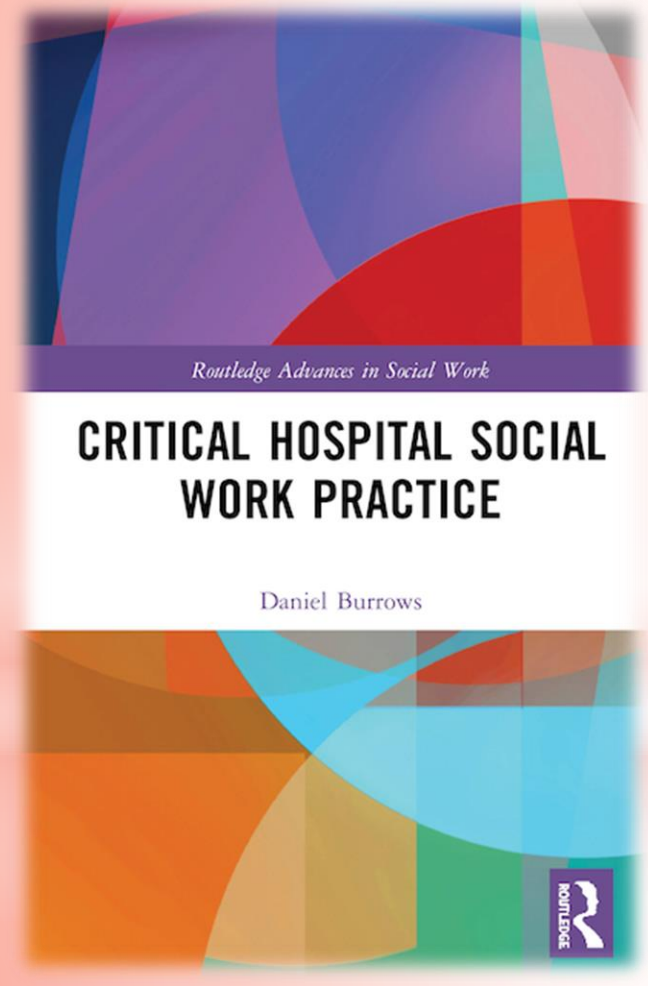
Enormous pressure from managers and clinicians to discharge patients quickly – like standing in a river

Discharge the central focus of social workers

Social work practice in a hospital reduced to a succession of bureaucratic tasks

Bureaucratic because social work department exercises power to allocate resources

My Study



Thesis component of professional doctorate

Ethnographic field work with a hospital social work team

Six weeks in total spent observing social workers and clinicians in hospital

Limited access to patients and carers

Interviews with social workers, clinicians, carers and patients

Bureaucratic/Neoliberal Social Work

Bauman(1989) Modernity and the Holocaust

Separation of care plan approver/denier from patient

Reduction of a person to a list of eligible bodily needs

Limited time leads to dehumanising corner-cutting

Fordist/Taylorist approaches

BUT social workers don't have a personal stake in the performance data – therefore there is still loyalty to the patient

Discretion and Street-level Bureaucracy (Lipsky, 1980)

How is it still Social Work?

IFSW description – pretty ambitious

Regard for human rights, social justice and empowerment a sine qua non of social work

Each tenet can be seen in the hospital social workers' practices

BUT highly individualistic approach

Negative freedoms

Social justice for the individual – not tackling systems

Empowerment only for individuals, not groups

Dramatization and Visibility

Goffman (1959) When we do anything around other people, we not only do it, we dramatize it

Dramatization of social work in hospital much more low-key than other professions

Ramshackle, isolated offices

Lack of visual emblems (uniforms, stethoscope etc.)

Lack of command of hospital spaces as a ‘stage’

Lack of visibility of social workers can lead to mistrust by clinicians (“You never get to see them.”)

BUT prevent social workers from being ‘sucked into things’

Discrepant Frames

Goffman (1974) Frame Analysis – how we make sense of social situations

Clinicians' frame: Complex negotiated hierarchy, but with consultant physician always at the top

Clinicians see social workers as part of hospital order, but social workers see themselves as outside it

Role as 'patient advocates' crucial

Working for a different bureaucracy helps maintain the distinction

There was a gentleman, from the first day I met him, I felt he didn't have capacity with regards to discharge destination because he couldn't retain information, he wasn't able to weigh up any risks, and we did a risk assessment with him, and his responses were just completely inappropriate, whereas the doctor thought that he had capacity. I challenged him on this and his response was, 'Oh, HSW1 [he called her by her first name], I have no doubt in my mind that he has capacity.' And I said, 'Well I'm sorry but, you know, I disagree. I'll come back and visit him in a few days.' I went back, I was still adamant he didn't have capacity. The doctor was adamant that he did, and the gentleman started deteriorating. And it took about six weeks and the doctor actually said, 'He doesn't have capacity.' Whereas this gentleman has gone from residential to needing a nursing home and now CHC. And the family had actually chosen a residential home that they thought their father would have been happy in, but now he couldn't go. – HSW1

I challenged him on one of the domains, and his response was, 'We need to get somebody more senior than yourself to attend the meeting.' – HSW1

She [the chair of the meeting] kept saying to me, ‘We’re in dispute.’ I said, ‘Well I’m not in dispute, I just have a different view.’ But she kept coming back to this, saying, ‘We’re in dispute,’ as if it was something very dramatic. So I said, ‘Well what does that mean?’ And it just means that all the paperwork gets sent up to the next level for a decision. Well, I don’t mind. If the decision goes against me, so be it. It’s up to the family to appeal. I’m not going to get excited about it. Not as excited as the chair was anyway. – HSW3

Dr 4 emphasises he does not think the application has any chance of success with the panel and therefore feels it should not go ahead. HSW5 asks aren't all his needs in the nature of his illness? Dr 4 says insistently that he is a Parkinson's specialist and he would say he is in a complex stage but he does not need extraordinary nursing care. HSW5 questions this – the illness is causing his nursing care needs. She turns to the family and asks them if they want to apply. The doctor says he does not want to waste time.

As soon as the nurse is gone, HSW5 advises the family members to wait and get a new CHC assessment once patient is in the community. She says the community nurses are much more thorough and more likely to get the sort of detail needed to get this through

Conflict and Harmony

Social workers openly challenging senior doctors a violation of the hospital order

Social workers assert loyalty to a separate bureaucracy (but have to manage pressures and control from both)

Social workers do a lot of work to maintain harmony:

- Sociable demeanour
- Use of humour
- Closing ranks with clinicians when patients/carers threatening
- Picking battles

The future

Clinicians in hospitals value social work highly – they want more of it

Focus on speedy discharge important but masks other important considerations – e.g. readmission rates

Much research in USA and Australia indicates that social work interventions can be effective in reducing readmissions (e.g. Alvarez, et al., 2016; Barber et al., 2015; Bronstein et al., 2015; Simpson et al., 2016; Cleak and Turczynski, 2014)

Health coaching offers a model that could be adopted and adapted by social workers in health-related settings (see e.g. Palmer et al., 2003; Lindner et al., 2003; Olsen, 2014)

Match between health coaching and common social work approaches and techniques (e.g. strengths-based work, solution-focused therapy, motivational interviewing, task-centred work)

References

Alvarez, R., Ginsburg, J., Grabowski, J., Post, S. and Rosenberg, W. (2016) 'The Social Work Role in Reducing 30 Day Readmissions: The Effectiveness of the Bridge Model of Transitional Care', *Journal of Gerontological Social Work* 59(3) p. 222-7.

Barber, R.D., Coulourides Kogan, A., Riffenburgh, A. and Enguidanos, S. (2015) 'A Role for Social Workers in Improving Care Setting Transitions: A Case Study', *Social Work in Health Care* 54(3) p. 177-92.

Bronstein, L.R., Gould, P., Berkowitz, S.A., James, G.D. and Marks, K. (2015) 'Impact of a Social Work Care Coordination Intervention on Hospital Readmission: A Randomized Controlled Trial', *Social Work* 60(3) p. 248-55.

Burrows, D. (2020) *Critical Hospital Social Work Practice.* Abingdon: Routledge.

Cleak, H.M. and Turczynski, M. (2014) 'Hospital Social Work in Australia: Emerging Trends or More of the Same?', *Social Work in Health Care* 53(3) p. 199-213.

Lindner, H., Menzies, D., Kelly, J., Taylor, S. and Shearer, M. (2003) 'Coaching for behaviour change in chronic disease: a review of the literature and the implications for coaching as a self-management intervention', *Australian Journal of Primary Health 9*(3), p.177-185.

Lipsky, M. (1980) *Street-Level Bureaucracy: The Dilemmas of Individuals in Public Services.* New York: Russell Sage Foundation

Olsen, J.M. (2014) 'Health Coaching: A Concept Analysis', *Nursing Forum* 49(1) p. 18-29).

Palmer, S., Tubbs, I. and Whybrow, A. (2003) 'Health coaching to facilitate the promotion of healthy behaviour and achievement of health-related goals', *International Journal of Health Promotion and Education* 41(3), pp.91-93.

Simpson, G., Pfeiffer, D., Keogh, S. and Lane, B. (2016) 'Describing an Early Social Work Intervention Program for Families after Severe Traumatic Brain Injury', *Journal of Social Work in Disability and Rehabilitation* 15(3-4) p. 213-33.