Social Work Practice in Secondary Setting – The Case of Medical Social Work in Hospital Setting in Hong Kong

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Table of Contents

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ABSTRACT

This research is an exploratory study of the role conflict faced by medical social workers in the secondary setting of hospital. In secondary setting, medical social work is only one part of the total process of providing health care services to patients. The role of medical social workers is beset by many conflicting demands and expectations from non-social work professionals, especially physicians. As a result, medical social workers enact an extremely complex and often vaguely defined role. Hence, it is necessary and urgent to clarify the role of medical social workers in hospitals for the sake of professional identity.

This research is the first empirical local attempt to clarify the role and function of medical social workers in the hospital setting. Its aim is to explore which roles and functions are distinct and specialized to medical social workers and search for their legitimate domain in a secondary setting. In this study, the conception of health care, whether the bio-medical or the holistic model, held by physicians and medical social workers, is used to examine the problems inherent in medical social workers' struggle for professional identification. Besides, this study also explores the relationship between interactional pattern and role perception. Owing to time constraint, Yan Chai Hospital is selected to conduct this exploratory study by case method. 39 physicians and 6 medical social workers of the hospital were interviewed.

The findings on health care conception suggest that although most physicians

interviewed held the holistic health care conception, but in actual practice, they paid little attention and priority to patients' psychosocial problems: most of them infrequently referred patients to medical social workers for treatment of emotional problems. The findings on role perception of medical social workers reveal that most physicians interviewed assigned low preference of medical social workers' counseling role of managing patients' emotional problems. They viewed providing concrete services to patients as the main function of medical social workers, therefore they referred a large number of patients to the latter to deal with their tangible or concrete problems, such as financial assistance. In contrast, the small number of medical social workers interviewed held a different perception from that of the physicians about their role. They agreed the provision of concrete services as one of their professional domain, but they viewed the provision of counseling services as their main role. In this regard, medical social workers faced different role expectations from their non-social work colleagues in the inter-disciplinary team; and they received large numbers of referrals from physicians for patients' concrete problems. To relate the health care conception with role conflict of medical social worker, it is obvious that the emphasise of the bio-medical model in actual health care provision by physicians means that the contributions of medical social workers are limited as patients' psychosocial problems are placed in low priority.

It is also found that the two professional groups infrequently interacted with each other. Hence, they had few opportunity to exchange information and share professional experiences between them. The infrequent interaction pattern might explain the misconception of medical social workers' role and function by physicians.

At last, implications for social work practice are discussed and areas for further study are suggested.

List of Tables

Tables

List of Figures

Figures

Chapter I

Introduction

Historically, social workers have been practiced in a variety of settings. In some settings, such as family service, child welfare agencies and public welfare agencies, social workers carry out sole function of the agency. In settings, such as hospital and clinic, school and court, social workers provide only one part of a broader service. From the perspective of social work, practice settings where social workers carry the sole function is called primary setting. In contrast to primary settings, a secondary setting is one where the major function is other than social work practice; the core task of the host setting is not social work itself; social workers then support the organization's primary function (Mechanic, 1983). In this research, the study focuses on social work practice in a multi-disciplinary setting – the hospital. Social workers practice in the secondary setting where the primary functions and tasks are medical treatment and medical care.

Social work practice is said to be carried out in secondary setting if the core task of the host setting is not social work itself. With reference to medical social work, it is carried out in the medical setting where the primary tasks are medical practice, such as medical treatment, nursing care and medical rehabilitation. The work of medical social workers is regarded as an ancillary service that enhances the goal achievement of the medical setting. In other words, as a secondary professional service within the hospital, medical social work must always be related to the primary function of the setting -- that is to provide adequate medical treatment and medical care to patients. To work in a

secondary setting, one of the major problems for social workers is their efforts to develop unique roles and functions which are supported by academic training and skills, at the same time that they have to adapt to the secondary setting in which social work is a different group of professions practicing in relation to the core function of the setting (Blackey, 1956). The roles and functions of medical social worker is so complicated that health care institutions are host settings in which the mission is defined and dominated by people other than social workers (Dane & Simon, 1991).

As a result of unprecedented advances in the physical sciences, the field of medicine and health care undergoes a process of intensive professionalization. The body of knowledge unique to medicine is specifically identified and in turn serves as a basis on which to define the medical profession. Medicine's domain is thereby established and its claim to be the rightful delineator of pathology is legitimated. Medicine's emergence as a profession capable of commanding wide respect has significant consequences for the structure of the contemporary health care system, the quality and availability of health care services offered, and the financial costs generated by the provision of these services. Medical social work is one of such health care services which role and function in hospitals are specifically affected by the professional ascendancy of medicine (Caputi, 1978). Phillips (1971, p.567), for example, characterises medical social work as having taken "the hospital and medical pattern for its role model". Besides, Dana, Banta and Deuschle (1974) identify the following four components of medical social work that reflect the influence of the medical model: (1) the acceptance of the physician's ultimate control of patient care, (2) the dominance of the medical model in diagnosis and treatment, (3) the concentration of intellectual and material resources on

crises-oriented intervention that is directed principally at the sick patient in the hospital bed, and (4) an orientation toward specialization. Such characteristics evolve as medical social workers adapted to the demands of the hospital setting and the requirements of medicine, the primary profession in this host setting.

Concomitant with the challenge experienced by medical social workers in hospitals is the long standing sense that their role is misunderstood, undervalued and secondary to the more dominant and prestigious members of hospitals. Research reveals that medical social work is viewed within a limited frame of reference by other medical professionals in hospitals. While physicians refer sizable numbers of patients for medical social work services, they perceive medical social work role as primarily encompassing concrete, instrumental services to patients (Wollock & Russell, 1972; Phillips, 1971). Watt (1977) also suggests that social work activities in hospitals are focused on achieving goals for patients as defined by physicians, with limited scope for action suggested by broader, health oriented definitions. These studies indicate a fundamental difference between medical social workers' view of their practice as being concerned with emotional and behavioral problems of patients and families, and physicians' more narrow perception that medical social work is primarily capable of providing assistance for transportation, locating of nursing homes, and the like. Hence, Schrager (1973, p.56) concludes that "clearly, the sanctions and obligations which medical social workers derive from their commitment to their profession; its system of values and beliefs; its ethical commitments, etc., seem to be discrepant from those provided by the power groups in the hospital, i.e. medical professionals and administrators". Under this situation, therefore, when medical social workers try to claim to their professional

domain, they have to strive to be clear about what they do and to avoid blurring their roles with other non-social work professionals in hospitals. It is because concerns about role blurring focus on gaining and retaining recognition and respect for their distinct professional contributions within the context of interdisciplinary activity (Davidson, 1990).

On the other hand, when we evaluate the development of health care system, we can find out that the conception of health care is shifted from traditional bio-medical model which emphasizes the biological sources of illness and its diagnosis and treatment (Field, 1993), in principle, to the recent holistic orientation of health care provision. Patients' physical, emotional, mental and social problems, difficulties, needs and maladjustment are all considered in the health care provision. Besides, the failure of medical model in treating the chronic illness and terminal illness, as well as stress symptom indicate that other professions' involvement in the health care provision is necessary so as to ensure good quality of service to the patient. In the hospital setting, sadness, grief, depression, family relationship problems and other psychosocial problems related to illness can be found everywhere. All these psychosocial problems are totally relevant to social work as its main objective focuses on patients' psychosocial functioning. Equally, a sound grasp of the bio-psycho-social unity in human life also results in recognising the important part played by health as both cause and effect in problems of personal functioning. This conception of health to a certain extent favours the contributions and development of medical social work in hospitals.

However, despite the growing recognition of the holistic nature of health, medicine is

still predominantly biological science oriented. In reality, the focus of a biological science oriented medicine is largely on curing and treatment with relatively little attention being devoted to the tasks concerned with psychosocial elements of illness and the maintenance of chronic conditions or to support of those who are incurable ill (Butrym, 1989). While the primary orientation of social work is a humanistic one, it is not surprising that the holistic approach of health advocated by social work is perceived as too costly (Thueson, 1978) and all too often as expendable (Raymond, 1977).

As a result, the role of medical social workers in hospital setting tends to be ambiguously defined. While the medical professionals expect medical social workers to provide only concrete services, medical social workers define their main role as including psychosocial functions. There exists great conflicting expectations regarding the appropriate role of medical social work between medical social workers and medical professionals. Medical professionals, the dominant professional group in hospital setting, have great influence on the role development and practice of medical social workers. The conception of health care held by medical professionals also affect the role played by the medical social worker in hospital setting. It is worried that unless social work could demonstrate its effectiveness to meet the goals of hospitals and the needs of patients, social work functions would be dramatically reduced (Schlesinger & Wolock, 1982).

Clearly, medical social work in hospitals is in a period of ferment, confronted with the potential both for growth and retrenchment. Therefore, the clarification and standardization of roles and functions of medical social workers which are commonly

accepted by both medical profession and medical social work are essential and necessary not only for social work profession but also for the development of health care provision to the people in need. Hence, in order to explore whether how the trends of health care provision affect medical social work role and function in hospitals, a research study is conducted in a hospital in Hong Kong. It is because research is an essential tool in helping medical social workers to clarify and develop their professional domain and contributions in the complicated health care organisation.

Purpose of the Study

To define the role of a profession is generally not an easy endeavor. However, no matter how difficult and controversial, the task of defining the role of medical social workers in hospitals is often a practical necessity, especially in contexts involving interdisciplinary activities. It is because medical social work in hospitals is only one part of the total process of providing health care for patients and families. Medical social workers are always working closely with other medical professionals. Although medical social workers interact frequently with these professionals, the role of medical social workers is often perceived inadequately by them. As a result, medical social workers enact an extremely complex and often vaguely defined role that is beset by many conflicting demands and expectations. Hence, to clarify the role and function of medical social workers in hospitals is necessary and urgent for professional identity. However, there is no empirical study of this area in Hong Kong. This research is the first empirical local attempt to clarify the role and function of medical social workers in hospital

setting.

In this study, the conception of health care held by both medical professional and medical social worker is used as a means to examine the problems inherent in the struggle for professional identification and recognition of medical social work in hospital setting. In this study, the focus is on how the conception of health care, whether bio-medical model or holistic care model, held by the medical profession and the medical social worker affect the role and function of medical social work in health care provision. Its aim is to explore which role and function are distinct and specialized to medical social workers and search for the domain of medical social work practice in hospital setting. It is hoped that the findings of this study will increase understanding of interdisciplinary role expectations of medical social workers and help to facilitate resolution of any confusion and differences about role and function of medical social workers in hospital setting.

Chapter II

Medical Social Work in Hospital Setting

II.1 Hospital

The word 'hospital' is derived from the Latin word 'hospitium', which means "a place where guests are received" (William, 1990, p.2). In modern usage, according to the Oxford Reference Dictionary (1986, p.398), hospital is defined as "an institution providing medical and surgical treatment, and nursing care for ill or injured people". In general, hospital is a diagnostic and treatment facility providing medical care and continuous nursing care for alleviation or cure of disease, illness, or injury to patients. It provides acute, chronic or specialized care to patients. As suggested by Merton (1949, p.151), hospital above all others constitutes "... a formal, rationally organized social structure involving clearly defined patterns of activity in which ideally every series of actions is functionally related to the purposes of the organization.". The medical function, which represents the primary purpose of the hospital's existence, is the central focus of all activity in the hospital (Blackey, 1956).

In contemporary society, hospital plays a key role in health care provision. It has gradually over many years become the place primarily concerned with the diagnosis and treatment of serious illnesses. It has been termed "the fastest growing component of health care since the turn of the century and it has increasingly replaced the home and the doctor's office or small clinic as the focus of physician's treatment and nursing

care" (Anderson & Anderson, 1979, p.373). Besides, due to the advances in medical technology, diagnostic and therapeutic services, because of their sophistication, complexity, and costliness, health care provision have moved from traditional office procedures by the private physician or small clinic to hospital. The growth of and expansion in hospital reflect the increased number and kinds of specialized services offered by hospitals. The impact is on the growth in facilities, specialists, technicians and other professions with their own goals and priorities (Miller & Rehr, 1983). In sum, hospital brings together powerful resources, both in professional personnel with different skills and in complex technical equipments so as to provide health care services to the society.

In addition, the term 'hospital' conjures up many images in contemporary society. Some equate it with the large, awesome, new medical centre complex, the place where medical miracles occur (Fuch, 1974), and the "physician's workshop in which physicians practice their skills in line with the available scientific knowledge and technology" (Boaz, 1977, p.551). Others view hospital with fear and as a place to die. The term "hospital' encompasses different meanings to different people.

In short, it is clearly a multifaceted institution that employs a wide variety of personnel and advance technology and serves diverse costly health care needs of the society.

II.2 Health Care Conception

II.2.i The bio-medical model

All along, the health care services are provided under the influence of the bio-medical model which is based on the knowledge evolved in the medical and physical sciences and technology. This model holds the view that the human body is analogous to a complex machine in which malfunctioning parts can be repaired or replaced and health thus restored (Taylor & Ford, 1989). In this model, people's health is predominantly a reflection of science's understanding of the disease process and the development of effective treatments. It emphasizes the biological sources of illness, diagnosis and treatment (Caputi, 1978 & Taylor and Field, 1993). Above all, this model views health as the absence of biological abnormality; the human body is linked to a machine to be restored to health through treatments of one sort or another which arrest, or reverse, the disease process; the health of a society is seen as largely dependent on the state of medical knowledge and the availability of medical resources (Taylor & Field, 1993).

The aim of the bio-medical model is repairing defectively functioning parts of the organism. Accordingly, this model is what Nuyens and Vansteenkiste (1978) calls 'passive health care'. It "isolates the physiological aspect from the totality of man" (Nuyens & Vansteenkiste, 1978, p. 25). In this way, the patient is degraded from a human being to a thing, namely the object of the treatment. It is forgotten that patients are not only subject to a number of physiological processes but also to psychic and social factors, and that they have their own reaction to illness. Although it is known that many disorders are psycho- or sociosomatic, this fact is hardly taken into account in the

treatment. In most cases, it is merely the symptoms that are combated (Nuyens & Vansteenkiste, 1978). It provides little scope to human aspects of functioning such as the effects of subjective experience resulting from social and environmental factors, or of inner states such as anxiety, resentment, insecurity and motivation. Medical attitudes towards pain provide a good example of the effect of an exclusively physiological orientation. According to this model, the perception of pain as a purely neurological phenomenon has led many medical professionals to deny the reality of pain because no physiological cause can be found. Ignoring the psychosocial causes and their effects on the pain bearer, it means that the only recognized treatment for pain is at physical or chemical nature, such as surgical treatment or drugs (Taylor & Ford, 1989).

Nuyens and Vansteenkiste (1978) stress that in this passive health care model, patients are primarily persons who are seeking and demanding advice, and are only objects of treatment. Nuyens and Vansteenkiste view the hospital as a workshop for repairing organs. It is not a home of and for the sick. In their study about the health care provision in general hospitals, the following conclusions are reached -- (1) patients are hemmed in by rules and orders; (2) thinking is done by the nurses who take over the patient's capacity of self-determination; and (3) doctor decides about everything and he or she is the one who knows best (Nuyens and Vansteenkiste,1978). Therefore, Nuyens and Vansteenkiste (1978) call for reform on health care. They view the passive health care model, i.e. the bio-medical model, as out-of-date and dehuman. Besides, the bio-medical model holds partly responsible for what is seen to be a central concern with cure rather than prevention or care. Within the hospital provision, the acute areas of medicine and surgery attract proportionally more funds than the long term services

provided for chronic patients and disabled people. In the field of cancer, the vast majority of the huge research funds goes to the search for cures, while many psychosocial causes go unchecked (Doyal & Epstein, 1983).

However, the changing patterns of illness in recent years indicate the limitation of bio-medical model in health care provision. Of course, medical intervention remains a viable mechanism and is of critical importance when illness occurs. In dealing with specific diseases and with physical trauma the armamentarium of medicine is undeniably effective. But, since the development of immunologic agents, most current illness problems are chronic (Brody, 1976). According to Shanas (1971), four out of five people in the United State aged 65 or above were reported to have a chronic illness. Brody (1975) also indicates that sixteen percent of the elderly non-institutionalized population in the United State were entirely unable to perform in major activities and an additional twenty-three percent were limited in action to a lesser degree. Rehr (1984) also indicates that the major recent health concerns are chronic illnesses and their consequences. In the United State, almost two-third of the population have one or more chronic. The major challenges for such chronic patients are often not strictly medical in nature but instead might better come under the problems in daily living. Apparently, their problems are more effectively confronted with coping strategies and social supports than with merely medical attention.

An examination of the area of chronic illness and disabilities reveals that a growing majority of patients with medical problems have predominant needs for social, psychological, and environmental interventions. Although the needs of these patients

for services by medical professionals continue, these needs must also be met by other health care professionals, such as medical social workers. As a result, the definition of health care services should include a wide range of both medical and social services designed to help the patients and their families achieve maximum level of health and well-being in the face of chronic physical or mental impairments.

In addition, the rapid development of hospice service is another evidence to prove the failure or inadequancy of traditional medicine to cope with certain illnesses. Furthermore, current approaches to the stress-disease relationship view diseases as an expression of "breakdown" in the wake of a prolonged failure in restoring an individual's "emotional homeostasis". This disturbance is a consequence of unsuccessful coping with "demands" which constantly confront an individual and hence become "stressors" and an individual's inability to judge the efficacy of medical activities. Hospitalization imposes further stressors: the alien environment, potentially threatening medical activities, and the isolation from primary social support (Ben-Sira, 1983). Stressors may emerge also from those changes in the sick person's normal primary and secondary environments as a consequence of his or her illness (Carlton, 1984). All these emotional problems faced by patients cannot be overcome by medical profession and medicine alone (Ben-Sira, 1987). Despite diseases and hospitalization impose an array of stressors, the most common of which are patients' subjective perceptions of the severity and prognosis of their diseases contribute effectively to their recovery. The treatment of presenting physical symptoms instead of the stressful situation may bring only temporary relief.

As the effectiveness of medicine and the appropriateness of the bio-medical model of health care come under increasing attack, so the medical dominance of health care services and health related issues are called into question. Zola (1975, p.38) argues that "medicine is becoming a major institution of social control .... the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made .... in the name .... of health."

In sum, there are different criticisms over the bio-medical model of health care provision. An emphasis on medicine deflects attention from non-medical sources of health. Seemingly, the only emphasis of medicine devalues the contributions of health care provision by other health care professionals, such as nurses and medical social workers. They are seen as ancillary, essentially secondary. The thrust of publicity about medicine is a case in point. It seems to suggest that given time and money 'physicians' or 'scientists' will find the cures to all diseases. Accordingly, the known preventable causes of much disease are not tackled (Bywaters, 1986).

Moreover, physician's power during the treatment process also has a lot of criticisms (Roberts,1985). Patients are expected to behave passively - to do what the physician orders - and are frequently assumed to be ignorant and incompetent to make judgments about what is in their best interests or even to know basic facts about their lives (Oakley, 1980). The control of information about diagnosis and treatment is a crucial mechanism in this exercise of power. Physicians not only assert this control in relation to patients but also over non-medically trained colleagues who may not be permitted to divulge

requested information. There is little or no expectation that people with similar health problems might have valuable knowledge to contribute to each other about the treatment or management of their common condition (Bywaters, 1986).

However, nowadays, " treating the patient as a person" (Seedhouse & Cribb, 1989, p11) is a simple, but also powerful, slogan with which almost everyone concerned with health care wishes to be identified.

II.2.ii. The Holistic care model

Current definition of health places an emphasis on the maximizing of social, mental, and physical well-being, reinforcing the concept of an outcome measurement of health factored to individual levels of functioning (Brody, 1976). The World Health Organization (1946, p.3) defines health as "... the state of complete physical, mental and social well-being and not merely the absence of infirmity." This current conception on health shifts the health care delivery from the bio-medical model to the 'holistic care' model which covers physical, emotional, mental and social - needs, problems, difficulties, disorders, disability and maladjustment of the patient (Hornby, 1993). According to Snoke and Weinerman (1965, p.627), the holistic care is " the organized provision of health services...., including a full spectrum of services from prevention to rehabilitation, continuity of care for the individual, emphasis upon the social and personal aspects of disease and its management, use of the health team concept including personal physician responsibility, and coordination of the diverse elements of modern scientific medical practice". This holistic care model emphasizes the link

between mind and body and the social context of health. Medical treatment is only one element, although a very important one, in the comprehensive range of health care services provided to the patient. According to this model, many factors which influence health are outside the direct control of individuals. For example, poor health has been associated with social factors such as poverty, poor housing, unemployment and manual work. Research has also consistently found links between emotionally stressful life events, the quality of people's social relationships and health (Taylor & Field, 1993).

Bywaters (1986) suggests six principles for holistic model of health care. First, health should be viewed as a basic human right and not as a commodity to be available on the basis of ability to pay. As a right, it must be equally available to all irrespective of class, sex, race, age, or region.

Second, responsibility for health should lie with people as consumers of health services rather than with experts. The idea that each of us should exercise final control over our own health has to find expression both in individual situations and in democratic processes. The consumers have to be empowered both in their encounters with health care professionals, and in controlling those elements in their environment which contribute to or undermine their health.

Third, besides medical factors the main sources of health also lie in social and environmental factors, such as income and wealth, housing, employment, education and leisure activities. Graham (1984) proposes a useful definition of poverty as living on an

income insufficient to purchase the material resources necessary for health. This definition suggests that any work to combat poverty is in reality health work. Therefore, the significance of the promotion of good health and the prevention of ill-health through the creation of a healthy environment is obvious.

Fourth, health care must assert the value of care as well as cure. This assertion of the significance of services which support people in caring for each other's ill health has implications not only for how money is allocated, but also for the attitudes, training, job descriptions and rewards of health care workers of all kinds within the hospital. Besides, asserting the value of care requires organizing for a re-thinking of current measures of efficiency within hospitals. Efficiency currently seems to be seen largely in terms of moving bodies through beds as rapidly as possible with often limited respect for or understanding of patients' living environment, or the significance of their health problem for them as individuals.

Fifth, patients have capacity of making decision about treatment and discharge. It is demonstrated that loss of self-control during medical care can cause ill-health (Oakley, 1980). Patients should have right to information about their body, about alternative possible treatments and their known consequences.

Finally, the access to non-medical services should not be only available via medical referral. For example, access to a medical social worker should be a right available to patients, unrestricted by an intermediary gate-keeper. Similarly patients should have access to lay sources of help, such as self-help groups.

In sum, greater numbers of people now acknowledge that whether individuals are temporarily injured, acutely or chronically ill, very old, physically or mentally disabled, their emotional state and coping skills are crucial factors having a direct impact on their health and ability to function. Advocacy for environmental changes, the reduction of psychological distress, and the development of the decision-making and problem-solving skills necessary to exercise some control over the environment and to pursue a more healthy lifestyle are the areas being discussed in today's health care provision (Black, 1984).

II. 3 Medical Professional

Although physician is only one of many health care professionals involving patient care, it is the one that most readily comes to mind when one thinks of medicine or health care. Traditionally physicians have been perceived by the general public as "public servants of rare intelligence, compassion, and skill" (Stanfield, 1990, p.86). Other uncritical faith in physicians is reinforced by the fact that they are an important elite class in the society. As Wertz (1973, p.270) puts it ".... since the turn of the century the medical profession has enjoyed increasing affluence, the highest social status of any occupational group, and unchallenged control over not merely the social and economic condition of its work, but .... its definition as well".

Physicians are involved with the treatment and prevention of human disease. They have the primary role in diagnosing human disease and in formulating a treatment plan for the

patient. Physicians also research the control and cure of disease. They are classified by type of practice or specific area of specialization. They must be familiar with all types of instruments, medical test, and medical equipment. They may perform surgery. They prescribe and give medication. They perform medical examinations, diagnose illnesses, and treat people who are suffering from injury or disease. They also advise patients on maintaining good health (Standfield, 1990).

Physicians dominate the health care provided to patients. They are usually the first and certainly the most important ones in deciding what the problem may be, how it should be treated, and what other health care services needed to become involved. Therefore, in the medical setting, they are the most important professionals because they mostly control patients' need of other health care services and control the services provided by other health care professionals to patients. Their authority in the hospital rests primarily on their monopoly over medical knowledge and skill. Hospitals would not survive without the physician's input, although other health care professionals have skills and expertise regarding the personal-and social-care aspects of medical treatment that is equally vital to the health care services provision in hospitals.

II.4 Medical Social Worker

According to Barker (1987, p.96), medical social work is defined as "the social work practice that occurs in hospitals and other health care setting to facilitate good health, prevent illness, and aid physically ill patients and their families to resolve the social and psychological problems related to the illness." In other words, social work in health

care field involves programs and services that meet the special needs of the ill, disabled, or handicapped. Medical social workers deal with the total emotional, social ,and physical needs of patient in whom the effects of illness go far beyond bodily discomfort.

Stenfield (1990) describes medical social workers as professionals who place emphasis on the effects of illness or disability to patients and their families. They are familiar with medical terms and in many cases know a great deal about specific diseases. They are skillful in helping patients and their families handle their personal problems that result from acute or chronic illness or disability. These problems may be social, emotional, financial or all three. In short, medical social workers too certain know about illness and its impact on patients and their families, but their major concern is with the personal and social strengths patients can marshal to recover and to make the maximum adjustment of which they are capable after their illness.

Moreover, Friedlander and Apte (1980) explain the existence of medical social worker in hospitals because physicians are not able to be acquainted with the family background, living conditions, financial condition, environment, habits, and personality of patients. Medical social workers make personal contact with patient and their families, to investigate their social and personal conditions, then to supply the factual background to physicians to help them in diagnosis and formulate treatment plan. Cabot, the first physician involves medical social worker in hospital, is an eloquent spokesman for teamwork between physician and medical social workers. He perceives the former as essentially "absent-minded" - unaware of the past and the future of the patients (Cabot, 1915, p.20). They are often blind to the 'background' and the 'foregrounds' of

their hospital patients. By backgrounds he means the social, psychological, economic, cultural, and environmental factors that contribute to the etiology of disease and influence the course of recovery. Foregrounds are the observable needs or feelings of patients that might be overlooked by physicians who bent on diagnosing and curing disease (Cabot, 1915). Cabot anticipated the recent recognition that existential fears, anxieties, discomfort, and alimentation may negatively affect compliance and health, and will certainly play havoc with the immediate quality of life. In fact, the very presence of medical social worker in hospitals attests to the truism that 'patients are people'. It reinforces the widely shared understanding that illness and disability may have a psychosocial etiology and certainly may carry profound psychosocial consequences for patients and their families.

Furthermore, Holosko and Taylor (1992) suggest several characteristics about medical social workers in hospital setting. they carry themselves in a professional demeanour; they are compassionate to patients in need; they are not afraid of accountability, as they face with it daily; they must be co-operative and team oriented; and last of all, they are able to negotiate systems effectively and have good interpersonal skills.

In sum, medical social work is one of specialties in social work practice. Medical social workers are found in most aspects of hospital services, whether acute, chronic or rehabilitative. Medical social workers practice in collaboration with physicians, nurses, and other health care professionals and take part in assessment, diagnostic, and treatment planning processes for patients. Medical social workers apply social work knowledge, skills, and values to health care. In other words, the purpose of medical

social work is to help the sick people; the method is to apply the general principle of social work in the medical setting. Medical social work is an extension of the practice of medicine on the one hand and of social work practice on the other (Tibbitt & Conner, 1989). Nowadays, medical social work is no stranger to the hospital setting. The majority of hospitals have the department of medical social work and a large number of medical social workers are employed in this secondary setting.

II.5 Medical Social Worker in the Secondary Setting - Hospital

Now, we turn to look at the main characteristics of medical social work in the secondary setting of hospital. In the hospital setting, the diagnosis treatment and prevention of illness depend on a large number and a wide range of different contributions and skills of the professionals in the health care services, as well as on complex machinery and laboratory equipment. The organizational framework which exists to support and co-ordinate the health care provision is usually large and often inflexible. Medical social workers are amongst one of the professional groups in the hospital setting, their function is frequently described as 'secondary' to the primary purpose of the hospital. The concept of 'secondary function' of medical social work needs to be clarified because it is open to different intrepretations, and leads to confused thinking. As hospitals are primarily concerned with the promotion of health and treatment of illness, medical social workers enact an extremely complex and often vaguely defined role that is beset by many conflicting demands and expectations. It is because as a secondary professional service within the hospital, medical social work must always be related to the primary function of the setting which is to provide

adequate medical treatment or medical care to patients. In fact, medical social work is still not considered as an essential or even a necessary service in fulfilling the function of the host setting because medical social work's area of professional competence is difficult to recognize, since it does not directly related with patients' apparent physical illness (Olsen & Olsen, 1967) to a greater extent, it is the result of the prevailing tendency among many physicians to view patients as medical cases rather than as whole persons.

In addition, medical social worker in hospitals always practice as member of a professional team. As team members normally come from different professions and with different specialties, they inevitably hold diverse points of view, perceptions and expectations concerning team functioning and each others' roles and responsibilities. This variance in role definition and expectation dynamically influences the way medical social workers in the team perceives their own roles. As a result, roles and responsibilies of medical social works in hospital are perceived differently by the other health care professionals. It is particularly important to notice that physicians are the most established professional group in the hospital team. They have a powerful influence over medical social work practice. They define medical social work practice through referral of patients, allocation of funds and multidisciplinary exchanges. Therefore, efficient and effective functioning of medical social workers depends in the hospital setting in large part on how medical professionals and health care professionals, physicians and nurses in particular, perceive their practice (Carrigan, 1978). Patti & Ezell (1988) study the performance priorities of medical social workers in hospitals and conclude that medical social workers need, to a great extent, the cooperation

(resources, support) of the medical professionals i.e. the physicians. In order to achieve performance targets or goals, they must be attentive to preferences and expectations of the medical professionals. Hence, medical social workers have a strong tradition that has acknowledged the superior status of medical professionals as a condition of their survival in hospitals (Kerson, 1981). In fact, medical social workers are continually confronted by other health care professionals and institutions about their roles, function, activities, worthiness and efficacy. This constantly raises the following questions : What is medical social work? How does it fit into the host setting? and How other professions affect medical social work practice in hospital? However, such questions are not generally the concern of social workers practicing in the majority of social welfare institutions and agencies, such as child and family services agencies. Therefore, medical social workers must tend to be very clear about who they are and what they are doing in the secondary setting. In short, "they cannot afford not to be" (Holosdo & Taylor, 1992, p.24).

Besides, medical social work practice always take account of the dominant authority of the medical professionals. In the hospital setting, where life and death are crucial concerns, the medical professionals thus assume the dominant position and enjoy higher authority than other health care professionals (Olsen & Olsen, 1967). The formal authority granted physicians by society and hospital, plus the high informal prestige enjoyed by the medical profession, means that physicians' role will normally overshadow other health care professionals in hospitals. Therefore, medical social workers must function within an authority system that places their profession in an ancillary and subordinate position. Medical social workers continually demonstrate the

value of their services to physicians and hospitals. This situation, needless to say, places them in a perpetually defensive position (Olsen & Olsen, 1967). Furthermore, medical social workers' position in this situation is further complicated because, in comparison with medical professionals, they are late-comers to the field of health care, then do not share the heritage of the tradition of that field. As suggested by Blackey (1956, p.43), "the more recent a profession's development in the institution, the more difficult is its struggle for identification when it is required to function close collaboration with a higher prestige profession which has a longer and more firmly established status and authority".

Moreover, the bio-medical model of health care held by the majority of medical professions has a decidedly mixed blessing effect on the development of medical social work in hospitals. On the one hand, it has inadvertently legitimized medical social work practice in that, historically, medical social workers serve patients' needs in areas that essentially physicians told them to. In essence, medical social workers fill gaps in the health care system that are not the domain, concern or interest of other health care professionals, for example, community liaising and arrangement of concrete resources for patients and their families. On the other hand, the bio-medical model has cast a long shadow on the profession of medical social work. This model generally hinders the power base of medical social work, affects its potential for role development, causes identity anxiety about its roles and compromises its professional autonomy (Holoske & Taylor, 1992). The status of medical social workers in hospitals is ancillary and subordinate. Medical social work assumes a role in hospital which allows it to function, but not to gather very much authority or autonomy. It has a place within the secondary

setting, but it has relatively little power over its own work and role. The autonomy of medical social work is thus greatly restrained.

As Webber (1947, p.148) states "a corporate group may be either autonomous or heteronomous .... Autonomy means that the order governing the group has been established by its own members on their own authority .... In the case of heteronomy, it has been imposed by outside agency". Kerson (1981) points out that within the confines of the health bureaucracy, medical social work begins and ends as heteronomous. It is instituted and to a great extent institutionalized by the medical profession.

On the whole, medical social workers practicing in hospital setting can be characterized as in a consistent struggle for role clarification. Having a place to stand within the field, the problems of role clarification, interprofessional collaboration and autonomy are all matters that are traditionally faced by them. In the present cost-conscious environment, medical social workers must be able to demonstrate that they provide cost-effective services that meet patients needs. To demonstrate the value of their services, medical social workers must clearly establish their distinctive role within the secondary setting and establish their function within the interprofessional health care team. As suggested by Rossen (1987), the key to medical social work' future in hospitals is the profession's ability to articulate its role within the context of change.

However, two visible and related trends make medical social work's claim to health

care provision more valid than ever before. First, there appears to be an increased acceptance by the general public of the concept that individuals should have a considerable degree of control over the state of their health, and that there is much that people can do to prevent illness and promote wellness (Black, 1984). Illich (1975) emphasizes that effective health care depends on self-care. He argues that reducing professional intervention in individual lives, whether from the medical of the helping professions, is vital because reliance on these services discourages self-care. But he believes that as an aid to self-care, interim intervention with the objective of reducing or eliminating long-term dependence is essential. This kind of intervention motivates the individual to accept more self-determination. He further suggests that part of social work orientation is to facilitate individuals' functions of self-care. He concludes that although in many situations the sense of dependency is caused by physical, social and mental impairment, it is within individuals' capacity to improve their health – that is , their level of functioning – and that it is desirable for them to accept the responsibility for doing so. However, in his opinion, the present health care system, to a greater degree, frustrates this objective.

Second, and perhaps even more important, there is a growing recognition among medical professionals and the public alike that psychological and environmental stress has a negative effect on health (Black, 1984). Current definitions of health place emphasis on psychosocial and environmental factors as well as individual functioning, it is a significant departure from their traditional emphasis on biological and medical attributes.

Finally, in an official publication of the American Hospital Association, Kockhorn (1982,p.1) delineates the role of the hospital and social work's responsibilities in the hospital. He stresses that "today the hospital has responsibilities that not only include preventive, rehabilitative, and follow-up services, but also extend beyond these services to making comprehensive care for persons in the community it serves". When meeting these responsibilities the hospital is obliged to draw on social work expertise in counseling patients and families about the internal and external stresses that may interfere with the effectiveness of medical treatment, and establishing communication with community groups and arranging community resources for patients and families.

In connection with the change of health care conception, the rise of the holistic care model, the changing patterns of disease, the failure of medicine to cure chronic illness, terminal illness and stress, and the essence of multidisciplinary teamwork in the provision of health care services to patients, all these are seemingly in favours of the development of social work in hospital. Hence, the essential functions of medical social work to provide treatment of emotional stressors of patients and to enhance the social functioning of patients are increasingly recognised than before in health care provision. Hence, despite ongoing fiscal constraints and the questioning of medical social work's place in the health care system, medical social workers still have opportunity to demonstrate the importance of their contributions in the secondary setting.

Chapter III

The Role of Medical Social Worker in Hospital

III.1 The Concept of Role

According to "The Social Work Dictionary" (Barker, 1987, p.141), role is defined as "a culturally determined pattern of behavior that is prescribed for an individual who occupies a specific status; also, a social norm that is attached to a given social position that dictates reciprocal action". Role is related to social status and social position.

The eminent anthropologist Ralph Linton (1963, pp.113-114) proposes a classic definition to role. The essential messages in Linton's formulation are:

> "A status, as distinct from the individual who may occupy it, is simply a collection of rights and duties. A role represents the dynamic aspect of a status. The individual is socially assigned to a status and occupies it with relation to other statuses. When he puts the rights and duties which constitute the status into effect, he is performing a role. Role and status are quite inseparable ... . Just as in the case of status, the term role is used with a double significance. Every individual has series of roles deriving from the various patterns in which he participates and at the same time, a role, general, which represents the sum total of these roles and determines what he does for his society and what he can expect from it. "

According to Linton, status and roles are inseparable.

Sarbin (1954) summaries Linton's ideas by stating that societies are structured into positions or statuses or offices. These positions are collections of rights and duties designated by a single term, e.g. teacher. The actions of persons are organized around these positions. Roles are defined in terms of the actions performed by the person to validate his or her occupancy of the position. Thus, all societies are organized around positions and the persons who occupy them perform specialized actions or roles. Furthermore, these roles are linked with the position and not with the person who is temporarily occupying the position (Saran, 1954). The concept of role position and status are related.

Znaniecki (1939) states that "nearly every individual who participates in the activities which bring a social group into existence becomes also a part of the product itself as a group member ... Being a group member means a specific kind of person who performs a specific kind of role. Every concrete individual performs in the course of his life a number of roles ... Every role involves the following components: (i) a social circle of which the performing person is the centre, i.e. a circle for patients; (ii) the persons' social self', i.e. their bodies and mind as represented and conceived by their social circle and themselves; (iii) the persons' status, i.e. the total 'rights' which their circle and themselves recognize in their roles; (iv) the persons' function, i.e. their 'total' duties which the social circle expects of them and which they tend to fulfill" (in Stein & Collard, 1985, p.184).

Merton (1957), in his studies of the bureaucratic structure and the personality involved, suggests that a particular social status involves, not only a single associate role, but an array of associated roles. This is a basic characteristic of social structure. In any social organization, it is integrated with a series of offices, of hierarchized statuses, in which inhere a number of obligations and privileges closely defined by the limited and specific rules. This fact of structure can be described by a distinctive term "role set". In Merton's terminology, role set is complemented by the way every individual occupies a variety of statuses, which, when added together, constitute one's status set (in Bide & Thomans, 1966, p.282).

Furthermore, Biddle & Thomas (1966) define roles in terms of actions performed by the persons who occupy a specific position. Individuals in society occupy positions, and their role performance in these positions is determined by five main factors: (i) social norms, demands and rules; (ii) the role performance of others in respective positions; (iii) those who observe and react to the performance ; (iv) the individuals' particular capacities and personality; and (v) the individuals' own understanding and conceptions of what their behavior should be (Biddle & Thomas, 1966, p.4).

In summary, the concept of role is closely related to status and position, and, task or behavior and function. A role can be defined as a prescribed pattern of behavior that is required by the occupation of a status or position in the social structure. Role refers to specialized activities to an individual or a member of a group. If a person has the qualities needed for performing the role for which he or she is needed, he or she has a definite social status. He or she, in turn, has functions to fulfill in connection with that

status (Stein & Cloward, p.1958). In short, role is a social task of functions carried out by an individual (by Murphy, 1947, in Stein & Cloward, 1958, p.184).

III.2 The Role and Function of Medical Social Worker

The literature review illustrates a lack of consistency and universally accepted definition on the role of medical social worker in hospital setting that clearly establishes what medical social worker does as contrasted with other medical and health care professions (Briggs, 1975). Some authors identify the role of medical social workers as exclusively involving the provision of concrete resources. For example, early in his expressed rationale for bringing social workers into hospitals, Cabot, (1928) who is the first medical professional to involve social worker in health care delivery process, emphasizes the 'linkage role' between medical and environmental resources. Morris (1974, p.524) reiterates much of the Cabot theme and stresses the role of social workers is to "handle the enlarged set of relationships between intricate networks of health and social services". In addition, Heyman (1961) categorizes the tasks of medical social workers as arranging practical welfare assistance to patients and these tasks can be undertaken by lesser trained staff than social workers. Besides, Carter and Jinks (1972) identify the activity of medical social workers with body moving and assist physicians merely to clear the bed.

Some other authors describe the role of medical social workers as exclusively involving with clinical assessment, intervention and counseling. For instance, Bartlett (1961,p.51) claims that "medical social worker is the only one in the health care with a consistent

and central focus on social functioning". Hirsch and Lurie (1969, p.75) believe that " social work brings to the health field a methodology to reduce the incidence of social crises that aggravate health problems". Sandman (1976) argues that medical social workers involve in formulating a 'diagnosis' which reflects the psychodynamic and socioeconomic factors affect the patient's reaction to illness and hospitalization. Butrym and Horder (1983, p.8) identify the role of medical social worker as " to help patients who experience a variety of problems in their social functioning; to prevent unnecessary suffering by means of early and appropriate intervention to stop problems escalating; and to promote social well-being". Blazyk & Canavan (1985 & 1986) stress that medical social workers should help the patient and family understand the impact of illness and hospitalization and negotiate the role changes in the family system precipitated by the illness and hospitalization and the reintegration of the sick member back into the family after discharge. Moreover, Barker (1987) and Stenfield (1990) view the role of medical social worker as to deal with the total emotion, social and physical needs of patients in whom the effects of illness go far beyond bodily discomfort. These authors suggest that medical social worker's role is to resolve the social and psychological problems of patients related to the illness. They are unlike those authors mentioned above who regard medical social worker's role primarily is to provide concrete services to patients.

Finally, some authors argue for a moderate viewpoint that the role of medical social workers should involve both concrete resources provision and clinical assessment, intervention and counseling. For example, Bracht (1978, p.30) suggests that " in general, social workers engage in professional practice with a major focus on social

functioning, the development of coordinated community resources, and providing linkages to broader social welfare services". Kane (1980) argues that the role of medical social workers is not only to place the patient in nursing home but also to engage the patient in a process of problem solving focused on analyzing the practical and emotional consequences of a decision. Coulton (1981) recommends medical social workers to help the patient and family by reducing feelings of hopelessness, increasing social support and providing information. In addition, according to Schlesinger (1985, p.201), medical social workers should help patients to understand their problems "stemming from illness, disability, resources deficit or both".

Furthermore, Bracht (1978) suggests five basic premises of social work practice in health care setting. These premises include: (1) social, cultural, and economic condition have a significant and measurable effect on both health status and illness prevention and recovery; (2) illness-related behaviors, whether perceived or actual, frequently disrupt personal equilibrium and coping abilities; (3) medical treatment alone is often incomplete, and occasionally impossible to render, without accompanying social support and counseling services; (4) problems in access to and appropriate utilization of health services are sufficiently endemic to our health care delivery system as to require concerted community action; and (5) multiprofessional health team collaboration is an effective approach to solving complex socio-medical problems of patients. Bracht further suggests four major functions of medical social worker in hospital setting. These functions are: (1) to enhance the problem-solving capacities of individuals when they participate in health care programs that assist patients with the social aspects of illness, disability, and recovery; (2) to serve as linkages for entry into the health care system

and also to coordinate programs of health and social care; (3) to promote effective and humane operation of health care systems; and (4) to contribute to the analysis and improvement of social policy and program development.

Besides, Carlton (1984, pp.147-149), in defining the components of the clinical role of medical social workers in hospitals, classifies medical social work practice into 19 functions. These functions are:

(i) Case finding or social risk screening
(ii) Preadmission planning
(iii) Psychosocial evaluation
(iv) Psychosocial intervention
(v) Financial assistance
(vi) Case consultation to hospital staff
(vii) Facilitation of use of hospital services
(viii) Health education
(xi) Discharge planning
(x) Information and referral
(xi) Facilitation of community agency referrals
(xii) Case consultation to community agencies
(xiii) Utilization review
(xiv) Research
(xv) Program consultation to hospital staff
(xvi) Hospital planning
(xvii) Program consultation to community agencies
(xviii) Community services
(xix) Community health planning

On the other hand, Holosko & Taylor (1992) state that medical social workers are playing multiple roles in the hospital setting. They reveal at least 34 roles which may be played by medical social workers (Holosko & Taylor, 1992, p.14):

Administrator
Teacher-educator
Researcher
Advocate
Membership builder
Patient screener
Community developer
Patient representative
Clinician
Crisis interventionist
Case finder
Discharge planner
Psycho therapist
Family Therapist
Marriage Counselor
Resource developer

Liaison worker	Service planner
Organizer	Enabler
Innovator	Facilitator
Pre-admission worker	Mediator
Supervisor	Assistant to physician
Team member	Sustainer
Collaborator	Practitioner-scientist
Consultant	Group worker
Negotiator	Assessor

Holosko & Taylor (1992) express that these multiple roles may be seen as a strength or a liability. Such a variety of roles illustrates the breadth of medical social work practice in the hospital setting, yet it also points to the difficulty of becoming a skilled practitioner because there are no clearly defined areas of function specific to medical social work practice in the hospital setting.

Holosko & Tyaylor do not provide a detailed description of every role but they point out that medical social work roles are sometimes defined in terms of complexes of responsibilities, tasks, skills, functions and knowledge (e.g. consultant, clinician, administrator); sometimes in terms of complexes of activity related to a single general task (e.g. discharge planner); sometimes as the knowledge, skills and tasks related to a specific population (e.g. psycho-therapy social worker) and sometimes in terms of a single activity (e.g. negotiator, enabler). In summary , according to Holosko & Taylor, medical social workers' roles can be defined in terms of functions, tasks and activities they perform in the hospital setting.

A BASW Working Party Report of the United States classifies the roles of social workers into 20 categories (BASW, 1977, pp.38-41):

(i) Diagnostician
(ii) Planner

(iii) Adviser
(iv) Clarifier
(v) Enabler
(vi) Counselor
(vii) Social Educator
(viii) Attitude/Behavior Changer
(xi) Consultant
(x) Mobilizer of Resources
(xi) Agent of Social Change
(xii) Public Educator
(xiii) Researcher
(xiv) Advocate
(xv) Mediator
(xvi) Care Giver
(xvii) Protector
(xviii) Agent of Social Regulation
(xix) Director
(xx) Manager

These roles are described on the basis of their functions and tasks.

According to the Report, none of the above roles is exclusive to social work. Many other people, like teachers, psychologist, and politicians, etc., do thing which are very similar to those which social workers may and can do. It is not, therefore, the simple performance of the roles which makes them 'social work roles', but the context in which they are performed. "If the purpose of the activity, the knowledge and skills in performing it, the values behind it, and the sanctions for it, constitute social work, then it can properly be called a social work role". (BASW , 1977, p.41).

Moreover, Carrigan (1978), in his study of a total of 180 persons from the fields of medicine, psychology, nursing and medical social work for their perceptions of both actual and expected interdisciplinary medical social work practice, sees the role of

medical social workers as consisted of 100 tasks. He catagorises those tasks into 6 board areas: (i) technical medication (includes 11 tasks); (ii) professional liaison (includes 9 tasks); (iii) counseling (includes 35 tasks); (iv) community mediation (includes 30 tasks); (v) indirect professional services (includes 7 tasks); (vi) professional orientation (includes 8 tasks). It seems that, by the size of the tasks, Cardigan has exhausted nearly all social work tasks performed by medical social workers in the hospital setting.

On the whole, the preceding literature review indicates that there is a lack of a standardised set of the roles, functions and tasks to be performed by medical social workers in hospitals. Many literature, including two local documents from the Hong Kong Social Workers Association and Social Welfare Department of the Hong Kong Government, stress that the role and functions of medical social workers should involve both concrete services and clinical services, such as counseling. But most important of all, there are no roles and functions which are exclusive to medical social workers. Many other health care professionals, like nurses, psychologists and psychiatrists, involve themselves in tasks and activities which are very similar to medical social workers.

III.3. Role Conflict

In certain situations individual may find themselves exposed to conflicting expectations; some people expect them to behave in one way, others in another, and these expectations are incompatible.

An examination of the literature concerned with role conflict reveals that this term is given different meanings by different authors. Some have used it to denote incompatible expectation in situations to which individuals are exposed, whether they are aware of the conflict or not. Other authors use "role conflict" to mean situations in which individuals perceive incompatible expectations. Some formulations of role conflict specify that individuals must be exposed to conflicting expectations that derived from the fact that they occupy two or more positions simultaneously. Other formulations include in role conflict of those contradictory expectations that are derived from individuals' occupancy of a single position. Some writers limit role conflict to situations in which individuals are exposed to conflicting legitimate expectations or obligations, whereas others do not make this restriction (Biddle & Thomas, 1966).

In addition, according to Zander, role relations between different professions within an organization will be influenced by the perceived relative power to influence members of other professions, the acceptance by individuals of their power position, the frequency of professional contacts, relative knowledge and skills between professions and the satisfaction individuals obtain from providing advice to others. (1957, p.131). Hence, role conflict may be existed due to the above reasons, especially in the case where there is the unequal power distribution among different professions.

Kahn et al (1966) develop the concept of the role episode to explain how individuals enact roles in organization and to understand the processes of adjustment to stresses in organizations. The role episode is shown in Figure I, which is a complete cycle of role

sending, response by the focal person, and the effects of that response on the role senders.

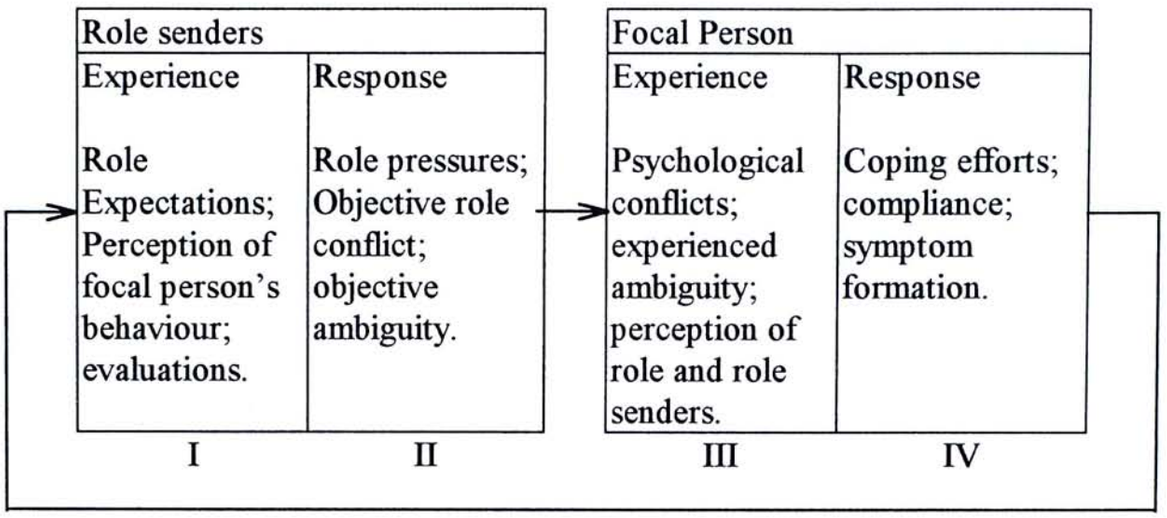

Figure I : A Model of the role Episode
Kahn et al (1966, p.182)

The four boxes (I to IV) represent events that constitute a role episode. The arrows connecting them imply a causal sequence. The episode starts with the existence of a set of role expectations held by role senders about a focal person and his or her behavior on the job. The experience of the role senders includes perceptive, cognitive, and evaluative components. In fact, each role sender behaves toward the focal person in ways determined by his or her own expectations and his or her own anticipation of the focal person's responses. Under certain circumstances, the role sender, responding to his or her own immediate experience attempts to influence the focal person in the direction of greater conformity with his or her expectations. Even mild communications about actual and expected role performance usually carry an evaluative connotation. Therefore, role expectations often lead to role pressures.

On the whole, there are situations in which a focal person perceives that the expectations of role senders to him or her are incompatible. Therefore, any situation in which the incumbent of a position perceives that he or she is confronted with incompatible expectations is called a role conflict.

III.4 Role Conflicts of Medical Social Workers in the Hosptial Setting

As health care services nowadays stress the holistic care to patients, in principle, the contributions of medical social work should be envisaged in the health care delivery system. However, in actual practice, the roles of medical social workers are often vague and confusing because the bio-medical model underpins the health care delivery process in hospital in the modern world. In the hospital, high technology medicine receives the majority of health care budgets. Medical research is predominately based upon the understanding of the underlying biochemical or genetic disease process with a view to discovering cures (Tayloy & Field, 1993). Biomedical research results in extraordinary scientific developments, applied in kidney dialysis, heart transplants, intensive care units, non-invasive diagnostic examinations and incredible surgical intervention (Rehr, 1984).

Medical social workers in the hospital setting have consistent uncomfortable sense that their roles and functions are misunderstood and misinterpreted by other medical and health care professionals. One study reports that the perceived lack of understanding about the role of medical social workers is the most serious problem to medical social workers (Schlesinger & Wolock, 1982). Discussions of the perceived role conflict of medical social workers have appeared in the social work literature since at least the

mid-1950s (Cowles & Lefcowitz, 1995 & 1992; Roberts, 1989; Schilling & Schilling, 1987; Mizrahi & Abramson, 1985; Bergman, Contro & Zivetz, 1984; Black, Morrison, Snyder & Tally, 1977; Mailick & Jordon, 1977; Nacman, 1975; Olsen & Olsen, 1967; Blackey, 1956). At the same time, several studies have been conducted to discern what differences exist between the views of medical social workers and medical professionals concerning the role of the former (Cowles & Lefcowitz, 1995 & 1992; Egan & Kadushin, 1995; Lister, 1980; Carrigan, 1978; Shrager, 1974; Phillips, McCulloch, Brown & Hambro, 1971; Olsen & Olsen, 1967).

According to these studies and other discussions of the issue, medical social workers expected their role to have more to do with counseling (Carrigan, 1978; Mizrahi & Abramson, 1985), psychotherapy (Olsen & Olsen, 1967), psychosocial problems (Phillips et al., 1971), or emotional and behavioral problems (Nacman 1975) than what medical professionals expect of their role. Concomitantly, medical professionals expected medical social workers to be environmental manipulators (Phillips et al., 1971), who performed instrumental tasks, such as providing assistance for transportation and locating nursing home (Nacman, 1975); they were to be more active in the area of concrete service provision (Carrigan, 1978; Mizrahi & Abramson, 1985); and they were to perform such activities as arranging for post-hospital care and making referrals to community resources (Olsen & Olsen, 1967). These studies also suggested that medical social workers generally expected their direct and concrete service role to be fairly equally to their role in solving the emotional and social-environmental problems of patients. However, medical professionals were not attuned to this position of medical social workers. Instead, they were inclined to perceive and expect medical

social workers' functions to be narrowly focused on social-environmental problems of patients and patients' families and on linking them with needed community resources and other external supports.

Olsen and Olsen (1967) analyzed the specific areas in which physicians and medical social workers disagreed in regard to the role of medical social workers. The findings revealed that physicians were more likely to give responsibility for financial arrangements to medical social workers than what the latter expected themselves to assume; however, physicians were less likely to give medical social workers responsibility for helping patients and families with social and emotional problems. Both professional groups agreed that medical social workers should help arrange for the post-hospital care of patients by referring them to community resources.

In another study, Carrigan (1978) identified a total of 180 professionals from the fields of medicine, psychology, nursing and medical social work of their perceptions of both actual and expected interdisciplinary medical social work practice. The findings show significant differences between medical social workers and other professionals regarding the medical social work functions of professional liaison (defined as mediation between the patient and organisation) and counseling. Medical social workers perceived themselves as performing these activities more often than they were perceived as doing by other groups of professionals. Furthermore, non-social work professionals expected less of medical social workers in these two areas than what medical social workers expected of themselves. However, non-social work professionals expected more of medical social workers in the area of concrete resources

provision both within and outside the hospital than what medical social workers expected of themselves. Results of other studies also confirm that concrete resources provision was considered to be the most important medical social work function by other health care professionals (Barker and Briggs, 1968).

Moreover, Lister (1980) examined the role expectations of 13 different groups of health care professionals. There were no consensus among the different groups that such tasks as calling the pastor at the patient's request, coordinating information and services, providing information to other health care facilities, helping patients with emotional problems including reactions to death and dying and informing other health care professionals of the needs of patients as belonged exclusively to medical social workers. Lister (1980) concluded that there was a lack of clarity and specificity regarding the role of medical social workers in hospitals.

In addition, Cowles and Lefcowitz (1995) studied the views of physicians, nurses and medical social workers concerning the role of medical social workers in addressing health-related patient problems. They concluded that physicians and nurses were likely to perceive environmental problems than emotional and behavioral ones of patients as the specialised domain of medical social workers. However, these two professional groups did not expect medical social workers not to work on psychosocial problems of patients. They just did not perceive patients' problems of the latter kind as distinctive of the medical social work practice.

In sum, it seems that the role of medical social workers in hospitals is ambiguously

defined. Non-social work professionals would expect and perceive medical social workers to do with providing concrete services, whilst medical social workers are likely to define their role as serving psychosocial functions. There exists great conflicting expectations regarding the appropriate role of medical social workers between medical social workers and non-social work professionals. This variance in role perception and expectation of medical social workers has great implications for the professional development of medical social work in hospitals. For instance, medical professionals' lack of clear understanding about the services that medical social workers can provide may preclude their requests for patient services from medical social workers or limit patient expectations for medical social work services. In Kulys's study (1983), he finds that medical social workers in an acute hospital reacted negatively to being described as people who arranged concrete services for patients. The sentiment seemed to derive from the association of concrete service provision with 'low skill' requirements of professional competency. Concrete service provision means that medical social workers are frequently required to work with elderly patients, a population some consider to expose them to hostility from patients and patients' families if they demand a longer hospitalization; and is frustrating if they are confronted with inadequate resources. In addition, it has been suggested that medical social workers experience a lack of recognition and support from physicians who generally view medical social workers solely in terms of 'clearing the beds' and ' moving bodies' (Carter & Jinks, 1972; Mizrahi & Abramson, 1985). The emphasis on high turnover, early discharge and bed occupancy are all pushing medical social work resources into facilitating turnover, and there is a danger that resources will be diverted from the less tangible services, such as counseling services which are vital to the practice of medical social workers.

There are several key factors which hinder the contributions and cause role confusion of medical social work in hospital settings. These factors also limit and restrain the roles performed by medical social workers in hospitals. First, in the hospital setting, medical social workers have little control or do not exclusively define the role and function they performed in the host setting. Instead, they respond to expectations defined by or in tandem with non-social work medical professionals. The medical physician is usually the first and certainly the most important person in deciding what is the problem of patients, how it should be treated, and what other health care professionals need to become involved (Enos & Sultan, 1977). In this regard, physician plays a critical role in securing and defining services for patients and patients' families; this role may be characterized as a " gatekeeper " (Pray, 1991, p.184). It is often the physician who identifies patient problems and, via referrals, ensures patient access to other health care services (Mechanic, 1979). Given this gatekeeping role, the knowledge physicians have about medical social work is critical for the service provision by medical social workers in hospitals. Furthermore, a more subtle gatekeeping function occurs when physicians define to the patient the role performed by medical social workers (Pray, 1991). In this way, the patient's service options is blocked and medical social workers cannot perform the role and function they expect of themselves. This referral system distorts the professional autonomy of medical social workers to set their own priorities and to define their own roles. The ensuing role ambiguity and role conflict of medical social workers thus become "a continuous feature of the history of the profession" (Butrym, 1967, p.22). In a study of physicians perception of their referral practices for hospitalized patients. Pray (1991) concludes that low referral rates were found for

patients with severe anxiety regarding illness and hospitalization, psychosomatic illness, and stillbirth, whilst high referral rates were found for financial difficulties, inability to care for self after hospitalization and medical condition requiring vocational change.

Second, the medical profession assumes the role of authority. Its longer development in hospital and its higher prestige in society contribute to medical profession's firmly established status. Wertz (1973, p.270) describes this phenomenon by suggesting that the medical profession "... has enjoyed increasing influence, the highest social status of any occupational group, and unchallenged control over not merely the social and economic conditions of its work, but ... its definition as well". Hence, the physician is normally the leader of the interdisciplinary team which controls the treatment and follow-up plans of patients, as well as services provided by other health care professionals, including medical social workers.

Third, the professional status of social work affects its status and position in hospitals. It is argued that social work is a semi-profession with all of the trappings of a profession (Makris, 1987). If it is perceived as of lower professional status, medical social work's domain and its role and function in hospital would be affected.

Fourth, the conception of health care held by medical professionals seems to have great influence on the role and function of medical social work in hospitals. Despite the growing recognition of the role of psychosocial stress in the etiology of disease, meeting patients' psychosocial needs is still not an inherent, integral component of medical intervention. Most medical professionals view patients' emotional disturbance,

if they are at all attentive to it, as an obvious accompaniment of the somatic disturbance, and it will be naturally resolved upon the solution of that disturbance (Leigh and Reiser, 1980). Many medical professionals thus consider the provision of emotional support a time-consuming luxury rendered at the expense of treating the "real" medical problem. They often perceive psychosocial support and counseling as secondary (Ben-Sira, 1987).

Taylor and Ford (1989, pp.22-23) suggest that by adopting the bio-medical model in health care provision, medical professionals have a dual advantage : " it makes their jobs more manageable and it also invests them with expertise of a distinct and exclusive kind". In contrast, a more holistic orientation exposes them to all the uncertainties which accompany the realm of knowledge concerning human as a unique ontological entity and as a social being. Physicians can no longer feel so confident in claiming an exclusive expertise because a multi-disciplinary approach prevails which calls for a very different orientation in health care. Their jobs become more complicated and diffuse. And they are exposed to a threat of their status: " membership of a team implies the acceptance of interdependence ".

It is also suggested that medical professionals, in general, prefer to deal with conditions that pose a diagnostic challenge and which they feel they can do something about. In contrast, they often feel uncomfortable with psychological or psychosocial problems, not only because they do not have the efficacy to treat them but also because they are seldom trained to feel comfortable in evaluating these problems. Moreover, care for such problems, unlike the application of discrete technical procedures, often increase

the uncertainties of their jobs.

Therefore, in the light of these factors, it is not surprising to notice that so many medical professionals are reluctant to adopt the holistic care model in health care provision. Hence, the health care conception held by the medical professional seems to have a decisive effect on the development of medical social work in hospitals. If physicians adopt the bio-medical model in health care provision, the role and contribution of medical social workers in such host setting may be vague and limited. Medical social workers may be viewed as "the handmaiden to the doctor" (Holosko & Taylor, 1992, p.24). Medical social work may be viewed as a luxury. As subordinate and ancillary to the medical profession, the development of medical social work in hospitals practice is greatly hindered. The medical professionals may perceive medical social worker to provide concrete services, like financial assistance and arrangement of post-hospital care, to patients. They overlook the role and function of the medical social worker in dealing with patients' emotional and psychological problems (Olsen and Olsen, 1967, Barker and Briggs, 1968, Carrigan, 1978 & Lister, 1980).

However, medical professionals are not homogeneous in their practice preference and the way they respond to patients. Some of them are more open than the others to the involvement of medical social workers in the health care delivery process. They may feel more comfortable to assess the psychosocial background of patients and to place the latter's psychosocial problems of patients at high priority during the treatment process. In fact, in hospitals, sadness, grief, depression and other psychosocial problems related to illness can be found everywhere. All these psychosocial problems

are totally related to the medical social work roles and functions. If medical professionals perceive these illness-related problems as essential to health care provision, the role and contribution of medical social workers should be well defined and role confusion of medical social workers can be greatly reduced.

Fifth, under the impact of the knowledge explosion, increasing members of the interdisciplinary team in the hospital setting share a common knowledge base. Coupled with the trend for hospitals to be seen less as an arena for professional practice and more as an instrument of cost effective health care delivery has lead to a weakening of the traditional claims for professional domain and an increased competition among various professions for limited resources. Nurses, psychologists, psychiatrists read the same books, undergo similar training (to a certain extent) and share many of the same skills as medical social workers. These disciplines aggressively look for opportunities to market their skills and claim access to hospital resources. In the eyes of these competitors, the psychosocial is by no means the exclusive domain of medical social work. In such a climate, more medical social workers in hospital are finding themselves practicing in arenas where the traditional support for their professional role definition are weaker and where other members of the interdisciplinary team are more aggressive in their claim for aspects of health care traditionally allotted to medical social work (Donnelly, 1992). For instance, Egan and Kedushin (1995) study of the role of medical social workers in hospital conclude that medical social workers in hospitals were perceived by nurses as only having an exclusive role in assessing and arranging the concrete, aftercare community services. The nurses, in their study, expanded their professional domain into areas traditionally considered within the sphere of medical

social work, such as the overall role of discharge planning, psychosocial assessment and intervention. The potential for role overlap between the two professions was obvious, particularly in the area of assessing the social and emotional problems of patients and families.

Finally, according to Zonder (1957), effective interaction and frequency of professional contact are important factors to affect the role relations between different professions within an organization. Interaction means "the opportunities and requirements presented for formal and informal social and professional contact during working hours and non-working hours" (Stamps & Piedmomte, 1986, p.18). Effective interaction and frequent interactions between different professions can increase mutual understanding about their practice, roles and responsibilities, and facilitate appreciation about each others' contributions. Interaction is critical to any organization because it is the process of information exchange, by which members of the organization are motivated for action, and this is crucial for any decision-making.

However, according to Butrym (1967), effective interaction is far more difficult to achieve than it is sometimes realized in the hospital setting. It is because in hospitals, the structure is characterized by a rigid status hierarchy that almost insures conflict between lower and higher-level professionals (Stamps & Piedmomte, 1986).

Besides, in case medical professionals pay little attention and interest about patients' psychosocial circumstances, then they are less likely to share the various medical data, the technical aspects of the medical diagnosis and the treatment plan to lay hospital

staffs, such as medical social workers. Butrym (1967) claims that to promote the domain of medical social work to medical professionals and to reduce the latter's misconception and misunderstanding about medical social work, it is absolutely essential and necessary to establish an effective interaction and contact network with medical professionals.

Chapter IV

Analytical Framework

Literature reveals that, from the perception of medical social workers, their role of medical social workers is to deal with the total emotion, social and physical needs of patients in whom the effects of illness go far beyond bodily discomfort. They are to work on the related social and psychological problems of patients' illness (Barker, 1987; Stenfield, 1990). However, several studies reveal that medical social workers continue to express concern that they are not duly respected by non-social work professionals in the hospital setting of their role of responsible for addressing the psychosocial correlates of health problems (Davidson, 1990; Joseph & Conrad, 1989; Kulys & Davis, 1987).

Traditionally, the domain of social work in health care is not clear nor exclusive. The role of medical social workers in hospital is not clearly defined. The problem of definition problem in collaboration is mainly attributed to the overlapping of practice domains between professions and their competition in areas which are not clearly assigned to anyone discipline. Overlapping of roles and functions can lead to duplication or lack of integration of interventions and services. A lack of clear role expectation also enables medical social work to assume new and undesirable roles and functions, such as bed clearance function. This situation constitutes an encroachment on the domain of the other profession claiming these function of its own, even when there is no consensus the function belongs to it (Kulys & Davis, 1987).

As Lister (1980, p.49) notes that "the roles of health team members overlap considerably. The overlapping of roles could be a source of conflict, particularly if it goes unrecognized by members of the inter-disciplinary team, or it could become the source of greater role diversity.

For instance, nurses and social workers are two professions whose members collaborate frequently within the health care system. Nursing has been characterized as a profession in transition. Nurses are expanding their role so that they are to be perceived as professionals with specialized skills, who are no longer subservient to physicians (Dimatteo, 1991; Kulys & Davis, 1987; Mindell, 1985; Schlesinger, 1985). Partially as a result of their efforts to gain greater autonomy and professional status, nurses have begun to perform activities, such as discharge planning, psychosocial assessment and intervention, which have been traditionally regarded as medical social work functions. As a consequence of these functions performed by nurse, they have expanded their role in this area by developing the "medical model" of discharge planning (Iglehart, 1990; Rorder & Taft, 1990; Volland, 1988). Psychosocial assessment is also a mandated function of nurses in the United State. Nurses perceive psychosocial functioning and assessment within their purview of knowledge and competence (Egan & Kadushin, 1995; Ben Sira & Szyf, 1992; Barry, 1989; Benner & Wrubel, 1989; Bevis, 1989).

However, overlapping and duplication of functions by medical social workers and nurses may have serious consequences in the cost conscious hospitals. Kulys and Davis (1986) suggest that if professions are perceived as having duplicating functions, the less essential profession may be eliminated for cost saving. In actual practice, it is inevitable

for an overlapping of roles between different professions in an inter-disciplinary team, but the question to medical social workers in this context is: Can they develop some uniqueness of their practice in hospitals? In this regard, the cost-effectiveness of their services in the health care system can be substantiated. Besides, medical social workers have to delineate specific knowledge and skills that are unique in more precise ways in order to ascribe the parametres of a specialized professional practice.

On the other hand, the medical achievements in the past forty years have been vast. Bio-medical research has resulted in extraordinary scientific developments, applied in kidney dialysis, heart transplants, chemotherapy, trauma and burn centres, neonatal and other intensive care units, physical rehabilitation, non-invasive diagnostic examinations and incredible surgical interventions. As medical care and public health systems have grown more sophisticated, they have contributed to the reduction in mortality and to the extension of life expectancy for all classes and races (Rehr, 1984). Despite all these, there are many incurable chronic diseases prevalent in society nowadays. Millions of people live with various degrees of limitation on their physical mobility and with chronic discomfort and dietary restrictions. Cancer is no longer necessarily equated with imminent death. However, for many cancer victims life involves periodic treatment and disfigurement and the pervasive fear of impending death. Using life-maintaining equipments such as dialysis requires massive physical and psychological adaptation. The movement toward deinstitutionalization of the mentally impaired has resulted in a large number of people with minimal capacity for self-care being left in communities in need of constructive activity and protection. Most people who suffer from these various chronic conditions need ongoing, lifetime care beyond that offered by medicine. Morris

(1978, p.89) points out that "medicine and science are able to keep people alive, but often with severe handicaps, some of which are physical, and some mental and emotional. Social arrangements do not remove those handicaps. A society and a scientific system that keep people alive has an obligation to do something about the conditions in which they live. A redistribution of effort between cure and care is an absolute necessity." In fact, screening for psychosocial problems indicates that considerable unmet needs exist among patients and their families (Clarke, Neuwirth, & Bernstein, 1986).

Clearly, the major health concerns today in advanced societies are chronic illness and their consequences, along with an epidemic of psychological ailments, stress induced illnesses and social diseases and disorders (Rehr, 1982). However, physicians have not been well equipped to deal effectively with these social problems and ailments. Hospitals, physicians and medical technology are not likely to achieve improved health status for those at bio-psycho-social risk. Since cure is not yet available for many chronic illnesses and disabilities, individual and family benefit from care can be judged largely in terms of social and physical functioning rather than of disease alleviation. Hence, the extent medical professional agrees about the responsibilities of psychosocial problems of patients and their families that are related to patient's health but are not medical in nature has direct and significant effect in the health care system, and most important it affects the medical social work practice and services provision to patients and families. It is because the concern of medical work is basically the improvement of the quality of life and social functioning from a psychosocial stance through promoting or restoring a mutually beneficial interactions between carers and patients (Ben-Sira,

1987).

In sum, health care and social work practice share a common concern for the well being of individuals, families and social groups. That this concern calls for collaboration between medical social workers and medical professionals. In spite of the relationship between these two professions being frequently fraught with difficulties and having lacked in equality of recognition and status, the place of medical social work is established in many hospitals. Medical social workers must prove that their services and interventions are beneficial to patients' and their families' experience of medical treatment.

In this study, the concept of role is related to status or position, tasks or functions. Role is defined as the prescribed pattern of behavior or action that entitles an individual to occupy a status or position. In the hospital setting, the role of medical social workers is not only defined by medical social workers themselves, but also defined by patients, hospital administrators, medical profession and the community as a whole. According to the concept of role episode (Kahn et al, 1966), for those who want to entitle the status of medical social workers, they must fulfill the expectations and functions presumed by others who represent role senders to that position. The role senders have a set of role expectations about focal persons. They hold perceptive, cognitive and evaluative experiences about the role of focal persons and they usually attempt to demand and influence the focal persons in the direction of greater conformity with their expectations. In the role episode, pressures and conflict will prevail when focal persons are facing incompatible expectations by role senders. Role conflict then exists in this

situation.

In the hospital setting, role senders include physicians, nurses and hospital administrators. In this study, the focal persons are medical social workers whereas role senders are physicians. The physician is selected as the role sender because, as mentioned before, he or she is usually the first and certainly the most important person in deciding what is the problem of patients and what other health care professionals need to become involved. Physician plays a "gatekeeper" role in securing and defining services for patients and patients' families. Physician identifies patient problems and, via referrals, ensures patient access to other health care services. Besides, physician enjoys high authority and prestige in the hospital structure and has power to control or influence the services provided by health care professionals. In actual practice, physician can control the role and function of medical social workers through referral system which distorts medical social workers' right to set their own priorities and to define their own roles.

In the hospital setting, medical social workers always play a subordinate position within the collaborative team. They practise in a secondary setting. Their power position is relatively weak as compared with medical professionals. Hence, role conflict is presumed as a part of the practice reality of medical social work in the secondary setting.

Literature reveals in the secondary setting of hospital that the professional development

and role definition of medical social workers are hindered and perceived differently by non-social work professionals. As mentioned before, there are several factors which effect the contributions of medical social workers in the hospital setting: the medical professionals' "gatekeeper" role; professional dominance and high prestige of medical professionals; the view of social work profession as a semi-profession and its lower prestige in the health care field; the health care conception held by medical professionals; functions overlap and professional competition from non-social work professionals; and the establishment of effective interaction or connection with medical professionals. To include all these factors in a study, a large scale time consuming research is required, that is beyond the current capacity of the researcher. Therefore, in this small scale study, the focus is on two factors: health care conception and interaction, of their effect on the role of medical social workers. To explore how health care conception, whether bio-medical model or holistic care model, held by medical professionals and medical social workers affect the role and function of medical social work in the hospital setting; to explore the relationships between interactional pattern and role perception held by medical professionals and medical social workers; to explore how medical professionals, and medical social workers perceived the role of medical social workers; and to explore the nature and degree of role conflict faced by medical social workers. It is essential to highlight that the factor of health care conception is selected in this study because the relationship between health care conception and role conflict of medical social wokrers is an area not explored in previous researches. Hence, this area is the main focus of this exploratory study.

Figure 2 and Figure 3 summarize the analytical framework of the study. Figure 2 shows

the overall role episode of medical social workers in the hospital setting. In the role episode, medical professional is the role sender and medical social worker is the focal person. Medical professionals perceive the role of medical social workers according to their overall experience as shown in the figure, whilst medical social workers respond to role perception according to their own experience and perception, and as a result, role conflict exists because of different experiences held by the two professional groups and the inconsistence about their role perception of medical social worker. On the other hand, Figure 3 specifies the role episode of medical social workers in the hospital setting adopted in this study. The specific factors or experiences – role perception of medical social worker, health care conception held by medical professional and medical social worker, and interactional pattern between medical professional and medical social worker – which affect the role definition of medical social workers are selected to explore the nature and extent of role conflict faced by medical social workers.

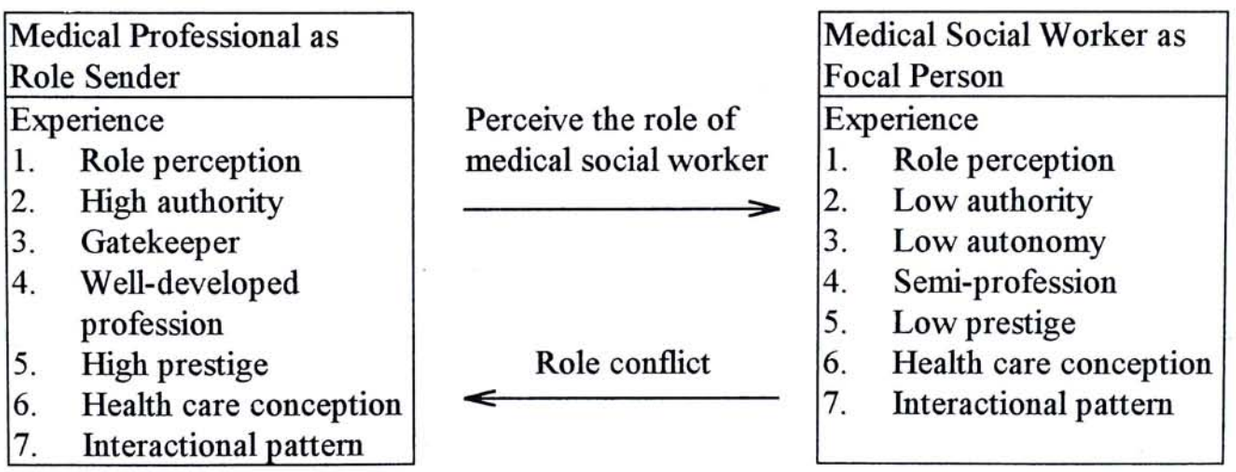

Figure 2 : The Overall Role Episode of Medical Social Workers in the Hospital Setting

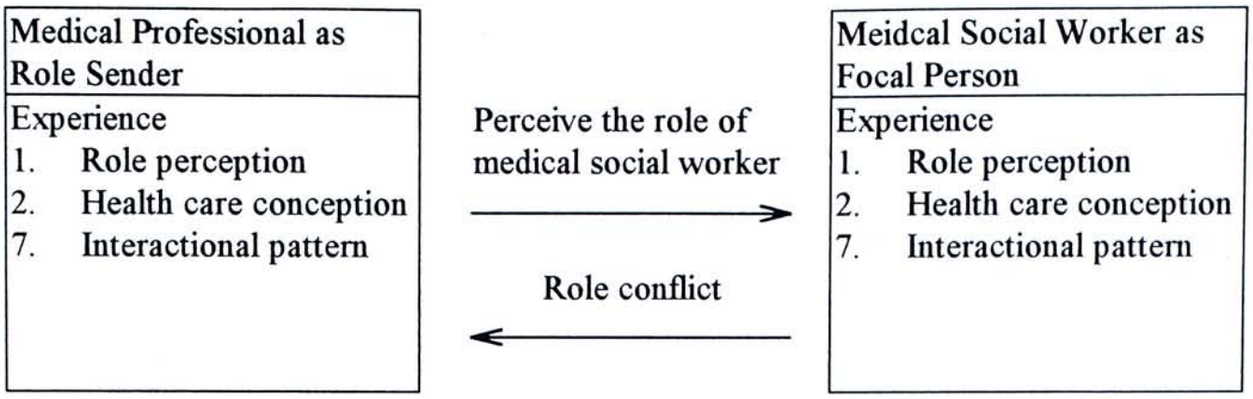

Figure 3 : The role Episode of Medical Social Workers in the Hospital Setting Adopted in this Study

Chapter V

Research Design and Methodology

V.1 Areas of the Study

The objective of this study is to clarify and define the role of medical social workers in hospital settings. In actual practice, the role of medical social workers in hospitals is defined differently by medical professionals and medical social workers. The perception and expectation of medical professionals and medical social workers of the role of medical social worker are sometimes incompatible. In this research, the study focuses on the following areas of exploration:

i) how medical professionals and medical social workers perceive and expect the role of medical social workers in hospital;

ii) the nature and extent of role conflict of medical social workers in hospital;

iii) the relationship between health care conception and the role of medical social workers in hospital;

iv) interaction between medical professionals and medical social workers.

V.2 Research Design

This study employs an explorative design to investigate the views of medical professionals and medical social workers concerning the roles of medical social workers in hospital and health care conception. The study was conducted in a hospital in Hong Kong. Yan Chai Hospital was used as a case for the study. The case study method was

selected because it is appropriate for the exploratory phase of an investigation (Yin, 1984). Only Yan Chai Hospital was selected in this study because the researcher had limited time, resources and manpower to conduct a large scale survey to include all hospitals in Hong Kong. Besides, due to time constraint, in-depth interview and observations could not be conducted. The nature of this study is only for exploratory purpose.

V.3 A Brief Account of Medical Social Work in Hong Kong

In Hong Kong, medical social work has quite a long history. In 1939, the Medical and Health Department appointed its first almoner to advise patients about medical services and welfare. In 1964, the name "almoner" was replaced by "medical social worker". In 1982, the Social Welfare Department took over the responsibility of providing medical social work to patients in all government hospitals. The medical social work in government subvented hospitals was provided by individual hospitals under the Medical and Health Department, and later the Department of Health.

When the Hospital Authority, which is a statutory body, was established on 1 December 1990 under the Hospital Authority Ordinance, it took over the management of all government hospitals and government subvented hospitals. The Hospital Authority is independent of, but accountable to, the Hong Kong Government through the Secretary for Health and Welfare who is responsible for the formulation of health policies and for monitoring the Authority's performance. The Hospital Authority has established in its corporate plan to the Year 2000 the following Corporate Vision:

"The Hospital Authority will collaborate with other health care providers and carers in the community to create a seamless health care system which will maximize health care benefits and meet community expectations." (Hospital Authority, 1996, p.3).

Under the management of the Hospital Authority, public hospitals are divided into two schedules. Schedule I hospitals represent all ex-government hospitals and Schedule II hospitals represents all ex-subvented ones. At present, the medical social work in Schedule I hospitals is provided by the Social Welfare Department whereas the medical social work in Schedule II hospitals is provided by Hospital Authority. In other words, there are two systems of medical social work in hospitals in Hong Kong.

According to an internal document of the Social Welfare Department, the tasks of medical social workers are classified into 5 groups (SWD document, pp.2-3) :

(i) General

1. To undertake psychological assessment into case situations and to detect the social and emotional problem involved.

2. To participate in the medical teamwork i.e. to collaborate with the medical and para-medical staffs in building up an integated disgnosis of each case and to formulate a dynamic plan for the total rehabilitation of the paitent and his family.

3. To liase with the outside agencies and to co-ordinate the community resources.

(ii) Practical or Environmental Assistance

1. To arrange assistance to patients and their families in cash or kind, to meet emergency situations caused by illness.

2. Plans for the care of children, either temporarily or permanently. when one or both of the paients fall sick.

3. Compassionate re-housing on medical and social grounds.

4. Ensuring that patients and their families, where applicable receive compensation under the Employee's Compensation Ordinance, the Criminal & Law Enforcement Injuries Compensation Scheme as well as other compensation such as for injury in traffic accidents and natural disaster.

5. Investigation of patient's home situation for the information of medical and other staff, helpful to the latter in making treatment/rehabilitation plans.

6. Arrangement for the provision of surgical and other appliances.

7. To make discharge plans jointly with patient, his family and the medical team.

This involves utilizations of and referral to a range of supporting community resources such as half-way house, home help services, community nursing, job placement service, vocational training centres, sheltered workshop and special school placement etc.

8. To process medical inquiry forms.

9. To help in the central registration of the disabled and the drug addicts.

(iii) Counselling

In counselling, the professional through the conscious use of the instrumental relationship with his client, aims to modify the latter's attitude and behavior. More specifically in medical setting, the major objectives of counseling are:-

1. to help patients accept their illness situation and to live with or overcome the limitation it brings along, whichever is more realistic.

2. to facilitate patients to make the best use of medical/rehabilitation services in the community.

Furthermore, counseling services may range from (a) simple information giving and interpretation/discussion for those who are, for instance, ignorant and apprehensive about their illness/treatment or in lack of knowledge about available community

resources, to (b) more intensive therapy for those who have personality/emotional problems and interpersonal difficulties related to their illness/disability.

(iv) Social Rehabilitation

This is mainly a process of enabling and facilitation re-integration of the physically, mentally, socially disabled patients back into the community. Other than offering the general, practical or environmental assistance and counseling services to the disabled and/or their significant others, an essential task of the Medical Social Worker is to collaborate with other medical and para-medical professionals in modifying the public's often stigmatizing attitude towards the sick and disabled through education and publicity.

(v) Research and Teaching

A Medical Social Worker may be called upon to participate in researches or to help in teaching the medical or para-medical staff (students) wherein he/she can contribute the share his/her expert knowledge on the psychosocial aspect of illness.

Besides, Hong Kong Social Workers Association jointly with the Working Group of Medical Social Work Service under the Hong Kong Council of Social Service also identified 10 functions performed by medical social workers: (Hong Kong Social Workers Association , 1991, pp. 2-3)

(i) Psychosocial assessment:

Medical social workers make social studies of patient's past and current health, social situations, and psychological conditions so as to assess, evaluate, and contribute to the total diagnosis and treatment job.

(ii) Counseling and therapy to individuals and their families:

Medical social workers provide crisis intervention and counseling to patients and families, assisting them to cope with the emotional reactions to the illness and threats to their life styles and independence, to help face the prognosis and the implication of the illness, and to deal with the related family problems and obstacles that result from the illness and/or disability.

(iii) Educational, self-help and therapeutic groups:

Medical social workers run groups for the patients and/or their family members, for instance, educational groups are conducted to teach patients and family members how to take care of the patients. Self-help and supportive groups are conducted to cultivate mutual support and concern among patients suffering from the same disease. Therapeutic groups aim to help patients gain self awareness, modify inappropriate attitudes or behaviors more effectively in interpersonal relationships.

(iv) Pre-admission planning:

Medical social workers provide interventive services to patients whose admissions are complicated or resisted due to their unacceptance of illness, intense fears, lack of knowledge of hospital procedures, or lack of adequate child care plans.

(v) Discharge planning:

Medical social workers provide specialized counseling and supportive services to patients and their families to ensure that the patients have planned programmes for continuing care, to re-integrate them into their family and community, and to assure the quality of reception and support to sustain their rehabilitation.

(vi) Practical assistance:

Medical social workers make provisions of assistance to solve immediate problems such as financial and housing which may interfere with patients' response to medical treatment, admission, and discharge plans.

(vii) Multi-disciplinary team work:

Medical social workers engage themselves in providing information and advice to various health-care professionals about the psychosocial needs of patients and the various ways in which such needs affect their ailments and syndromes, striving for the comprehensive and feasible treatment modality for patients.

(viii) Empirical research:

Medical social workers conduct research to identify the psychosocial needs of patients and their families, and alternative treatment modalities.

(ix) Mobilizing community resources:

Medical social workers mobilize appropriate community resources to meet the needs of patient and their families. This is done by identifying and advocating for new community resources, by participating in relevant community activities, and by participating in innovative and pilot projects launched by the hospital and the community.

(x) Social Work Education:

Medical social workers participate in the in-service training of medical and other hospital professionals, and in the education of social work students, medical students, student nurses and students of other allied health disciplines to enhance their awareness of the psychosocial problems of the patient so as to enlist appropriate medical social work service in the treatment process.

The above two papers or documents are very important to explain the medical social work service in hospitals in Hong Kong. The first paper represents the points of view from the medical social workers in Schedule I hospitals whereas the Second paper represents the points of views on medical social work services from the Social Welfare Department, i.e. the medical social services in Schedule I hospitals. These two papers show the overall agency expectations of medical social workers in Hong Kong.

V.4 Yan Chai Hospital as a Case Study

As mentioned in above, Yan Chai Hospital was selected as a case for study. Yan Chai Hospital was founded in 1973. It has been known as a charity hospital offering services to the residents of Tsuen Wan and neighbouring districts. With the completion of the extension in 1993, the hospital has developed into a self-contained acute general hospital with 24-hour Accident and Emergency (A&E) service and future capacity of providing 850 beds. The number of beds of the hospital has increased from 175 as at December 1993 to 548 beds at present. In addition, the staff has increased from 435 to 1579 in this same period. Besides, a Polyclinic providing general and specialty out-patient medical consultation has also been in service since 1983. The hospital provides specialty services in Medicine, Surgery, Orthopaedics and Traumatology, Paediatrics, Ear, Nose and Throat (ENT) and Ophthalmology. Other health care services include A&E Service, Intensive Care Treatment, Diagnostic Radiology Service, Pathology Service, Electro-medical Diagnostic Service, Day Surgery Service, Physiotherapy, Occupational Therapy, Dietetics, Medical Social Services, Patient Resources Centre, etc.

Furthermore, the mission statement of the Hospital is "with kindness of heart & concern for other's sickness & distress, we serve the community by putting health care in the front" (Yan Chai Hospital, July 1995, p.11). As claimed by the Hospital Chief Executive, the target of the hospital is "to delivering comprehensive, quality health care which contribute to the complete physiological, physical and psycho-social well being of the local community" (Yan Chai Hospital, 1995, p.5).

Although Yan Chai Hospital is a community hospital in Schedule II hospitals of Hospital Authority, it consists of the majority of specialty services and other health care services provided by other Schedule I and II hospitals. Hence, the problem of its representativeness may be minimized.

V.5 Population Groups

There are two population groups in the study. The first population group is physicians of the Yan Chai Hospital. It includes the physicians in the hospital who had or might have direct referrals to medical social workers. In sum, this population group includes the physicians from the Specialty of A&E Department, Medicine, Surgery, Orthopaedics and Traumatology, Paediatrics, ENT, General Out-Patient Department (GOPD) and Intensive Care Unit (ICU). There are totally 97 physicians in this population group. The study covers all physicians in this population group and no sampling is needed. In other words, the whole population group is the subject of the study.

The another population group is medical social workers in the Yan Chai Hospital. There are 6 medical social workers (including the Department Manager) in the Hospital. This study covers all of them and also no sampling is needed. In other words, all medical social workers in the Hospital are subjects of the study.

V.6 The Limitations of Case Study Method

There are several limitations on using case study methods. The case study method is limited by its lack of representativeness (Hamel, 1991). Hence, it has limited external validity or generalization because the samples are obtained from only a selected sections of the population which could not be assumed to represent all members of the population (Cowles & Lefcowitz, 1992). It has less vigor in data collection, and the analysis of the findings may open to the problem of bias caused by the subjectivity of the researcher (Hamel, 1991).

Despite case study method has its limitations as mentioned above, nevertheless it does allow an investigation to retain the holistic and comprehensive characteristics of the study subject, in our case it is the medical social work practice in the hospital. In fact, case study method is employed by some researchers when they study the role conflict of medical social workers in hospitals (for example, Olsen & Olsen, 1967; Carrigan, 1978). Furthermore, owing to limited time, resources and manpower, it is impossible for the researcher to conduct a large scale survey which would be viewed as having greater representativeness, validity and generalization.

V.7 Questionnaire Design

There is no established questionnaire directly applicable to this study. The questionnaire

is designed by the researcher based on literature review and work experience in hospitals. In this study, there are two sets of questionnaires – one for medical professionals and the other one for medical social workers. The design of the two sets of questionnaires is smiliar.

All questions in the questionnaire are 'fixed-alternative' questions. According to Selltiz, Wrightsman and Cook (1976, p.313), fixed alternative questions "may help to ensure that the answers are given in a frame of reference that is relevant to the purpose of the inquiry and in form that is usable in the analysis." However, omission of possible alternative responses in the set answers might lead to bias or misdirect the respondents to choose an answer not congruent to their exact opinion (Selltiz, Wrightsman & Cook, 1976).

Besides, while open-ended questions might allow more freedom for the respondents to provide answers beyond the biased framework of the study, it might have the disadvantage of making the respondents feel vague and trouble-some. Thus, some respondents might tend to leave the open-ended questions unanswered in a self-administrated questionnaire. With reference to the use of self-administrated questionnaire in data collection, 'fixed-alternative' questions seem to be more appropriate. Special attention has been taken to avoid omission of possible alternative responses and relevant questions when setting the questionnaire.

The questionnaire is composed of four parts. Part one includes questions about health care conception. Part two is the perception of the role of medical social workers. Part

three is the measurement of pattern of interaction and impression. Part four includes questions about the personal data of the respondents. The two sets of questionnaires are attached in Appendix 3 and Appendix 4.

V.7.i Part I: Health Care Conception

In this part, the questions are divided into two sections. The first section includes the questions about how the respondents believe, in principle, about the health care conception. The questions in this section of the two sets of questionnaires are exactly the same. The second section measures the actual practice of the respondents in their provision of health care services. The questions of this section of the two sets of questionnaires are basically the same except the first two questions.

The content of this part of the questionnaire is designed mainly through the researcher's work experience and literature review.

V.7.ii Part II: The Perception of the Role of Medical Social Workers

In this part of the questionnaire, close-ended questions are used to elicit information regarding the role of medical social workers in hospital. Based on previous researches in this area (Carrigan, 1978; Lister, 1980; cowles & Lefcowitz, 1992 & 1995; Egan & Kadushin, 1995), the tasks of medical social workers can be divided into two categories – Concrete Services and Counseling Services. For each of the tasks within these two categories, the respondents are asked to indicate on an Ordinal Scale ranging from

"Solely done by other professionals", "Jointly done by MSW and other Professionals", "Solely done by MSW", and "Don't know". Finally, the respondents are also asked to make a conclusion about the role of medical social workers – if they provide "Only concrete services", "Both concrete services and counseling services", "Only counseling services:, and "Don't know".

In this part, the design of the two sets of questionnaire is exactly the same.

V.7.iii Part III: Pattern of Interaction and Impression

In this part, the questions are divided into two sections. The first section includes the perception of the working and professional attitudes of the two professional groups, whereas the second section measures the pattern of interaction between medical professionals and medical social workers. Ordinal Scale is also employed in this part.

The question design of this part mainly takes reference from a research which studied the inter-professional perceptions on communication and co-operation among social workers and primary teachers (Ross, 1987). Finally, the design of the two sets of questionnaire is exactly the same in this part.

V.7.iv Part Four: Personal Data

This part consists of questions which elicit information about the demographic characteristics of the respondents. It includes the variables of sex, age, years in current

job, years of professional services, and specialty.

The design of the two sets of questionnaire is exactly the same in this part.

In sum, the two sets of questionnaire are designed to measure the health care conception, role perception of medical social workers, mode of interaction and working attitudes between medical professionals and medical social workers. The design of the questionnaires for the two groups of subjects is basically similar except for a slight modification in the format of actual practice in provisions of health care services to patients.

V.8 Data Collection

In data collection, the self-administered questionnaire was sent by hand to respondents in each specialty and department of the hospital. Instrument packets include a cover memo and a return envelope. A number of techniques for securing a better response rate were adopted. They included eliciting preliminary support from Hospital Chief Executive and various department heads, attaching an introductory memo and an return-envelope with the questionnaire, and following up by a second memo and telephone. All these techniques were useful in raising the percentage of returns.

Data was collected between the period from mid-May 1996 to mid-June 1996 through self-administered questionnaires. A total of 103 questionnaires were sent to the 97

selected physicians and 6 medical social workers. A totally of 45 completed questionnaires were returned, 39 from physicians and 6 from medical social workers. There was an overall response rate of 43.7 percent (40.2 percent from physicians and 100 percent from medical social workers).

Chapter VI

Findings and Analysis

The findings obtained from physicians and medical social workers will be analysed seperately. As the smaple size of medical social workers is small and the difference of the sample size between these two groups is large, it is inapporpriate to compare the findings between the two groups. Hence, the findings obtained from medical social workers are used as supplementary data to analyse the role perception and role conflict of medical social workers.

VI.1. Findings Obtained from Physicians

VI.1.i. The Characteristics of the Respondents

In this study, the number of respondents for physicians were 39. The characteristics of them were described in Table 1. As shown in Table 1, the majority of physicians in this study were male (84.6%), aged between 26 and 35 (71.8%), professional experiences ranged from 1 year or below (20.5%) and 2 to 4 years (64.1%), worked for Yan Chai Hospital from 1 year or below (18%) and 2 to 4 years (61.5%), and worked in the specialties of Medicine (23,1%), Surgical (15.4%), Orthopaedic (15.4%), Paediatrics (12.8%), and A&E Department (20.5%).

As the Yan Chai Hospital has been fully operated since 1993, the majority of staff are young and fresh, and the majority of them work in the Hospital for only 1 to 2 years.

Hence, the characteristics of the respondents for physicians in this study are compatible with the characteristics of the staff of the Yan Chai Hospital. Besides, as the number of responding for physicians is very small, it is statistically insignificant to correlate the findings of the characteristics of physicians with other variables.

Table 1: The Characteristics of the Physician Group

		N	%
Sex:			
	Male	33	84.6
	Female	6	15.4
		(39)	(100.0)
Age:	21 - 25	0	0
	26 - 30	14	35.9
	31 - 35	14	35.9
	36 - 40	7	18.0
	41 - 45	2	5.1
	46 - 50	0	0
	51 - 55	2	5.1
	56 or above	0	0
		(39)	(100.0)
Professionals experiences:	1 year or below	8	20.5
	2 - 4 years	25	64.1
	5 - 7 years	1	2.6
	8 - 10 years	2	5.1
	11 - 13 years	1	2.6
	14 - 16 years	1	2.6
	17 - 18 years	0	0
	20 years or above	1	2.6
		(39)	(100.0)
Years of Employment in Yan Chai Hospital :	1 year or below	7	18.0
	2 -4 years	24	61.5
	5 -7 years	2	5.1
	8 - 10 years	2	5.1
	above 10 years	2	10.3
		(39)	(100.0)

Specialty :	Medicine	9	23.1
	Surgical	6	15.4
	Orthopaedic	6	15.4
	Paediatrics	5	12.8
	A&E	8	20.5
	GOPD	2	5.1
	ICU	2	5.1
	ENT	1	2.6
		(39)	(100.0)

VI.1.ii The Health Care Conception

The Part I of the questionnaire aims at collecting data concerning the physicians' points of view about the health care conception. This part is divided into two sections. The first section explores the health care conception held by physicians, whereas the second section tests their actual professional practice. The findings are analyzed to explore if their actual practice are consistent with their health care conception. The findings are presented in the following tables.

As shown in Table 2, over 90% of responding physicians held the holistic health care conception, that is, as mentioned in literature review before, "health is the state of complete physical, mental and social well-being" ; "besides bio-medical factors there is a link between emotionally stressful lift events and social factors, and illness"; and "social, emotional and environmental conditions have a significant and measurable effect on illness recovery and prevention". Moreover, refer to Table 2 (Statement 4), over 90% of them strongly disagreed (28.2%) and disagreed (64.1%) that the task of physicians is to treat patients' disease only. Furthermore, refer to Statement 5, all

respondents (23% strongly agreed and 71.8% agreed) believed that "health care services include full spectrum of services from prevention to medical treatment, medical care, counseling and continuity of care". Moreover, refer to Statement 9, concerning the hospital missions, 17.9% of physicians strongly agreed and 56.4% of them agreed that the hospital missions do envisage both bio-medical and psycho-social factors in planning of health care services to patients.

The findings obtained from responding physicians about their health care conception revealed that the majority of them held the conception of holistic health care and believed that their tasks were not to treat patients' disease only. The psycho-social factors of patients should also be considered during the treatment process.

Table 2 : The Health Care Conception Held by the Physician Group

	Health Care Conception	**Physician**	
		N	**%**
1.	Health is the state of complete physical, mental and social well-being.		
	a. Strongly Agree	19	48.7
	b. Agree	20	51.3
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0
2.	Besides bio-medical factors, there is a link between emotionally stressful life events and illness.		
	a. Strongly Agree	12	30.8
	b. Agree	27	69.2
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0

3.	Besides bio-medical factors, there is a link between social factors, such as poverty, poor housing, unemployment and manual work, and illness.		
	a. Strongly Agree	12	30.8
	b. Agree	27	69.2
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0
4.	The task of medical doctor is to treat patients' disease only.		
	a. Strongly Agree	0	0
	b. Agree	1	2.6
	c. Neutral	2	5.1
	d. Disagree	25	64.1
	e. Strongly Disagree	11	28.2
	f. Don't know	0	0
5.	Health care services include a full spectrum of services from prevention to medical treatment, medical care, counseling and continuity of care.		
	a. Strongly Agree	12	30.8
	b. Agree	27	69.2
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0
6.	Social, emotional and environmental conditions have a significant and measurable effect on illness recovery.		
	a. Strongly Agree	9	23.0
	b. Agree	28	71.8
	c. Neutral	1	2.6
	d. Disagree	1	2.6
	e. Strongly Disagree	0	0
	f. Don't know	0	0

7.	Social, emotional and environmental conditions have a significant and measurable effect on illness prevention.		
	a. Strongly Agree	6	15.4
	b. Agree	27	69.2
	c. Neutral	5	12.8
	d. Disagree	1	2.6
	e. Strongly Disagree	0	0
	f. Don't know	0	0
8.	Illness-related behaviours, such as frustration, depression, worry and the like, will not disrupt personal coping abilities.		
	a. Strongly Agree	0	0
	b. Agree	0	0
	c. Neutral	1	2.6
	d. Disagree	22	56.4
	e. Strongly Disagree	14	35.9
	f. Don't know	2	5.1
9.	The hospital missions envisage both bio-medical and psycho-social factor in planning of health care services to patients.		
	a. Strongly Agree	7	17.9
	b. Agree	22	56.4
	c. Neutral	6	15.4
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	4	10.3

However, the findings of responding physicians' actual practice revealed that the majority of them only paid little attention and priority on assessing and managing the psycho-social problems of patients. Although the majority of physicians held the conception of "holistic health care", in actual practice, as shown in Table 3(Statements 3 to 6), there were only a few (7.7% always and 15.4% frequent) paid highest priority in managing patients' social problems and (10.2% always and 18% frequent) paid highest priority in treating patients' emotional problems. This phenomenon reflected that in principle, the majority of physicians did agree with the "holistic health care", but

in actual practice, they only paid little attention and priority in providing "holistic care" to patients.

Other findings in this part were consistent with the above analysis. As shown in Table 3 (Statement 1), over 85% of physicians referred patients with emotional problem to medical social workers only infrequently, ranged from 61.5% for "sometimes", 23.1% for "seldom" and 2.6% for "not at all". Only 10.2% and 2.6% of them frequently and always respectively referred patients to medical social workers to deal with patients' emotional problem. Nevertheless, refer to Statement 2, over 85% of physicians frequently and always referred patients to medical social workers to deal with patients' social problem. 33.3% of them frequently and 53.9% of them always referred patients with social problems to medical social workers.

These findings reflected that in actual practice, although the majority of physicians paid little attention and priority in managing patients' psycho-social problems, they only referred patients with emotional problems to medical social workers infrequently, in contrast, they always referred patients to medical social workers to deal with patients' social problems. In other words, physicians were more willing to refer patients with social problem than emotional problem to medical social workers. There might have three possible reasons behind this situation. First, in actual practice, physicians might pay only little attention on patients' emotional state. Second, they might perceive the role of medical social workers as only dealing with patients' social problems. Third, they might have referred patients with emotional problems to other medical professionals, such as psychiatrists or clinical psychologists.

Finally, Table 3 (Statement 7) also revealed that 23.1% of physicians always and 38.5% of them frequent considered the assessment and recommendations of medical social workers in planning patients' treatment plan. In other words, more than half of them did respect the role of medical social workers, no matter this role related to concrete services only or both concrete and counseling services.

Table 3 : The Actual Practice of the Physician Group

	Actual Practice	N	%
1.	I refer patients to medical social workers to deal with their emotional problem.		
	a. Not at all	1	2.6
	b. Seldom	9	23.1
	c. Sometimes	24	61.5
	d. Frequent	4	10.2
	e. Always	1	2.6
	f. Don't know	0	0
2.	I refer patients to medical social workers to deal with their social problems.		
	a. Not at all	0	0
	b. Seldom	0	0
	c. Sometimes	5	12.8
	d. Frequent	13	33.3
	e. Always	21	53.9
	f. Don't know	0	0
3.	I pay highest priority in assessing patients' emotional condition.		
	a. Not at all	0	0
	b. Seldom	13	33.3
	c. Sometimes	17	43.6
	d. Frequent	3	7.7
	e. Always	6	15.4
	f. Don't know	0	0
4.	I pay highest priority in treating patients' emotional condition.		
	a. Not at all	0	0
	b. Seldom	13	33.3
	c. Sometimes	15	38.5
	d. Frequent	7	18.0
	e. Always	4	10.2
	f. Don't know	0	0
5.	I pay highest priority in assessing patients' social background.		
	a. Not at all	0	0
	b. Seldom	10	25
	c. Sometimes	16	41.0
	d. Frequent	7	18.0
	e. Always	6	15.4
	f. Don't know	0	0

6.	I pay highest priority in managing patients' social problems.		
	a. Not at all	0	0
	b. Seldom	11	28.2
	c. Sometimes	19	48.7
	d. Frequent	6	15.4
	e. Always	3	7.7
	f. Don't know	0	0
7.	In patient's treatment plan, the assessment and recommendations of medical social workers are considered seriously.		
	a. Not at all	0	0
	b. Seldom	2	5.1
	c. Sometimes	13	33.3
	d. Frequent	15	38.5
	e. Always	9	23.1
	f. Don't know	0	0

VI.1.iii Role Perception of Medical Social Workers

In this study, the role of medical social workers is divided into two areas – providing concrete services and counseling services, which are shown in the Part II of the questionnaire. With reference to the related western studies (e.g. Cowles & Lefcowitz, 1995 & 1992; Egan & Kedushin, 1995; Lister, 1980; Carrigan, 1978; Olsen & Olsen, 1967; etc.), the concrete services consist of nine tasks, while counseling services include eight tasks. The physicians are asked to identify, according to their perception, whether these tasks are mostly the domain of medical social workers or other professionals, or jointly done by medical social workers and other professionals. This part aims at exploring the role and domain of medical social workers in hospitals, and the extent of role conflict faced by medical social workers.

Table 4 : Role Perception of Medical Social Workers by the Physician Group

	Tasks	Physician	
A.	**Concrete Services**	**N**	**%**
1.	Assisting patients to make financial arrangement for medical and other needs.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	22	56.4
	c. Solely done by MSW	17	43.6
	d. Don't know	0	0
2.	Gathering social histories of patients to supplement their medical histories.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	30	76.9
	c. Solely done by MSW	9	23.1
	d. Don't know	0	0
3.	Assessing social functioning of patients.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	30	76.9
	c. Solely done by MSW	9	23.1
	d. Don't know	0	0
4.	Helping patients with social problems related to their illness, disability or impending death.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	38	97.4
	c. Solely done by MSW	1	2.6
	d. Don't know	0	0
5.	Assessing the social impact of patients' illness on their family.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	30	76.9
	c. Solely done by MSW	9	23.1
	d. Don't know	0	0

6.	Helping families of patients with social problems related to patients' illness, disability or impending death.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	31	79.5
	c. Solely done by MSW	8	20.5
	d. Don't know	0	0
7.	Determine patients' need for social services.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	23	29.0
	c. Solely done by MSW	15	38.4
	d. Don't know	1	2.6
8.	Determine type of extended care needed by patients.		
	a. Solely done by other professionals	4	10.2
	b. Jointly done by MSW and other professionals	32	82.1
	c. Solely done by MSW	2	5.1
	d. Don't know	1	2.6
9.	Making referrals for community services for patients who require post-hospital care.		
	a. Solely done by other professionals	3	7.7
	b. Jointly done by MSW and other professionals	23	59.0
	c. Solely done by MSW	13	33.3
	d. Don't know	0	0
B.	**Counseling Services**	**N**	**%**
1.	Helping patients adjust to hospital routine and role as a patient.		
	a. Solely done by other professionals	2	5.1
	b. Jointly done by MSW and other professionals	30	76.9
	c. Solely done by MSW	3	7.7
	d. Don't know	4	10.3
2.	Helping patients adjust to separation from family.		
	a. Solely done by other professionals	2	5.1
	b. Jointly done by MSW and other professionals	27	69.2
	c. Solely done by MSW	7	18.0
	d. Don't know	3	7.7

3.	Assessing the emotional state of patients.		
	a. Solely done by other professionals	1	2.6
	b. Jointly done by MSW and other professionals	33	84.6
	c. Solely done by MSW	5	12.8
	d. Don't know	0	0
4.	Interpret the emotional feelings of patients to medical doctor.		
	a. Solely done by other professionals	3	7.7
	b. Jointly done by MSW and other professionals	29	74.3
	c. Solely done by MSW	6	15.4
	d. Don't know	1	2.6
5.	Helping patients with emotional problems related to their illness, disability or impending death.		
	a. Solely done by other professionals	2	5.1
	b. Jointly done by MSW and other professionals	33	84.6
	c. Solely done by MSW	3	7.7
	d. Don't know	1	2.6
6.	Assessing the psychological impact of patients' illness on their family.		
	a. Solely done by other professionals	2	5.1
	b. Jointly done by MSW and other professionals	30	76.9
	c. Solely done by MSW	5	12.8
	d. Don't know	2	5.1
7.	Helping families of patients with emotional problems related to their illness, disability or impending death.		
	a. Solely done by other professionals	1	2.6
	b. Jointly done by MSW and other professionals	30	76.9
	c. Solely done by MSW	7	17.9
	d. Don't know	1	2.6
8.	Conducting group counseling to patients and/or their families with emotional problems.		
	a. Solely done by other professionals	2	5.1
	b. Jointly done by MSW and other professionals	20	51.3
	c. Solely done by MSW	11	28.2
	d. Don't know	6	15.4

As shown in Table 4 (Statement A1), concerning the concrete services, 43.6% of physicians perceived that "assisting patients to make financial arrangement" as solely done by medical social workers, whereas 56.4% of them perceived that this task should be done jointly by medical social workers and other professionals. Besides, refer to Statement A7, 38.4% of them perceived that "determine patients' need for social services" should be done solely by medical social workers, whilst 59% of them perceived this task should be jointly done by medical social workers and other professionals. Besides, refer to Statements A2 and A3, one-fourth of physicians believed that "assessing social background and functioning of patients" have exclusively the medical social worker domain, even if three-fourth of them believed that these tasks should be done jointly by medical social workers and other professionals. Moreover, refer to Statements A5 and A6, when the social problems of patients are related to their families, about one-fourth of physicians perceived that these tasks should be the exclusive medical social work domain. But about three-fourth of physicians disagreed that these tasks are exclusively done by medical social workers, instead these tasks should be done jointly by medical social workers and other professionals. In addition, refer to Statement A9, one-third of physicians perceived the task of "making referrals to community services for patients" as exclusive domain of medical social workers, whilst 59% of them perceived this task as the domain of both medical social workers and other professionals. But it was interesting that 7.7% of them perceived this task as the domain of non-social work professionals.

Furthermore, despite responding physicians were more eager to refer patients with social problems to medical social workers, but Table 4 (Statement A4) revealed that

only 2.6 percent of them believed that "helping patients to solve social problems" was exclusively the medical social work domain, 97.4 percent of them perceived this task as the domain of both medical social workers and other professionals.

Finally, refer to Statement A8, 82.1% of physicians perceived the task of "determining type of extended care needed by patients" as the domain of both medical social workers and other professionals. But 10.2% of them excluded this task from the medical social work domain. There was only 5.1% of physicians perceived this task as the exclusive domain of medical social workers.

In sum, despite physicians referred frequently patients with social problems to medical social workers, the majority of them did not perceive the tasks involved to solve the social problems of patients were the exclusive domain of medical social workers. But when refered them to some tangible services, such as financial assistance, referrals to community services and deal with patients' needs for social services, one-third to two-fifth of them believed that these services should be done solely by medical social workers.

On the other hand, as shown in Table 4, concerning the counseling services, about 85% of physicians perceived that all tasks should be the domain of both medical social workers and other professionals. However, refer to Statements B3 and B4, 12.8% of them and 15.4% of them perceived that the tasks of "assessing the emotional state of patients" and "intrepreting the emotional feelings of patients to physicians" respectively were the exclusive domain of medical social workers. Besides, refer to Statements B6

and B7, when the emotional problems were related to patients' families, 12.8% and 17.9% of them percieved that the tasks of "assessing the psychological impact of patients' illness on their families" and "helping families of patients with emotional problems" respectively as the exclusive domain of medical social workers. Besides, refer to Statement B8, about one-third of physicians believed that "group counseling to patients and families" is the exclusive domain of medical social workers.

Above all, in this study, physicians perceived the role of medical social workers mainly dealing with patients' social problems, especially tangible problems, such as financial problem and caring problem. Some concrete services were perceived as the exclusive domain of medical social workers by some of responding physicians. But only a few counseling tasks were perceived as the exclusive domain of medical social workers by a few responding physicians. Although physicians disagreed that the counseling tasks were main and exclusive domain of medical social workers, they did not exclude medical social workers from these tasks. As shown in Table 5, 92.3% of responding physicians perceived the role of medical social workers consisted of both concrete services and counseling services, even if their major tasks were related to concrete services. Moreover, the findings in this part were consistent with the findings about physicians' actual practice, that is physicians frequently referred patients with social problems to medical social workers and less frequently referred to the latter to deal with patients' emotional problems.

Table 5 : Summary of Role Perception of Medical Social Workers by the Physician Group

Role Perception	Physician	
	N	%
1. Only concrete services	2	5.1
2. Both concrete services and counseling services	36	92.3
3. Only counseling services	0	0
4. Don't know	1	2.6

VI.1.iv Patterns of Interaction

This part focuses on the patterns of interaction between medical social workers and physicians, and how each professional group perceives the cooperation, working and professional attitudes of the other group. The data collected is used to explore if the extent of contacts between these two groups would affect each others' perception about working and professional attitudes, and then affect the perception of role of medical social workers by physicians. As mentioned before, effective and frequent interactions between physicians and medical social workers is assumed to facilitate mutual understanding, and to appreciate other team members of the opposing profession. There are two sections in this part – perception of working and professional attitudes and patterns of interaction. The finding are presented in the following tables.

Table 6 : Perception of Working and Professional Attitudes of Medical Social Workers by Physicians

	Preception of Working and Professional Attitude	**N**	**%**
1.	They are cooperative with other professionals over problems.		
	a. Strongly Agree	7	17.9
	b. Agree	32	82.1
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	0	0
2.	They are easy to talk to.		
	a. Strongly Agree	5	12.8
	b. Agree	31	79.5
	c. Neutral	3	7.7
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	0	0
3.	They are helpful.		
	a. Strongly Agree	6	15.4
	b. Agree	33	84.6
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	0	0
4.	They conduct things in a professional manner.		
	a. Strongly Agree	5	12.8
	b. Agree	23	59.0
	c. Neutral	8	20.5
	d. Disagree	1	2.6
	e. Strongly disagree	0	0
	f. Don't know	2	5.1
5.	They have clear professional objectives.		
	a. Strongly Agree	4	10.2
	b. Agree	20	51.3
	c. Neutral	11	28.2
	d. Disagree	1	2.6
	e. Strongly disagree	0	0
	f. Don't know	3	7.7

6.	They encourage collaboration.		
	a. Strongly Agree	4	10.3
	b. Agree	24	61.6
	c. Neutral	7	17.9
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	4	10.2
7.	They are sensitive to the problem of other professionals.		
	a. Strongly Agree	3	7.7
	b. Agree	16	41.0
	c. Neutral	13	33.3
	d. Disagree	1	2.6
	e. Strongly disagree	0	0
	f. Don't know	4	10.3
8.	They share knowledge about cases with other professionals.		
	a. Strongly Agree	5	12.8
	b. Agree	24	61.6
	c. Neutral	9	23.6
	d. Disagree	1	2.6
	e. Strongly disagree	0	0
	f. Don't know	0	0

As shown in Table 6 (Statements 1, 2 and 3), near 100% of physicians strongly agreed and agreed that medical social workers were "cooperative", "easy to talk to" and "helpful".

Besides, refer to Statements 4 and 5, about two-third of them strongly agreed or agreed that medical social workers "conduct things in a professional manner" and "have clear professional objectives". About one-third of them kept their impression "neutral" and "don't know" in this area. In addition, refer to Statement 6, about two-third of responding physicians strongly agreed or agreed that medical social workers "encourage collaboration", and one-third had the impression in the catagories of

"neutral" and "don't know". However, refer to Statement 7, only 41% of responding physicians agreed that medical social workers "were sensitive to the problem of other professions". Over two-fifth of them had the impression in the categories of "neutral" and "don't know". Finally, refer to Statement 8, 12.8% of them strongly agreed and 61.6% of them agreed that medical social workers "share knowledge about cases with other professionals", and 23.6% of them perceived this area as "neutral".

Above all, nearly all of responding physicians perceived that the working attitudes of medical social workers were good, but some of them disagreed that medical social workers practice in a professional manner and the like. Most importantly, the findings revealed that there was a substantial minority of responding physicians responded the categories of "neutral" and "don't know" about the working attitudes and professional manner of medical social workers. These findings reflected that these physicians might have only little understanding about the work and profession of medical social work and their interaction with medical social workers might be infrequent.

Table 7: Pattern of Interaction Between the Two Professional Groups as Perceived by Physicians

Nature of Interaction	Physician	
	N	%
1. Case conference		
a. Not at all	10	25.6
b. Seldom	12	30.8
c. Sometimes	6	15.4
d. Frequent	6	15.4
e. Always	4	10.2
f. No Answer	1	2.6

2.	Regular meeting		
	a. Not at all	14	35.9
	b. Seldom	16	41.0
	c. Sometimes	3	7.7
	d. Frequent	3	7.7
	e. Always	1	2.6
	f. No Answer	2	5.1
3.	Ward round		
	a. Not at all	14	35.9
	b. Seldom	14	41.0
	c. Sometimes	5	12.8
	d. Frequent	3	7.7
	e. Always	1	2.6
	f. No Answer	0	0
4.	Joint treatment		
	a. Not at all	9	23.1
	b. Seldom	7	17.9
	c. Sometimes	18	46.2
	d. Frequent	4	10.2
	e. Always	0	0
	f. No Answer	1	2.6
5.	Joint program		
	a. Not at all	14	35.9
	b. Seldom	8	20.5
	c. Sometimes	10	25.6
	d. Frequent	6	15.4
	e. Always	0	0
	f. No Answer	1	2.6
6.	Informal occasion		
	a. Not at all	11	28.2
	b. Seldom	14	35.9
	c. Sometimes	9	23.1
	d. Frequent	3	7.7
	e. Always	2	5.1
	f. No Answer	0	0

We now turn to the pattern of interaction between physicians and medical social workers. Before analyzing the findings, it is necessary to elaborate the meaning of the nature of each interaction. For case conference, it refers to the participation of multi-

disciplinary professionals to discuss the case nature and the welfare plan for patients. Regular meetings refers to the meetings called and chaired by hospital administrators to discuss the hospital plan or issues. Ward round means different groups of professionals to assess and handle the problems of patients. Ward round may be done by members of one professional groups or members from different professional groups together. Joint treatment means members from different professional groups to join together to deal with patients' problems. Joint program refers to those hospital activities organized or implemented by members from different professional groups. Finally, informal occasions refer to those recreational activities like ball games.

Table 7 shows the very important findings about the interactional pattern between physicians and medical social workers. 70% to 90% of physicians had infrequent interactions with medical social workers in all forms. As the interaction between physicians and medical social workers were infrequent, their understanding about the professional practice and domain, and work attitude was limited which might thus affect how they perceived the role and function of medical social workers.

IV.2 Findings Obtained from Medical Social Workers

IV.2.i The Characteristics of the Medical Social Worker Group

In this study, all medical social workers in the Hospital were included. As shown in Table 8, the majority of medical social workers in this study were female (83.3%), aged between 21 and 35 (99.9%) with medical social work experiences ranged from 1 year

or below (50%) to 2 years to 10 years (50%). Besides, half of them worked in Yan Chai Hospital for 1 year or below only and another half worked for 2 to 4 years. From these finding, the majority of medical social workers in Yan Chai Hospital were young and fresh with few professional experiences in working in hospital settings.

Table 8: The Characteristics of the Medical Social Worker Group

		N	%
Sex:			
	Male	1	16.7
	Female	5	83.3
		(6)	(100.0)
Age:	21 - 25	2	33.3
	26 - 30	2	33.3
	31 - 35	2	33.3
	36 - 40	(6)	(99.9)
Professionals experiences:	1 year or below	3	50.0
	2 - 4 years	1	16.7
	5 - 7 years	1	16.7
	8 - 10 years	1	16.7
		(6)	(100.1)
Years of Employment in Yan Chai Hospital :	1 year or below	3	50.0
	2 -4 years	3	50.0
		(6)	(100.0)

VI.2.ii The Health Care Conception

This part aims at collecting data concerning the medical social workers' points of view about the health care conception. Like the questionnaire for physicians, this part is divided into two sections. The first section explores the health care conception held by

medical social workers, whilst the second seciton tests their actual practice. The findings are analyzed to explore whether their actual practices are consistent with their health care conception. The findings are presented in the following tables.

Table 9 : The Health Care Conception Held by the Medical Social Work Group

	Health Care Conception	**Medical Social Worker**	
		N	**%**
1.	Health is the state of complete physical, mental and social well-being.		
	a. Strongly Agree	3	50.0
	b. Agree	3	50.0
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0
2.	Besides bio-medical factors, there is a link between emotionally stressful life events and illness.		
	a. Strongly Agree	2	33.3
	b. Agree	4	66.7
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0
3.	Besides bio-medical factors, there is a link between social factors, such as poverty, poor housing, unemployment and manual work, and illness.		
	a. Strongly Agree	1	16.7
	b. Agree	5	83.3
	c. Neutral	0	0
	d. Disagree	0	0
	e. Strongly Disagree	0	0
	f. Don't know	0	0

4. The task of medical doctor is to treat patients' disease only.

a.	Strongly Agree	0	0
b.	Agree	0	0
c.	Neutral	1	16.7
d.	Disagree	4	66.7
e.	Strongly Disagree	1	16.7
f.	Don't know	0	0

5. Health care services include a full spectrum of services from prevention to medical treatment, medical care, counseling and continuity of care.

a.	Strongly Agree	2	33.3
b.	Agree	4	66.7
c.	Neutral	0	0
d.	Disagree	0	0
e.	Strongly Disagree	0	0
f.	Don't know	0	0

6. Social, emotional and environmental conditions have a significant and measurable effect on illness recovery.

a.	Strongly Agree	2	33.3
b.	Agree	3	50.0
c.	Neutral	1	16.7
d.	Disagree	0	0
e.	Strongly Disagree	0	0
f.	Don't know	0	0

7. Social, emotional and environmental conditions have a significant and measurable effect on illness prevention.

a.	Strongly Agree	2	33.3
b.	Agree	4	66.7
c.	Neutral	0	0
d.	Disagree	0	0
e.	Strongly Disagree	0	0
f.	Don't know	0	0

8.	Illness-related behaviours, such as frustration, depression, worry and the like, will not disrupt personal coping abilities.		
	a. Strongly Agree	0	0
	b. Agree	0	0
	c. Neutral	2	16.7
	d. Disagree	3	50.0
	e. Strongly Disagree	2	33.3
	f. Don't know	0	0
9.	The hospital missions envisage both bio-medical and psycho-social factor in planning of health care services to patients.		
	a. Strongly Agree	0	0
	b. Agree	2	33.3
	c. Neutral	3	50.0
	d. Disagree	1	16.7
	e. Strongly Disagree	0	0
	f. Don't know	0	0

As shown in Table 9, similar to the findings of physicians, most of the responding medical social workers held the holistic health care conception. Refer to Statement 4, one out of six strongly disagreed and four of them disagreed that the task of physicians was to treat patients' disease only. Besides, refer to Statement 5, two of them strongly agreed and four of them agreed that "health care services include full spectrum of services from prevention to medical treatment, medical care, counseling and continuity of care". Concerning the hospital mission, refer to Statement 9, two of them agreed and one of them disagreed that the hospital missions did envisage both bio-medical and psycho-social factors in planning of health care services to patients.

Above all, nearly all of them held the conception of holistic health care.

Besides, as shown in Table 10 (Statement 1), 3 out of 6 of medical social workers, in actual practice, received frequently and always referrals from physicians to deal with patients' emotional problem. This finding was inconsistent with the findings of physicians that only about 15% of physicians frequently and always referred patients with emotional problems to medical social workers. This inconsistent finding might be due to the different conceptions about patients' emotional problem held by these two professional groups. Or it might be because, in actual practice, although physicians only referred these patients for medical social workers to deal with their social problems, the latter, during the intervening process, not only dealt with patients' social problems, at the same time also dealt with their emotional problems. On the other hand, refer to Statement 2, all of the responding medical social workers, in actual practice, indicated that they always and frequently received referrals from physicians to deal with patients' social problems. This finding is consistent with that of the physicians.

Furthermore, refer to Table 10 (Statements 3 to 6), two-third of medical social workers responded that they always paid highest priority in assessing patients' emotional condition and social background whereas there was only one-third of them always paid highest priority in treating patients' emotional problem and half of them paid frequent highest priority in treating patients' emotional problem, in contrast, five of them always paid highest priority in managing patients' social problems. This phenomenon might be caused by heavy referrals from physicians to manage patients' social problems.

Finally, refer to Statement 7, 3 out of 6 medical social workers indicated that their assessments and recommendations were seriously considered by physicians in planning

patients' treatment plan, while another half responded only "sometimes". To compare with the result of physician, there was only slightly difference.

In sum, to compare the actual practice of physicians with their health care conception held, there is great inconsistence. They believed that the health care provision should follow the conception of "holistic care", but in their actual practice, the majority of them paid only little attention and priority on assessing and dealing with patients' psycho-social problems. In contrast, the actual practice of medical social workers was consistent with their conception of holistic health care. They paid highest priority on assessing patients' emotional and social problems. Despite in actual practice, they could only afford limited time to deal with patients' emotional problem. It might be because they held heavy caseloads on managing patients' social problems as referred by physicians.

Table 10 : The Actual Practice of the Medical social Worker group

	Actual Practice	**N**	**%**
1.	I receive referrals from medical doctor to deal with patients' emotional problems.		
	a. Not at all	0	0
	b. Seldom	1	16.7
	c. Sometimes	2	33.3
	d. Frequent	2	33.3
	e. Always	1	16.7
	f. Don't know	0	0

2.	I receive referrals from medical doctor to deal with patients'social problems.		
	a. Not at all	0	0
	b. Seldom	0	0
	c. Sometimes	0	0
	d. Frequent	2	33.3
	e. Always	4	66.7
	f. Don't know	0	0
3.	I pay highest priority in assessing patients' emotional condition.		
	a. Not at all	0	0
	b. Seldom	1	16.7
	c. Sometimes	1	16.7
	d. Frequent	0	0
	e. Always	4	66.7
	f. Don't know	0	0
4.	I pay highest priority in treating patients' emotional condition.		
	a. Not at all	0	0
	b. Seldom	0	0
	c. Sometimes	1	16.7
	d. Frequent	3	50.0
	e. Always	2	33.3
	f. Don't know	0	0
5.	I pay highest priority in assessing patients' social background.		
	a. Not at all	0	0
	b. Seldom	0	0
	c. Sometimes	1	16.7
	d. Frequent	1	16.7
	e. Always	4	66.7
	f. Don't know	0	0
6.	I pay highest priority in managing patients' social problems.		
	a. Not at all	0	0
	b. Seldom	0	0
	c. Sometimes	0	0
	d. Frequent	1	16.7
	e. Always	5	83.3
	f. Don't know	0	0

7.	In patient's treatment plan, the assessment and recommendations of medical social workers are considered seriously.		
	a. Not at all	0	0
	b. Seldom	0	0
	c. Sometimes	3	50.0
	d. Frequent	0	0
	e. Always	3	50.0
	f. Don't know	0	0

VI.2.iii Role Perception of Medical Social Workers

In this study, the role of medical social workers is divided into two areas providing concrete services and counseling services. Medical social workers were asked to identify, according to their perception, whether which tasks were mostly the domain of medical social workers or other professionals, or jointly done by medical social workers and other professionals. This part aims at exploring the role and domain of medical social workers in hospitals, and the extent of role conflict faced by medical social workers.

Table 11: Role Perception of Medical Social Workers by the Medical Social Work Group

	Tasks	Medical Social Worker	
		N	%
A.	**Concrete Services**		
1.	Assisting patients to make financial arrangement for medical and other needs.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	4	66.7
	c. Solely done by MSW	2	33.3
	d. Don't know	0	0

2.	Gathering social histories of patients to supplement their medical histories.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	3	50.0
	c. Solely done by MSW	2	33.3
	d. Don't know	1	16.7
3.	Assessing social functioning of patients.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	4	66.7
	c. Solely done by MSW	2	33.3
	d. Don't know	0	0
4.	Helping patients with social problems related to their illness, disability or impending death.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	4	66.7
	c. Solely done by MSW	2	33.3
	d. Don't know	0	0
5.	Assessing the social impact of patients' illness on their family.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	1	16.7
	c. Solely done by MSW	5	83.3
	d. Don't know	0	0
6.	Helping families of patients with social problems related to patients' illness, disability or impending death.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	1	16.7
	c. Solely done by MSW	5	83.3
	d. Don't know	0	0
7.	Determine patients' need for social services.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	6	100.0
	c. Solely done by MSW	0	0
	d. Don't know	0	0

8.	Determine type of extended care needed by patients.		
	a. Solely done by other professionals	1	16.7
	b. Jointly done by MSW and other professionals	5	83.3
	c. Solely done by MSW	0	0
	d. Don't know	0	0
9.	Making referrals for community services for patients who require post-hospital care.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	3	50.0
	c. Solely done by MSW	3	50.0
	d. Don't know	0	0
B.	**Counseling Services**	**N**	**%**
1.	Helping patients adjust to hospital routine and role as a patient.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	5	83.3
	c. Solely done by MSW	0	0
	d. Don't know	1	16.7
2.	Helping patients adjust to separation from family.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	4	66.7
	c. Solely done by MSW	1	16.7
	d. Don't know	1	16.7
3.	Assessing the emotional state of patients.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	5	83.3
	c. Solely done by MSW	1	16.7
	d. Don't know	0	0
4.	Interpret the emotional feelings of patients to medical doctor.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	3	50.0
	c. Solely done by MSW	3	50.0
	d. Don't know	0	0

5.	Helping patients with emotional problems related to their illness, disability or impending death.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	4	66.7
	c. Solely done by MSW	2	33.3
	d. Don't know	0	0
6.	Assessing the psychological impact of patients' illness on their family.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	3	50.0
	c. Solely done by MSW	3	50.0
	d. Don't know	0	0
7.	Helping families of patients with emotional problems related to their illness, disability or impending death.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	2	33.3
	c. Solely done by MSW	4	66.7
	d. Don't know	0	0
8.	Conducting group counseling to patients and/or their families with emotional problems.		
	a. Solely done by other professionals	0	0
	b. Jointly done by MSW and other professionals	2	33.3
	c. Solely done by MSW	4	66.7
	d. Don't know	0	0

As shown in Table 11 (Statement A1), concerning the concrete services, 2 out of 6 medical social workers perceived that "assisting patients to make financial arrangement" was solely done by medical social workers, whereas four of them perceived that this task should be done jointly by medical social workers and other professionals. Besides, refer to Statements A2 and A3, 2 out of 6 medical social workers believed that "assessing social background and functioning of patients" were exclusively the medical social worker domain. Four of them believed that these task

should be done jointly by medical social workers and other professionals. Moreover, refer to Statement A4, 2 out of 6 medical social workers believed that "helping patients to solve social problems" was exclusively the medical social work domain, whilst 4 of them perceived this task was the domain of both medical social workers and other professionals. In addition, refer to Statement A5, when assessing the social problem of patients' families, half of the responding medical social workers agreed that it is the exclusive medical social work domain. However, in managing the social problem of patients' families, refer to Statement A6, 4 of the responding medical social workers perceived as their exclusive domain. Furthermore, it was very interesting to note that all responding of medical social workers, refer to Statement 2A7, perceived the task of "determining patients' need for social services" as not the exclusive medical social work domain. They thought that this task should be done jointly by medical social workers and other professionals. Besides, one of the responding medical social workers, refer to Statement A8, excluded the task of "determining type of extended care of patients" as their domain. Five of them perceived this task as the domain of both medical social workers and other professionals. Finally, refer to Statement A9, 3 out of 6 medical social workers agreed with the task of "making referrals to community services for patients" as exclusive domain of medical social workers. Half of them perceived this task as the domain of both medical social workers and other professionals.

Above all, it is quite clear that all medical social workers in this study perceived the role of providing concrete services within their domain, but most of them did not agree to take up these tasks exclusively. However, when the social problems are related to patients' families, the significant proportion of them perceived this task as their

exclusive domain.

On the other hand, refer to Table 11 (Statement B1) concerning the counseling services, five out of 6 medical social workers perceived that "helping patients adjust to hospital routine and role as a patient" was the domain of both medical social workers and other professionals. No medical social workers perceived this task as exclusive job of medical social workers. However, refer to Statement B2, concerning the task of "helping patients adjust to separation from family", only one of them perceived it as exclusive domain of medical social workers. About two-third of them believed this task as the domain of both medical social workers and other professionals. In addition, refer to Statement B3, five of them perceived that the task of "assessing the emotional state of patients" should be done jointly by medical social workers and other professionals. But one of them perceived this task as exclusive domain of medical social workers. However, refer to Statement B4, half of the responding medical social workers believed that " to interpret the emotional state of patients to physicians" was the exclusive domain of medical social workers. Moreover, as referred to Statement B5, two of them perceived the task of "managing patients" emotional problem was the exclusive domain of medical social workers. Four of them perceived this task as the domain of both medical social workers and other professionals. Furthermore, refer to Statement B6, half of the responding medical social workers believed that the task of "assessing the psychological impact of patients' illness on their families" is the exclusive domain of medical social workers. Refer to Statement B7, for the task of solving the emotional problem of patients' family, four of them perceived it as the exclusive domain of medical social workers. Finally, refer to Statement B8, four of responding medical

social workers believed that "group counseling to patients and families" was the exclusive domain of medical social workers. But two of them perceived this task as the domain of both medical social workers and other professionals.

In sum, as shown in Table 12, all responding medical social workers believed in providing both concrete services and counseling services, but compared with concrete services, most of them perceived that most tasks related to counseling services, especially deal with the emotional problems of patients' families and group counseling, as their exclusive domain. However, this perception would face a lot of challenge because physicians in this study paid little priority and relatively few of them frequently referred to patients' emotional problems to medical social workers.

Table 12: Summary of Role Perception of Medical Social Workers by the Medical Social Work Group

Role Perception	Medical Social Worker	
	N	%
1. Only concrete services	0	0
2. Both concrete services and counseling services	6	100.0
3. Only counseling services	0	0
4. Don't know	0	0

VI.2.iv Patterns of Interaction

This part focuses on the patterns of interaction between medical social workers and physicians, and how medical social workers perceive the working and professional attitudes of physicians.

Table 13 : Perception of Working and Professional Attitudes of Physicians by Medical Social Workers

	Perception of Working and Professional Attitude	**N**	**%**
1.	They are cooperative with other professionals over problems.		
	a. Strongly Agree	0	0
	b. Agree	3	50.0
	c. Neutral	2	33.3
	d. Disagree	1	16.7
	e. Strongly disagree	0	0
	f. Don't know	0	0
2.	They are easy to talk to.		
	a. Strongly Agree	0	0
	b. Agree	3	50.0
	c. Neutral	3	50.0
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	0	0
3.	They are helpful.		
	a. Strongly Agree	0	0
	b. Agree	2	33.3
	c. Neutral	4	66.7
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	0	0
4.	They conduct things in a professional manner.		
	a. Strongly Agree	0	0
	b. Agree	4	66.7
	c. Neutral	2	33.3
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	0	0
5.	They have clear professional objectives.		
	a. Strongly Agree	0	0
	b. Agree	3	50.0
	c. Neutral	2	33.3
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	1	16.7

6.	They encourage collaboration.		
	a. Strongly Agree	0	0
	b. Agree	2	33.3
	c. Neutral	3	50.0
	d. Disagree	0	0
	e. Strongly disagree	0	0
	f. Don't know	1	16.7
7.	They are sensitive to the problem of other professionals.		
	a. Strongly Agree	0	0
	b. Agree	0	0
	c. Neutral	2	33.3
	d. Disagree	3	50.0
	e. Strongly disagree	0	0
	f. Don't know	1	16.7
8.	They share knowledge about cases with other professionals.		
	a. Strongly Agree	0	0
	b. Agree	4	66.7
	c. Neutral	1	16.7
	d. Disagree	1	16.7
	e. Strongly disagree	0	2
	f. Don't know	0	0

As shown in Table 13 (Statements 1, 2, 3 and 6), half of the responding medical social workers agreed that physicians are "cooperative" and "easy to talk to", but one-third to half of them impressed "neutral" in these areas. And one of them disagreed that physicians are "cooperative". Besides, only two of them agreed that physicians are "helpful" and "encourage collaboration". 3 to 4 of them responded "neutral" in these areas. Moreover, refer to Statements 4 and 5, 3 to 4 of them agreed that physicians "practice in a professional manner" and "have clear professional objectives". But two of them responded "neutral" in these areas. In addition, refer to Statement 7, it was interesting to find out that three of the responding medical social workers disagreed that physicians "are sensitive to the problem of other professionals" and another half

responded "neutral" and "don't know". None of them impressed that "physicians are sensitive to the problem of other professionals". Finally, refer to Statement 3, four of the responding medical social workers agreed that physicians "share knowledge about cases with other professionals", but only one responded in the category of "neutral" and "disagree" respectively.

In sum, half of the responding medical social workers were impressed that physicians are "uncooperative", "unhelpful", "uneasy to talk to", and "not encourage collaboration". But most of them were impressed that physicians practiced in professional manner and had professional objectives, but they were not sensitive to the problem of other professionals. The majority of them also agreed that physicians did share knowledge about cases with other professionals. Above all, there was also a high proportion of the responding medical social workers, ranged from one-third to two-third, gave the answer "neutral" on their impression about the cooperation, working and professional attitudes of physicians. These findings reflect that the understanding about the profession and practice of physicians by the responding medical social workers might be inadequate, and the interaction between them might be limited.

Table 14: Pattern of Interaction Between the Two Professional Groups as Perceived by Medical Social Workers

Nature of Interaction	Medical Social Worker	
	N	%
1. Case conference		
a. Not at all	0	0
b. Seldom	1	16.7
c. Sometimes	1	16.7
d. Frequent	2	33.3
e. Always	2	33.3
f. No Answer	0	0

2.	Regular meeting		
	a. Not at all	1	16.7
	b. Seldom	2	33.3
	c. Sometimes	1	16.7
	d. Frequent	0	0
	e. Always	1	16.7
	f. No Answer	1	16.7
3.	Ward round		
	a. Not at all	0	0
	b. Seldom	1	16.7
	c. Sometimes	3	50.0
	d. Frequent	0	0
	e. Always	0	0
	f. No Answer	2	33.3
4.	Joint treatment		
	a. Not at all	1	16.7
	b. Seldom	0	0
	c. Sometimes	3	50.0
	d. Frequent	0	0
	e. Always	1	16.7
	f. No Answer	1	16.7
5.	Joint program		
	a. Not at all	0	0
	b. Seldom	3	50.0
	c. Sometimes	2	33.3
	d. Frequent	1	16.7
	e. Always	0	0
	f. No Answer	0	0
6.	Informal occasion		
	a. Not at all	1	16.7
	b. Seldom	3	50.0
	c. Sometimes	1	16.7
	d. Frequent	1	16.7
	e. Always	1	16.7
	f. No Answer	0	0

Finally, as shown in Table 14, 4 to 5 of the responding social workers had infrequent interactions with physicians in all forms except case conference. 4 of them responded

that they frequently interacted with physicians in the form of case conference.

The findings of the two professional group about their interactional pattern are consistent. Both groups revealed infrequent interaction between them in all forms, except case conference.

Chapter VII

Discussion

There are limitations in generalizing the results of this study because of the small sample size (39 for physicians and 6 for medical social workers) and because the study is conducted is a selected hospital. Such a small sample size always raises concern that the respondents may not represent the larger population of interest. Moreover, as the sample is obtained from a selected hospital, it cannot be assumed that the findings can generalize to members of the respective professional groups in other hospitals. Besides, as the size difference between the two groups is large, it is not easy to have meaningful comparsion. Therefore, the results of medical social workers is used to supplement the finding of physicians.

Given these limitations, the findings suggest that although most physicians believed that holistic health care with a good model in providing health care services to patients, in actual practice, they paid only little attention and priority on managing patients' psychosocial problems, even if most of them believed that the task of physicians was not to deal with patients' disease only. As they paid little attention on the psychosocial problems of patients, it is inevitable that they referred only small numbers of patients with emotional problem to medical social workers. In spite of physicians did not exclude medical social workers from providing counseling services to manage patients', most of them did not frequently refer patients with emotional problem to medical social workers. In this study, there is no findings to suggest that physicians had referred patients with emotional problems to non-social work professionals for treatment, or

they had just let their need unmet. Apparently, there was a rather great inconsistence between physicians' actual practice and their conception of health care. In principle, they held the holistic health care conception, but in practice, they followed the bio-medical model. This study does not suggest any reasons behind this phenomenon. But literature reveals that, as mentioned before, many medical professionals were likely to view patients' emotional disturbance as an obvious accompaniment of the somatic disturbance which "naturally" would be resolved upon the solution of that disturbance (Leigh and Reiser, 1980). Therefore, if patients' emotional disturbance is caused by illness, it will be naturally resolved when their illness is recovered. This implies that medical professionals might thus consider the provision of counseling and emotional support as time-consuming and secondary. Beside, Taylor and Ford (1989) suggest that the holistic health care exposes many medical professionals to all the uncertainties because they are unfamiliar to view patient as an unique ontological entity and as a social being. The multi-disciplinary approach also poses cause as a threat to their status and authority. Also from research findings, it is known that many medical professionals often felt uncomfortable to deal with the psychological or psychosocial problems of patients because they gave no great efficacy in treating them and they had seldom been trained in treating these problems (Tayler & Ford, 1989).

For more thorough and clear understanding about this phenomenon, it is highly recommended and essential to conduct another research study because it not only affects the provision of quality health care to patients but also affects the role definition and development of medical social work in the hospital setting. It is because medical professional, according to the role episode, is the role sender to affect the role of the

focal person, that is medical social worker.

On the other hand, the findings of medical social workers show that the actual practice of medical social workers was consistent with their conception of health care. They paid highest priority in managing the psychosocial problems of patients. But compared this with their priority paid to manage the social problems of patients, they accorded obvious higher priority to the latter. It may be because they received much more referrals from physicians to deal with patients' social problems than emotional problems. This explanation is supported by the findings of this study: there was a significant proportion of physicians perceived the major role of medical social workers as providing tangible services and concrete services to patients. This result may be relevant to the "bed clearance role" of medical social workers. Physicians might regard medical social workers as "their handmaiden" at heart. Although most of physicians did not exclude medical social workers from counseling services, they referred few patients with emotional problem to medical social workers. In this regard, how the emotional need of patients is met requires further exploration: whether it is managed by physicians themselves; or it is referred to non-social work professionals, such as clinical psychologists; or it is managed by nurses who keep frequent contacts with patients; or it is simply neglected.

Literature reveals that some authors suggest that medical social workers provide concrete services to patients only (Cabot,1928; Morris, 1974); some authors argue that the domain of medical social workers is providing counseling services or psychotherapy (Bartlett, 1961; Barker, 1987); and some authors view the domain of medical social

workers include both concrete services and counseling services (Bracht, 1978; Kane, 1980). There is a lack of consistency and universally accepted definitionon the role of medical social workers in hospital. Different health care professionals define the role of medical social workers differently. Medical social workers have consistent uncomfortable sense that their roles are misunderstood and misinterpreted by other medical and health care professionals. Previous researches (Olsen & Olsen, 1968; Carrigan, 1978 ; Lister, 1980; Cowles & Lefcowitz, 1992 & 1995; Egan & Kadushin, 1995) show that medical social workers expected their role to have more to do with counseling, Psychotherapy, or emotional and behavioural problems than what medical and health care professionals expect of their role. Although medical and health care professionals did not exclude medical social workers from providing counseling services to patients, they expected medical social workers to provide mainly concrete service to patients.

Besides, even if the small size of the sample of medical social workers in this exploratory study, the findings reveal that medical social workers had faced obvious role conflict . Most of them believed that concrete services should be included in their domain but they refused to accept these services as their exclusive domain. In contrast, concerning the counseling services, the significant proportion (ranged from one-third to half) of them perceived these services as their exclusive domain. To compare this finding with that of the physicians, a smaller proportion of later (about one-fifth) held the same perception regarding counseling service as the exclusive domain of medical social workers. The role conflict is obvious when the tasks are related to manage the psychosocial problems of patients' families. Above all, it is another essential area need

for further study. To study if which health care or medical professionals is or are most suitable to handle the psychosocial problems of patients' families. In this exploratory study, the physicians not only paid little priority and attention to manage patients' emotional problems, but also revealed their low preference for medical social workers to handle these problems, even if counseling service is the key domain of social work profession. In other words, medical social workers do have ability and knowledge to deal with patient' emotional problems. But in actual practice, they have only little opportunities to contribute in this area because their contribution is hindered by medical professionals who despite held holistic health care conception in mind, they paid only little priority to follow this conception in their actual practice. Most of them practiced under the bio-medical model of health care.

Finally, the findings suggest that the interaction between medical social workers and physicians was seldom. Their inadequate interaction means that they had little opportunities to exchange and share their practice and professional experiences. This might explain a significant proportion of responding physicians (about one-third) were "neutral" or "didn't know" whether medical social workers conducted things in a professional manner and whether they had professional objectives. In contrast, it is very interesting to point out that although the professional domain of physicians has been well-established, one-third of the responding medical social workers were "neutral" when asked about the professional manner and professional objectives of physicians. Moreover, all responding physicians agreed that medical social workers were helpful, cooperative and easy to talk to, whilst only one-third of their medical social work colleagues had the similar impression of them. In this study, we do not have sufficient

data to explain this discrepancy in expectation between the two professional groups. To conduct another study is highly recommended in this area because high quality health care services require inter-disciplinary approach with effective pattern of communication and interaction.

Implication for Further Study

In this exploratory study, it explored the areas of how physicians view the conception of health care and their actual practice; how do they perceive the role of medical social workers; what is the relationship between health care conception held by medical professionals and medical social workers and the latter's role conflict; and the interactional pattern between these two professional groups. However, as mentioned above, there are many other essential areas which could not be covered in this small scale exploratory study. But this study does facilitate some areas for further study. They are:

a. What are the reasons for medical professionals, in principle, hold the holistic health care conception, but in their actual practice, they pay only little attention on managing patients' emotional problems.

b. As medical professionals show low preference for medical social workers to deal with patients' emotional problems, how can these emotional problems be solved? and which professionals are most suitable to take up the responsibility to solve the emotional problems of patients.

c. How do the two professional groups interact and what is their communication pattern to exchange information?

d. As the sample size of this study is too small, a large scale survey is suggested to study the role conflict of medical social workers in the hospital setting it is because if medical social workers could not define their roles and functions according to their professional domain, their professional status, identification and development will be hindered.

Chapter VIII

Conclusion

The role of medical social workers in hospital has never been clearly defined. Ambiguity of role definition can contribute to problems in collaboration because roles may overlap and professions may compete in areas which are not clearly assigned to one discipline. Overlapping of roles can lead to duplication or lack of integration of interventions and services. A lack of clear role definition and expectations can enable a profession to assume new roles and functions. This situation can constitute an confusion on the domain of the profession claiming these functions as its own, even when there is no consensus these tasks belong to it (Kulys & Davis, 1987). In the hospital setting, collaboration with other medical and health care professionals is important for medical social work practice. When there is no consensus about what tasks are belonged to medical social workers and what tasks are belonged to the other health care professionals, they may feel frustrated, unappreciated, and threatened. In this exploratory study, responding physicians and medical social workers did not have a consensus about the role and function of the latter in hospitals. While medical social workers perceived their main roles and functions as providing counseling services to patients and their families; due to their different role expectations, physicians only referred few patients with emotional problems to medical social workers for treatment. Role ambiguity and role conflict do exist in medical social work's practice in the secondary setting of hospital.

Besides, this study explored the physicians' perception of health care conception, and the extent their actual practice was affected by it. It was found that most responding physicians held the holistic health care conception in mind, but in their actual practice, they paid only very limited time and attention on managing patients' psychosocial problems. This had great effect on the practice of medical social workers because they only referred a few patients to medical social workers for treatment of emotional problems. The seemingly 'unmet' emotional problems of patients are an area for concern. In contrast, medical social workers believed in holistic health care model and their practice was predominantly directly by it: medical social workers paid more attention and priority in providing counseling services to patients and their families. However, their practice orientation was greatly hindered by medical professionals who were the 'gate-keeper' by controlling case referrals in the hospital. Besides, by referring very few counselling cases to medical social wokrers, does it mean the responding physicians did not believe in the professional competence of their social work colleagues in handling the emotional problems of patients and their families? Needless to say, this is a great concern for social work practice in the secondary setting of the hospital.

Furthermore, the findings of this exploratory study reveal infrequent interactions between medical social workers and physicians in all forms of contacts. Hence, both groups of professionals had limited understanding of each other's professional domain, practice and objectives. Therefore, accordingly, the domain of medical social workers were misinterpreted and misunderstood by physicians.

Implication for Medical Social Work Practice

As suggested by the research findings, despite they referred few counselling cases to medical social workers, physicians in this study also believed that the domain of medical social work should include both concrete services and counseling services. However, they also believed that many tasks of medical social work in hospitals could be shared by non-social work professionals. Therefore, medical social workers may need to consider accepting a shared rather than dominant responsibility for many of their social work tasks. But in this shared responsibility, medical social workers must describe as accurately as possible the actual role they play. They have to take an active part in determining their own role. They have to take aggressive steps to ensure that they fulfill the roles they feel competent. They have to show the physician and the rest of health care team, in as much depth as possible, what they could accomplish and how.

Besides, medical social workers should actively establish effective communication channels with medical professionals and health care professionals so as to share with them the actual domain of medical social work, and at the same time to bring about their awareness of the effects of social and emotional factors in illness and recovery. The effective channels may include case conference, hospital meetings, ward round, coffee breaks, etc. In short, only if the medical profession and health care profession have the thorough understanding about the actual domain and professional objectives of medical social work, the professional identity of medical social work in hospitals can be achieved.

Besides, the study raises another practice issue. That is, what are the clinical components of the medical social work role in procuring concrete services? Is this a role focused narrowly on referring patients and families to services in the community? Or, alternatively, are psychosocial tasks, such as engaging patients and families in decision making about the treatment plan, helping them express feelings regarding discharge plan, part of the process of providing concrete services? The former role can become that of the handmaiden concerned with less professional tasks, whilst the latter role is consistent with professional practice. Hence, despite the nature of patients' problems is predominantly controlled by medical professional by the referral system, what kind of servcies or interventions provided by medical social workers to patients and families are within the control of medical social workers.

Finally, research is another useful method in promoting the professional domain of medical social workers and minimizing the role ambiguity and role conflict of medical social workers. Unfortunately, social workers have become defensive about the question of research, which has often been raised as a negative challenge implying the ineffectiveness of casework and other services (Fischer, 1973). But a positive direction is needed. As suggested by Black (1984,p.89), "social work will succeed in the goal of becoming a core health profession only if it achieves clarity about the psychosocial aspects of health and illness, the techniques workers apply, and the resulting outcomes". He further suggests that social work intervention needs to be described with enough specificity so that they can be replicated. Their outcomes will need to be defined and tested to refine intervention strategies and to demonstrate to others the impact of social work. Thus, the challenge is not to conduct research for its own sake. Research is a

means and not an end in itself, but to undertake it as a way to vertify and expand social work's knowledge and skills, improve the clinical services social workers have to offer and, equally important, to provide some of the important evidence social work will need in demonstrating its contributions in health care services, and then to negotiate more autonomy and authority in the hospital structure.

Appendix 1

Memorandum

仁 濟 醫 院
YAN CHAI HOSPITAL

From : Victor TAM, MSW
Extn. : 8073
Date : 31 May 1996

To : Dr. Cheng, HCE
via DM(MSS)

Research Project in YCH

I am studying a Master Program in Social Work at the Chinese University of Hong Kong. As part of requirement, I have to complete a research project which aims at exploring the relationship between role and function of medical social worker and the health care provision in hospital setting. As a staff of Yan Chai Hospital, I propose to select Yan Chai Hospital as the case for my research project.

I would like to seek your approval to allow me to conduct the research project in the hospital. Your kind support is very essential for the success of the study.

Victor TAM
Medical Social Worker
YCH

Appendix 2

Memorandum

仁 濟 醫 院
YAN CHAI HOSPITAL

From : Victor TAM, MSW
Extn. : 8073
Date : 5 June 1996

To :

Research Project in YCH

I am studying a Master Program in Social Work at the Chinese University of Hong Kong. As part of requirement, I have to complete a research project which aims at exploring the relationship between role and function of medical social worker and the health care provision in hospital setting. As a staff of Yan Chai Hospital, I propose to select Yan Chai Hospital as the case for my research project. The project has been approved by Dr. CHENG, HCE.

It is hoped that this study will provide useful information that will facilitate better collaboration between medical social worker and medical professional, and the development of a health care delivery system that is more beneficial to patients and their families.

You have been selected through a random sampling method. It is sincerely hoped that you would kindly complete the attached Questionnaire and return it to me at Patient Resources Centre before **12.6.96**. The information collected was strictly confidential.

I would be very much appreciate your help in completing the research project. Your kind support is very essential for the success of the study. If you have any question about the research project, please feel free to contact me at Extn. 8073.

Victor TAM
Medical Social Worker
YCH

Appendix 3

A Research on Social Work Practice in Secondary Setting — The Case of Medical Social Work in Hospital Setting in Hong Kong

Questionnaire for Medical Professional

[Part I]

A. To what extent do you agree with the following statements about the conception of health care?

Please ☑ whichever appropriate.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know	
1.	Health is the state of complete physical, mental and social well-being.	❑	❑	❑	❑	❑	❑	❑
2.	Besides bio-medical factors, there is a link between emotionally stressful life events and illness.	❑	❑	❑	❑	❑	❑	❑
3.	Besides bio-medical factors, there is a link between social factors, such as poverty, poor housing, unemployment and manual work, and illness.	❑	❑	❑	❑	❑	❑	❑
4.	The task of medical doctor is to treat patients' disease only.	❑	❑	❑	❑	❑	❑	❑
5.	Health care services include a full spectrum of services from prevention to medical treatment, medical care, counseling and continuity of care.	❑	❑	❑	❑	❑	❑	❑

6.	Social, emotional and environmental conditions have a significant and measurable effect on illness recovery.	❑	❑	❑	❑	❑	❑	❑
7.	Social, emotional and environmental conditions have a significant and measurable effect on illness prevention.	❑	❑	❑	❑	❑	❑	❑
8.	Illness-related behaviours, such as frustration, depression, worry and the like, will not disrupt personal coping abilities.	❑	❑	❑	❑	❑	❑	❑
9.	The hospital missions envisage both Bo-medical and psychosocial factors in planning of health care services to patients.	❑	❑	❑	❑	❑	❑	❑

B. To what extent the following statements applied in your actual practice?

Please ☑ whichever appropriate.

		Not at all	Seldom	Sometimes	Frequent	Always	Don't know	
1.	I refer patients to medical social workers to deal with their emotional problem.	❑	❑	❑	❑	❑	❑	❑
2.	I refer patients to medical social workers to deal with their social problems.	❑	❑	❑	❑	❑	❑	❑

3.	I pay highest priority in assessing patients' emotional condition.	❑	❑	❑	❑	❑	❑	❑
4.	I pay highest priority in treating patients' emotional problem.	❑	❑	❑	❑	❑	❑	❑
5.	I pay highest priority in assessing patients' social background.	❑	❑	❑	❑	❑	❑	❑
6.	I pay highest priority in managing patients' social problems.	❑	❑	❑	❑	❑	❑	❑
7.	In patient's treatment plan, the assessment and recommendations of medical social workers are considered seriously.	❑	❑	❑	❑	❑	❑	❑

[Part II]

To what extent the following tasks, according to your perception, are performed by medical social workers?

Please ☑ whichever appropriate.

A. Concrete Services

		Solely done by other professionals	Jointly done by MSW & other professionals	Solely done by MSW	Don't know	
1.	Assisting patients to make financial arrangement for medical and other needs.	❑	❑	❑	❑	❑

2.	Gathering social histories of patients to supplement their medical histories.	❑	❑	❑	❑	❑
3.	Assessing social functioning of patients.	❑	❑	❑	❑	❑
4.	Helping patients with social problems related to their illness, disability or impending death.	❑	❑	❑	❑	❑
5.	Assessing the social impact of patients' illness on their family.	❑	❑	❑	❑	❑
6.	Helping families of patients with social problems related to patients' illness, disability or impending death.	❑	❑	❑	❑	❑
7.	Determine patients' need for social services.	❑	❑	❑	❑	❑
8.	Determine type of extended care needed by patients.	❑	❑	❑	❑	❑
9.	Making referrals for community services for patients who require post-hospital care.	❑	❑	❑	❑	❑

B. Counseling Services

1.	Helping patients adjust to hospital routine and role as a patient.	❑	❑	❑	❑	❑

2.	Helping patients adjust to separation from family.	❑	❑	❑	❑	❑
3.	Assessing the emotional state of patients.	❑	❑	❑	❑	❑
4.	Interpret the emotional feelings of patients to medical doctor.	❑	❑	❑	❑	❑
5.	Helping patients with emotional problems related to their illness, disability or impending death.	❑	❑	❑	❑	❑
6.	Assessing the psychological impact of patients' illness on their family.	❑	❑	❑	❑	❑
7.	Helping families of patients with emotional problems related to their illness, disability or impending death.	❑	❑	❑	❑	❑
8.	Conducting group counseling to patients and/or their families with emotional problems.	❑	❑	❑	❑	❑

C. **<u>In your perception</u>, medical social workers provide**

❑ Only concrete services ❑
❑ Both concrete services and counseling services
❑ Only counseling services
❑ Don't know

[Part III]

A. To what extent do you agree with the following statements about the impression of medical social workers you have encountered with?

Please ☑ whichever appropriate.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know	
1.	They are cooperative with other professionals over problems.	❑	❑	❑	❑	❑	❑	❑
2.	They are easy to talk to.	❑	❑	❑	❑	❑	❑	❑
3.	They are helpful.	❑	❑	❑	❑	❑	❑	❑
4.	They conduct things in a professional manner.	❑	❑	❑	❑	❑	❑	❑
5.	They have clear professional objectives.	❑	❑	❑	❑	❑	❑	❑
6.	They encourage collaboration.	❑	❑	❑	❑	❑	❑	❑
7.	They are sensitive to the problem of other professions.	❑	❑	❑	❑	❑	❑	❑
8.	They share knowledge about cases with other professionals.	❑	❑	❑	❑	❑	❑	❑

B. In your experience, what is extent of contacts with medical social workers in regards to the following ways?

Please ☑ whichever appropriate.

		Not al all	Seldom	Sometimes	Frequent	Always	No answer	
1.	Case conference	❑	❑	❑	❑	❑	❑	❑
2.	Regular meeting	❑	❑	❑	❑	❑	❑	❑
3.	Ward round	❑	❑	❑	❑	❑	❑	❑
4.	Joint treatment	❑	❑	❑	❑	❑	❑	❑
5.	Joint program	❑	❑	❑	❑	❑	❑	❑
6.	Informal occasion e.g. lunch, sport activities.	❑	❑	❑	❑	❑	❑	❑

[Part IV] Personal Data :

Please ☑ whichever appropriate.

1. Sex :

❑	Male	❑	Female	❑

2. Age :

❑	21 - 25	❑	26 - 30	❑
❑	31 - 35	❑	36 - 40	
❑	41 - 45	❑	46 - 50	
❑	51 - 55	❑	56 or above	

3. How long have you worked for this hospital?

- ❑ 1 year or below
- ❑ 2 - 4 years
- ❑ 5 - 7 years
- ❑ 8 - 10 years
- ❑ above 10 years

4. How long have you held your current job?

- ❑ 1 year or below
- ❑ 2 - 4 years
- ❑ 5 - 7 years
- ❑ 8 - 10 years
- ❑ 11 - 13 years
- ❑ 14 - 16 years
- ❑ 17 - 19 years
- ❑ 20 years or above

5. Specialty :

- ❑ Medicine
- ❑ Surgical
- ❑ O & T (Orthopaedic)
- ❑ Paediatrics
- ❑ A & E
- ❑ GOPD
- ❑ ICU
- ❑ ENT.
- ❑ Others (Please specify : _____)

END

THANK YOU!!

A Research on Social Work Practice in Secondary Setting — The Case of Medical Social Work in Hospital Setting in Hong Kong

Questionnaire for Medical Social Worker

[Part I]

A. To what extent do you agree with the following statements about the conception of health care?

Please ☑ whichever appropriate.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know	
1.	Health is the state of complete physical, mental and social well-being.	❑	❑	❑	❑	❑	❑	❑
2.	Besides bio-medical factors, there is a link between emotionally stressful life events and illness.	❑	❑	❑	❑	❑	❑	❑
3.	Besides bio-medical factors, there is a link between social factors, such as poverty, poor housing, unemployment and manual work, and illness.	❑	❑	❑	❑	❑	❑	❑
4.	The task of medical doctor is to treat patients' disease only.	❑	❑	❑	❑	❑	❑	❑
5.	Health care services include a full spectrum of services from prevention to medical treatment, medical care, counseling and continuity of care.	❑	❑	❑	❑	❑	❑	❑

6.	Social, emotional and environmental conditions have a significant and measurable effect on illness recovery.	❑	❑	❑	❑	❑	❑	❑
7.	Social, emotional and environmental conditions have a significant and measurable effect on illness prevention.	❑	❑	❑	❑	❑	❑	❑
8.	Illness-related behaviours, such as frustration, depression, worry and the like, will not disrupt personal coping abilities.	❑	❑	❑	❑	❑	❑	❑
9.	The hospital missions envisage both bio-medical and psychosocial factors in planning of health care services to patients.	❑	❑	❑	❑	❑	❑	❑

B. To what extent the following statements applied in your actual practice?

Please ☑ whichever appropriate.

		Not at all	Seldom	Sometimes	Frequent	Always	Don't know	
1.	I receive referrals from medical doctor to deal with patients' emotional problems.	❑	❑	❑	❑	❑	❑	❑
2.	I receive referrals from medical doctor to deal with patients' social problems.	❑	❑	❑	❑	❑	❑	❑

3. I pay highest priority in assessing patients' emotional condition. ❑ ❑ ❑ ❑ ❑ ❑ ❑

4. I pay highest priority in treating patients' emotional problem. ❑ ❑ ❑ ❑ ❑ ❑ ❑

5. I pay highest priority in assessing patients' social background. ❑ ❑ ❑ ❑ ❑ ❑ ❑

6. I pay highest priority in managing patients' social problems. ❑ ❑ ❑ ❑ ❑ ❑ ❑

7. In patient's treatment plan, my assessment and recommendations are considered seriously by medical professional. ❑ ❑ ❑ ❑ ❑ ❑ ❑

[Part II]

To what extent the following tasks, according to your perception, are performed by medical social workers?

Please ☑ whichever appropriate.

A. Concrete Services

	Solely done by other professionals	Jointly done by MSW & other professionals	Solely done by MSW	No comment	
1. Assisting patients to make financial arrangement for medical and other needs.	❑	❑	❑	❑	❑

2.	Gathering social histories of patients to supplement their medical histories.	❑	❑	❑	❑	❑
3.	Assessing social functioning of patients.	❑	❑	❑	❑	❑
4.	Helping patients with social problems related to their illness, disability or impending death.	❑	❑	❑	❑	❑
5.	Assessing the social impact of patients' illness on their family.	❑	❑	❑	❑	❑
6.	Helping families of patients with social problems related to patients' illness, disability or impending death.	❑	❑	❑	❑	❑
7.	Determine patients' need for social services.	❑	❑	❑	❑	❑
8.	Determine type of extended care needed by patients.	❑	❑	❑	❑	❑
9.	Making referrals for community services for patients who require post-hospital care.	❑	❑	❑	❑	❑

B. Counseling Services

1.	Helping patients adjust to hospital routine and role as a patient.	❑	❑	❑	❑	❑

2.	Helping patients adjust to separation from family.	❑	❑	❑	❑	❑
3.	Assessing the emotional state of patients.	❑	❑	❑	❑	❑
4.	Interpret the emotional feelings of patients to medical professional.	❑	❑	❑	❑	❑
5.	Helping patients with emotional problems related to their illness, disability or impending death.	❑	❑	❑	❑	❑
6.	Assessing the psychological impact of patients' illness on their family.	❑	❑	❑	❑	❑
7.	Helping families of patients with emotional problems related to their illness, disability or impending death.	❑	❑	❑	❑	❑
8.	Conducting group counseling to patients and/or their families with emotional problems.	❑	❑	❑	❑	❑

C. <u>In your perception</u>, medical social workers provide

❑ Only concrete services ❑
❑ Both concrete services and counseling services
❑ Only counseling services
❑ No Answer

[Part III]

A. To what extent do you agree with the following statements about the impression of medical doctors you have encountered with?

Please ☑ whichever appropriate.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know	
1.	They are cooperative with other professionals over problems.	❑	❑	❑	❑	❑	❑	❑
2.	They are easy to talk to.	❑	❑	❑	❑	❑	❑	❑
3.	They are helpful.	❑	❑	❑	❑	❑	❑	❑
4.	They conduct things in a professional manner.	❑	❑	❑	❑	❑	❑	❑
5.	They have clear professional objectives.	❑	❑	❑	❑	❑	❑	❑
6.	They encourage collaboration.	❑	❑	❑	❑	❑	❑	❑
7.	They are sensitive to the problem of other professions.	❑	❑	❑	❑	❑	❑	❑
8.	They share knowledge about cases with other professionals.	❑	❑	❑	❑	❑	❑	❑

B. In your experience, what is extent of contacts with medical doctors in regards to the following ways?

Please ☑ whichever appropriate.

		Not al all	Seldom	Sometimes	Frequent	Always	No answer	
1.	Case conference	❑	❑	❑	❑	❑	❑	❑
2.	Regular meeting	❑	❑	❑	❑	❑	❑	❑
3.	Ward round	❑	❑	❑	❑	❑	❑	❑
4.	Joint treatment	❑	❑	❑	❑	❑	❑	❑
5.	Joint program	❑	❑	❑	❑	❑	❑	❑
6.	Informal occasion e.g. lunch, sport activities.	❑	❑	❑	❑	❑	❑	❑

[Part IV] Personal Data :

Please ☑ whichever appropriate.

1. Sex :

❑	Male	❑	Female	❑

2. Age :

❑	21 - 25	❑	26 - 30	❑
❑	31 - 35	❑	36 - 40	
❑	41 - 45	❑	46 - 50	
❑	51 - 55	❑	56 or above	

3. How long have you worked for this hospital?

- ❑ 1 year or below
- ❑ 2 - 4 years
- ❑ 5 - 7 years
- ❑ 8 - 10 years
- ❑ above 10 years

4. How long have you held your current job?

- ❑ 1 year or below
- ❑ 2 - 4 years
- ❑ 5 - 7 years
- ❑ 8 - 10 years
- ❑ 11 - 13 years
- ❑ 14 - 16 years
- ❑ 17 - 19 years
- ❑ 20 years or above

5. Specialty :

- ❑ Medicine
- ❑ Surgical
- ❑ O & T (Orthopaedic)
- ❑ Paediatrics
- ❑ A & E
- ❑ GOPD
- ❑ ICU
- ❑ ENT.
- ❑ Others (Please specify : _____)

END

THANK YOU!!

BIBLIOGRAPHY

A BASW Working Party Report, "The Social Work Task", 1977.

Abramson, J., & Mizrahi, T., "Strategies for Enhancing Collaboration Between Social Workers and Physicians", Social Work in Health Care, Vol. 12(1), Fall 1986.

Anderson, R. & Anderson, O.W., "Trends in the Use of Health Services", In Freeman, H.E, Levine, S. & Reeder, L.G., "Handbook of Medical Sociology" Ed. 3, Englewood Cliffs, NJ., Prentice-Hall, Inc., 1979.

Badawi, M., & Biamonti, B., "Social Work Practice in Health Care", Woodhead-Faulkner, 1990.

Banton, Michael, "Roles: An Introduction to the Study of Social Relations", Tavistock Publications, 1965.

Bartlett, H.M., "Social Work Practice in the Health Field", National Association of Social Workers (U.S.A.), 1961.

Bartlett, H.M., "Ida M Cannon : Pioneer in Medical social Work", The Social Service Review, Vol. 49, No. 1, March 1975.

Bartlett, H.M., "A Professional Reminiscence", Health & Social Work, vol. 1, No. 1, Feb. 1976.

Belson, W.A., "The Design and Understanding of Survey Questions", Gower Publishing Co. Ltd., 1981.

Ben-Sira, A. & Davies, P., "Social Work and Health Care", Heinemann Educational Book, 1984.

Ben-Sira, A. "Social Work in Health Care : Needs, Challenges and Implications for Structuring Practice", social Work in Health Care, Vol. 13 (1), 1987.

Bergman, A.S., Contro, N. & Zivetz, N., "Clinical Social Work in a Medical Setting", Social Work in Health Care, 9, 1984.

Biddle, B.J., & Thomas, E.J., "Role Theory : Concepts and Research", John Wiley & Sons, Inc., 1966.

Black, D.B., Morrison, J., Snyder, L. & Tally, P., "Model fro Clinical Social Work Practice in a Health Care Facility", Social Work in Health Care, 3, 1977.

Black, D.B., "Looking Ahead : Social Work as a Core Health Profession ", Health & Social Work, Vol. 9, Vol. 2, Spring 1984.

Blackey, E., "Social Work in the Hospital : A Sociological Approach", social Work, Vol. 1, No. 1, Jan, 1956.

Blazyk, S. & Canavan, M., "Therapeutic Aspects of Discharge Planning", Social Work, 30(6), 1985.

Blazyk, S. & Canavan, M., "Managing the Discharge Crisis Following Catastrophic Illness or Injury", Social Work in Health Care, 11(4), 1986.

Boaz, R.F., "Health Care System", In Turner, J.B., "Encyclopedia of social Work", NASW, 1977.

Bracht, N.F., "Social Work in Health Care : A Guide to Professional Practice", The Haworth Press, 1978.

Brody, E.M., "Long Term Care : The Decision-making Process and Individual Assessment", Social Welfare Forum, May 10, 1975.

Brody, S.J., "Common Ground : Social Work and Health Care", health & Social Work, Vol. 1, No. 1, Feb. 1976.

Butrym, A., & Horder, J., "Health, doctors and social workers", Routledge & Kegan Paul, 1983.

Butrym, Zofia, "Social Work in Medical Care", Routledge & Kegan Paul, 1967.

Bywaters, P., "Social work and The Medical Profession - Arguments Against Unconditional Collaboration", British Journal of Social Work, 16, 1986.

Caputi, M.A., "Social Work in Health Are : Past and Future", Health and Social Work, Vol. 3, No. 1, February 1978.

Carlton, T.O., "Clinical Social Work in Health Settings" A Guide to Professional Practice with Exemplars", Springer Publishing co., New York, 1984.

Caroff, P., "Clinical Social Work : Present Role and Future Challenge", Social Work in Health Care, Vol. 13 (3), 1988.

Carrigan, Z.H., "Social Workers in Medical Settings : Who Defines Us?", Social Work in Health Care, Vol. 4(2), Winter 1978.

Carter, D. & Jinks, J., "The Next Step in Medical Social Work", Social Work Today, 2, 1972.

Clarke, S., Neuwirth, L., & Bernstein, R.H., "An Expanded Social Work Role in a University-based Group Practice : Service Provider , Physician Educator, and Organizational Consultant", Social Work in Health Care, Vol. 11(4), 1986.

Coulton, C., "Discharge Planning as a Decision -making Process", Discharge Planning Update, 1(3), 1981.

Cowles, L.A., & Lefcowitz, M.J., "Interdisciplinary Expectations of the Medical Social Worker in the Hospital Setting", Health & Social Work, Vol. 17(1), 1992.

Cowles, L.A., & Lefcowitz, M.J., "Interdisciplinary Expectations of the Medical Social Worker in the Hospital Setting: Part 2", Health & Social Work, Vol. 20(4), 1995.

Dana, B., Banta, H.D. & Deuschle, K.W., "Agenda for the Future of Inter-professionalism"., in Rehr, Helen, "Medicine and Social Work : An Exploration in Inter-professionalism", New York: Prodist, 1974.

Dane, B.O., & Simon, B.L., "Resident Guests : Social Workers in Host Settings", Social Work, No. 36, 1991.

Davidson, K.W., "Evolving Social Work Roles in Health Care : The Case of Discharge Planning", Social Work in Health Care, Vol. 4(1), Fall 1978.

Davidson, K.W., " Role Blurring and the Hospital Social Worker's Search for a Clear Domain", Health and Social Work, Vol. 15(3), 1990.

Donnelly, J.P.l " A Frame for Defining Social Work in a Hospital Setting", Social Work in Health Care, Vol. 18, No. 1, 1992.

Doyal, L. & Epstein, S.S., "Cancer in Britain : The Politics of Prevention ", London, Pluto Press, 1983.

Egan, M. & Kadushin, G., "Competitive Allies: Rural Nurses' and Social Workers' Perceptions of the Social Work Roln the Hospital Setting", Social Work in Health Care, Vol. 20(3), 1995

Enos, D.D. & Sultan, P., "The Sociology of Health Care : Social, Economics, and Political Perspectives", Praeger Publishers, 1977.

Fanshel, David, "Future of Social Work Research", National Association of Social Workers Inc., 1980, pp.119-137.

The Federation C.B., "An Ecological Perspective on social Work Practice in Health Care", Social Work in Health Care, Vol. 3(1), Fall 1977.

Fink, A., "How to Analyze Survey Data", SAGE Publications, 1995.

Fuchs, V.R., "Who shall Live? Health Economics and Social Choice", New York : Basic Books, Inc., 1974.

Germain, C.B., "Social Work Identity, Competence, and Autonomy : The Ecological Perspective", Social Work in Health Care, Vol. 6(1), Fall 1980.

Goldie, K., "Social Workers, Views of their Roles as Discharge Planners with Elderly Patients in Acute Care Hospitals", UM1 Dissertation Services, 1989.

Goldstine, Dora, "Readings in the Theory & Practice of Medical Social Work", The University of Chicago Press, 1954.

Gross, A.M., & Taylor, P.A., "Social Work Practice in Health Care Settings", 2nd edition, Canadian Scholars' Press, 1992.

Hardy, M.E.& Conway, M.E., "Role Theory: Perspectives for Health Professionals", Appleton & Lange, 1988.

Hay, J.W., "Health Care in Hong Kong : An Economic Policy Assessment", The Chinese University Press, 1992.

Heyman, M., "A Study of Effective Use of Social Workers in Hospital: Selected Findings and Conclusions", Social Service Review, 35(4), 1961.

Hong Kong Social Workers Association, "Position Paper on the Provision of Medical social Services in Hospitals, Sept. 1991.

Hornby, S., "Collaborative Care : Inter-professional, Interagency and Inter-personal", Blackwell Scientific Publications, 1993.

"Hospital Authority Annual Report 1991-1992", Hospital Authority.

"Hospital Authority Annual Plan 1996-1997 ", Hospital Authority.

Howard, J. & Strauss, A., " Humanizing Health Care", John Wiley & Sons, 1975.

Huntington, J., " Social Work and General Medical Practice: Collaboration or Conflict?", George Allen & Unwin, 1981.

Illich, I., "Medical Nemesis : The Expropriation of Health", London : Calder & Boyars, Ltd., 1975.

Jones, R.H., "The Doctor and the Social Services", The Athlone Press, 1971.

Joseph, M.V. & Conrad, A.P., "Social Work Influence on Interdisciplinary Ethical Decision Making in Health Care Settings", Health & Social Work, Vol. 14, 1989.

Kadushin, G. & Kulys, R. "Job Satisfaction Among social Work Discharge Planners", Health & Social Work, vol. 10, No. 3, August `995.

Kahn, R.L., "The Social Psychology of Organizations", John Wiley & Sons, Inc., 1966.

Kane, R., "Discharge Planning : A undischarged responsibility?", Health & Social Work, 5(1), 1980.

Keller, S.M., Domanski, M.D., Macks, G., Manley, J.J., & Winder, D.E.L., "Productivity Measurement System for Administrators of Social Work Programs in Health Care", Society for Social Work Administrators in Health Care, 1993.

Kerson, T.S., "Medical Social Work : The Pre-professional Paradox", New York : Irsington, 1981.

Kogan, L.S., "Social Science Theory and Social Work Research", National Association of Social Workers, 1959, pp.28-45.

Kruzich, J.M. & Powell, W.E, "Decision -making Influence : An empirical study of Social Work, Vol. 20, No. 3, august 1995.

Kulys, R., "Future Crises and the Very Old : Implications for discharge planning", Health & Social Work, 8, 1983.

Kylys, R., & Davis, S.M., "Nurse, and Social Workers : Rivals in the Provision of Social Services?" Health & Social Work, Vol. 12, 1987.

Leigh, H. & Reiser, F., "The Patient", New York, Plenum, 1980.

Linton, Relph, "The Study of Man", New York : Appleton-Century, 1936.

Lister, L., "Role Expectations of Social Workers and Other health Professionals", health & Social Work, Vol. 5, No. 2, may 1980.

Lowe, J.I., & Herranen, M., "Conflicting in Teamwork : Understanding Role and Relationships", Social Work in Health Care, Vol. 3(3), Spring 1978.

Mailick, M.D., & Jordon, P., "A Multi-model Approach to Collaborative Practice in Health Settings", Social Work in Health Care, 2, 1977.

Makris, D., "An Assessment of Core Social Work Journals from 1980 to 1985 with Particular Reference to Research & Practice Implications", Unpublished Masters' Thesis, Faculty of Graduate Studies, School of Social Work, University of Windsor, 1987.

Mechanic, D., "Handbook of Health, Health Care, and the Health Professions", The Free Press, 1983.

Merton, R.K. "Social Theory & Social Structure", Glencee Ill. : Free Press, 1949.

Meyer, C.H., "The Perils and Promises of the Health Practice domain"., social Work in Health Care, Vol. 10(2), Winter, 1984.

Miller, R.S. & Rehr, H., "Social Work Issues in Health Care", Prentice Hall, Inc., Englewood Cliffs, New Jersey, 1983.

Mizraki, T. & Abramson, J., "Sources of Strain Between Physicians and Social Workers : Implication for Social Workers in Health Care Settings", Social Work in Health Care, 10, 1985.

Morris, R., "Social Work Function in a Caring Society : Abstract Value, Professional Preference and the Real World", Journal of Education for Social Work, 14(2), 1978.

Moser, C.A. & Kalton, G., "Survey Methods in Social Investigation", 2nd Ed., Gower Publishing Co. Ltd., 1989.

Nacman, M., "A Systems Approach to the Provision of Services in Health Settings", social Work in Health Care, 1, 1975.

Navarro, V., " Health & Medical Care in the United State: A critical analysis", Baywood Publishing Co. Inc., 1975.

Nuyens, Y. & Vansteenkiste, J. "Teaching Medical Sociology", Martinus Nijhoff Social Sciences Division : Boston, 1978.

Oakley, A. "Women Confined : Towards a Sociology of Childbirth", Robertson, 1980.

Olsen, K.M. & Olsen, M.E., "Role Expectations and Perceptions for Social Workers in Medical Settings", Social Work, July 1967.

Oppenheim, A.N., "Questionnaire Design and Attitude Measurement", Heinemann, London, 1966.

Patti, R.J., & Ezell, M., "Performance Priorities and Administrative Practice in Hospital Social Work Departments", social Work in Health Care, Vol. 13(3), 1988.

Peterson, K.J., "Changing Needs of Patients and Families in the Acute Care Hospitals: Implications for Social Work Practice", Social Work in Health Care, Vol. 13(2), 1987.

Phillips, B., McCulloch, J.W., Brown, M.J. & Hambro, N., "Social Work & Medical Practice", Hospitals, Feb., 1971.

Pray, J.E., "Responding to Psychosocial Needs ; Physician Perceptions of their Referral Practices for Hospitalized Patients", Halth & Social Work, Volume 16, No. 3, August 1991.

Prins, H.A. & Whytem M.B.H., "Social Work and Medical Practice", Pergamon Press, 1972.

Quartaro, E.G., & Hutchison, R.R., "Interdisciplinary Education for Community Health : The Case for Nursing and Social Work Collaboration", Social Work in Health Care, Vol. 1(3), Spring 1976.

Ratliff, B.W., Timberlake, E.M., & Jentsch, D.P., "Social Work in Hospitals", Charles C. Thomas Publisher, 1982.

Raymond, F.B., "Social Work Education for Health care Practice", Social Work in Health Care, Vol. 2, No. 4, Summer 1977.

Rehr, H., "More Thoughts in American Health Care", New York, Rodist, 1982.

Rehr, H., "Health Care and social Work Services : Present Concerns and Future Directions", Social Work in Health Care, Vol. 10(1), Fall 1984.

Roberts, C.S., "Conflicting Professional Values in Social Work and Medicine", Health & Social Work, Vol. 14, No. 1, Feb. 1989.

Roberts, H., "The Patient Patients", Pandora, 1985.

Rosenberg, G., & Rehr, H., "Advancing Social Work Practice in the Health Care Field : Emerging Issues and New Perspectives", The Haworth Press, 1983.

Ross, J.W., "Health Social Work : Narrowing the Gulf between practice and academia", Health & Social Work, volume 9, No. 3. August 1994.

Ross, M., " The Social Workers and Primary Teachers: Inter-professional Perception, Communication and Cooperation", The British Library, 1987.

Rubin, A., & Babbie, E., "Research Methods for Social Work", 2nd edition, Wadsworth, Inc., 1993.

Ruster, P.L., "The Evolution of Social Work in a Community Hospital", Social Work in Health Care, Vol. 20(4), 1995.

Sandman, G., "Discharge Planning : A social Worker's Perspective", In McKeehan, K. "Continuing Care" ed., St. Louis, C.V. Mosby, 1981.

Sarbin, T., "Role Theory", in Gardner, L. "The Handbook of Social Psychology", Addison Wesley Publishers, 1954, pp.223-258.

Schilling, R.F. & Schilling, R.F., "Social Work & Medicine : Shared Interests", Social Work, 32, 1987.

Schlesinger, E.G., & Wolock, I., "Hospital Social Work Today", Vol. 13, No. 48, 1982.

Schlesinger, E.G., "Health Care Social Work Practice, Concepts and Strategies", St. Louis, Times Mirror/Mosby, 1985.

Schrager, J., "Social Work Departments in Selected University Affiliated Hospitals", Michigan, 1973.

Seedhouse, D. & Cribb, A., "Changing Ideas in Health Care", John Wiley & Sons, 1989.

Selltiz, C., Wrightsman, L., & Cook, S.W., "Research Methods in social Relations", New York : Holt, Rinehart & Winston, 1976.

Shanas, E. "Measuring the Home Health Needs of the Aged in five Countries", Journal Gerontology 26, January 1971.

Shrager, J., "Social Work Departments in University Hospitals : Some issues in manpower utilization", Syracuse, NY : Syracuse University Press, 1974.

Skidmore, R.A., Thackeray, M.G., & Farley, O.W., "Introduction to Social Work", 5th Edition, Prentice-Hall International, Inc., 1991, pp.148-162.

The Social Welfare Department, "The Medical Social Service in the Social Welfare Department".

Stamps, P.L. & Piedmonte, E.B., " Nurses & Work Satisfaction: An Index for Measurement", Health Administration Press Perspectives, 1986.

Stanfield, P.S., "Introduction to the Health Professions", Jones & Bartlett Publishers, Inc., 1990.

Stein, H.D. & Cloward, R.A., "Social Perspectives on Behavior", The Free Press, New York, 1958, pp.171-262.

Strean, Herbert S., "Role Theory, Role Models and Casework : Review of the Literature and Practice Applications", Social Work, April 1967.

Taylor, R. & Ford, J., "Social Work and Health Care", Jessica Kingsley Publishers, 1989.

Taylor, S. & Field, D., "Sociology of Health and Health Care", Blackwell Scientific Publication, 1993.

Thueson, J., "Panel Provides 1978 Update on Hospital Social Work", Hospitals, August 1978.

Tibbitt, J. & Connor, A., "Change and Diversity in Hospital social Work". In Taylor, R. & Ford, J., "Social Work & Health Care", Jessica Kingsley Publisher, 1989.

Toren, N., "Social Work: The Case of a Semi-Profession", SAGE Publishions, 1972.

Towle, C., "The Learner in Education for the Professions", Chicago : University of Chicago Press, 1954.

Vourlekis, B.S. & Leukefeld, C.G., "Making Our Case : A Resource Book of Selected Materials for Social Workers in Health Care", NASW, 1989.

Watt, M.S., "Therapeutic Facilitator : The Role of the Social Worker in Acute Treatment Hospitals in Ontario", University of California, 1977.

Weick, Ann, "The Concept of Responsibility in a Health Model of Social Work", Social Work in Health Care, Vol. 10(2), Winter 1984.

Wertz, R.W., "Readings on Ethical and Social Issues in Biomedicine", Englewood Cliffs, N.J. : Prentice-Hall, 1973.

Whyte, P., " Social Work & Medical Practice", Pergamon Press, 1972.

Williams, C.C., Bracht, N.F., Williams, R.A., & Evans, R.C., "Social Work and Nursing in Hospital Settings : A Study of Inter-professional Experiences", Social Work in Health Care, Vol. 3(3), Spring 1978.

William, J.A., "Hospital Management in the Tropics & Subtropics", MacMillan, 1990.

Wilson, J., & Setturlund, D., "Towards Holistic Social Work Practice in General Medical Settings", Social Work in Health Care, Vol. 12(2), Winter 1986.

Wollock, I., & Russell, H.J., "Physicians Views and Use of Social Services", Journal of Perth Amboy General Hospital, October 1972.

World Health Organization, "Constitution of the World Health Organization, Preamble", Geneva, Switzerland, 1946.

Zola, I.K., "Medicine as An Institution of Social Control", In Cox, C. & Mead, A. (eds.), "A Sociology of Medical Practice", London, Collier-macMillar, 1975.