PITY OR PEDESTAL?
PERCEPTIONS AND PRACTICES OF CHRONIC DISEASE AND DISABILITY
IN HOSPITAL SOCIAL WORK

by

Heather Lamb

Bachelor of Journalism, Carleton University, 2001

PRACTICUM SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

December 2012

© Heather Lamb, 2012
Abstract

This practicum report details my experiences in hospital social work on two medical wards at a regional hospital in British Columbia, located outside the Lower Mainland. The practicum learning goals are framed around professional understanding of disability and chronic disease within the hospital environment. While the focus of the practicum was on developing my own social work experience, I have included my perceptions of the larger hospital system as it relates to people with disabilities with implications for social work practice noted. The medical and social models of disability will be used to provide a basis for understanding the practical experiences encountered in this work. This report and practicum do not include any research data, but rather focus on personal growth as a practitioner and awareness of the ways the medical system works.
Table of Contents

ABSTRACT .................................................. II

TABLE OF CONTENTS ........................................ III

ACKNOWLEDGEMENTS ........................................ V

CHAPTER ONE: INTRODUCTION .......................... 1

CHAPTER TWO: SITUATING MYSELF IN HOSPITAL SOCIAL WORK .... 3

CHAPTER THREE: LITERATURE REVIEW .................... 7

TERMINOLOGY ................................................. 7

HISTORY AND CONTEMPORARY BREADTH OF HOSPITAL SOCIAL WORK ....... 9
  Models of disability ........................................ 12
  Supervision ................................................ 14

DELINEATION OF ROLES IN HOSPITAL SOCIAL WORK ..................... 17

ETHICS IN HOSPITAL SOCIAL WORK .......................... 22

THEORIES OF DISABILITY ....................................... 26
  Theories of disability in hospital work ..................... 29

CHAPTER FOUR: ORGANIZATIONAL INFORMATION .................. 35

CHAPTER FIVE: PRACTICUM LEARNING CONTRACT ................... 36

GENERAL ACTIVITIES .......................................... 36
  Shadowing experienced social workers in several departments ...... 36
  Discharge planning and referral ......................................... 37
  Actively participating in interdisciplinary team meetings ........... 38
  Grief and loss work with patients and families ...................... 38
  Psychoeducational and education work with patients and families ... 39
  Assessments .................................................................. 40

SPECIFIC GOALS .............................................. 41
  Knowledge of medical/social issues faced by social workers .......... 41
  Knowledge and use of community resources .......................... 42
  Knowledge of a range of health services, programs and health professionals .... 43
  Knowledge of medical terminology ............ 45
Knowledge around adult guardianship and adult protection ........................................ 45
Communication and intervention skills ............................................................................. 46
Understanding of the medical and social models of disability in hospital social work ... 48

CHAPTER SIX: PRACTICUM ACTIVITIES AND LEARNINGS ................................................. 50

FRAMING MY OBSERVATION AND LEARNING METHODS ..................................................... 50

EYESIGHT ................................................................................................................................. 51
Physical environment .................................................................................................................. 52
Recognition of people ............................................................................................................... 52
Perceptions of disability from other staff .................................................................................. 53

HOSPITAL SOCIAL WORK AS I EXPERIENCED IT ............................................................. 59
Regular activities ....................................................................................................................... 59
Unusual situations ..................................................................................................................... 60

CHAPTER SEVEN: IMPLICATIONS FOR HOSPITAL-BASED PRACTITIONERS ..................... 62

CHAPTER EIGHT: CONCLUSION ......................................................................................... 66

REFERENCES .......................................................................................................................... 67
ACKNOWLEDGEMENTS

I would like to express my deep appreciation to my academic supervisor, Dawn Hemingway, who has provided incredible support and encouragement to me throughout my Masters degree. Sandra Harker, my agency supervisor, has been a wonderful teacher, coach, mentor, and support during my practicum; her passion for this work is one of the reasons I chose to focus on hospital social work in the first place. Dr. Nancy Jokinen, my third committee member, has been immensely generous in sharing her knowledge of disability studies and research practices. My thanks also go to Dr. Glen Schmidt, who has taught me so much about social work practice and academic writing.

I owe a debt of gratitude to the patients for sharing their stories with me and trusting me to assist them during their stay in hospital. They taught me a lot about resilience, human nature, and the process of interacting with the medical system. I also owe a special thanks to all the staff who welcomed me, taught me about their various professions, allowed me to shadow them and ask numerous medical questions, and generally helped me become part of the professional team. Their hard work and dedication was wonderful to witness.

Pat Harris deserves a special mention for providing a wonderfully supportive and enjoyable work environment throughout my first year of this program and for being my sounding board when I became overwhelmed. The following people have also made an important contribution to my academic pursuits over the years: Elizabeth Woods, who told me to write, a skill which has an important but underrated value in social work; Dave Tait, who encouraged me into the helping professions; Ryan James and the entire supervisory team at the UNBC Community Care Centre, for the help and support in developing my clinical skills; my classmates, for being part of the process with me from the first day; and my parents, for being there through everything.
CHAPTER ONE: Introduction

Hospital social work is a challenging career that ideally should include extensive on-the-job training for new hires. However, the reality of the work environment means that orientation time is limited. Doing a practicum in hospital social work meant I received top-quality training in how to do the job; it also meant hard work, a steep learning curve, and development in my personal and professional abilities. I knew right from the start that this was the right placement for me, a feeling which was confirmed throughout my placement; however, it was not an easy practicum choice. I struggled with many of the ethical dilemmas inherent in hospital work, as well as the challenges of working with people undergoing significant medical treatments or approaching death. My focus on disability within this environment, which is consistent with my overall study and work interests, was made more personal by my own visual impairment.

This practicum was a fulfilling, challenging, and educational experience that has taught me a lot about myself, our hospital system, our society, and how to work effectively as a social worker to enhance the care that people with disabilities or chronic health concerns receive in the hospital. It became clear to me that while I enjoy hospital social work and hope to find opportunities to return to this setting after graduation, this type of work is not for everyone. In this report I will give the reader a better sense of what hospital work is, through exploration of its history, ethical challenges, role definitions, and its perceptions of disability. I will include a description of the typical activities a social worker on the Internal and Family Medicine Units would engage in, as well as the learning process that I experienced, both professionally and personally, as I moved through my practicum.
This report consists of eight chapters. Chapter One introduces the concepts of hospital social work and my learning process. Chapter Two focuses on my background and experience as they relate to hospital social work. The literature review in Chapter Three provides information on terminology used in hospital social work, the history of hospital social work and how it is practiced now, a description of the current roles in hospital social work, ethical challenges frequently encountered in hospital work, and the theories of disability that underpin my practicum learnings. Chapter Four includes information about the organization and structure where the practicum took place. Chapter Five outlines my learning contract and how I met the goals set out in it. Chapter Six describes my practicum learnings in detail and provides further information on hospital social work through my experiences. Chapter Seven focuses on implications for social work practice specific to disabilities and hospital work, and Chapter Eight summarizes my practicum experiences.
CHAPTER TWO: Situating Myself in Hospital Social Work

Having a disability with respect to my vision, some of my earliest memories involve being in the hospital in Vancouver for eye surgery and hearing stories from my mother, a nurse, about her work. Various employment experiences have allowed me to interact with the health care system on behalf of and with clients who have a variety of disabilities. This ranged from writing notes to doctors about issues that clients had difficulty communicating directly to their doctors, to sitting in during medical assessments for provincial disability benefits. I have also had the opportunity to hear stories from people with spinal cord injury about their experiences in acute care and rehabilitation after an accident, as well as the ongoing challenges of accessing appropriate specialist medical care outside the BC Lower Mainland.

I knew that my position as a person with a disability would impact how I work within the system. I have benefited greatly from medical interventions which have allowed me to maximize my vision. At the same time, I know the importance of advocacy when dealing with the medical system. I can also appreciate the importance of incorporating the social model into the ongoing medical care that people receive. I identify strongly with Field’s (1993) assertion that, “I don’t hide my disability and I don’t ‘overcome’ it either. It’s just something I live with” (p. 18). I also do not consider myself to be a “supercrip” (Janz & Rak, 2007, p. 82), whereby a person with a disability is viewed by society as doing something extraordinary and put on a pedestal because of it. My vision is an integral part of who I am, but it does not define me.

In general, I do not think it was obvious to the patients I came into contact with that I have a disability; however, my knowledge of disability issues and oppression from a personal
perspective informed how I perceived the situations I witnessed within hospital social work. Priestly (1997) argues that disability researchers must be aware of how being a person with a disability versus an able-bodied person doing research on people with disabilities affects the final outcome. Although this practicum did not involve a research component, my learning and ability to perform hospital social work duties was impacted by my personal experience. I would suggest that I have a unique position, having a disability that is not obvious to the casual observer. This background gave me the ability to interact with people in the hospital ostensibly from the able-bodied perspective and without the labels that are often put on people with disabilities, but with the intimate knowledge of what it means to live with a disability. However, as I will discuss later, the way I was perceived by a few staff members because of my disability did become part of my practicum learning experience. Because I was not doing research, I generally did not disclose my disability to patients. In a few selected circumstances I did mention it, usually because I had walked by a patient already known to me, without recognizing them. I also brought it up with a couple of patients who were dealing with vision loss, in circumstances where I felt that limited and specific self-disclosure would be beneficial to their adjustment process.

I made my supervisor aware of the potential challenges I might face working in the hospital setting with my level of vision. These included: difficulty reading patient files or notes if they are handwritten or in small font, the possible need for larger print on a computer, and challenges in recognizing the faces of either patients or staff. Vernon (1997) suggests that when a researcher, or in this case a practicum student, identifies strongly with members of the group being observed, exercises in reflexivity are essential to understanding the experience. Reflexivity was a part of ongoing supervision sessions as well as an essential
component in the journaling that I did daily throughout the practicum. Reflexivity involves self-awareness and self-understanding, including the capacity to "undertake an ongoing examination of what I know and how I know it" (Patton, 2002, p. 64, original emphasis). Reflective thinking requires awareness of the experiences that affect current thinking and how new events are woven into self-concept (Patton). Although I did not expect my disability to affect my relations with staff, when it did come up, I found reflexivity helpful. I started by reflecting on my own, through writing, walking, and thinking; once I felt more comfortable with my own response to what was happening, I discussed it with supervisors.

My own experiences prior to this practicum had aroused my interest in exploring how people with physical disabilities experience our health care system and how the psycho-social needs of the people receiving the service are addressed. I was interested to see how I could use my social work knowledge to work within the system to facilitate communication between patients and professionals to enhance the experience that people with disabilities have in health care. As I entered this practicum, I was very aware that my previous work experience had only allowed me to see one aspect of our health care system. I was curious how social workers manage to stay true to social work values while working within a system that has been largely built on the medical model. I wanted to explore how the medical and social models are integrated within hospital social work, in particular regarding people with physical disabilities.

My goal was not to judge the system, but rather to better understand how it works and whether there are aspects of the continuum of care that could be enhanced to better serve the needs of people with disabilities and all patients. As is the case with someone new to any setting, I think it is important to avoid jumping to conclusions based on initial impressions,
hence why I spent a lot of time observing the mechanics of the hospital system and trying to understand why it works the way it does. I feel that this approach enabled me to experience aspects of the system that would have been closed to me if I had come in with a more judgemental attitude. Staff members from all professions were willing to take the time to explain their processes to me, which allowed me to learn a wider range of perspectives on patient care in the hospital. While my conclusions about my practicum experience are based on my social work education and on the social model of disability lens, my insight into the larger system has assisted me in coming to an understanding of hospital social work that reflects the diversity of professional work that occurs within the hospital.
CHAPTER THREE: Literature Review

Hospital social work has been around in various forms as long as social work itself has been identified as a separate job classification; it paralleled the rise of the modern hospital environment (Cowles, 2000). While there are many similarities between hospital social work and social work in other contexts, some features of hospital work are unique and will be explored here to provide context for my practicum experience. Extensive reading before the practicum helped me to better understand what I was seeing at the hospital and provided an important foundation for my practicum work. No amount of reading, however, can replace practical experience.

Terminology

The literature includes references to both patients and clients in the context of hospital social work. Although I generally prefer to use the term client for my social work practice, the term patient will be used in this report to remain consistent with the terminology used by other professionals in the hospital setting. I found this distinction helpful during my time at the hospital because it made communication with all staff easier.

Disability has many meanings, which are based on context and theoretical lens; these will be explored further in the section on disability theories. For the contexts of this practicum and report, the focus will be on physical impairments, with an understanding that there is often overlap between physical and mental health concerns. Although age by itself is not a disability, changes in functioning that occur during the aging process can cause a person to experience similar societal challenges to those experienced by people with disabilities (Overall, 2006). Therefore, the social constructs of aging will be accepted as part of the larger context of disability for the purposes of this report.
Independence is another term that has several different meanings. As Beaulaurier and Taylor (2001) point out, when used in the medical context independence usually means being physically able to complete daily living tasks without assistance from another person or device. However, for people with limited physical functioning, independence is usually understood by those familiar with disability issues to mean the ability and opportunity to determine one’s own care, which includes who will provide assistance and when and how it will be provided (Beaulaurier & Taylor). Some of the forms used in the hospital setting do not make this distinction clear, so I struggled initially with how to fill in certain sections on the forms to accurately reflect the systemic understanding of the term, while staying true to my beliefs that anyone can be independent when provided with the right resources.

The terms hospital social work and medical social work are both used in the literature. Social work in health care settings is also a common term. Hospital social work has been defined as:

the provision of social services in hospitals and similar health centres, most often within a facility’s department of social services or social work. The services provided include: preventive, rehabilitative, and follow-up activities, as well as discharge planning and information gathering and providing. Other services include assisting patients with the financial and social aspects of their care and counselling patients and their families. (Barker, 1999, p. 221)

In contrast, medical social work has been defined as:

The social work practice that occurs in hospitals and other health care settings 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. Medical social
work also sensitizes other health care providers about the social-psychological aspects of illness. (Barker, 1999, p. 296)

The definition of hospital social work is preferred because it includes a more comprehensive understanding of the reasons patients find themselves in a hospital setting. It also provides a more extensive list of what a social worker in this setting might be expected to do, which is consistent with the literature explored in the section on role delineation. For the sake of clarity, the term hospital social work will be used in this report, to indicate the physical location where this practicum took place, rather than the more general reference to health care settings. Also, the social workers at the hospital refer to themselves as hospital social workers, making this the preferred term.

**History and Contemporary Breadth of Hospital Social Work**

The exact origins of hospital social work in North America are difficult to ascertain, because the earliest incarnations of the role were not called social work per se and social work roles evolved differently in various health settings (Dhooper, 1997). Between about 1850 and 1900, health care in the United States became more organized, with the development of hospitals that resemble our modern institutions (Doss-Martin & Stokes, 1989). Dhooper suggests that one of the earliest social work positions in a hospital was at Massachusetts General Hospital in Boston. Dr. Richard Cabot felt it was important to have a comprehensive understanding of the patient’s circumstances, including family and home issues; to gather this information he used a model similar to one he had observed at a Children’s Aid Society (Dhooper). Other hospitals followed this model and social work roles were gradually implemented in hospitals across North America.
In his review of the history of hospital social work in the United States, Nacman (1990) argues that social work has moved away from its narrow focus in the late 1800s which involved the “‘friendly visitor’, sympathetic to the plight of the patients, but paternalistic and moralistic” (p. 11). Busca (1992) suggests that early social workers worked from a charitable stance and were concerned mainly with the “material welfare of patients who [were] about to leave the hospital” (p. 36). However, Praglin (2007) argues that some early social workers were aware that factors external to the person affected health. Ida Cannon, one of the pioneering hospital social workers, stated that:

> It is because of the complexity of the social problems involved in the various groups of patients, and the interdependence of the medical and social treatment, in any attempt at adequate solution, that the social worker is needed in our hospitals.

(Cannon, 1913, cited in Judd & Sheffield, 2010, p. 869)

This early conceptualization has been maintained in the profession and has helped to inform other professionals about the nature of hospital social work. Over the past century, “social workers have helped to break down barriers that separated the physical aspects of patient care from psychosocial factors” (Nacman, p. 20). Busca argues that while social workers are still interested in ensuring appropriate fit between the patient and the environment, the work is now “informed by the knowledge of social factors and how they underpin individual concerns” (p. 36). Although social workers still spend much of their time working with individuals, structural factors as described by Mullaly (2010) inform the education of professionals, as well as the framework by which current hospital social work is carried out. I found that the hospital social workers I had contact with are very much aware of structural issues and work on a daily basis to advocate for patients and for a better system. Because this
work is often done at the same time as work for individual patients, it can be hard to differentiate between the two.

Hospital social work, at its core, aims “to clarify and address the psycho-social factors associated with diagnosis and treatment of the patient’s medical illness” (Gregorian, 2005, p. 2). Today, this also includes work with the patient’s family, knowledge of community resources, discharge planning, end-of-life issues, and child protection cases (Gregorian). Because hospitals do not gain any revenue from the services that social workers provide, restructuring often involves elimination of social work positions, or role amalgamation with other professionals (Gregorian). Butterfield (1989) points out that social workers “improve the scope and quality of patient care” (p. 68); however, as Silverman (2008) notes, most hospital administrators do not have a social work background, meaning that social workers have to make an extra effort to ensure that social work values are followed and appreciated in the organization. According to Silverman, hospital social work:

has settled into a functional survival mode. Drifting efficiently from crisis to crisis, we react to the winds of change but have lost navigational rights to the ship. In an ecological environment that is not conducive to social work life, we adapt-and at times survive-but creative leadership and change management required for true growth has proved difficult. (p. 90)

Consequently, social workers must be willing and able to understand the system within which they work, while developing the ability to advocate for change from within. Sulman, Savage, Vrooman, and McGillivray (2005) point out the importance of social workers using their advocacy skills to facilitate change, both for patients and for the profession as a whole. At the
same time, social workers also need to continue to refine what hospital social work is and what it can or should be within an ever-evolving health care system (Dhooper, 1997).

During my practicum I regularly witnessed social workers discussing the profession and its scope with other professionals. This was done for a number of reasons, including to ensure that patients received adequate social work support while in hospital or upon discharge, as well as to enhance recognition within the system of the valuable work that social workers do in the hospital environment. This recognition is essential in creating a culture where social work is considered a necessary element in the range of health care options provided to patients in the hospital setting. The social workers appeared to be very comfortable doing this and I found myself having similar conversations later in my practicum, especially with staff members who were newer to the hospital and interested in learning about all professions that have a role in patient care.

**Models of disability**

Llewellyn and Hogan (2000) describe a number of models used in disability studies. Although they point out the limitations of relying on theoretical models, they suggest that models can help us understand information and ways of working or doing research.

**Medical model**

Most health organizations are built primarily on the medical or disease model. Mackelprang and Salsgiver (2009) define this as involving a focus on pathology, problem resolution within the reality of the diagnosis, and an emphasis on fixing the problem. Beaulaurier and Taylor (2001) argue that medical rehabilitation for people with disabilities became much more prominent after the Second World War, bringing social workers into close contact with people who have disabilities. The stated goal of this work was to restore a
person's physical functioning to the point that a return to paid labour was possible, even if that meant "altering patients in ways that made them more physically capable of dealing with an unaltered world" (Beaulaurier & Taylor, p. 71, original emphasis). While physical rehabilitation is an important part of the medical care that people receive, if the focus remains on restoration or cure for too long, the person may start to feel de-valued if the medical interventions are ultimately unsuccessful in fixing the disease or disability (Beaulaurier & Taylor). In fact, Doss-Martin and Stokes (1989) suggest that modern hospitals have not adapted well to new chronic disease patterns, relying instead on organizational methods developed when hospitals were first created and disease patterns were far different. Bracht (1990) argues that most modern medical problems are chronic or long-term in nature, meaning that a focus on different ways of treating these patients should be part of the ongoing modifications to our health care system.

It is logical that doctors follow the medical model, especially immediately after an accident or injury when saving life, limbs, and maximum functioning is necessary. Fook (1993) suggests that making decisions for a person can be justified during a crisis, but as soon as the immediate situation is dealt with, the individual’s opportunity to make choices must be restored and encouraged. This includes decisions about medical care. Beaulaurier and Taylor (2001) point out that social workers have an important role to play in helping people take control over their medical decisions as soon as possible, with the goal of ensuring they can do as much as is possible or appropriate independently before they leave the hospital. The possibility of transition from the medical model, or acute medical care, to the social model, will be explored throughout this report. The emphasis will be on understanding how hospital care can shift away from the "outmoded notions of the social worker in
opposition to the hierarchical medical model in hospitals in favor of a much more collaborative approach” with all team members, including the patient and family (Duffy & Healy, 2011, p. 112).

**Social model of disability**

Over the longer term of a patient’s care, the social model of disability brings in an important perspective that acknowledges the larger societal issues surrounding disability. This model focuses on the environmental or structural challenges related to disability or disease, rather than locating the problem within the individual (Mackelprang & Salsgiver, 2009). Under this model, social workers focus on awareness of and change to societal barriers, while providing advocacy, interventions, and education to patients. Gregorian (2005) suggests that the interplay between these two models is an ongoing challenge for hospital social workers, especially regarding interdisciplinary team meetings. I noticed during my practicum that social workers need to regularly bring up and emphasize the importance of recognizing structural barriers because these concepts are not at the forefront of organizational thinking when it comes to disability and health care. The section on disability theories will explore this issue further.

**Supervision**

Supervision was an important part of this placement. As Pockett (2003) explains, quality of supervision is an essential part of whether practicum students choose to pursue employment in hospital settings after completing school. Gregorian (2005) defines hospital supervision as an “interactive process [where] clinicians can discuss difficult cases, identify issues of counter-transference and become more skilled in understanding the impact of the systems issues on their practice” (p. 12). Gregorian’s use of the word interactive is important,
and is consistent with Tsui’s (2005) argument that supervision should be a “horizontal relationship of professional peers” (p. 128), rather than being seen as a negative or disciplinary activity. With a practicum, the student must take a lead role in ensuring that supervision needs are being met, both to provide for adequate learning opportunities and to ensure that the student’s emotional well-being is maintained throughout the experience. I found that I was able to ask for what I needed in terms of supervision. I benefited from strong supervision during this practicum, which included regular debriefing as necessary and ongoing opportunities to talk through situations related either to specific patients or the system, in order to maximize my learning.

My supervisor provided mainly educational supervision, which Erera and Lazar (1994) define as “the transmission of professional knowledge and skills” (p. 40). Supervision time was not structured in any way but rather occurred as necessary. I found that having a supervisor who was available and willing to talk whenever I needed to helped a lot in managing the stress I sometimes felt when dealing with emotionally challenging patient situations. Having consistent access to and opportunity to learn from my supervisor provided me with the rich educational experience that enabled me to learn the job and develop my own skills, an essential part of education supervision (Sulman et al., 2005). I also had the chance to access other hospital social workers as needed to benefit from their expertise on specific issues and to speak to my academic supervisor as needed. I especially appreciated the opportunity to discuss meanings of disability with several of the other hospital social workers and was pleased to find that their perceptions and definitions were very similar to those I already held.
Stress and burnout are factors in social work practice in general; strong supervision is known to help to mitigate some of the negative effects of a stressful work environment (Tsui, 2005). In fact, one of the questions asked at the interview prior to being accepted for this practicum involved my understanding of self-care. Badger, Royse, and Craig (2008) found that occupational stress is common in hospital social work, showing the importance of a strong supervisory relationship and attention to self-care. Dhooper (1997) outlines a number of self-care techniques recommended for hospital social workers, which include: stress management, time management, self-empowerment (focused on ability to change or improve even very difficult situations), conflict resolution, and ability to develop partnerships with other professionals. As I went through the practicum, I saw over and over the importance of maintaining strong self-care routines for myself. These included daily journaling, walking to and from the hospital, eating well, and seeking opportunities outside of the hospital to engage in activities I enjoy. It was more difficult as a temporary member of the staff to involve myself in some of the other techniques Dhooper outlines because it took time to develop strong relationships with other staff. However, I was assisted in doing this by my supervisor, who had already developed excellent working relationships with the other staff; because I was with her, I was included from the start. I found that by the end of my four months, I was included by other staff on my own merits and the extra comfort associated with feeling like a true part of the team was helpful in my own self-care, especially as I got busier when I took over more of the caseload.

I observed that hospital social workers have limited time for accessing supportive supervision because of the busy environment they work in, but have developed informal debriefing opportunities with other social workers and this system appears to work well for
them. I was used to more intense supportive clinical supervision as I had through my first practicum doing clinical counselling. Supportive clinical supervision is concerned with managing work-related stress and assisting the worker in personal development that is related to work skills (Rauktis & Koeske, 1994). Because of the intensity of the learning at this practicum and the hectic hospital environment, as well as the emotional nature of many of the patient situations I worked with, my ability to continue to access clinical supervision through my previous practicum supervisor was essential to maintaining a healthy perspective on this practicum. Confidentiality was preserved by avoiding mention of any details about patients. The focus was on my own development as a social worker and my ability to maintain self-care in a challenging work environment. Having benefited from supportive clinical supervision during two excellent but challenging practicum experiences I plan to continue to seek out opportunities for this type of supervision in the future.

**Delineation of Roles in Hospital Social Work**

Professional role boundaries, or distinctions between the responsibilities of workers in different disciplines, are expected to become more blurred in health care (Dhooper, 1997). Egan and Kadushin (1995) suggest that nurses and social workers are especially vulnerable to role overlapping, which may lead to misunderstandings about professional roles and responsibilities. Overlapping roles can result in job loss if two professions are perceived to be performing the same function (Egan & Kadushin). As Judd and Sheffield (2010) point out, increased competition between nurses and social workers for scarce jobs continues to be a concern. Auerbach, Mason, and Laporte (2007) argue that nurses may be viewed by administrators as “more cooperative than social workers in facilitating speedy discharges” (p. 19), an important factor when bed utilization and costs are of paramount consideration.
Pockett (2003) suggests that ambiguity in roles can lead to burnout in social workers in an already emotionally challenging job. Rural hospitals or those experiencing budget shortfalls may be especially susceptible to lack of role clarity (Egan & Kadushin), while simple lack of awareness of the important range of social work activities may result in the role being devalued (Auerbach et al.). According to Davis, Baldry, Milosevic, and Walsh (2004), confusion about roles can also lead to lack of accountability within the organization, duplication of services, or services not being provided when needed.

Services provided by social workers may be viewed as secondary activities in the hospital setting (Siefert, 1989), or nonessential when costs need to be cut (Auerbach et al., 2007). However, Egan and Kadushin (1995) found that social workers felt they were “better qualified than nurses to assess and intervene in social and emotional problems” (p. 3), while discharge planning is generally seen to be a social work responsibility. Davis et al. (2004) observed that despite discharge planning usually being seen as part of social work’s primary role in hospital settings, social workers in their study spent more time on assessments, counselling activities, and liaison work. In general, Egan and Kadushin found substantial similarity in how social workers and nurses defined the social work role in the hospital setting, with many psychosocial tasks viewed as joint role responsibilities. Leukefeld and Battjes (1989) also provide evidence that health professionals report overlap amongst the members of interdisciplinary teams. The conclusion that can be drawn from the literature I have reviewed is that social work roles are often not specifically outlined, leading to great variance across departments and hospitals. I observed that the social workers themselves appeared to have a good idea of their roles and were comfortable carrying out their responsibilities, but the scope of practice was a challenging one to explain to new social
workers who were being orientated during my practicum. I also noticed some difference
between the different departments in the hospital in terms of what social workers are
expected to do by other staff. This variance is challenging for new social workers but also for
other staff who work on several floors. Good professional communication between members
of different occupational groups mitigated some of the challenges of this process.

Gibbons and Plath (2009) point out the increased importance of interdisciplinary
teams, particularly as resources become scarcer. Thompson and Hess (1989) suggest that the
purpose of social workers on interdisciplinary teams is to “identify patient/system needs from
the concrete resource/advocacy level to the abstract psychosocial/counselling level” (p. 35).
Roles include “broker, technical expert, educator, diagnostician, counsellor/therapist,
coordinator, supervisor, consultant, administrator, planner, developer, advocate, and
researcher” (Thompson & Hess, p. 35). Leukefeld and Battjes (1989) review work by a
number of authors and include lists of social work responsibilities in health, most of which
are covered in the above list, although the language used varies by author. Butterfield (1989)
argues the importance of social workers taking on an educational role with patients and their
families, particularly regarding the medical problem, effective self-monitoring strategies, and
problem solving skills. This may also involve information about changing patterns of patient
thinking and action, as well as environment (Butterfield). The Canadian Association of
Social Workers (n.d.) suggests that the social work role within health care has a person-in-
environment perspective and “by working within the framework of the determinants of
health, social workers make the necessary links between the physical, social, emotional and
economic impacts of health” (section 4), for both patients and other professionals.
The complexity of roles presented here indicates how challenging hospital social work is. Thompson and Hess (1989) suggest five main areas to focus on mastering in order to become an effective practitioner: human behaviour and the social environment, social services policy and resources, social work knowledge, research, and practical experience. Included in the above list is knowledge of common diseases and medical interventions (Thompson & Hess), a key component in social work education and practicum experiences, although not one covered in most social work classes.

A continuum of professional responsibility in hospital work developed by Thompson and Hess (1989), shows how doctors and social workers can maintain autonomy in some areas but share responsibility for others. For example, patient education and counselling are seen as shared tasks, depending on the specific nature of the patient concern, but attention to community resources and psychosocial factors would fall more clearly within the social work role. I observed that sometimes patients took more notice of information presented by a doctor, an area where good working relationships between social workers and doctors can lead to collaboration for enhanced patient care. However, Collins (1989) points out the challenges of role delineation with other professionals, in particular because patients and families may be confused by the different perceptions that each profession has towards patient care. As Hukam (2008) points out, “the medical practitioner may see medical symptoms and bodily function as that which both describes and defines the client, whereas the social worker may see psychosocial influences, as that which describes and defines the same client” (p. 15). Because “hospitals can be daunting and disempowering places for people” (Gibbons & Plath, 2009, p. 734), it is essential that hospital social workers develop
the ability to help patients and their families understand the process and the roles of different professionals within the system.

There may be lack of clarity amongst professionals about each others’ roles (Leukefeld & Battjes, 1989), hence why part of my practicum involved developing an understanding about what other professionals at the hospital do. Because patients and families often require a complex range of interventions that cannot realistically be provided by only one profession (Leukefeld & Battjes), this learning was essential to my ability to work with other professionals, provide appropriate referrals, and communicate effectively with patients and families. Due to the lack of consensus about social work roles in the literature, I spent time observing experienced social workers in several departments to allow me more opportunity to explore and understand this key component of hospital social work, especially as it relates to people with disabilities.

Each section of the hospital operates differently, but most have some form of team meetings to discuss patient progress and prognosis. These interdisciplinary meetings provided an excellent opportunity for me to enrich my understanding of what the other professionals do, especially as they differ in each part of the hospital. Each social worker has a slightly different style in these meetings, but all the ones that I observed were excellent at interjecting the social information that is so vital to full patient care and appropriate discharge. I also found that other professionals were interested in learning about my perceptions of the social work role as a newcomer to the work environment. This interest shows the positive collaboration that happens routinely in all hospital departments in which I spent time.
Ethics in Hospital Social Work

The challenges of adhering to both social work ethics and facility requirements can make hospital social work a demanding career choice (Proctor, Morrow-Howell, & Lott, 1993). Juggling the often-conflicting needs of clients, families, other professionals, and scarce resources challenges social workers to be creative when resolving ethical dilemmas when one part of the code of ethics is in conflict with or needs to supersede another (Proctor et al., 1993). Deciding which ethical principle should take priority in any given situation is one that hospital social workers must consider on an ongoing basis. Abramson (1981) suggests that in many cases social workers are challenged by ethical decision making because of the desire to contribute to the health and welfare of patients, even when that conflicts with patient self-determination or organizational policies. Sulman, Savage, and Way (2002) argue that social workers frequently confront the challenge of meeting both organizational needs for cost reduction and patient care needs. Auerbach et al. (2007) point out that “the question of who is the client may be unduly influenced by the need to remain employed” (p. 21), a fact that can put a lot of strain on workers.

Abramson (1981) points out that because the hospital social worker or other professional determines if the patient is competent to make his or her own decisions, the potential is there for workers to act paternalistically even when they have the best of intentions. I observed a number of discussions about competency and made several referrals to have patients assessed for level of competency. Because all adults are considered capable under the law unless it can be proven that they are not, these assessments are not undertaken lightly. In the context of discharge planning, Abramson argues that there are no easy answers because many of the principles social workers are expected to uphold can be in conflict,
given the complexity of issues present in hospital work. Proctor et al. point out that the principles of self-determination and the clients' best interest may often be in conflict, providing challenges for social workers who must make a decision about which principle will prevail.

Dhooper (1997) suggests that social workers will continue to face more ethical challenges in their work for several reasons: populations are becoming more diverse; advances in technology are making life-prolonging interventions possible, with their related cost and moral challenges; availability of care questions will continue to arise; and issues of professional knowledge and patient choice will continue to come up. Barnes (1998) argues that new medical interventions which prolong life will increase the number of people with disabilities, creating more need for social workers who understand disability in the health context and who can effectively work through the related ethical dilemmas. Dhooper points out that chronic illness and disease will continue to challenge the health care system because the focus will need to shift to include more forms of non-acute care for people who will never be cured of their disease or disability. People are now living for many years with illnesses and disabilities once considered life-ending, posing challenges for all medical professionals in terms of ethics (Cowles, 2000). Bracht (1990) points out that few communities are set up properly to care for people with long-term medical problems outside of the medical settings, especially as numbers of people who need these services are increasing.

Ethical dilemmas in health care can be characterized as issues of time or staffing, creating problems prioritizing patients or choosing between patient and administrative work; lack of hospital beds or other resources, both within the hospital and in the community, as
well as patient financial concerns; organizational or government policies; conflicts of interest; and disagreements amongst professionals about care options (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). Similarly, the major dilemmas are considered to involve:

- individual patient care conflicts, end-of-life care, advance directives, competency and surrogate decision making, informed consent, protecting patient rights and withdrawing or withholding treatment to broader work place concerns over appropriate levels of staffing, resource availability, procedural justice, autonomy, and collegiality. (Ulrich, O'Donnell, Taylor, Farrar, Danis, & Grady, 2007, p. 1706-7)

These often-conflicting goals and needs create many opportunities for ethical challenges in social work. I observed social workers deliberating over a number of serious dilemmas and ran into a few during my individual work with patients. The social workers regularly consult one another to determine courses of action and to learn from the situations that come up in each department. Being part of the ethical decision making process was an important part of my practicum.

How social workers adapt their practice to fit the shifting realities of health care will continue to be an important issue as our population ages and our understanding of our health care system evolves. Ethics are not only important from the perspective of appropriate patient care, but also because “ethics-related stress is an occupational stress that is the emotional, physical and psychosocial consequences of moral distress” (Ulrich et al., 2007, p. 1709). Moral distress has been defined as “when one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action” (Raines, 2000, quoted in Kälvemark, et al., 2004, p. 1076). Kälvemark et al. suggest that self-care strategies
by individual workers are only a small part of the solution to ethical dilemmas; organizations also need to develop policies and cultures where ethical challenges can be more easily resolved. Proctor et al. (1993) found that ethical dilemmas require more workers spending longer periods of time on one patient concern, highlighting the need for efficient ethical decision making processes in order to provide services to more patients. My experience supports Proctor et al.’s findings, with significant social work time spent on a small number of highly complex patient situations that involved ethical decision making. While I think that workers become more proficient in their ability to deal with ethical dilemmas as they gain experience, the reality is that the uniqueness of individual patient situations will continue to create ethical challenges that take time to resolve.

Judd and Sheffield (2010) studied hospital social workers in the United States and found that very few identified spending time on ethical issues in their work. The authors suggest that respondents were in fact involved in ethical challenges on a regular basis, but did so as part of the discharge and direct patient care services aspects of their jobs, not as part of systemic attention to ethical issues (Judd & Sheffield). Proctor et al. (1993) found that ethical dilemmas occur frequently in hospital social work, especially in discharge planning, meaning it is essential that ethics is part of the practicum learning process. The ways in which experienced social workers navigate the ongoing ethical dilemmas encountered in the hospital environment, on both the individual and systemic levels, was a major focus of this practicum placement. Given the complexity of issues social workers encounter on a daily basis, Ulrich et al. (2007) argue that no amount of advance reading can replace the hands-on learning experience. Having been through this intense process, I agree with Ulrich et al. Many times I observed or participated in discussions about ethical dilemmas; the individual
nature of each dilemma made it impossible to predict when ethical concerns would occur or what they would involve. Early on, I was unaware of the nuances of ethical challenges that my supervisor and I encountered, and was appreciative of her years of experience to point out pieces that I would have missed. It is also important to be aware of the potentially positive nature of ethical dilemmas, as are Proctor et al. when they point out that the high frequency of ethical dilemmas in hospital social work may reflect worker commitment to providing high quality services to patients.

Theories of Disability

Disease and disability affect all of us at some point in our lives, either through our own medical conditions, or those of friends or family members. As we age, we are more likely to come into contact with the medical system and to have chronic conditions (Santrock, Mackenzie-Rivers, Malcomson, & Leung, 2011). Bracht (1990) provides older statistics that give an idea of how many Americans are affected directly by disability. The prevalence depends on what definitions are used, but by some estimates, up to 50% of American citizens have either a disability or a chronic disease. Livneh and Antonak (2007) suggest that about one in five Americans has a disability that interferes with daily living. In British Columbia, approximately one in six adults has a disability (Stephen, 2005). In Canada as a whole, 14.3% of the population was living with an activity-limiting disability, according to 2006 statistics (Statistics Canada, 2010). However, this does not include chronic diseases that are not currently limiting activities as defined in the report. Instead, it includes only those “adults and children whose daily activities are limited by a physical, mental, or other health-related condition or problem” (Statistics Canada, p. 6). The report refers to people who have self-identified as needing help in daily activities and whether or not they are
receiving that help. Many more Canadians would be considered to have chronic diseases that are not currently affecting their daily living activities, for which they can currently manage independently, or who have not acknowledged that they need assistance. These diseases and disabilities do impact their medical care and future identification in the category of having a disability. Despite the challenges of providing accurate statistics, the Statistics Canada report makes clear that older adults are more likely to experience an activity-limiting disability. People with disabilities are also far more likely to report having unmet health care needs, despite regular access and use of the health care system (McColl, Jarzynowska, & Shortt, 2010). Because our population is aging, disability issues will become increasingly important for hospital social workers and all medical professionals to consider.

As introduced earlier, there are two main theories about how disability is viewed by society. These models impact how individuals view themselves, how society is organized to meet the needs of people with disabilities, and how those working in the medical and helping professions conceptualize their work with people who have disabilities. The medical or individual model views disability in terms of “diagnosis and solution in medical knowledge” (Barnes, Mercer, & Shakespeare, 1999, p. 21). Since the medical profession normally deals with people who are ill, the sick role has traditionally been given to people with disabilities, even if they are only interacting with the medical profession to obtain proof of disability in order to receive financial benefits (Quinn, 1995). Bracht (1990) points out that people with chronic diseases or disabilities are not always in poor health, but will likely have episodes of poor health during which time treatment is required.

Under the medical model, the person with a disability is seen as the victim of a tragedy, and in need of others to provide care (Barnes et al., 1999). The medical system plays
the role of alleviating the individual or familial suffering caused by the disability (Hiranandani, 2005). Rehabilitation and cure are the goals under this model, with professionals providing the expertise to "overcome, or at least minimize, the negative consequences of the individual's 'disability'" (Barnes et al., p. 21).

The physical or mental health impairment is seen to cause a reduction in ability to perform activities such as those required for daily living or work. These were outlined by the World Health Organization (WHO) in its International Classification of Impairments, Disabilities, and Handicaps in 1981, which looked at the consequences of impairments (Barnes et al., 1999). The latest WHO classification is the International Classification of Functioning, Disability and Health (ICF), which includes environmental factors as one variable in disability (WHO, 2012). This newest categorization scheme shows how the social model of disability is being incorporated into societal conceptions of disability.

The social model of disability views physical impairment itself as an individual concern, while the disablement is imposed by a society that excludes people based on physical ability (Barnes et al., 1999). This model "questions impairment as necessarily a personal tragedy, and asserts that the notion of individual inadequacy is socially reproduced" (Hiranandani, 2005, para 1). Individuals experience disability differently, with these experiences being seen as fluid and open to adjustment as societal conditions and environments change. Diverse factors such as income, family circumstance, physical environment, transportation, education, and employment all impact disability (Barnes et al.).

The social model grew out of efforts by people with disabilities in a number of countries, advocating for themselves and for changes to the social and political climates in which they lived (Barnes et al., 1999). Since the 1960s, this movement has advanced
disability theories and studies significantly (Mackelprang & Salsgiver, 2009) with the goal in the United States of equal access that has been nominally obtained for people of different ethnic backgrounds (Quinn, 1995). However, Quinn points out that some people prefer not to use the disability label because it may put them in a dependent position that they do not identify with. Today people with disabilities still face many challenges. Beaulaurier and Taylor (2001) point out that most members of society do not actively discriminate against people with disabilities; yet people with disabilities are often considered in name only when things as diverse as building designs, job qualifications, and education programs are developed. Barnes et al. suggest that the social model encompasses a range of perspectives on disability, but for the purposes of this practicum, the basic definition supplied above will be used.

Theories of disability in hospital work

In hospital work, the medical model is an important perspective for professionals to use during acute care, such as immediately after an accident or diagnosis (Quinn, 1995). It allows the person to regain as much physical function as possible and acknowledges that most people do not want to lose functional ability. Ideally, professionals would have an understanding of both models and how to integrate them to provide optimal continuity of care for patients as they move through the phases of their hospital stay. From what I observed in the hospital, most patients are appreciative of the range of medical interventions that are offered, including rehabilitation to maximize functional ability. However, people with chronic disabilities or conditions would also benefit from a better professional awareness of the larger societal picture that impacts people with disabilities once they leave hospital.
One of the challenges with the medical model is that it places the patient in a dependent position because the professionals are viewed as the experts, with loss of function perceived as a failure, and the person in a position of needing charity (Barnes et al., 1999). Using the medical model terminology and perspective over the long term is problematic because people with disabilities are not always sick nor will they get better in the usual sense of the term. Asking a person to adapt to an inaccessible environment, either physical or social, is part of the traditional way of viewing disability as a primarily negative experience, where positive results depend on the individual adjusting effectively (Mackelprang & Salsgiver, 2009). Those who are unable to adjust, for whatever reason, are viewed as being resistant or less capable of accepting reality.

In locating the problem outside of the individual, the social model suggests societal barriers are the source of the person’s challenges to full participation in society (Mackelprang & Salsgiver, 2009). Cowles (2000) suggests that social workers should help the health care system shift from its traditional approach on curing to a “more supportive approach to helping (caring) at each level of health intervention” (p. 310-311, original emphasis). This idea fits in well with the social model perspective, whereby the patients’ social situations and perspectives are considered of paramount importance when choosing the most appropriate interventions for the person.

While the social model perspective should ideally be considered during the entirety of a person’s stay in hospital, it is especially applicable as people move through or complete the direct medical intervention phase and transition to life after injury or diagnosis. Using this model removes blame for the situation from the individual and encourages people to look at the macro-level factors that impact their situation. Fook (1993) points out the importance of
drawing connections between the challenges an individual experiences following diagnosis and the societal conditions that create those disabling barriers. Doing so takes away the guilt or blame often associated with these feelings and also provides opportunities for both the patient and social worker to challenge the current system. As such, this model fits into the structural views described by Mullaly (2010).

Quinn (1995) suggests that social workers who work with people who have disabilities should consider adopting a structural framework that looks at solutions within environments and systems first and individual deficiencies only if the problem persists. Quinn’s ideas fit well with my own experience in disability work. The hectic hospital environment sometimes makes it difficult to fully enact Quinn’s approach, because there often is insufficient time to truly create changes in the larger systems. In many ways, hospital social workers deal with crisis situations and do not always have the option of exploring situations in as much detail as they would like. Most patients are in for only a short time and the hospital system’s goal is for social workers to find a workable discharge plan in as short a time as possible. The hospital social workers I observed do an admirable job of creating comprehensive discharge plans with patients in limited time periods and do their best to advocate strongly for the necessary structural changes along the way, but it is a challenging position to be in.

During my exploration of disability conceptualization in the hospital, I found it useful to be aware of the psychosocial responses to illness and injury that patients sometimes experience. While these vary widely depending on the person’s age, personality, socioeconomic status, family situation, reason for hospitalization, etc., some common themes can be observed. According to Lilliston (1990), responses to sudden physical injury can
include: changes in body image and ability; personal perceptions of time, especially related to sleep cycles and medication; experiences of loss; and emotions such as anxiety, fear, guilt, or anger. Coping strategies that the hospital social worker may encounter amongst patients who have experienced injury may include: desire to connect with others who have similar experiences; interest in seeking additional information; distractions; rationalization; stoicism; use of food, cigarettes or other substances; tendency to blame; and isolation (Lilliston, 1990). How healthy these coping mechanisms are depends on the person and their natural support system; social workers need to use effective assessment skills to develop an understanding of when to intervene with a patient’s unhealthy coping strategies and when to encourage the patient to find space and time to work through the changes they have experienced on their own.

Mailick (1990) reminds social workers to be aware of pre-injury psychosocial factors, which will have a direct impact on the person’s response to injury or illness. Bracht (1990) points out the challenges that family members of the person with the disease or disability may experience, which include stress, increased chance of others developing a disease, caregiver concerns, and relationship problems. Recognizing how a patient’s response fits into their overall personality and environment, and knowing where and when those responses need short term social work intervention within the hospital, referral for longer term work, or no intervention was part of my learning process. I learned a lot from watching the other social workers interact with patients during this process and worked on developing my own style in consultation with my supervisor. I had contact with patients who were very early in the process of understanding a new diagnosis, and the responses ranged from denial to complete hopelessness. Others had a more stoic attitude and some people seemed to come to
a positive view of the diagnosis quite quickly. While supportive family generally appeared to indicate better or earlier acceptance, challenging family situations seemed to be almost worse than having no social or familial supports at all. I was keen to observe and participate in this process; a key point for me was to let the patient determine the process, rather than having me try to impose my own views. I believe strongly that disability does not have to mean that quality of life is over but I also recognize that everyone deals with disability differently and this will change for each person over time. It was helpful for me to discuss this with my supervisor to ensure that I was keeping my own views at a healthy distance from the patients’ needs.

Mailick (1990) differentiates between how a patient and family deal with the “crisis of diagnosis” (p. 108) and their adaptation to the longer term health challenges of chronic disease or disability. During the first phase, Mailick suggests that the social worker must assist with expression of feeling, access to information, knowledge of resources, and acceptance of the diagnosis during the initial stages, while more attention is paid later on to identity, employability, relationships, and community issues. Brashier (2006) points out that response to disability may include “chronic sorrow” (p. 458), a term referring to the ongoing challenges of integrating one’s disability into the larger life context. This is especially true for people with progressive diseases such as Multiple Sclerosis (MS); as the person experiences changes in the way the disease affects them physically or mentally, the new reality also affects other aspects of life in different ways (Brashier). The same is true for disabilities like spinal cord injury, because each life stage the person goes through is affected by the disability (Brashier); even if the person is not consciously aware of the adjustment process, it still occurs on some level.
Hospital social workers have a much larger role to play in the early stages of diagnosis, as well as when the conditions change, requiring additional contact with the medical system. Other aspects of adaptation are carried out more often by other departments within the health authority, such as those dealing with home support or community health. Ensuring continuity of care for patients during this process was important. This work included developing relationships with professionals from other departments to share information on a patient’s progress as needed, to make sure that patients would still be assisted in this process after leaving hospital.

While I had some prior experience working with people who are adjusting to disability or chronic illness, most of these previous interactions were with people who had received their diagnosis some time before and were having difficulty adjusting. Developing my skills in how to facilitate the adjustment process effectively for patients and their families using short term intervention strategies was an important part of my learning, although I did not have the opportunity to engage as much in this process as I would have liked.
CHAPTER FOUR: Organizational Information

The practicum took place at a regional hospital in British Columbia, Canada. I have chosen to not name the hospital in this report to respect the anonymity of the patients and staff that I worked with. My practicum supervisor was an experienced hospital social worker with a Master of Social Work. As per the Canadian Institute for Health Information guidelines, this medium-sized hospital has between 200 and 399 beds (2012). This hospital provides a full range of health services, some of which include emergency, acute, rehabilitation, and psychiatric wards. All of these units have social work services available.

I spent most of my time on the Internal Medicine and Family Medicine Units (IMU and FMU). Patients on these floors had a wide range of reasons for admission, which included problems related to the heart, lungs, abdomen, kidneys or bladder, strokes, undiagnosed concerns, exacerbation of chronic diseases, people with complex medical needs awaiting placement in long term care, and caregiver burnout. The variety of reasons that people came to hospital made this an invaluable learning experience because every day provided something different for me. Between the two units, there were up to 65 patients at any given time. A portion of these are usually waiting for long term care assessments or placement, and they are assisted by another social worker. However, my supervisor and this other social worker share an office and help each other as needed with their caseloads; consequently, I became familiar with all the patients. Because patients move from one part of the hospital to another as their medical needs change, all the social workers have regular contact to ensure continuity of care.
CHAPER FIVE: Practicum Learning Contract

The complex nature of the hospital environment made it difficult to articulate specific goals prior to entering the practicum. However, in the learning contract I anticipated and articulated some general activities and specific goals. I will provide a summary of what I did and what I learned, related to both general activities and specific goals.

General Activities

Shadowing experienced social workers in several departments

I spent the first couple of weeks of my practicum shadowing my supervisor. This included going to interdisciplinary meetings and family meetings, watching patient assessments, and observing as my supervisor went through the process of helping the patient decide what resources, if any, were needed. My supervisor very quickly gave me small tasks to complete to help me begin to understand her job better; these included: writing up the chart notes after each encounter with a patient, finding information in the charts, learning how to find and fill out forms and information on the shared computer system, and any number of other tasks that social workers do every day. By being able to start participating actively right away, my learning was increased because it is far more challenging to engage directly in an activity than it is to observe someone else doing the task.

I was able to spend three weeks with the other social workers, while my supervisor was on holidays. Not only was this time really interesting for me, I was able to learn a fair amount about the way the hospital works and how the social workers work together to find solutions to challenging patient problems. I also worked with a few of the same patients as they went to a different ward for the continuation of their care. In so doing, I was able to see the entire process of their care and how each department focused on a different aspect of the
work. Observing different social work styles was also helpful to me as I worked to develop my own style based on aspects of the styles of every worker I observed.

**Discharge planning and referral**

Discharge planning takes up a significant amount of time for social workers in some departments at the hospital. This process involves a wide range of activities, which can include: helping the person understand housing options, liaising with home support services, providing referrals to community resources and/or completing forms for those referrals, liaising with other hospital workers to ensure all the patient’s needs can be met on discharge, talking to the patient and the family about what the person will need, and generally ensuring that discharge will go as smoothly as possible. Being an effective part of this process requires flexibility on the part of the social worker because plans must change to accommodate the patient’s changing physical and mental health situation during the hospital stay. I found that trying to plan too early in the course of the admission meant that initial plans needed to be changed too many times; however, leaving the planning until too late in the process made it difficult to ensure that everything could be in place in time for discharge. Duffy and Healy (2011) point out the importance of flexible discharge planning for older adults in particular, because their physical and mental health can change significantly in a short time. The discharge process is made smoother when the social worker has a strong relationship with other staff and can stay current with new information about the person’s discharge date and needs.

As I progressed through the practicum I found that providing information early in the person’s stay was important so that the patient and family could begin to think about what they wanted to do. Often people needed to hear the information several times because the
system is confusing for those who have not experienced it before. As I took on more of the discharge planning work on my own, I became more adept at having these conversations, as well as liaising with other staff during the planning process.

**Actively participating in interdisciplinary team meetings**

Team meetings happen several times a week in each department. The purpose is to ensure that everyone has the same current information on the patient, which includes medical, emotional, social, and home life issues. Discharge planning is discussed as appropriate, as are upcoming tests, treatments or interventions (both medical and social). For patients who did not change much from day to day, these meetings sometimes felt a bit repetitive. However, for many patients who only stayed a short time or were dealing with more complex situations, these meetings provided an essential opportunity to share information. Early on it was difficult for me to participate much in these meetings, partly because of shyness and partly because I did not know the patients directly so I felt I had less to contribute. As I worked more independently with patients I had more to say and felt that I was able to contribute in a positive way to the care that patients received and the way that staff perceived patient needs.

**Grief and loss work with patients and families**

Although I was not able to engage with grief-related matters as much as I had expected, I did have the opportunity to work in a number of ways with patients and families around grief issues. In some cases this involved helping a family explore options for where they wanted the patient to die and helping the patient and family discuss death. I had the opportunity to work with a number of patients who had recently received new or updated diagnoses of disability or chronic disease. This work was difficult but fascinating for me.
because I have very definite ideas about the value of life after diagnosis and I had to be very careful to ensure that I kept my own value system out of the discussions. It was important for me to respect where these patients were at in the process of understanding their diagnosis and I learned a lot from just sitting with them and providing support. I hope to do more of this work in the future.

**Psychoeducational and education work with patients and families**

Much of the work I did at the hospital involved education for someone, whether it was to staff about patients' social situations, or to patients and their families around the system or their diagnosis. The medical system as a whole is confusing even to people who work within it. I spent a lot of time outlining the services that are available, especially around home support and facility care. I found that this took more of my time than did explanations of actual diagnoses. While I developed a level of comfort with the major or common diagnoses at the hospital, my medical knowledge was not adequate to have in-depth conversations about particular diseases. I found that people often asked me for more specifics on their situations or for advice about treatment options, which social workers are not qualified to give. In those situations, it was helpful to explore ways of having the discussions with the doctors; in some cases this involved a family meeting or an informal bedside chat, but sometimes the patient was able to have the discussion independently with the doctor after we talked about what and how to ask. This process gave me a greater appreciation for doctors and nurses who can explain medical information in layperson’s terms because patients can then get what they need directly. I enjoyed the educational part of the placement because it helped me reinforce my own learning and was a very concrete way of assisting patients.
Assessments

Assessments are an essential part of hospital work, because they provide the information that social workers use to proceed with all other aspects of the work. It took time to develop my ability to approach assessments with new patients in a conversational manner that allowed me to gather the necessary information without sounding like I was grilling them for information. Observing other social workers during this process helped me to become more comfortable. An assessment needs to be thorough and to cover a number of basic areas, while retaining the flexibility to change focus based on the individual patient's needs. Common aspects of the assessment included: living situation (both social and environmental), finances, formal and informal support systems, community resources currently being accessed, history of admissions or medical problems and how they were being managed, concerns about discharge, and future planning. The specifics of what was included during the assessment process varied from department to department within the hospital but the same general topics were covered for all. At times a patient or family would request a social worker for something very specific; in those cases, the assessment was less thorough, but my supervisor still expected me to be watching and listening for certain things that would indicate the need for further involvement. Because social workers cannot see all patients, an initial screening is done and those patients who are: seniors, with more serious diagnoses, living outside of the city, or being transferred to other hospitals were added to the social work caseload. Some required only an assessment to determine that they did not need social work intervention. However, some of the typical indicators of the need for more follow-up included: lack of informal supports, frequent admissions, multiple diagnoses, and mental health challenges.
Specific Goals

In close consultation with my practicum supervisor, and under the general direction of my academic supervisor, I developed the specific goals for my practicum. While these were modified a bit during the progress of my practicum, discussed below, they provided an excellent opportunity for me to stay on track with my learning and to evaluate my progress.

Knowledge of medical/social issues faced by social workers

I planned to attend any workshops offered by the organization during my practicum, especially those related to disease or disability. Unfortunately, fewer workshops are available during the summer, when my practicum took place, and those offered at lunchtime often conflicted with family meetings. However, I did attend a full day workshop on conflict resolution within the workplace and a number of information sessions occurred in conjunction with social work team meetings. I was also able to expand my knowledge in a variety of areas by listening during informal discussions and asking questions of the relevant professionals.

One of my goals was to develop a lay-person's understanding of the following illnesses: stroke, cancer, heart disease, kidney failure, Multiple Sclerosis, by reading journal articles, by exploring patient information on these topics, and by researching information on services offered by outside agencies. I read quite a bit of information about a variety of diseases and never handed out information pamphlets to patients or family members without reading them first and having a basic understanding of the material. I also paid attention during meetings and discussions with health professionals to gather as much knowledge as I could from them. Learning about medical knowledge is obviously an ongoing process, but I do feel that I have a reasonable level of understanding about some of the main causes and
risk factors for these diseases, how they affect the person's functioning and course of treatment, as well as implications for discharge or community functioning.

**Knowledge and use of community resources**

I planned to develop a good knowledge of community resources used by hospital social workers. My goal was to meet and arrange tours of at least the following resources: hospice; two long-term care facilities (one private, one government), an adult day centre; and a homeless shelter. I was able to visit hospice, an adult day program, a government-run seniors’ facility, and a private facility. I was not able to visit a homeless shelter but became more familiar with the various services offered through listening to patients and other staff, and speaking to shelter staff during discharge planning for several patients. I found the visits useful because I was able to visualize the facilities I was offering as options to patients and therefore could describe them more accurately. I was particularly impressed with hospice, which seemed to embody a positive approach to the natural process of death.

I wanted to arrange tours or interviews with other community resources, such as Victim Services; a seniors’ organization; ICBC; or WorksafeBC. At my midterm evaluation we chose to substitute three programs for vulnerable seniors and a heart health clinic for Victim’s Services, ICBC, and WorkSafe. The focus on seniors had become apparent as more relevant to my learning goals as I progressed through the practicum. While I did not make it to the heart clinic, I did visit with members of staff for all three programs for seniors and viewed one program in action. I was also able to attend a meeting where referrals to these programs are triaged based on the severity of the situation and the person’s needs. I also spoke to several seniors’ organizations by phone to find out more about their services.
I also planned to develop effective use of related community resources. I wanted to be able to independently assess which community resources are available to a client and refer effectively to ensure successful use of resources. As I learned more about the available services and spent more time assessing patients, I developed my ability to determine the options that might work best for that person and how to explain those options. While patients and families appreciate the professional who has enhanced knowledge of resources, the ultimate decision about which resources to access must still be made by the patient, and I was careful to present information to patients in that way. The age and cognitive ability of the patient, as well as available family support, affected how decisions were made, but except in cases of declared incompetence, everyone has the right to make their own decisions. Learning about how to facilitate this process with people who have a range of abilities was an important process for me to be part of.

**Knowledge of a range of health services, programs and health professionals**

I planned to meet with a range of social workers employed at the hospital to learn the diversity of roles. I was able to spend at least a day with almost all of the social workers at the hospital to find out about their roles. I found this particularly interesting for several reasons: I was able to observe varied styles of social work practice, as each worker's personality and experience impacts the way they work; I also developed a greater understanding of the breadth of social work done within the hospital, as well as the continuity of care for patients. This was one of the most valuable experiences of my practicum, especially as it occurred near the end when I was feeling very comfortable on IMU and FMU.
I hoped to meet with representatives of as many of the following programs/services as available: physiotherapy, occupational therapy; nutrition; mental health and addictions services; home and community care services; pastoral care; and elderly services. I enjoyed the opportunity to meet with a variety of other professionals. Through this experience, I gained a greater appreciation for the range of services provided to patients in the hospital and how these professionals work together to meet the needs of each patient to ensure optimal outcomes. Although members of the professional team do learn the basics about each others’ fields and, in particular, learn to recognize when to refer a patient to another professional, I do not think they can effectively cover for each other without affecting overall outcomes. Learning to recognize and value the contributions of each profession in the hospital system was an important part of my practicum experience.

From what I observed, I think it is essential that hospital social workers be team players, able to work effectively with people from a range of disciplines. Although most people can identify when teams are working well or poorly, defining good teamwork is harder to do. McCallin (2001) argues that a group of people working together does not necessary make a team, and good team work does not happen automatically. As Mariano (1989) points out, “three factors appear to promote or hinder interdisciplinary activities: goal and role conflict, decision-making, and interpersonal communication” (p. 287). When professionals have strong awareness of their own scope of practice and the flexibility to communicate and collaborate well with those from different professional backgrounds, then teamwork can be achieved. McCallin notes that when patient outcomes are viewed as the central goal of health care team work, then teams tend to function better. I was impressed with the team work that I saw during my practicum, whereby members of several professions
learned about each others’ skills and seemed to have a genuine respect for the different but essential roles that each played in patient care.

**Knowledge of medical terminology**

My goal was to develop a 'dictionary' of regularly used medical and systemic terminology encountered during the practicum, which would include an understanding of how to communicate these concepts to patients and families. I created a spreadsheet of medical terms and simple explanations of their meanings, which I could use while talking to patients. Although I did use an old medical dictionary borrowed from my mother, I found the internet more helpful in terms of finding explanations that would be easily understood regardless of one’s medical knowledge or experience. I also found it helpful to ask patients about their knowledge of their diagnosis and prognosis; not only did this tell me what they already knew and needed to learn about, but it gave me clues about effective language to use when talking to other patients with similar diagnoses.

**Knowledge around adult guardianship and adult protection**

I planned to review pertinent legislation and policies regarding adult protection and interview the adult protection consultant or designate. It would be impossible to gain a comprehensive understanding of the adult guardianship legislation during one practicum, but I did have the opportunity to go through the written legislation and copied the most relevant sections so that I can review them as needed. I met with the adult guardianship worker and learned the scope of her position. She gave me some examples of situations where the legislation does need to be used and explained how workers would proceed in those instances. I also participated in discussions about competency specific to a couple of patients and was able to read the subsequent reports from the doctors regarding their level of
competency. Because every situation is unique, this is an area that I will continue to study as I move into different jobs.

**Communication and intervention skills**

My expectation was to shadow my supervisor for 2-3 weeks to learn skills specific to working with patients on the Internal and Family Medicine Units. These units are so complex that shadowing was an important part of my learning. I watched my supervisor interact with patients on a number of common issues, such as transfer to other hospitals, and then started doing those interventions on my own. Even late in my practicum, I shadowed my supervisor on particularly complex cases so that I could experience her way of working through certain complicated procedures with patients. This part of my practicum was especially valuable because of my supervisor’s range of experience and her willingness to share with me why she was doing things in a certain way.

A significant part of my practicum was expected to involve meeting with clients either independently or with my supervisor to assess and establish what services were needed for safe discharge and make referrals as appropriate. Regular formal and informal meetings with patients comprised a lot of my practicum work. Early on in my practicum I read a patient’s chart and reported to my supervisor that this person did not need to be seen because he had already been seen by a social worker. She pointed out a couple of potential red flags in the notes from the other worker and suggested that it was important to still speak to the patient. After I had a conversation with the person and wrote up my notes, my supervisor asked about one particular thing the patient had said. This detail had made it into my notes, but without my understanding of the potential concerns it raised. This was something we needed to make another professional aware of, which we did, and then had a discussion about
the importance of recognizing information that needs to be explored further. This experience taught me something important: all information needs to be analyzed with a critical eye as to how it might affect the person’s safety, security, and options for discharge planning. I believe that I became much more thorough with both my assessments and ability to pull the essential information from them as I progressed through this practicum.

One of my goals was to learn to complete documentation as required on each client, which would then be reviewed and co-signed by my supervisor. Initially my written assessments were fairly brief. I quickly learned to include more information, partly because my supervisor does complete notes and expects the same from students, but also because I recognized the value of being able to read a fully-articulated assessment in the charts. When an assessment is written thoroughly, the next worker in to see that patient does not have to go over the same information again; whereas if the notes are less complete, the next person is left guessing at what was talked about, and may have to repeat much of the same work. Charting thoroughly does take longer initially but it ultimately saves time, effort, and frustration for both the patient and social workers.

My expectation was that I would progressively take on more responsibility for managing the social work caseload independently throughout the practicum. This would be done with ongoing consultation and supervision from my supervisor. As the practicum progressed, the size of my own caseload increased. However, it remained important to have someone to discuss things with to ensure that I was not missing essential components of the situations and had offered the appropriate range of options. This consultation was especially helpful with situations where the resources to assist the person simply do not exist. During the last part of my practicum, I carried the pager and responded to most inquiries, except in
regard to patients my supervisor had met with in the past. This involved being able to prioritize the work and alter my plans as new situations developed. Many times it felt chaotic and I was not sure if I would be able to complete everything on time. In order to facilitate my ability to learn from what I was doing, my supervisor assisted as necessary when things became too busy. I chaired some family meetings and participated far more actively in the regular team meetings because I was the one providing more of the social work services at that time. I found that staff members were very willing to come to me instead of my supervisor if they needed something for a patient, which meant I had to respond to more requests but also showed me that they respected my ability to handle new situations.

Understanding of the medical and social models of disability in hospital social work

My entire practicum had a disability focus and my plan was to observe all situations from this lens. At times it was difficult to remember to analyze situations for these specific ideas because the medical model permeates most of the system and I was simply too busy. The social workers are adept at bringing up the social model to ensure that patient care has a more holistic focus, especially closer to discharge, but they do not usually explicitly state that they are doing this. Therefore, I had to remind myself to watch for how and when these two perspectives are used and if or when there is a shift from the medical model to the social model.

I found that the medical model was dominant with most staff, especially with most nurses, doctors, and allied health professionals other than social workers. This was not surprising to me, although the depths to which each individual worker used the medical model varied from person to person. I saw some wonderful examples of staff who clearly understood that the larger societal context played an important role and was pleased at the
amount of positive advocacy particular staff used in relation to the ideas of the social model of disability. However, the general attitudes were more in line with the medical model, which meant that social workers had an important role to play in ensuring that social model perspectives were also heard.

All these learning goals provided me an opportunity to frame what I was seeing in the hospital and use theory to analyze the importance of everyday occurrences. At times it was easy to get caught up in the daily busyness of the hospital environment, but my daily journaling and active reflection on disability in the hospital helped me to stay on track with my learning.
CHAPTER SIX: Practicum Activities and Learnings

Framing My Observation and Learning Methods

I had planned to build time into my daily schedule to allow for documentation and journaling at the end of every day. However, the nature of hospital work made that very difficult to do and I altered my plans very early on in this practicum. Instead, I budgeted time every evening at home to do my journaling. I found this to be effective because I had the opportunity to deal with any residual emotions or stress from the day during my walk home. By the time I sat down to write, I had the energy and insight to effectively document what I had learned that day and any challenges I had experienced. Although doing my journaling at home did cut into my personal time a bit, it was a much more successful strategy, and one that I was able to maintain. When doing my writing I was careful to avoid any direct or indirect reference to patients or hospital staff that might identify them in any way. I described common patient situations using terms like “senior” or “with dementia” rather than using specific descriptors. In this way, I was able to write extensively about the situations I witnessed and my own growth as a practitioner, without compromising the anonymity of the patients and staff with whom I came into contact. It was an effective method for documenting practicum experiences and reflecting on practicum learnings (Bhandari, 2011).

The focus of my work was on learning about and performing social work duties within the hospital setting. Observation was the primary focus of information gathering, with questions to my supervisor and other social workers comprising the majority of the information I received. However, I was pleasantly surprised by how much interaction I had with other professionals, especially nurses, physiotherapists, occupational therapists, dietitians, and speech language pathologists. These interactions provided me an important
opportunity to learn about the different but equally valuable lenses that each profession brings to patient interactions. I feel that I was able to develop a much more comprehensive view of hospital social work because I learned about the roles each professional has in this setting. This was gained through shadowing members of each profession for a few hours, observation of their work with patients, reading their notes on patient charts, and regular interactions during rounds. By understanding the perspective each profession brings to patient work, I was able to anticipate which aspects of patient care they would need to be involved in, and how they would contribute to discharge planning for each patient. I also developed a much stronger respect for the important role they play.

Some of the autoethnographic methods outlined by Chang (2008) were useful to situate myself within the practicum, and to help me evaluate my progress as a social work student with a disability working in a hospital setting. Chang defines autoethnography as “cultural analysis and interpretation with narrative details” (p. 46). For my purposes the focus was on how my understanding of and ability to perform the tasks of hospital social work developed within the context of disability in the hospital; consequently, the majority of my reflection was on self in context. My expectation was to develop a greater understanding of the interplay between myself, my skills as a social worker, the hospital setting, and disability issues. Observing my process in this way provided me an opportunity to evaluate my own work and growth while paying attention to the larger context of perceptions of disability within the hospital.

Eyesight

Prior to entering this practicum I spent a good deal of time considering how my visual impairment would impact my work in this setting. While I would prefer that it not be an issue
in any work environment, my eyesight has come up, both in negative and positive terms, in previous experiences. I needed to reflect on how it might affect this practicum, especially given my focus on disability within the hospital setting. I found that I had to re-evaluate how my eyesight was affecting my learning and my work throughout the practicum, especially given some of the responses people had to my eyesight.

**Physical environment**

The hospital is a busy place with a lot of equipment being moved around. Beds are switched depending on patient needs, diagnostic machines are moved from room to room, and patients are taken to other floors for tests. There are always a lot of staff and visitors in the hallways, along with equipment that is in the process of being moved. Meal carts, cleaning carts, spare wheelchairs, and a myriad of other obstacles are constantly shifting through the halls and rooms. It was challenging to pay attention to everything as I moved through the halls, to avoid running into people or equipment. I found this took a lot of attention and energy, leaving less for recognizing individuals as I moved through the hallways.

**Recognition of people**

I have always had trouble recognizing faces. It takes time for me to focus on the details of a person’s face without getting too close and staring at the person; I rely heavily on hairstyles, clothing, voice, and context to recognize people. Due to the sheer volume of staff, new patients, and family members, recognition was a challenge for me at the hospital. I tried to let the regular staff know about this for two reasons: to avoid offending people if I did not recognize them after numerous meetings, and to gain their assistance in recognizing staff who were present less frequently, such as doctors. My supervisor aided me in this; by calling people by name when she met them, I was slowly able to recognize the people I had the most
contact with. However, it was difficult with doctors in particular, who are not regularly on
the wards, and family members. I coped by calling patients by name every time I saw them,
to ensure I had the right person, as people were moved to different rooms without much
warning, and asking for people’s names when I needed to.

I do not believe that my challenges in recognizing people caused any major
impediments to my practicum learning. I have learned good compensation skills over the
years. At times I had to simply ask for a person’s name; I do not like to admit to needing
extra help, so asking was a hard but necessary task when I could not figure it out any other
way. I sometimes felt and feel inadequate when I have difficulty doing something that so
many people take for granted. Most people can recognize faces and know they know the
person but not connect with the person’s name. I honestly do not know whether I have ever
met a particular person before until I hear the name. With my level of vision, this will be an
ongoing challenge for me, but I cannot hide behind this as an excuse when pursuing my
social work career. Being in the busy hospital environment pushed me out of my comfort
zone at times in terms of having to find alternate ways to recognize people, which is a
valuable part of my development in social work practice.

Perceptions of disability from other staff

Prior to this practicum, I had not seriously considered how other staff would react to
my vision, except in terms of my ability to recognize faces. Because I do not watch myself
read, I forget how my reading style can look to people who do not know me. My strategies
for reading include holding papers very close to my eyes and moving my head to see across
the page; I have developed my reading style subconsciously over many years and it is so
much a part of me that I do not think about how it looks to others. However, very early in my
practicum, I started getting comments from a small number of staff, probably fewer than ten in total, about my reading style, ranging from mere curiosity to outright negative judgement. My response to the first comments was complete shock that medical professionals would judge a person so negatively based on a disability. To give them the benefit of the doubt, I realized that they might not be aware of my visual impairment and started stating simply what my vision is and that I have always read this way. Most of the people who commented appeared satisfied with this response and did not comment again, but a couple people made negative comments a few more times. I also had a few medical professionals make negative comments about the appearance of my eyes. On the other hand, one professional spent quite a while having what seemed like a positive conversation on my vision, before concluding that it is “amazing” that someone with my level of vision can complete a Masters. These comments mirror some of the historical perceptions of disability that focus on pity for the disabled person or raising ordinary accomplishments to hero status, such as with the idea of the super-crip or putting a person with a disability on a pedestal for completing ordinary tasks (Mackelprang & Salsgiver, 2009). While the number of people who made comments was quite small in comparison to the large number of staff I interacted with during this practicum, enough people did comment about my own disability, as well as making negative comments about patients’ disabilities, to make me interested in exploring this further.

Most staff from all the professions represented at the hospital had positive or neutral perceptions of disability and interacted with me based on my abilities. The social workers in particular were aware of disability issues; when they asked about my vision, they did so not as a judgment but simply to understand me better and to learn about my reality. Members of some professional groups appear to be more aware of social model perceptions of disability
even if they do not use that terminology, but unfortunately enough negative comments were made to impact my practicum experience. As a person new to the environment, it would have been easy to lose my confidence based on the assumptions of experienced staff, and it certainly encouraged me to reflect on the ways in which people with disabilities experience the hospital system, both as professionals and as patients.

These occurrences got me thinking about perceptions of disability by medical professionals and how these might relate to patient care. Based on my observations, I have some concerns about how people with certain diseases and disabilities are viewed by staff. Comments such as “unmotivated” to describe a patient who is not getting out of bed may reflect a true lack of motivation, but may also mask pain, social circumstances, or emotional challenges that impact how the patient feels about moving. Other comments raised concerns for me, such as those indicating that patients with Parkinson’s or MS should just try harder and would thus overcome their physical challenges. The “blaming the victim” (Mackelprang & Salsgiver, 2009, p. 96) mentality is well-documented and puts the onus on the patient to overcome the disability. When this is not possible, the patient is blamed. These attitudes indicate a lack of awareness about the physical and mental health realities people with these diseases may be facing.

Although negative attitudes towards people with disabilities in the general workplace appear to be relatively common (Zeytinoglu et al., 1999), I was surprised to hear them in the medical environment. As a result of the comments made to me by a few staff members and some of the things I overheard about patients, I decided to search the academic literature for perceptions of disability held by medical professionals. I was uncertain about whether I would find anything or whether this topic had been systemically studied. However, I was
able to find a number of studies that show generally negative perceptions towards disability by medical professionals, described in more detail next.

Individual beliefs about disability are created when “perception of one characteristic leads to inference or prediction of a range of others within a person”, developed through personal experience and societal teachings (Gething, 1992, p. 809). These inferences can be negative, positive or neutral. Medical professionals may not be aware of the negativity of their attitudes because they are learned from society (Stienstra, 2012). Reeve (2000) points out, regarding counsellors, that workers are brought up in the same society that allows oppressive structures to exist, so it is no surprise that these attitudes also exist amongst professionals.

The literature suggests that most medical professionals are able to express politically correct attitudes about people with disabilities while being evaluated on their attitudes (Hordon, 1994). In fact, students are known to self-report interactions with people who have simulated disabilities to reflect what Hordon calls “society’s pressure to be kind” (p. 203). However, Gill (2000) found in her literature review that some of the measurement tools used to capture attitudes towards disabilities can skew results when people intentionally answer with excessively positive responses; the true test comes in real-life situations where people have to act on their internal attitudes, especially when the workplace is busy. Specific to nurses, Brillhart and Wyers (1990) point out that internalized beliefs, whether positive or negative, directly affect the quality of care that nurses provide to patients. Therefore, if attitudes are negative in any way, the care that patients receive will be shaped in subtle ways, even if this is not immediately obvious to an observer.
Medical professionals generally see only those people who are experiencing problems in their lives, therefore they may develop inaccurate perceptions of disability simply because they do not normally interact with people who are coping well (Gething, 1992; Hordon, 1994). Gething also suggests that professional organizations may implicitly encourage these stereotypes so that staff do not have to make their own effort to get to know patients or clients as individuals, but instead can rely on a stereotype. Hean, Macleod-Clark, Adams & Humphris (2006) point out that these attitudes “may guide the professional in an appropriate manner when facing an individual from this patient group for the first time” (p. 2). However, these same attitudes may “create a reality through a process of self-fulfilling prophecy” (Hean et al., 2006, p. 2). When these attitudes are paternalistic (Stienstra, 2012), they are consistent with the medical model where the professional is also the expert (Mackelprang & Salsgiver, 2009). Sinick (1981) points out that when a professional tries to imagine what it must be like to live with a particular disability, the fiction is often worse than the reality of what the person actually lives with. People who live with something on a daily basis learn coping strategies that are not available to a person during a simulation. Therefore, professionals may develop a misleading view of the quality of life that people with disabilities experience. Previous contact with people who have disabilities, or exposure to this group outside of the work setting, is believed to improve professional attitudes towards people with disabilities (Gill, 2000; Haskell, 2010; Hordon).

Gill (2000) provides literature showing that mental health professionals often have negative attitudes towards disability in general. For example, depression is often seen as a normal response to disability and some professionals may conclude that intervention is not necessary for these people. While sadness is often associated with the process of adjustment
to disability, longer term depression needs to be investigated. Lack of professional action is particularly problematic when it comes to suicidal ideation; workers who assume that the person is justified in feeling suicidal because of the nature of the disability may not be as quick to offer much-needed help (Brashler, 2006). Gill suggests that medical professionals consistently devalue quality of life for people with disabilities, in comparison to the people themselves who generally self-evaluate quality of life as fairly good once the initial challenges of disability adjustment are dealt with. In fact, some medical professionals believe that death is preferable to life with disability, while patients' perceptions of their own quality of life is not directly related to level or severity of the disability (Brashler).

Gill (2000) argues that medical professionals receive little to no education about structural barriers for people with disabilities so that the medical model, described as “diagnosis and solution in medical knowledge” (Barnes et al., 1999, p. 21), is the only perspective of which medical professionals have working knowledge. Gill suggests that physicians in particular have personality traits of “high performance expectations who try to keep emotions under control and who react poorly to perceived failure” (p. 535). This is significant because it places the failure to cope squarely on the individual and results in blame to the patient, both for the inability to heal the initial injury and failure to adapt and accept the disability when cure is not possible. On the other hand, Kircus and Brillhart (1990) suggest that medical professionals feel helpless when they are unable to fix the underlying disability. This reaction may skew the way they view people with disabilities. Gill argues that these personality factors make medical professionals less able to deal with the complicating social and societal factors surrounding disability. Either way, these perceptions are problematic because “disabled people often identify inappropriate staff attitudes and
behaviours as the biggest barrier to using health services” (Ten Klooster, Dannenberg, Taal, Burger, & Rasker, 2009, p. 2563). Despite the sometimes negative aspects of my own experience, I observed that some medical professionals do understand the problems associated with these attitudes and, when encouraged to do so, are working to promote more well-rounded perceptions of disability, a change which will take time but have enormous benefits for people with disabilities and our health care system as a whole.

Hospital Social Work as I Experienced It

Hospital social work encompasses a vast range of activities. Every day brought something new, although certain activities recurred on an almost daily basis. To give the reader a sense of the situations I encountered, both with my supervisor and more independently once I had shadowed her for a few weeks, I will break down these activities into common ones and unusual ones. I will comment on what I learned from each and how these relate to the broader picture of hospital social work.

Regular activities

Although each hospital unit has different schedules, all had daily or weekly “rounds” where members of the interdisciplinary team met to discuss each patient, including medical, emotional, and social issues, as well as care or discharge planning. While sometimes time-consuming, these meetings provide an excellent opportunity to ensure holistic care and planning for the patients because a variety of professionals have input.

Other activities that happened almost daily included talking to patients prior to their transfer to other hospitals for treatment, especially people going for angiograms, which cannot currently be done at this hospital. Because patients normally get discharged from the other hospital and have to pay for their own transportation back to their home town, social
workers always explain the process to them so appropriate plans can be made. Liaison to set up home support services for people on discharge happened regularly, as did helping people access community services such as Meals on Wheels (hot meals delivered to the home) or HandyDart (a specialized transit service). I also did assessments for people who were being considered for the rehabilitation facility at the hospital, which was used for people to build up strength, endurance, and daily living skills prior to discharge. For every patient I saw, I did a general assessment, which included information on their living situation (both physical location and social attachments), formal and informal supports, functioning prior to hospital admission, and expected challenges on discharge. Although I did become very comfortable with all of the above activities, none of them became routine to me, simply because each patient presented a unique situation. Even when I thought something would be a routine encounter, information would come up showing that the situation was more complex, requiring different or more intensive social work interventions. Consequently, I developed a level of comfort with the systems, information, and types of interventions that might be necessary for each patient, but had to be ready for the unexpected. This prevented me from ever getting bored and meant that every day there was something new to learn. Although it seemed a bit too hectic at times, I appreciated the opportunity for continuous learning and found that I prefer an environment that is dynamic and challenging as this was.

**Unusual situations**

During the course of my practicum I experienced some situations that occurred less frequently, but which were by no means uncommon in hospital work. Each one provided me an opportunity to learn from the situation and develop my own skills in handling new types of requests, while providing valuable service to the people involved.
The first situation involved a patient who was being considered for a specialized rehabilitation facility in another province. The application process was extensive and included information from all members of the professional team, as well as a video of the patient's physical, mental, and communication abilities. Coordinating the process took considerable time and taught me a lot about the importance of persistence in gathering needed information from busy staff. I also had the opportunity to observe and reflect on this patient's recovery, dynamics in the close-knit and supportive family, and the medical system's handling of a complex patient.

Another situation involved a patient whose physical limitations made it challenging for the family to provide adequate care at home, but the patient was reluctant to make the decision to go into a facility. The family dynamic in this situation was complicated and I spent a lot of time in individual discussions with various family members as well as with the patient, trying to help them find a solution that would be workable for everyone. One of the challenges was to gather information from everyone involved while maintaining patient confidentiality. I was able to observe this process in action while shadowing my supervisor and appreciated the opportunity to develop these skills for myself. Decisions about whether to go into a facility or how much help to have at home are challenging for all patients and families; when there are complications like blended families, it can be even more difficult for staff to know whom to talk to in the family and for the family unit to make decisions. Although these situations are not uncommon in the hospital environment, this was the first one that I worked through on my own, hence why I found it especially difficult. Since most of the patients I worked with are seniors, these care decisions and their related challenges will become more common as our population ages.
CHAPTER SEVEN: Implications for Hospital-Based Practitioners

It would be unfair of me to attempt to make sweeping recommendations after only four months in the hospital environment. It is a complex system with many factors at play that are not always immediately obvious to an observer. The challenges for all professional staff in an environment like this is to provide optimal patient care under often hectic conditions where each professional group working with a given patient has a slightly different perspective on what that care should look like. Therefore, I will focus my thoughts on practice implications to disability work within the hospital, using social work values to guide the discussion.

In general, I was very impressed with how well social workers perceive disability within the hospital and the amount of advocacy and effort they put into ensuring that patients get what they need. This can range from informal comments during the regularly scheduled meetings where professionals convene to discuss each patient, to chart notes alerting others of important aspects of the patient’s care, to bringing up information during family meetings or with doctors. Much of the work that social workers engage in involves advocacy, although I noticed that when I was engaged in it, I did not always call it that in my own mind. Almost every patient required some form of advocacy, but often it was so informal that it was not an obvious part of the work until I spent time reflecting on it and discussing it with my supervisor. Although advocacy is already part of the social work job description, social workers would do well to further promote awareness of their scope of practice in the hospital so that all staff could be more aware of the range of social work interventions that occur and the importance of the informal advocacy that happens every day.
I found that the social workers were very aware of disability, both in terms of the physical limitations or challenges it created for patients and also the wider social, environmental, and societal challenges it raised. They regularly raise these issues with other staff to show that disability does not have to mean inability, but that it can often cause social challenges, particularly related to discharge planning. They are quick to advocate for a person’s right to make their own choices and to live at risk, if deemed competent to do so, while providing the support and options that are available to people so that risk can be minimized.

My suggestions for social workers include continuing to be good advocates for patients and providing appropriate education and resources to patients, families, and other staff. Social workers seem to be the most likely to consider the whole person, including the environment, which is an essential part of the work that gets missed when medical professionals talk about “the stroke in room 3”. This type of language is common in the hospital setting, and in my opinion, detracts from the staff’s ability to view the person as more than simply a medical problem. The very nature of social work takes into account the larger picture of a person’s life and their environment, creating a more holistic view. By continuing to advocate that this view be considered by all members of the professional team, social workers have the opportunity to slowly affect change in the attitudes of all professionals towards patient care. This work can take the form of regular and informal conversations and suggestions, to more structured educational sessions for all staff that stress the importance of the social model of disability and structural social work in general. In part, this can be achieved by more regular social work team meetings, where social workers develop strategies to educate other staff, as well as patients and families, about the social
model (Cowles, 2000) and ways to assist people with disabilities to achieve higher self-evaluated quality of life. Included in this work should be education about community resources so that all staff are aware of the range of supports available to patients once they leave the hospital (Haddock, 2009). Instead of taking over the social work role of discharge planning, greater knowledge amongst staff would help all staff promote community supports to patients and increase continuity of care at times when social workers are not generally available, such as on weekends.

I would also encourage social workers to continue to fight against the attitude that disability can or should be blamed for every problem a person has. Brashler (2006) suggests that to make disability the scapegoat for everything does a disservice to the person themselves and disability overall. Not everything is directly related to disability and all staff members need to be aware of the range of reasons why a person might be experiencing a particular challenge. By promoting this attitude, social workers will continue to help enhance everyone’s understanding of disability and the range of impacts it can have.

In the broader context of how hospital-based practitioners understand and work with people who have disabilities or chronic diseases, I feel strongly that patient care would be enhanced by increasing practitioner use of critical reflection to better understand how assumptions about disability affect practice. As Fook (2013) points out, critical approaches to practice focus on relationships between individual assumptions and social environments, as well as how those affect professional decision-making. These concepts are taught as part of social work education and also comprise part of educational and supportive supervision functions within the helping professions (Tsui, 2005). Extending reflective practice to include all hospital-based practitioners would be one way to encourage all professionals to
become more aware of their own perceptions and how these perceptions affect practice. As Delany and Watkin (2013) demonstrate, reflective practice developed for social workers can be effectively adapted for use with other health care professionals to enhance their understanding of themselves and their practice.
CHAPTER EIGHT: Conclusion

Being able to do my practicum in the hospital provided me with an amazing opportunity to develop my social work skills in an intense practice setting, while exploring issues related to my passion for disability work. I was challenged on a daily basis to broaden my understanding of what health care is and how social work can effectively fit into a setting that is created on a model so different from how social workers normally expect to practice.

Regarding my central focus on how disability is viewed within the hospital system, I saw many examples of practice that makes me hopeful that attitudes towards disability are shifting towards a more holistic view of the value of people with disabilities and how their needs can and should be met within the hospital system. I was especially pleased by the crucial role that hospital social workers play in helping patients with disabilities and chronic diseases have as positive a hospital experience as possible under difficult circumstances. I believe that with continued effort on the part of hospital social workers and other professionals who work from a social model of disability perspective that patient care can continue to evolve to best meet the needs of patients of all ability levels during their hospital stay.
References


doi: 10.1177/0020872804043958


doi:10.1080/00981380902928935


