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# Advancing Social Work Education for Practice in Healthcare: Transforming Education and Bridging the Classroom to Practice Gap

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Advancing Social Work Education for Practice in Healthcare: Transforming Education and  
Bridging the Classroom to Practice Gap

by

Katrinna M. Matthews

A Banded Dissertation in Partial Fulfillment  
Of the Requirements for the Degree  
Doctor of Social Work

St. Catherine University | University of Saint Thomas  
School of Social Work

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### Abstract

This banded dissertation explores medical social work education as it relates to teaching social work students the skills and knowledge necessary to be effective in a healthcare setting. In addition, this banded dissertation identifies deficits in current curricula related to medical social work education and barriers to effective medical social work practice. This banded dissertation consists of three separate but closely related scholarly products. Bronstein's Model of Interdisciplinary Collaboration, the Biopsychosocial-spiritual model, and the authors lived experiences serve as the conceptual framework that supports the findings of this research.

The first scholarly product is a conceptual article that examines the history of medical social work as it relates to educating social workers for social work practice in a healthcare setting. The purpose of Product One was to explore the history of medical social work education and the current deficits in social work curricula related to educating students for effective medical social work practice. Product one findings indicated that social workers are not adequately prepared for practice in a healthcare setting and that generalist social work education is not sufficient for educating future medical social workers.

The second scholarly product is an exploratory qualitative research study aimed at identifying the barriers to effective medical social work practice. Twenty-three current medical social workers participated in the study. Three major themes were identified as barriers to effective medical social work culture: medical culture, lack of knowledge, and limited exposure.

The third and final product of this banded dissertation is a peer-reviewed presentation of scholarly product one at the 2019 BPD Annual Conference in Jacksonville, Florida. The primary purpose of the presentation was to educate social work educators on medical social work practice. The presentation provided attendees with a detailed overview of the roles and

responsibilities associated with medical social work practice, the history of medical social work education, and current deficits in social work education as relates to educating students for practice in a healthcare setting. In addition, social justice issues were addressed especially as they relate to healthcare and medical social work practice.

In summary this body of scholarly work contributes to the existing body of knowledge regarding medical social work education and the barriers associated with effective medical social work practice. Implications for social work education include developing medical social work curriculum, strengthening existing social work curricula to include content relevant to medical social work practice, and strengthening medical social work field practicums. Implications for research suggest that further research needs be conducted on programs that offer medical social work courses and/or tracks and more extensive research needs to be done with current medical social workers.

*Keywords: healthcare, medical social work, interdisciplinary collaboration, biopsychosocial-spiritual, social work education, specialized practice, deficits, barriers, health disparities*

### Dedication

This dissertation is dedicated to my parents, Quentin and Patricia Matthews. I am who I am because who you are. You two have always provided me with unwavering support, unconditional love, and a strong belief in my abilities. You two have allowed me to dream and to reach for the stars without fear of failure and for that I am forever grateful. Your love and support means more than you will ever know.

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To my cohort 3 family, I love and cherish each of you and the value that you have added to my life. I came into this program expecting this to be a lonely and competitive journey and vowing to make “no new friends.” I have broken that vow sixteen times! I consider each of you a life-long friend and there is no other group of people that I would want to share this journey with.

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Advancing Social Work Education for Practice in Healthcare: Transforming Education and  
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Healthcare in the United States is a complex system that is impacted by multiple variables such as insurance/payor sources, supply and demand, policy and processes, and the motivation to achieve quality outcomes. At the heart of this complex system are patients and their families. Patients enter this complex system at all stages of life with a multitude of chronic and acute physical ailments. Patients are thrust into the healthcare system having a lack trust in the healthcare system, limited understanding of their diagnosis and prognosis, poorly informed of their insurance benefits or not having insurance, and being victims of health disparities and ultimately predisposed for poor health outcomes. In addition, patients face life adjustment issues associated with their health conditions, such as changes in employment status, loss of wages, changes in their family structure, roles, and responsibilities and ultimately a loss of life as they once knew it.

As a result of the impact that illness has on patients and their families, medical social workers can be found across the continuum of healthcare in various healthcare settings such as public health, acute, and chronic health settings (NASW, 2011). Patients and their families depend on medical social workers to assist them with understanding their diagnosis, prognosis, treatment options, and treatment regimen. Medical social workers also find themselves serving as the liaison between the patient and their family and the healthcare team and act as the patient's advocate for ensuring that patients receive all necessary benefits, services, and entitlements that will aid in patients receiving the best quality of care possible.

Undoubtedly medical social work is a specialized area of social work practice that requires a specialized skill set and foundational knowledge of the biological/physical component

of biopsychosocial-spiritual assessment and interdisciplinary collaboration. Considering the complexity associated with medical social work practice it is imperative that schools of social work adequately equip graduates with the skills and knowledge necessary to be effective medical social workers. Schools of social work are not oblivious to the specialized skill set and foundational knowledge required for effective medical social work practice, although it is believed that generalist social work education is sufficient for preparing graduates to work in a healthcare setting (Beddoe, 2013; Berkman, 1996; Gregorian, 2005; Kadushin & Egan, 1997).

This banded dissertation proposes that due to the complexity of medical social work practice and the need for medical social workers to have a specialized skill set and foundational knowledge of biological/physical functioning and interdisciplinary collaboration, that generalist education is necessary, but not sufficient. The scholarly products included in this banded dissertation explores the history of educating social workers for practice in healthcare, examines barriers to effective medical social work practice, and proposes implications for social work education.

Department of Labor predictions indicate that by 2020 medical social workers will increase by 34 percent and will account for 25 percent of all social work professionals (Mitchell & Joosten, 2014). Therefore, it is imperative that medical social workers receive a social work education that will enable them to be effective in a healthcare setting. It is important that social work education incorporates a medical social work curriculum that “meet the needs of students and professionals, which directly affect the needs of patients” (Mitchell & Joosten, 2014, p. 236). In addition, medical social work curriculum should be inclusive of content that strives to provide future medical social workers with a thorough “understanding of U.S. health disparities from multiple perspectives” (Mitchell, 2012, p. 482).

### **Conceptual Framework**

The theoretical framework guiding this banded dissertation is Bronstein's Model for Interdisciplinary Collaboration, the Biopsychosocial-Spiritual Model, and the author's lived experience as a medical social worker. Bronstein's Model for Interdisciplinary Collaboration assumes that in order to effectively serve clients, social workers must be able to function on teams that are composed of various professionals from other disciplines (Bronstein, 2003). This model also assumes that social work professionals will utilize interpersonal skills to adequately serve on teams with collective goals for assisting clients. Whereas, the biopsychosocial-spiritual model assumes that the person cannot be fully separated from the environment and/or relationships (Sulmasy, 2002).

This conceptual framework is appropriate for this body of scholarly work because medical social work is team oriented and social workers working in a healthcare setting will likely be a member of an interdisciplinary team. Therefore, for social workers to effectively fulfill their roles as medical social workers they must have a working understanding of interdisciplinary collaboration. Research supports training social workers on interdisciplinary collaboration so that social workers understand the role of interdisciplinary collaboration, their role on the interdisciplinary team, and develop confidence as it relates to social work's importance in interdisciplinary collaboration (Ambrose-Miller & Ashcroft, 2016).

In addition to being able to effectively function as a member of an interdisciplinary team, medical social workers must also have a solid understanding of the biopsychosocial-spiritual model, with special emphasis on the biological aspect. In order for helping professionals (e.g., doctors, nurses, and social workers) to effectively assist clients, it is imperative that professionals are comfortable and competent in assessing clients for biological, psychological, and social

needs (Ell, Oh, & Wu, 2016). In addition, the biopsychosocial model is especially relevant to social work practice in a healthcare setting because social workers must fully understand how biological processes impact an individual's psychological and social functioning (Vourlekis, Ell, & Padgett, 2001). Therefore, the biopsychosocial-spiritual model proves to be appropriate for this body of scholarly work because the person, environment, and relationships are interrelated and highly depended on each other. In the context of medical social work, the biopsychosocial-spiritual model assumes that in order to treat a person's illness, there must be understanding of the person's environment and relationships, because the person cannot be separated from those things and because the environment and relationships have the potential to positively or negatively impact a person's health and well-being (Engel, 2012; Sulmasy, 2002).

The conceptual frameworks of Bronstein's Model for Interdisciplinary Collaboration, the Biopsychosocial-Spiritual Model, and the author's lived experience as a medical social worker guide the conceptual paper, the research study, and the peer-reviewed conference presentation.

### **Summary of Banded Dissertation Products**

This banded dissertation is composed of three scholarly products. Product one is a conceptual paper that reviews the literature on the history of medical social work education and aims to illustrate the current deficit that exists in medical social work education. The article is conceptually grounded in Bronstein's model of interdisciplinary collaboration and the biopsychosocial-spiritual model. The article details the rigor of early medical social work curricula with special emphasis on the pre-requisites, required courses, and the post-graduation training. This article formulates rationale regarding the rigor of early medical social work curricula, and raises consciousness regarding current social work curriculum, by arguing that current social work curricula does not properly prepare social workers to work effectively in a

health care setting. The article poses questions such as “How well trained are current medical social workers,” “Did they receive their training on the job or part of their social work graduate curriculum,” and “Did medical social work curriculum lose its standing as a separate entity within the social work master program, when the American Association of Medical Social Workers was consolidated with other social work associations to form the National Association of Social Workers?” Last, the article proposes areas for further research and implications for social work education to strengthen education to better equip social work graduates with the necessary skills and knowledge to be effective medical social workers.

The second product for the banded dissertation is a research article based on an exploratory qualitative research study. The study sought to identify barriers to effective medical social work practice. Semi-structured interviews were completed with 23 current medical social workers. Current medical social worker was defined as a social worker who is currently employed as a medical social worker in a healthcare setting (hospital, dialysis, oncology, Veterans Administration, primary care, hospice, outpatient clinic, etc.), and that possessed a BSW (bachelor of social work) and/or a MSW (master of social work) degree. Findings from this study were consistent with existing literature and suggested several barriers such as limited knowledge regarding biological functioning, limited exposure to interdisciplinary collaboration, and insufficient preparation for working in a healthcare setting.

Product three is a presentation of scholarly product one/conceptual article given at the 2109 Annual BPD Conference in Jacksonville, Florida. Product three aimed to inform participants on medical social work practice, the history of medical social work education, and social justice issues related to healthcare. In addition, product three provided participants with implications for social work education.

### **Discussion**

Findings from this banded dissertation are consistent with current social work literature regarding social workers' unpreparedness for practice in healthcare settings. Preparing medical social workers for practice in healthcare has been an area of contention for social work educators and practitioners since the inception of medical social work practice. This contention is evidenced by the findings of product one of this banded dissertation, which demonstrates the struggle to develop adequate medical social work education. Formal medical social work education dates back to the early 1900s. At its inception medical social work education was extensive and took place during the student's course of graduate study. Initial preparation for practice as a medical social worker required a specific set of courses that were developed by the American Association of Medical Social Workers (AAMSW). The required courses were a combination of specialized content that was taught in the classroom and through medical social work field practicums. Early medical social workers were expected to have a broad knowledge base that included knowledge of medical settings, case management, biological functioning, the impact of illness on various systems, prevention, and public health.

Current medical social workers are faced with the same expectations as early medical social workers. The need for a broad knowledge base remains, although the preparation for medical social workers has changed drastically. The education standards developed and implemented by the AAMSW are no longer in existence. Current medical social work preparation is largely inconsistent and generalist social work education is considered to be adequate preparation for social work practice in a healthcare setting. Product two of this banded dissertation focuses on the experiences of current medical social workers and their perceived barriers to preparedness for practice in a healthcare setting.



Several themes related to social workers' unpreparedness for medical social work practice emerged from the findings. The most emergent themes were medical culture, lack of knowledge, and limited exposure; all of which ultimately contribute to social workers' unpreparedness for practice in a healthcare setting. Overall, participant interviews indicated that medical social workers are receiving their training on the job rather than in their social work programs. These findings were consistent with the findings of product one.

As evidenced by the research in this banded dissertation there is a deficit in current social work curricula as it relates to adequately preparing social work graduates to effectively practice in a healthcare setting. Medical social work is currently the fastest growing area of social work practice and is expected to grow by 20% by 2026 (Bureau of Labor Statistics, 2018). Taking into account the growth of medical social work practice it is very important that schools of social work address this deficit and commit to developing curricula and/or adapting current curricula to adequately prepare social work graduates for medical social work practice. If schools of social work fail to address this deficit it is likely that social work will lose ground in the healthcare arena and medical social work jobs will be given to other allied health professionals.

### **Implications for Social Work Education**

The implications for social work education are broad and include developing medical social work curriculum and infusing current courses with appropriate medical content. Social work education needs a stronger curriculum to train social workers for practice in healthcare. Therefore, the greatest implication for social work education is the need for curricula development specifically focused on medical social work practice. Social work education needs new courses that are tailored to medical social work practice. Courses that focus on basic medical terminology, basic disease pathology, and courses that focus on conceptualizing the

biological component of biopsychosocial-spiritual assessments. In addition, social work educators should focus on integrating medical social work content into existing courses. For example, social work policy courses should integrate content that extends beyond understanding the history and development of Medicare and Medicaid and that focuses on current healthcare systems and the role that Medicare and Medicaid plays within those systems, as well as the stigma and health disparities that are associated with utilization of Medicaid benefits.

Social work educators must also recognize that group work and team work are not synonymous. Social workers are well trained for group work and traditionally social workers do well in groups. Although social workers are not trained on team work, which results in social workers often struggling to work with a team, especially an interdisciplinary team. Social work educators must commit to infusing current course content with material that focuses on interdisciplinary collaboration and effectively navigating teams.

It is also important that social work educators, especially field directors work to develop healthcare practicums in healthcare settings other than hospitals. Field directors typically place social work interns in hospitals and consider that to be sufficient for medical social work exposure and training. Field directors should focus on developing field practicums in acute care clinics, chronic care clinics, and community health clinics in order to expose students to a variety of medical social work practice settings and to ensure that students have a medical social work practicum experience that includes more than discharge planning.

Last, social work educators must incorporate content related to health disparities and social determinants of health into existing courses. Discussing poverty and the impacts of poverty is simply not enough. Students need to be exposed to the factors that socially determine health outcomes and how certain social determinants impact access to healthcare. In addition,

students to need to be exposed to interventions and treatment models that will enable them to effectively work with those negatively impacted by the healthcare system, health disparities, and social determinants of health. Exposing students to this content will not only better prepare them for practice in a healthcare setting but will also better equip future medical social workers to tackle the grand challenge of closing the health gap.

### **Implications for Future Research**

The scholarly products of this banded dissertation overwhelmingly suggest that social work education does not adequately prepare graduates for practice in a healthcare setting. There is solid implication for future research regarding educating medical social workers. Product one provided sufficient data regarding the deficits in social work education, as it relates to preparing students for practice in a healthcare setting. The deficits are clear, although the sufficiency is not. Therefore, research needs to be conducted on programs that offer medical social work courses, medical social work tracks, and/or medical social work certificate programs. A lot can be learned from the programs that are successfully educating students for medical social work practice. Educational practices/models from those programs can be adopted and utilized by other programs, in an effort to provide consistent and adequate medical social work education.

Future research is warranted on current medical social workers and their perceived barriers to medical social work practice. Product two provided data regarding current medical social workers' perceived barriers to medical social work practice although more data is needed from a larger and more diverse sample size. Future research on current medical social workers' perception would prove to be beneficial to both schools of social work and employers of medical social workers. As indicated by product two data, medical culture is a primary barrier to effective medical social work practice. Therefore, further research on current medical social workers

would likely lead to implications for medical social worker employers that could ultimately alleviate this barrier.

Understanding how medical social workers can be the most effective is another area of future research. Considering that there is an increasing aging population with increased healthcare needs, an ever-changing healthcare system, and an ever-increasing group of individuals who are disproportionately impacted by health disparities; it is imperative that we gain a better understanding of how best to utilize medical social workers. Research studies focused on finding the best fit for medical social workers in healthcare is essential to ensuring that patients are receiving the best medical social services possible and that their needs are being met in the most effective manner.

### **Conclusion**

The scholarly products in this banded dissertation highlight the rigor that was historically associated with medical social work education and the gap that currently exists between social work education and medical social work practice. Furthermore, the findings of this banded dissertation align with previous research which indicates that medical social work practice is a specialized area of social work practice and that schools of social work are not consistently or adequately preparing graduates to practice in a healthcare setting. In conclusion, the research of this banded dissertation uses history and current voices from the field to highlight the deficiency of current medical social work education. Past medical social workers were subjected to a rigorous course of study; although the patients they served likely had far less complex issues than today's patients. Considering the complexities of today's patients and the current healthcare system, schools of social work should use the historical roots of medical social work education to influence current curricula.

## Comprehensive Reference List

- Allen, H., Wright, B. J., Harding, K., & Broffman, L. (2014). The role of stigma in access to health care for the poor. *The Milbank Quarterly*, 92(2), 289-318.  
doi: 10.1111/1468-0009.12059
- Allen, K. M. & Spitzer, W. J. (2016). *Social work practice in healthcare: Advance approaches and emerging trends*. Thousand Oaks, CA: Sage.
- Andrews, C. (2014). Unintended consequences: Medicaid expansion and racial inequality in access to health insurance. *Health & Social Work*, 39(3), 131-133.  
doi:10.1093/hsw/hlu024
- Beddoe, L. (2013). Health social work: Professional identity and knowledge. *Qualitative Social Work*, 12(1), 24-40. doi:10.1177/1473325011415455
- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work*, 41(5), 541-551. doi:10.1093/sw/41.5.541
- Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Annals of Family Medicine*, 2(6), 576-582. doi:10.1370/afm.245
- Boyce, L., & Scott, V. (1986). Curriculum planning for social work in health care: The practitioner's view. *Australian Social Work*, 39(3), 37-43.  
doi:10.1080/03124078608549881
- Bracht, N. F. (1978). Chapter 22: Building a Health Care Concentration: Curriculum Guidelines for Schools of Social Work. In *Social Work in Health Care: A Guide to Professional Practice* (pp. 317-326). Taylor & Francis.

- Bronstein, L. R. (2003). A Model for Interdisciplinary Collaboration. *Social Work, 48*(3), 297-306. doi:10.1093/sw/48.3.297
- Bronstein, L., Kovacs, P., & Vega, A. (2007). Goodness of fit: Social work education and practice in health care. *Social Work in Health Care, 45*(2), 59-76.  
doi:10.1300/J010v45n02-04
- Browne, T., Keefe, R. H., Ruth, B. J., Cox, H., Maramaldi, P., Rishel, C., & ... Marshall, J. (2017). Advancing social work education for health impact. *American Journal of Public Health, S3*, S229-S235. doi:10.2105/AJPH.2017.304054
- Bureau of Labor Statistics, U.S. Department of Labor. (2018). *Occupational Outlook Handbook, Social Workers*. Retrieved from <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm>
- Cabot, R. C. (1909). *Social Service and the Art of Healing*. New York, NY: Moffat Yard and Company.
- Chaddock, R. (2016). Integrating early multi-disciplinary advance care planning into core social work practice: Social workers' bread and butter. *Journal of Social Work Practice, 30*(2), 129-138. doi:10.1080/02650533.2016.1168382
- Cooner, T. S. (2011). Learning to create enquiry-based blended learning designs: Resources to develop interdisciplinary education. *Social Work Education, 30*(3), 312-330.  
doi:10.1080/02615479.2010.482983
- Council on Social Work Education (2015). *Educational policy and accreditation standards*. Alexandria, VA: CSWE. Retrieved from:  
[https://www.cswe.org/getattachment/Accrediation/Accreditation-Process/2015EPAS/2015EPAS\\_Web\\_Final.pdf.aspx](https://www.cswe.org/getattachment/Accrediation/Accreditation-Process/2015EPAS/2015EPAS_Web_Final.pdf.aspx)

Council on Social Work Education (2017). *2016 Statistics on Social Work Education in the United States: A summary of the CSWE Annual Survey of Social Work Programs*.

Alexandria, VA: CSWE. Retrieved from:

<https://www.cswe.org/CMSPages/GetFile.aspx?guid=6e8bc9e7-ebd6-4288-bc7a-d2d427d68480>

Cowles, L.A., & Myron J. L. (2015). Interdisciplinary expectations of the medical social worker in the hospital setting: Part 2. *Health and Social Work, 20*(4), 279-286. Retrieved from:

[http://link.galegroup.com/apps/doc/A17940532/HRCA?u=tel\\_a\\_unionu&sid=HRCA](http://link.galegroup.com/apps/doc/A17940532/HRCA?u=tel_a_unionu&sid=HRCA)

Darnell, J. S. (2013). Navigators and assisters: Two case management roles for social workers in the Affordable Care Act. *Health and Social Work, 38*(2), 123-126.

doi:10.1093/hsw/hlt003

DeBonis, J. A., Becker, M. A., Yoo, J., Capobianco, J., & Salerno, A. (2015). Advancing social work education: Lessons learned from piloting an integrated healthcare curriculum.

*Journal of Social Service Research, 41*(5), 594. doi:10.1080/01488376.2015.1081859

Education for Medical Social Work: The Curriculum Content. (1951). *American Association of Medical Social Workers Education Committee, Curriculum Content Subcommittee*.

Retrieved from University of Minnesota Social Welfare History Archives. (NASW:

AAMSW Box 31, Folder 381).

Engel, G. L. (2012). The Need for a New Medical Model: A Challenge for Biomedicine.

*Psychodynamic Psychiatry, 40*(3), 377-396. doi:10.1521/pdps.2012.40.3.377

Grant, D. M., & Toh, J. S. (2017). Medical social work positions: BSW or MSW?. *Social Work in Health Care, 56*(4), 215-226. doi:10.1080/00981389.2016.1265633

- Gregorian, C. (2005). A career in hospital social work: Do you have what it takes? *Social Work in Health Care*, 40(3), 1-14. doi:10.1300/J010v40n0301
- Horevitz, E., & Manoleas, P. (2013). Professional competencies and training needs of professional social workers in integrated behavioral health in primary care. *Social Work in Health Care*, 52(8), 752–787. <https://doi.org/10.1080/00981389.2013.791362>
- Hospital Social Work. (1929). In *Social Work Year Book 1929* (Fred S. Hall ed.). Retrieved from <http://umedia.lib.umn.edu/node/542286>
- Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education*, 52(1), 18. doi:10.1080/10437797.2016.1112629
- Kadushin, G., & Egan, M. (1997). Educating students for a changing health environment: An examination of health care practice course content. *Health & Social Work*, 22(3), 211–222. doi:10.1093/hsw/22.3.211
- Keigher, S. M. (1997). What role for social work in the new health care practice paradigm?. *Health and Social Work*, 22(2), 149-155. doi:10.1093/hsw/22.2.149
- Kovacs, P. J., & Bronstein, L. R. (1999). Preparation for oncology settings: What hospice social workers say they need. *Health & Social Work*, 24(1), 57-64. doi:10.1093/hsw/24.1.57
- Liley, D. G. (2003). Bridging the gap between classroom and practicum. *Journal of Gerontological Social Work*, 39(1-2), 203-217. doi:10.1300/J083v39n01\_17
- Maramaldi, P., Sobran, A., Scheck, L., Cusato, N., Lee, I., White, E., & Cadet, J. (2014). Interdisciplinary medical social work: A working taxonomy. *Social Work in Health Care*, 53(6), 532-551. doi:10.1080/00981389.2014.905817
- Medical Social Work. (1949). In *Social Work Year Book 1949: A Description of Organized*



- Activities in Social Work and in Related Fields* (Margaret B. Hodges ed., Tenth Issue).  
Retrieved from <http://umedia.lib.umn.edu/node/542295>
- Medical Social Work. (1951). In *Social Work Year Book 1951: A Description of Organized Activities in Social Work and in Related Fields* (Margaret B. Hodges ed.).  
Retrieved from <http://umedia.lib.umn.edu/node/542296>
- Medical Social Work. (1954). In *Social Work Year Book 1954: A Description of Organized Activities in Social Work and in Related Fields* (Russell Kurtz ed., Twelfth Issue).  
Retrieved from <http://umedia.lib.umn.edu/node/542297>
- Medical Social Work. (1960). In *Social Work Year Book 1960: A Description of Organized Activities in Social Work and in Related Fields* (Russell Kurtz ed., Fourteenth Issue).  
Retrieved from <http://umedia.lib.umn.edu/node/542299>
- McEwen, S. (2015). Social work in health care when conventional meets complementary: Nonspecific back pain and massage therapy. *Health & Social Work, 40*(1), 19-25.  
doi: 10.1093/hsw/hlu041
- Mitchell, F. M. (2015). Racial and ethnic health disparities in an era of health care reform. *Health & Social Work, 40*(3), e66-e74. doi:10.1093/hsw/hlv038
- Mitchell, J. A. (2012). Integrating education on addressing health disparities into the graduate social work curriculum. *Journal of Teaching in Social Work, 32*(5), 471-486.  
doi:10.1080/08841233.2012.725458
- Mitchell, K. R., & Joosten, D. M. (2014). Determinants of health concentration selection among University of Southern California MSW students. *Health & Social Work, 39*(4), 230-237.  
doi:10.1093/hsw/hlu033

- NASW Center for Workforce Studies and Social Work Practice. (2011). *Social Workers in Hospitals and Medical Centers: Occupational Profile*. Retrieved from <http://workforce.socialworkers.org/studies/profiles/Hospitals.pdf>
- National Association of Social Work. (2016). *NASW Standards for Social Work Practice in Healthcare Settings*. Retrieved from <https://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf>
- National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers*. Washington, DC. NASW Press.
- Nimmagadda, J., & Murphy, J. I. (2014). Using simulations to enhance interprofessional competencies for social work and nursing students. *Social Work Education*, 33(4), 539-548. doi:10.1080/02615479.2013.877128
- Owen, C. L. (2009). Consumer-driven health care: Answer to global competition or threat to social justice? *Social Work*, 54 (4), 307-315. doi.10.1093/sw/54.4.307
- Pardasani, M., & Bandyopadhyay, S. (2014). Ethnicity matters: The experiences of minority groups in public health programs. *Journal of Cultural Diversity*, 21(3), 90-98. doi: 10.1037/a0023673
- Phillips, M. & Fitzsimons, V. (2015). The affordable care act: Impact on case managers. *Professional Case Management*, 20(6), 323-327. doi:10.1097/NCM.0000000000000125
- Praglin, L. J., (2007). Ida Cannon, Ethel Cohen, and early medical social work in Boston: The foundations of a model of culturally competent social service. *Social Service Review*, 81(1), 27-45. doi:10.1086/511013
- Redmond, H. (2001). The health care crisis in the United States: A call to action. *Health and Social Work*, 26(1), 54-57. doi: 10.1093/hsw/26.1.54

- Reinhold, M.I., Otieno, S., & Bacon-Baguley, T. (2017). Integrating interprofessional experience throughout a first-year physician assistant curriculum improves perceptions of health care providers. *Journal of Interprofessional Education & Practice*, 6, 37-43. doi:10.1016/j.xjep.2016.12.001
- Report of the Committees on the Training of Hospital Social Workers. (1922). *The American Hospital Association: Presented to the Board of Trustees at the Convention of the Association*. Retrieved from University of Minnesota Social Welfare History Archives. (NASW: AAMSW Box 31, Folder 369).
- Rischel, C. W. (2014). Teaching note—Integrating prevention content into clinical social work practice courses. *Journal of Social Work Education*, 50(4), 752-762. doi:10.1080/10437797.2014.947166
- Ross, J. W. (1993). Redefining hospital social work: An embattled professional domain. *Health and Social Work*, 18(4), 243-247. doi:10.1093/hsw/18.4.243
- Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K., Wyche, K., & Sliwa, S. (2017). *Profile of the social work workforce*. Retrieved from <https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx>.
- Sampson, A. (2010). *Informing social work practice through the enhancement of the biological perspective: A course intervention model for human service professional working with youth and problems of conduct* (Doctoral Dissertation). Retrieved from <https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=3305&context=etd>
- Silverman, E. (2008). From ideological to competency-based: The rebranding and maintaining of medical social work's identity. *Social Work*, 53(1), 89-91. doi:10.1093/sw/53.1.89

Sims, D. (2011). Achieving collaborative competence through interprofessional education:

Lessons learned from joint training in learning disability nursing and social work. *Social Work Education, 30*(1), 98-112. doi:10.1080/02615471003748056

Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated

health: An opportunity for social work. *Social Work in Health Care, 54*(5), 383-407. doi:10.1080/00981389.2015.1025122

Sulmasy, D. P. (2002). A Biopsychosocial-Spiritual Model for the Care of Patients at the End of

Life. *Gerontologist, 42*(suppl\_3), 24-33. doi:10.1093/geront/42.suppl\_3.24

Sweet, B. V., Madeo, A., Fitzgerald, M., House, J. B., Pardee, M., Zebrack, B., ... Mueller, B. A.

(2017). Moving from individual roles to functional teams: A semester-long course in case-based decision making. *Journal of Interprofessional Education & Practice, 7*, 11-16. doi:10.1016/j.xjep.2017.01.003

Volland, P. J., Berkman, B., Phillips, M., & Stein, G. (2003). Social work education for health

care. *Social Work in Health Care, 37*(4), 1-17. doi:10.1300/J010v37n04\_01

Walter, K. L., Spencer, M. S., Smukler, M., Allen, H. L., Browne, T., Maramaldi, P.,...

Uehara, E. (2016). *Health equity: Eradicating health inequalities for future generations*. Working Paper No. 19.

Williams, J. H. (2013). Disparities, disproportionalities, differences, and discrepancies.

*Social Work Research, 37*(4), 309-311. doi:10.1093/swr/svt039

Zayas, L. H., & Dyche, L. A. (1992). Social workers training primary care physicians:

Essential psychosocial principles. *Social Work, 37*(3), 247-252. doi:10.1093/sw/37.3.247

Educating Students for Medical Social Work Practice: Closing the Gap Between Classroom and  
Practice

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### Abstract

Medical social work is a specialized area of social work practice that requires a specific skill set. Medical social workers work in various healthcare settings and are charged with a multitude of responsibilities. Medical social workers are vital members of interdisciplinary teams, and play a major role in biopsychosocial- spiritual assessments, although findings from previous studies suggest that emphasis on medical social work preparation has not been a priority of social work programs (Bronstein, Kovacs, & Vega, 2007; Mitchell & Joosten, 2014). This conceptual paper will review the literature on the subject along with the author's lived experience as a medical social worker, to illustrate the deficit in medical social work education and to advocate for social work education that adequately prepares social workers to thrive in a healthcare setting.

*Keywords:* medical social work, health care setting, interdisciplinary team, biopsychosocial-spiritual assessment, health disparities, curricula

## Educating Students for Medical Social Work Practice: Closing the Gap Between Classroom and Practice

Medical social workers are faced with grave challenges. Medical social workers must deal with health disparities, increases in chronic illness, an increasing aging population, and a significant increase in the prevalence of socially and environmentally determined diseases (Volland, Berkman, Phillips, & Stein, 2003). It is imperative that medical social workers receive a social work education that will enable them to be effective in a healthcare setting. Yet, social work curricula leave graduates substantially unprepared (DeBonis, Becker, Yoo, Capobianco, & Salerno, 2015; Mitchell, 2012; Mitchell & Joosten, 2014). Scholars suggest that social work education should reform to meet the needs of students and health care professionals to positively impact patient outcomes (Mitchell & Joosten, 2014). Moreover, social work curricula lack inclusive content on U.S. health disparities to prepare future medical social workers to navigate multiple perspectives (Mitchell, 2012).

Findings from a recent study reinforces the perceived gap in social work curricula to prepare social workers for the challenges of the health care setting, and recommends the incorporation of integrated health courses and specialized training into the current social work practice curricula (DeBonis et al., 2015). It should not be forgotten that social work curricula require attention to biological dimensions, as well as, the cultural, social, psychological, environmental, and spiritual aspects of social functioning (Berkman, 1996). The purpose of this article is to increase awareness of the gap between medical social work practice and social work education, especially as it relates to social work education's limited focus on interdisciplinary collaboration and the biological aspect of biopsychosocial-spiritual assessment. In addition, the

author will advocate for integration of evidence-based practice models that support effective medical social work practice into the existing social work curriculum.

This article is grounded in lived experiences as a social work student, medical social worker, and social work educator, Bronstein's Model for Interdisciplinary Collaboration, and the Biopsychosocial-Spiritual Model. These models will serve as the conceptual framework because healthcare is team oriented and social workers working in a healthcare setting will likely be a member of an interdisciplinary team. In addition, this framework will assist social workers in effectively fulfilling their roles as medical social workers, by supporting interdisciplinary collaboration and providing a solid understanding of the biopsychosocial-spiritual model, with special emphasis on the biological aspect. This understanding is important because having limited understanding of the biopsychosocial-spiritual model will negatively impact the effectiveness of a medical social worker, as well as limit medical social workers' roles under the Affordable Care Act (ACA) as care managers, and ultimately impact the professions' mission to reduce health disparities and close the health gap.

### **Elements Critical to Effective Medical Social Work Practice**

One element that is highly critical to a medical social worker's effectiveness is a solid understanding of the biological aspect of the biopsychosocial-spiritual perspective. Social workers in a health care setting must understand biology and how biological factors manifest in acute and/or chronically ill individuals. Limited understanding of biology and biological factors put medical social workers at a disadvantage regarding being able to effectively serve their clients.

Another critical element to a medical social worker's effectiveness is the ability to work in interdisciplinary teams that are charged with collaborating on patient care and interventions. It



is widely accepted in social work education and the medical field that effective interdisciplinary collaborations result in better outcomes for patients. This is evident in the Council on Social Work Education (CSWE) Education Policy and Accreditation Standards (2015) and the ACA's emphasis on coordinated care (Phillips & Fitzsimons, 2015). More specifically, CSWE supports course work that integrates behavioral health, social work practice in medical settings, and interprofessional learning (Jones & Phillips, 2016). Although, studies indicate that medical social workers are not adequately prepared by social work programs (Berkman, 1996; DeBonis et al., 2015; Mitchell, 2012; Mitchell & Joosten, 2014).

Despite the clear need for social workers to be foundationally solid in the biopsychosocial-spiritual perspective and interdisciplinary collaboration, social workers often experience difficulty in these areas and tend to be poorly trained. While CSWE supports social work practice in the medical setting, recent literature acknowledges that medical social workers depend on continuing education and extensive on the job training due to limited medical social work preparation (Mitchell, 2012).

Department of Labor predictions indicate that by 2020 the need for medical social workers will increase by 34 percent and will account for 25 percent of all social work professionals (Mitchell & Joosten, 2014). Considering that medical social work is an area of high demand for social work practitioners, it is imperative that social work students begin obtaining adequate education that will allow them to be effective medical social workers. In the following section the conceptual framework that supports this article will be explained.

### **Conceptual Framework**

The author's lived experiences, Bronstein's Model for Interdisciplinary Collaboration and the Biopsychosocial-Spiritual Model, will serve as the conceptual framework for this article.

Interdisciplinary collaboration is defined as “an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own” (Bronstein, 2003, p. 299). Interdisciplinary collaboration is viewed as having five major components that are necessary for social workers to have optimal collaboration with other professionals. The five components are interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection of process (Bronstein, 2003). Bronstein’s Model for Interdisciplinary Collaboration also considers the four primary factors that influence interdisciplinary collaboration. Bronstein (2003) recognizes that the *factors of influence* include professional role, structural characteristics, history of collaboration, and personal characteristics; and that factors are contextualized in interdisciplinary collaboration. The *factors of influence* have the potential to be proponents or opponents of effective interdisciplinary collaboration.

The biopsychosocial model was developed by George Engel and first introduced to clinicians in 1977 (Engle, 2012). Engle created the model as a “holistic” alternative to the biomedical model (Borrell-Carrió, Suchman, & Epstein, 2004). The biopsychosocial model is composed of three distinct parts; biological, psychological, and social. The model is systemic in nature and considers biological, psychological, and social factors to interact interdependently and thereby create complex interactions as it relates to understanding health, illness, and health care delivery (Engel, 2012). The biopsychosocial model is considered to serve as a philosophy of clinical care and a practical guide for professionals. Philosophically the model provides practitioners with a way of understanding how a patient’s experiences of suffering, disease, and illness are impacted systemically on various levels, from the societal to the molecular. At the practical level, the model offers practitioners a method for understanding patients’ personal experiences as a preeminent contributor to accurate diagnosis, health outcomes, and humane care

(Borrell-Carrió et al., 2004). The biopsychosocial model provides the foundation for the biopsychosocial-spiritual model. The next section will explain the biopsychosocial-spiritual model and its relevance to clinical care.

### **Biopsychosocial-spiritual Model**

The biopsychosocial model and the biopsychosocial-spiritual model differ, in that the biopsychosocial-spiritual model considers spiritual factors. According to the biopsychosocial-spiritual model, everyone is affected by spirituality in some way or some form (Sulmasy, 2002). The biopsychosocial-spiritual model assumes that spirituality “helps shape who each patient is as a whole person, and when life-threatening illness strikes, it strikes each person in his or her totality” (Sulmasy, 2002, p. 27). Totality is defined as the biological, psychological, social, and spiritual aspects of the person, thus viewing the person as whole that is composed of distinct parts, rather than viewing each aspect separately (Sulmasy, 2002).

Bronstein’s Model for Interdisciplinary Collaboration and the Biopsychosocial-spiritual Model are related in regard to providing effective medical social work, because to treat a patient effectively there must be collaboration with other professionals, such as doctors, nurses, physical therapists, and dieticians. Social workers must have a working knowledge of various professions and the expertise those professionals bring to the team. Medical social workers in turn, must be knowledgeable or at least familiar with biomedical information, and have working knowledge of the biological effects of illness and medications (Volland et al., 2003). Effective medical social work is difficult to achieve without a solid balance of interdisciplinary collaboration and knowledge of the biopsychosocial-spiritual model with increased emphasis on the biological component.

## Literature Review

### History of Medical Social Work and Medical Social Work Education

Medical social work is not a new phenomenon. In fact, social workers have been working in healthcare settings for more than one hundred years (Beddoe, 2013). Medical social work was first established in the United States in 1905 at the Massachusetts General Hospital in Boston, at the request of Dr. Richard Cabot (Hospital Social Work, 1929). Dr. Cabot recognized that understanding a patient's social environment and psychosocial functioning is necessary because illness is highly impacted by social determinants. Cabot also believed that understanding a patient's social situation is critical to assisting the patient with identification and proper utilization of personal and community resources (Medical Social work, 1960). Based on the principles set forth by Dr. Cabot, medical social workers were soon hired to the staff of Bellevue Hospital in New York City and John Hopkins Hospital in Baltimore (Hospital Social Work, 1929).

Initially medical social work was referred to as hospital social work or medical social service, and had the primary purpose of furthering the medical care of the patient by a method of medical social case study and treatment, that included making the physician aware of significant information pertaining to the patient's personality and environment (Hospital Social Work, 1929). Early medical social workers were subjected to a rigorous course of study that was created and enforced by the American Association of Medical Social Workers (AAMSW). In 1921, the AAMSW organized a standing committee on education. The sole purpose of the committee was to collect data from schools of social work on medical social work educational preparation and social workers' preparedness for practice in a healthcare setting (Medical Social Work, 1949). The committee was comprised of physicians, nursing educators, hospital social

workers, and educators in general social services. The committee conducted an exhausting evaluation of the medical social work educational content of seventeen schools of social work. The committee released its findings in 1922 and at that time recommended that a two- year curriculum was necessary as a foundation for medical social work practice (Report of the Committees on the Training of Hospital Social Workers, 1922).

Beginning in 1922 the training for medical social workers and the associated curriculum underwent several revisions. By 1951 the AAMSW had determined that the curriculum for medical social work practice must consist of specialized in-class content accompanied by supervised post-graduate practice in the field of healthcare (Education for Medical Social Work: The Curriculum Content, 1951). By 1953 twenty-six colleges and universities were offering specialized content in the form of a medical social work curriculum and were accredited by CSWE (Medical Social Work, 1954). Near the end of the 1950s and into 1960 the AAMSW continued to forge the path for advanced training for medical social workers. The AAMSW adopted the standard that in addition to the two-year master of social work program, medical social workers must be supervised for the first two years of post-graduate practice. The AAMSW felt that supervised post-graduate practice was necessary for medical social workers to develop and integrate the skills and knowledge essential to effective medical social work practice (Medical Social Work, 1960).

The training of medical social workers remained an area of constant assessment and revision and in 1975 CSWE issued a memorandum regarding developing social workers for entry into the healthcare field (Bracht, 1978). The memorandum outlined the goals and objectives essential to a health care curriculum. The CSWE recommended that health care education should focus on training social workers to collaborate with other members of the

health care team, and that medical social work curriculum should have a more significant focus on biological and physiological course content (Bracht, 1978).

Medical social work emerged as an answer to meet the needs of society, especially those that were impacted by illness. The primary goal of medical social work was to look at the patient as a complete person and to understand the impact that their environment and personal habits have on their illness, or how those things contribute to their illness (Gregorian, 2005; Maramaldi et al., 2014; Praglin, 2007). Medical social work grew rapidly in response to this need and the AAMSW took great pride and ownership in providing patients with well-trained medical social workers. Medical social workers underwent extensive training as part of their graduate studies. The AAMSW took the education of medical social workers very seriously and spent countless hours developing curriculum and ensuring that schools of social work were providing the best and most relevant medical social knowledge to students who planned to enter the field of medical social work upon graduation (Education for Medical Social Work: The Curriculum Content, 1951; Medical Social Work, 1951; Medical Social Work, 1954; Medical Social Work, 1960; Praglin, 2007).

### **A Departure from the Past**

The AAMSW set forth high standards and believed that their standards were in the best interest of the patients. The AAMSW understood that patients needing medical social work services were of a special population and the social worker's work with them was very time sensitive and highly impacted by other conditions, related and unrelated to the patient's illness. Medical social work was held in very high regard and was highly respected by other disciplines. Medical social workers were welcomed members of the interdisciplinary team and they were thought to bring value and insight that could not be achieved from other disciplines (Maramaldi et

al., 2014; Praglin, 2007). The curriculum and field practice for medical social workers was extensive, yet rewarding. The shift away from the medical social work curriculum that was established by the AAMSW can likely be attributed to the curriculum policy statement that was issued in 1982 by CSWE. The policy statement approved the development of concentrations and allowed schools of social work flexibility in the structure and content (Boyce & Scott, 1986). The gap between medical social work education and medical social work practice is a direct remnant of CSWE's decision to allow the structure and content of concentrations to be at the discretion of the school. Literature indicates that current social work curricula is inconsistent in preparing social workers to practice in a healthcare setting, thereby creating medical social workers who do not have the required knowledge base or skills for medical social work practice (DeBonis et al., 2015; Mitchell, 2012; Mitchell & Joosten, 2014; Volland et al., 2003).

### **The State of Contemporary Medical Social Work Practice**

Today medical social workers are not relegated primarily to hospitals, and instead medical social workers practice in various healthcare settings such as public health, acute, and chronic care settings (NASW, 2016). Furthermore, medical social workers tend to play a major role in specialized medical departments that include but are not limited to pediatrics, oncology, nephrology, transplant, and emergency/trauma. Medical social workers in the healthcare field not only serve in clinical roles, they also serve in the capacity of hospital leadership, managers and administrators for specific medical or hospital programs, and community outreach (NASW Workforce Studies, 2011). The following sections will highlight the specific roles, skills, and knowledge base that is associated with contemporary medical social work practice.

**Medical social work roles.** Due to the varied roles of medical social workers across the continuum of healthcare, medical social workers are charged with specific job functions and

responsibilities that include, but are not limited to: (a) comprehensive biopsychosocial-spiritual assessment of patients; (b) assisting patients and their families or caretakers with understanding the patient's diagnosis, prognosis, and treatment options; (c) psychosocial education to involve education on the roles of the health care team, levels of care, entitlements, insurance, advance directives, and community resources; (d) assisting with interpreting information and communicating with various members of the patient's health care team; (e) serving as a member of the interdisciplinary health care team and educating the team on the patient's psychosocial issues; (f) facilitating and promoting effective communication among the health care team; (g) securing resources as needed to cover medications, durable medical equipment, and various other medical related or physician ordered home services; (h) and policy advocacy (Berkman, 1996; Gregorian, 2005; NASW Workforce Studies, 2011). In addition, medical social workers are tasked with actively participating in interdisciplinary treatment planning, arranging placement at skilled nursing facilities, rehabilitation centers, and nursing homes, assisting patients with applying for local and federal subsidies, and monitoring patients' adherence with prescribed treatment regimen. It is also important to acknowledge that medical social workers are expected to work with administrators to control healthcare costs by means of proactive discharge planning that results in decreased patient length of stays (Cowles & Lefcowitz, 1995; Redmond, 2001; Ross, 1993; Silverman, 2008). With the multitude of roles and responsibilities that are required of medical social workers it is not surprising that medical social workers must possess a specialized skill set that will enable effectiveness in a healthcare setting.

**Required skills.** Medical social workers are expected to be skilled in performing all tasks and associated responsibilities quickly, efficiently, independently, and with a high-level of flexibility (Gregorian, 2005). Medical social workers must be skilled in creatively navigating



their day to day responsibilities while making patient care a priority. Communication is key in a healthcare setting, therefore it is important that medical social workers are skilled in developing rapport, trust, and mutually respected relationships with patients, patients' families and/or caretakers, and other medical professionals within the healthcare setting as well as medical professionals outside the healthcare setting, such as nursing home administrators, home health representatives, and durable medical equipment providers (Chaddock, 2016; Reinhold, Otieno, & Bacon-Baguley, 2017; Sims, 2011). Overall it is essential that medical social workers possess well developed interprofessional collaborative practice skills (Sweet, et al., 2017). Last, medical social work practice requires that medical social workers are skilled in navigating a host environment that is not necessarily conducive to social work practice, does not always value and respect the medical social worker's role and/or perspective, and often times presents situations that are in direct conflict with the values and principles of ethical social work practice (Redmond, 2001; Silverman, 2008; Zayas & Dyche, 1992). Medical social workers' skills alone are not enough for effective medical social work practice. Medical social workers must be able to effectively integrate their skills with specific medical knowledge.

**Required knowledge.**

*Biological/physical component of biopsychosocial-spiritual assessment.* Medical social work practice requires a basic understanding of the physiology of disease, prognosis, and treatment options (Gregorian, 2005). Medical social workers need to be comfortable with biopsychosocial-spiritual assessments and understanding how biological/physical functioning is impacted by illness or the disease process, and how psychosocial issues impact health and wellness (Gregorian, 2005; McEwen, 2015). In addition, medical social workers work with medically vulnerable patients such as those with diagnosis of end stage renal disease, AIDS/HIV,

sickle cell, Alzheimer's, and cancer. As a result, it is necessary for medical social workers working with these medically vulnerable patients to be knowledgeable of the special needs associated with the given diagnosis, diagnosis specific terminology, medications, resources, and impacts on quality of life (Allen & Spitzer, 2016; McEwen, 2015; Volland, 2003).

***Interdisciplinary collaboration.*** Interdisciplinary collaboration is integral to healthcare and medical social workers must be knowledgeable of interdisciplinary collaboration (Sims, 2011; Reinhold, et al., 2017). It is important that medical social workers understand their role and responsibilities on the interdisciplinary team and that medical social workers understand the roles and responsibilities of the other professionals on the team (Sweet, et al., 2017). Medical social workers should have a working knowledge of team dynamics and must be confident in advocating for what's in the best interest of the patient, despite resistance from the team. In addition, medical social workers are required to be knowledgeable of how to effectively communicate with the interdisciplinary team and how to present patient's information to the team from a social work perspective (Jones & Phillips, 2016).

***Knowledge of systems that impact healthcare.*** In conjunction to being knowledgeable of the biological/physical component of biopsychosocial-spiritual assessment and interdisciplinary collaboration, medical social workers are required to be knowledgeable of health disparities and the role of poverty as relates to health and wellness. To adequately assess patients and to ensure that the interdisciplinary team has a well-rounded understanding of the patient's social status, medical social workers must recognize that poverty is a key determinant in health, healthcare access, and stigma associated with healthcare. Medical social workers must also understand that patients of low socioeconomic status experience stigma associated with being uninsured, underinsured, and utilizing public assistance such as Medicaid (Allen, Wright, Harding &

Broffman, 2014). Medical social workers' knowledge of health disparities should encompass a working understanding of other social determinants of health and access to healthcare; such as environment, education, political representation, access to fresh food, unequal distribution of resources, and unjust social and economic policies (Darnell, 2013; Mitchell, 2015; Pardasani & Bandyopadhyay, 2014; Williams, 2013). Finally, when examining health disparities medical social workers should be knowledgeable of the fact that in the U.S. people of color or individuals from historically disenfranchised groups tend to have higher rates of morbidity and higher rates of mortality associated with preventable conditions, especially when compared to white Americans (Mitchell, 2015).

### **Deficits in Educating Contemporary Medical Social Workers**

Medical social workers require an advance skill set that is often developed on the job, rather than in the classroom (Kovacs & Bronstein, 1999; Mitchell, 2012). Literature indicates that current social work curricula is inconsistent in preparing social workers to practice in a healthcare setting, thereby creating medical social workers who do not have the required knowledge base or skills for medical social work practice (Volland et al., 2003). The U.S. healthcare system is consistently changing and is heavily impacted by chronic illness, increasing aging population, health inequalities, reduced insurance reimbursements, mergers, and labor shortages (Browne et al., 2017; Liley, 2003; Mitchell, 2012; Volland et al., 2003). The changes in the healthcare system has resulted in increased specialization and requirement for biomedical knowledge and increased interdisciplinary collaboration. Unfortunately, social work education is struggling to keep up with the changes in the healthcare system, which is creating a widening gap between medical social work education and medical social practice. (Keigher, 1997; Liley, 2003). Kovacs and Bronstein's study of hospice social workers implicated a need for schools of social work to

offers courses and or content related to the medical social work practice, in order to better prepare social workers for a healthcare setting (1999). Recent literature further suggests that social work education must expand the social work curricula to encompass a broader knowledge base, especially as it relates to preparing social workers for the challenges associated with practice in healthcare (Browne et al., 2017). The following section will explore the deficits in social work education that are related to biopsychosocial-spiritual assessments.

**Biopsychosocial-spiritual assessment deficits.** Social workers tend to be well educated in conducting and conceptualizing psychosocial-spiritual assessments; however, biological integration warrants improvement (Sampson, 2010). Although, medical social workers must have basic knowledge of biological functioning and must be able to conceptualize patients' needs from a biopsychosocial-spiritual perspective (Stanhope, Videka, Thoming, & McKay, 2015). In the review of the literature, findings from several studies indicated that medical social workers enter the field with limited understanding of basic health information (Gant & Toh, 2017; Stanhope, et al., 2015). In addition, scholars who write about medical social work education propose that social work curricula offer minimal content related to medical social work practice and that medical social workers enter the field without formal training in medical terminology, disease processes, biomedical knowledge, and biological functioning (Berkman, 1996; Gant & Toh, 2017). It should also be noted that a study of hiring practices among health care managers revealed that acute care experience is valued over degree (BSW/MSW) because new social work graduates do not receive formal medical social work training in their programs of study (Gant & Toh, 2017). It is important that schools of social work update curricula to include health information and content related to biological processes. This is especially important for graduates who enter a healthcare setting, although all social work graduates will

benefit from this information because understanding of biological processes is important regardless of practice setting and stage in the life cycle (Browne et al., 2017).

**Interdisciplinary collaboration deficits.** Interdisciplinary collaboration is essential to medical social work practice. Due to the complex health issues and multitude of social problems that impact patients, medical social workers must be able to collaborate with a team of professionals (Bronstein, 2003). Social work education is a strong supporter of interdisciplinary collaboration and social work education is committed to educating students on interdisciplinary collaboration. This commitment is evidenced by CSWE's 2015 EPAS, which mandate schools of social work to integrate interdisciplinary collaboration into the curriculum (CSWE, 2015). Despite CSWE's commitment to educating social work students on interdisciplinary collaboration, medical social workers are continuing to enter the field unfamiliar with interdisciplinary collaboration in a healthcare setting, unable to articulate their role on team, and unable to adequately function as an effective member of the team (Cooner, 2011, Kovacs & Bronstein, 1999).

**Systems that impact healthcare deficits.** Findings from research studies indicate several factors that contribute to health disparities. These factors include, but are not limited to poverty, employment status, neighborhood violence, unstable communities, underperforming schools, racism, oppression, trauma, and any social determinate that affects individuals' optimal growth and development, and access to resources (Darnell, 2013; Mitchell, 2015; Pardasani & Bandyopadhyay, 2014; Williams, 2013). In addition, multiple research studies conducted by various researchers show that health and behavioral health risks and outcomes are systemically worse for racial and ethnic minorities (Allen et al., 2014; Andrews, 2014; Mitchell, 2015; Pardasani & Bandyopadhyay, 2014; Walter et al., 2016; Williams, 2013). As the population in

the U.S. continues to grow and become more racially and ethnically diverse, medical social workers will need social work education that will allow them to effectively address and aide in the alleviation of health disparities, increase access to healthcare, increase quality of healthcare services for minorities, improve health outcomes for those at greatest risk, and ultimately close the existing health gap (Stanhope et al., 2015; Williams, 2013).

Schools of social work offer a variety of electives and field practicum experiences, and due to the lack of structure and content of electives social work education does not ensure that medical social work graduates are adequately prepared to assess or intervene with patients impacted by health disparities (Mitchell, 2012).

The reviewed literature clearly indicates that medical social workers require specific skills and knowledge, especially as it relates to interdisciplinary collaboration and conceptualizing the biological component of biopsychosocial-spiritual assessments. Previous studies indicated that medical social workers are not adequately prepared for medical social work practice upon graduation and that most social workers obtain their greatest learning on the job and not in the classroom (Berkman, 1996; DeBonis et. al., 2015; Grant & Toh, 2017; Kovacs & Bronstein, 1999; Mitchell & Joosten, 2014; Mitchell, 2012). These findings suggest that there is a gap between social work education and medical social work practice. The following section will provide an overview of the author's lived experience as a medical social worker and implications for social work education and future research.

## **Discussion**

### **Lived Experience as a Medical Social Worker**

Prior to becoming a master level social work educator, I was employed as a full-time medical social worker for ten years. As the lead social worker for my region, my primary

responsibilities included working with the interdisciplinary treatment team to create patient center care plans, completing biopsychosocial-spiritual assessments, adjustment counseling, discharge planning, and securing needed resources. I was also actively involved in other activities that were directly related to patient care and that supported my role on the interdisciplinary team; such as training newly hired social workers, hosting health fairs and community engagement activities, and supervising social work interns.

Despite entering the healthcare field with a bachelor (BSW) and a master in social work (MSW), I was unprepared for the medical social work role. While, I was very confident in my ability to engage with patients and their families and my ability to conceptualize human development, person-in- environment, and systems theory; I was very limited in my knowledge of medical terminology, interdisciplinary collaboration, and understanding of the biological aspect of biopsychosocial-spiritual assessments. My BSW and MSW programs did not offer a medical social work course and had very few medical social work field placements. I was not fortunate enough to obtain one of those placements. In addition, I had very limited exposure to the medical model and the physiology of disease, therefore I was not prepared to advocate for patients as the sole social worker on a team of highly trained medical professionals. Furthermore, I was unprepared to explain my role or advocate for my profession among the other disciplines that made up the interdisciplinary team.

My start as a medical social worker revealed a gap between my social work education and practice. To thrive as a medical social worker, I had to commit to learning on my own. I had to seek out a medical social work mentor, doctors, nurses, and other professionals to teach me basic medical terminology, basic disease pathology, and treatment regimens. While, my greatest

learning occurred on the job, patients deserve a social work professional that is prepared prior to entering the field.

It is also important to note that as a medical social worker I worked with individuals that were victims of health disparities. My social work education prepared me to work with marginalized clients and populations; however, I was not introduced to social determinants of health or the impact of social determinants on health and optimal well-being. This knowledge came from direct practice with individuals who are members of at risk and/or marginalized populations. My professional experience provides a first-hand account of the deficits in social work education in preparing medical social workers. Social work education must be committed to consistently integrating current curricula with content that is reflective of medical social work practice. The possibilities for medical social work are expanding and social work education must prepare social work students to take on the opportunities that are available for medical social workers. The following section will provide implications for social work education and future research based on first-hand experience and the previous findings from the literature.

### **Implications for Social Work Education**

**Integrating interprofessional education (IPE) opportunities and assignments into existing course content.** Medical social workers will work in a host environment, such as a hospital or clinic. Therefore, preparation for interdisciplinary collaboration should start in the classroom with integration of IPE opportunities and assignments into existing social work course content. IPE content can be infused into existing social work content through in-class role plays, interdisciplinary simulations, and assignments that highlight the purpose and importance of interdisciplinary collaboration (Nimmagadda & Murphy, 2014). In addition, IPE infusion can occur by utilizing case studies that promote critical reflection on teamwork with professionals



such as doctors, nurses, and pharmacists. Integration of IPE content into existing social work course content is important because it provides students with a safe space to learn and properly develop interdisciplinary collaboration skills. Infusion of IPE content is also important because students have the opportunity to receive hands on instructions from social work professors, students are taught to value teamwork and collaboration with other professionals, and most importantly students learn first-hand how successful interdisciplinary collaboration is tied to successful patient outcomes.

**Developing healthcare practicums.** Evidence indicates that medical social workers learn how to be an effective medical social worker on the job, rather than in the classroom; therefore, developing healthcare related practicums is essential to social work education. Healthcare practicums will expose future social workers to tasks as well as the necessary knowledge that is required for medical social work practice. In addition, a medical social work field practicum allows students to practice conceptualizing the biological component of biopsychosocial assessments as well as serve as a member of an interdisciplinary team. Membership on an interdisciplinary team as an intern allows students to learn the roles and responsibilities of the various disciplines, in addition to practicing team dynamics with the support of a field supervisor.

**Increasing biological content.** The reviewed literature supports increasing social work knowledge of biological functioning as relates to the biopsychosocial assessment of patients. It can be argued that having a basic understanding of biological functioning is useful in areas of social work practice, but especially useful for medical social workers. Social worker educators should infuse course content with information that aims to provide students with a basic understanding of biological functioning and impaired biological functioning impacts mental

health and social functioning. Social worker educators must also be committed to increasing course content that exposes students to the social determinants of health and common health issues; such as hypertension, diabetes, and cardiovascular disease. It is important that social work educators teach students that components of the biopsychosocial-spiritual model are interdependent and it is not possible to impact one component without impacting other components.

**Incorporating medical social work practice models into practice classes.** Prevention is a key component of medical social work practice and the alleviation of health disparities Rischel (2014). Therefore, prevention focused practice is necessary. As social workers work to close the health gap, social workers will be advocating and assisting with policy formulation that is geared toward preventive integrated care. Consequently, it is highly important that social work students are adequately prepared to utilize prevention practice models in direct practice settings (Rischel, 2014). Social work graduates will likely be hired into positions that work directly with clients that are impacted by the gaps in the healthcare system. Therefore, it is essential that social work graduates have a working understanding of prevention and how to integrate prevention and practice. In addition, social work graduates would benefit from learning how to utilize health promotion and wellness models such as the Health Belief Model (HBM) and Transtheoretical Model (TTM) (Allen, 2016).

**Incorporating content targeted at addressing healthcare deficits.** Addressing healthcare deficits and closing the healthcare gap are ethical responsibilities for social workers. Social workers are ethically obligated to advocate for disenfranchised groups and policies and systems that negatively impact those groups. The National Association of Social Workers (NASW) Code of Ethics promotes social and political advocacy. The NASW Code of Ethics

supports “social and political action that seeks to ensure that all people have access to the resources, employment services, and opportunities they require to meet their basic human needs and to develop fully” (NASW, 2017, 6.04a). In addition, the NASW Code of Ethics states “social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice” (NASW, 2017, 6.04a).

The NASW Code of Ethics clearly establishes social worker’s role in advocating for policy reforms and improved access to services for all people. Therefore, it is important that social work educators create course content that addresses health deficits and that teaches students how to work with clients that are impacted by these deficits. Social workers’ involvement in advocacy and policy reform as it relates to closing the health gap will allow social workers to uphold the NASW Code of Ethics, as well as be key players in Medicaid expansion and maximizing resources to assist individuals who are currently underinsured (Andrews, 2014).

### **Implications for Further Research**

Medical social work remains a highly attractive field of practice for many social workers, yet the training that was initially a part of the graduate curriculum that was developed especially for medical social workers seems to have disappeared. The shift away from the medical social work curriculum that was established by the AAMSW can likely be attributed to the curriculum policy statement that was issued in 1982 by the Council on Social Work Education, which failed to formalize the structure and content of concentrations (Boyce & Scott, 1986).

Future research is warranted on current social work curriculum as it relates to training medical social workers. There are many questions that remain unanswered. However, due to the

ever-changing landscape of the healthcare system, the human condition, and the increasing demand for medical social workers in the private and public sector; the most important question is when are social work educators going to realize that there is a need to integrate an increased focus on knowledge of biological functioning and interprofessional collaboration into existing social work course content and/or existing social work curricula? My experience as a social work educator leads me to believe that the answer is now. Social work educators are realizing that there is a gap between social work education and medical social work practice. Although, there has to be more than a realization. There has to be a commitment to closing the gap.

### **Conclusion**

Addressing the gap between social work education and medical social work practice requires infusing current social work curricula at all levels with biological information and adjusting course content to allow for broader conceptualization of biological functioning. In addition, social work educators must be committed to partnering with other disciplines such as nursing and pharmacy to create opportunities for development of interdisciplinary collaboration skills. It is important for social work educators to commit to the infusion of biological content and IPE. This commitment is critical because the need for well-trained medical social workers will remain for years to come, especially as we continue to have oppression, discrimination, and social injustice, all of which contribute to health and well-being or lack thereof. The social work profession has a long-standing commitment to providing social work services to those impacted by illness and has maintained a strong position on universal provisions to healthcare (Owens, 2009). The social work profession needs to have a solid standing in healthcare, in order to take a leading role in closing the health gap, advocate for and help to implement socially just healthcare policies, and develop prevention initiatives. Although, if this is to be accomplished schools of

social work education must make medical social work preparation a priority and adequately prepare future social workers to thrive in a healthcare setting.

## References

- Allen, H., Wright, B. J., Harding, K., & Broffman, L. (2014). The role of stigma in access to health care for the poor. *The Milbank Quarterly*, *92*(2), 289-318. doi: 10.1111/1468-0009.12059
- Allen, K. M. & Spitzer, W. J. (2016). *Social work practice in healthcare: Advance approaches and emerging trends*. Thousand Oaks, CA: Sage.
- Andrews, C. (2014). Unintended consequences: Medicaid expansion and racial inequality in access to health insurance. *Health & Social Work*, *39*(3), 131-133. doi:10.1093/hsw/hlu024.
- Beddoe, L. (2013). Health social work: Professional identity and knowledge. *Qualitative Social Work*, *12*(1), 24-40. doi:10.1177/1473325011415455
- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work*, *41*(5), 541-551. doi:10.1093/sw/41.5.541
- Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *Annals of Family Medicine*, *2*(6), 576-582. doi:10.1370/afm.245
- Boyce, L., & Scott, V. (1986). Curriculum planning for social work in health care: The practitioner's view. *Australian Social Work*, *39*(3), 37-43. doi:10.1080/03124078608549881
- Bracht, N. F. (1978). Chapter 22: Building a Health Care Concentration: Curriculum Guidelines for Schools of Social Work. In *Social Work in Health Care: A Guide to Professional Practice* (pp. 317-326). Taylor & Francis.
- Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, *48*(3),

297-306. doi:10.1093/sw/48.3.297

Bronstein, L., Kovacs, P., & Vega, A. (2007). Goodness of fit: Social work education and practice in health care. *Social Work in Health Care, 45*(2), 59-76.

doi:10.1300/J010v45n02-04

Browne, T., Keefe, R. H., Ruth, B. J., Cox, H., Maramaldi, P., Rishel, C., & ... Marshall, J. (2017). Advancing social work education for health impact. *American Journal of Public Health, S3*, S229-S235. doi:10.2105/AJPH.2017.304054

Bracht, N. F. (1978). Chapter 22: Building a Health Care Concentration: Curriculum Guidelines For Schools of Social Work. In, *Social Work in Health Care: A Guide to Professional Practice* (pp. 317-326). Taylor & Francis.

Chaddock, R. (2016). Integrating early multi-disciplinary advance care planning into core social work practice: Social workers' bread and butter. *Journal of Social Work Practice, 30*(2), 129-138. doi:10.1080/02650533.2016.1168382

Cooner, T. S. (2011). Learning to create enquiry-based blended learning designs: Resources to develop interdisciplinary education. *Social Work Education, 30*(3), 312-330. doi:10.1080/02615479.2010.482983

Council on Social Work Education (2015). *Educational policy and accreditation standards*.

Alexandria, VA: CSWE. Retrieved from:

[https://www.cswe.org/getattachment/Accrediation/Accreditation-Process/2015-](https://www.cswe.org/getattachment/Accrediation/Accreditation-Process/2015-EPAS/2015EPAS_Web_Final.pdf.aspx)

[EPAS/2015EPAS\\_Web\\_Final.pdf.aspx](https://www.cswe.org/getattachment/Accrediation/Accreditation-Process/2015-EPAS/2015EPAS_Web_Final.pdf.aspx)

Cowles, L. A., & Lefcowitz, M. J. (1995). Interdisciplinary expectations of the medical social worker in the hospital setting: Part 2. *Health and Social Work, 20*(4), 279-286. Retrieved from: [http://link.galegroup.com/apps/doc/A17940532/HRCA?u=tel\\_a\\_unionu&sid=HRA](http://link.galegroup.com/apps/doc/A17940532/HRCA?u=tel_a_unionu&sid=HRA)

- Darnell, J. S. (2013). Navigators and assisters: Two case management roles for social workers in the Affordable Care Act. *Health and Social Work, 38*(2), 123-126  
doi:10.1093/hsw/hlt003
- DeBonis, J. A., Becker, M. A., Yoo, J., Capobianco, J., & Salerno, A. (2015). Advancing social work education: Lessons learned from piloting an integrated healthcare curriculum. *Journal of Social Service Research, 41*(5), 594-621.  
doi:10.1080/01488376.2015.1081859
- Education for Medical Social Work: The Curriculum Content. (1951). *American Association of Medical Social Workers Education Committee, Curriculum Content Subcommittee*. Retrieved from University of Minnesota Social Welfare History Archives. (NASW: AAMSW Box 31, Folder 381).
- Engel, G. L. (2012). The need for a new medical model: A challenge for biomedicine. *Psychodynamic Psychiatry, 40*(3), 377-396. doi:10.1521/pdps.2012.40.3.377
- Grant, D. M., & Toh, J. S. (2017). Medical social work positions: BSW or MSW?. *Social Work in Health Care, 56*(4), 215-226. doi:10.1080/00981389.2016.1265633
- Gregorian, C. (2005). A career in hospital social work. *Social Work in Health Care, 40*(3), 1-14.  
doi:10.1300/J010v40n03 01
- Hospital Social Work. (1929). In *Social Work Year Book 1929* (Fred S. Hall ed.). Retrieved from <http://umedia.lib.umn.edu/node/542286>
- Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education, 52*(1), 18-29.  
doi:10.1080/10437797.2016.1112629



Keigher, S. M. (1997). What role for social work in the new health care practice paradigm?.

*Health and Social Work*, 22(2), 149-155. doi:10.1093/hsw/22.2.149

Kovacs, P. J., & Bronstein, L. R. (1999). Preparation for oncology settings: What hospice social

workers say they need. *Health & Social Work*, 24(1), 57-64. doi:10.1093/hsw/24.1.57

Liley, D. G. (2003). Bridging the gap between classroom and practicum. *Journal of*

*Gerontological Social Work*, 39(1-2), 203-217. doi:10.1300/J083v39n01\_17

Maramaldi, P., Sobran, A., Scheck, L., Cusato, N., Lee, I., White, E., & Cadet, J. (2014).

Interdisciplinary medical social work: A working taxonomy. *Social Work in Health Care*,

53(6), 532-551. doi:10.1080/00981389.2014.905817

Medical Social Work. (1949). In *Social work year book 1949: A description of organized*

*activities in social work and in related fields* (Margaret B. Hodges ed., Tenth Issue).

Retrieved from <http://umedia.lib.umn.edu/node/542295>

Medical Social Work. (1951). In *Social Work Year Book 1951: A Description of Organized*

*Activities in Social Work and in Related Fields* (Margaret B. Hodges ed.).

Retrieved from <http://umedia.lib.umn.edu/node/542296>

Medical Social Work. (1954). In *Social work year book 1954: A description of organized*

*activities in social work and in related fields* (Russell Kurtz ed., Twelfth Issue). Retrieved

from <http://umedia.lib.umn.edu/node/542297>

Medical Social Work. (1960). In *Social work year book 1960: A description of organized*

*activities in social work and in related fields* (Russell Kurtz ed., Fourteenth Issue).

Retrieved from <http://umedia.lib.umn.edu/node/542299>

- McEwen, S. (2015). Social work in health care when conventional meets complementary: Nonspecific back pain and massage therapy. *Health & Social Work, 40*(1), 19-25.  
doi: 10.1093/hsw/hlu041
- Mitchell, F. M. (2015). Racial and ethnic health disparities in an era of health care reform. *Health & Social Work, 40*(3), e66-e74. doi:10.1093/hsw/hlv038
- Mitchell, J. A. (2012). Integrating education on addressing health disparities into the graduate social work curriculum. *Journal of Teaching in Social Work, 32*(5), 471-486.  
doi:10.1080/08841233.2012.725458
- Mitchell, K. R., & Joosten, D. M. (2014). Determinants of health concentration selection among university of southern California MSW students. *Health & Social Work, 39*(4), 230-237.  
doi:10.1093/hsw/hlu033
- NASW Center for Workforce Studies and Social Work Practice. (2011). *Social Workers in hospitals and medical centers: Occupational profile*. Retrieved from <http://workforce.socialworkers.org/studies/profiles/Hospitals.pdf>
- National Association of Social Work. (2016). *NASW standards for social work practice in healthcare settings*. Retrieved from <https://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf>
- National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers*. Washington, DC. NASW Press.
- Nimmagadda, J., & Murphy, J. I. (2014). Using simulations to enhance interprofessional competencies for social work and nursing students. *Social Work Education, 33*(4), 539-548. doi:10.1080/02615479.2013.877128

- Owen, C. L. (2009). Consumer-driven health care: Answer to global competition or threat to social justice? *Social Work, 54* (4), 307-315. doi:10.1093/sw/54.4.307
- Pardasani, M., & Bandyopadhyay, S. (2014). Ethnicity matters: The experiences of minority groups in public health programs. *Journal of Cultural Diversity, 21*(3), 90-98.  
doi: 10.1037/a0023673
- Phillips, M. & Fitzsimons, V. (2015). The affordable care act: Impact on case managers. *Professional Case Management, 20*(6), 323-327. doi:10.1097/NCM.0000000000000125
- Praglin, L. J., (2007). Ida Cannon, Ethel Cohen, and early medical social work in Boston: The foundations of a model of culturally competent social service. *Social Service Review, 81*(1), 27-45. doi:10.1086/511013
- Redmond, H. (2001). The health care crisis in the United States: A call to action. *Health and Social Work, 26*(1), 54-57. doi: 10.1093/hsw/26.1.54
- Reinhold, M. I., Otieno, S., & Bacon-Baguley, T. (2017). Integrating interprofessional experience throughout a first-year physician assistant curriculum improves perceptions of health care providers. *Journal of Interprofessional Education & Practice, 6*, 37-43.  
doi: 10.1016/j.xjep.2016.12.001
- Report of the Committees on the Training of Hospital Social Workers. (1922). *The American Hospital Association: Presented to the Board of Trustees at the Convention of the Association*. Retrieved from University of Minnesota Social Welfare History Archives. (NASW: AAMSW Box 31, Folder 369).
- Rischel, C. W. (2014). Teaching note—Integrating prevention content into clinical social work practice courses. *Journal of Social Work Education, 50*(4), 752-762.  
doi:10.1080/10437797.2014.947166

Ross, J. W. (1993). Redefining hospital social work: An embattled professional domain. *Health and Social Work, 18*(4), 243-247. doi:10.1093/hsw/18.4.243

Sampson, A. (2010). *Informing social work practice through the enhancement of the biological perspective: A course intervention model for human service professional working with youth and problems of conduct* (Doctoral Dissertation). Retrieved from <https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=3305&context=etd>

Silverman, E. (2008). From ideological to competency-based: The rebranding and maintaining of medical social work's identity. *Social Work, 53*(1), 89-91. doi:10.1093/sw/53.1.89

Sims, D. (2011). Achieving collaborative competence through interprofessional education: Lessons learned from joint training in learning disability nursing and social work. *Social Work Education, 30*(1), 98-112. doi:10.1080/02615471003748056

Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social Work in Health Care, 54*(5), 383-407. doi:10.1080/00981389.2015.1025122

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *Gerontologist, 42*(suppl\_3), 24-33. doi:10.1093/geront/42.suppl\_3.24

Sweet, B. V., Madeo, A., Fitzgerald, M., House, J. B., Pardee, M., Zebrack, B., ... Mueller, B. A. (2017). Moving from individual roles to functional teams: A semester-long course in case-based decision making. *Journal of Interprofessional Education & Practice, 7*, 11-16. doi:10.1016/j.xjep.2017.01.003

Volland, P. J., Berkman, B., Phillips, M., & Stein, G. (2003). Social work education for health care. *Social Work in Health Care, 37*(4), 1-17. doi:10.1300/J010v37n04\_01

Walter, K. L., Spencer, M. S., Smukler, M., Allen, H. L., Browne, T., Maramaldi, P.,...

Uehara, E. (2016). *Health equity: Eradicating health inequalities for future generations*.

Working Paper No. 19.

Williams, J. H. (2013). Disparities, disproportionalities, differences, and discrepancies.

*Social Work Research*, 37(4), 309-311. doi:10.1093/swr/svt039

Zayas, L. H., & Dyche, L. A. (1992). Social workers training primary care physicians:

Essential psychosocial principles. *Social Work*, 37(3), 247-252. doi:10.1093/sw/37.3.247

Baptism by Fire: Barriers to Social Workers' Preparedness for Medical Social Work Practice

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### Abstract

The National Association of Social Workers (NASW) recognizes that certain areas of social work practice require a specialized skill set. One of the areas of social work practice that requires a specialized skill set, according to NASW, is medical social work. The purpose of this qualitative exploratory study was to explore barriers to effective medical social work practice. Twenty-three current medical social workers were interviewed using a semi-structured interview. Three predominant themes were identified as barriers to effective medical social work practice: medical culture, lack of knowledge, and lack of exposure. Implications for social work education are proposed.

*Keywords:* medical social work, health care setting, social work education, NASW, practice standards, specialized practice

### Baptism by Fire: Barriers to Social Workers' Preparedness for Medical Social Work Practice

Approximately forty-eight thousand students graduated from CSWE accredited social work programs in 2016 (CSWE, 2017). These graduates will enter the profession of social work in various areas of practice and will face the inevitable challenges of working with diverse clients who have complex personal issues and who are heavily impacted by systemic issues. Undoubtedly, many of these graduates will enter into medical social work as their practice area of choice, which is not surprising considering that 29% of all social workers work in a healthcare related setting (Salsberg et al., 2017). Generalist social work education is intended to adequately prepare social work graduates to thrive in any setting and is believed to provide knowledge and skills that can be applied across settings and client populations. Therefore, social work graduates should be well equipped to work in healthcare settings as medical social workers. However, the National Association of Social Workers (NASW) recognizes that certain areas of social work practice require a specialized skill set. One of the areas that requires a specialized skill set, according to NASW, is medical social work. NASW's Standards for Social Work Practice in a Healthcare Setting (2016) explicitly states that medical social work is an "area of specialization within the social work profession..." and "requires a distinct skill set and knowledge base..." (p.18).

Medical social work or social work in healthcare settings is reportedly the fastest growing area of social work practice and it is anticipated that medical social work will grow an additional 20% by 2026 (Bureau of Labor Statistics, 2018). This growth is substantial thereby making medical social work second only to child welfare and school social work. Medical social workers are tasked with having a baseline understanding of disease, diagnosis, and treatment regimen; helping clients navigate the effects of illness on them and their families; understanding insurance



and healthcare systems; advocating for socially just healthcare policies; and serving as an integral member of the interdisciplinary team (Berkman, 1996; Gregorian, 2005; NASW Workforce Studies, 2011). Considering that medical social work practice is an “area of specialization”; how well prepared are undergraduate and graduate level social work graduates for entering a healthcare setting?

The need for medical social workers is evident, therefore social work educators must be prepared to fill medical social work positions with graduates who are well prepared and who will thrive in a healthcare setting. Social workers are needed to help reduce health disparities, initiate healthcare policy changes, and aide clients in reaching their full potential despite having a chronic/acute illness. This paper addresses barriers to preparedness of medical social workers upon entry into medical social work practice. The results from a qualitative exploratory study with medical social workers are reported as well as implications for preparation of future medical social workers.

## **Literature Review**

### **History of Medical Social Work**

Dr. Richard Cabot, a Harvard educated physician, addressed the need for social workers to be a part of the healthcare team. Dr. Cabot believed that:

As well might one try to pick up a man’s shadow and carry it away as to treat his physical ills by themselves without knowledge of the habits that so often help to make him sick and the character of which these habits are the fruit... The average practitioner is used to seeing his patients flash by him like shooting stars-out of darkness into darkness. He has been trained to focus upon a single suspected organ till he thinks of his patients almost like disembodied diseases. (Cabot, 1909, p.32-33)

Dr. Cabot realized very early in the benefit that social workers could bring to the healthcare setting. Dr. Cabot believed that in order to effectively treat patients, the whole patient, including the patient's social situation must be treated and not just the patient's illness (Cabot, 1909; Medical Social work, 1960). As a result, Dr. Cabot and social worker Ida Cannon established the first department of social work in a hospital, in the United States, at the Massachusetts General Hospital in Boston in 1905 (Gregorian, 2005; Hospital Social Work, 1929). Based on the principles set forth by Dr. Cabot, medical social workers were soon hired to the staff of Bellevue Hospital in New York City and John Hopkins Hospital in Baltimore (Hospital Social Work, 1929). Initially medical social work was referred to as hospital social work or medical social service, and had the primary purpose of furthering the medical care of the patient by a method of medical social case study and treatment, that included making the physician aware of significant information pertaining to the patient's personality and environment (Hospital Social Work, 1929).

### **Historical Training of Medical Social Workers**

The training or educational requirements for early medical social workers was created and enforced by the American Association of Medical Social Workers' (AAMSW), standing committee on education. The committee was comprised of physicians, nursing educators, hospital social workers, and educators in general social services. The first medical social workers were taught by the apprentice system, very much like early doctors and lawyers (Report of the Committees on the Training of Hospital Social Workers, 1922).

Throughout the 1920s, 1930s, and 1940s drastic changes were made to medical social work curricula and by the 1950s the AAMSW education committee had developed a sound medical social work curriculum. A major milestone regarding the solidifying of the medical

social work curriculum occurred in 1950, when the “responsibility for accrediting the medical social work sequence of courses in schools of social work was accepted by the American Association of Schools of Social Work” (Medical Social Work, 1951, p. 318). Another milestone in giving medical social work a solid footing in schools of social work, occurred the following year, in 1951, when the AAMSW released the “Education for Medical Social Work: The Curriculum Content” manual (1951). The manual provided schools of work with a detailed outline of the medical social work curriculum and all associated requirements. In addition, the manual specified that educational preparation for medical social work practice is no less than a master’s degree from a school of social work that is a member of American Association of Schools of Social Work (Education for Medical Social Work: The Curriculum Content, 1951). Most notably, the manual noted that “the essential curriculum for medical social work is a combination of basic and specialized content taught both in the classroom and through supervised practice in the field” (Education for Medical Social Work: The Curriculum Content, 1951, p.3). The manual explicitly outlined the required medical social work curriculum and all schools of social work that had a medical social work program utilized the manual.

### **Current Training for Medical Social Workers**

Current training or educational requirements for medical social workers differs greatly from the training of the past. In comparison to historical requirements, today medical social workers can possess a BSW or MSW degree from a CSWE accredited school of social work or social work program, and must be in compliance with the licensing requirements of the state and/or jurisdiction of practice (NASW, 2016). Current medical social workers are not required to complete a specialized medical social work curriculum. Generalist social work training is sufficient for employment in a healthcare setting.

Current research suggests “BSW and MSW education curricula provide limited specific course material in acute care medical social work, despite the fact that health care is one of the larger employers of registered social workers” (Grant & Toh, 2017, p. 216). In addition, there is a consensus across studies that social workers often enter healthcare settings with minimal to no training in medical terminology or disease processes and oftentimes require extended supervision, extensive on the job training, and training via continuing education (Grant & Toh, 2017; Horevitz & Manoleas, 2013; Mitchell, 2012). Social work students also recognize the gap between social work curricula and practice in a healthcare setting, which is evidenced by Liley’s study of MSW students’ perception of preparedness for field practicum (2003). Study findings indicate that the “only field practicum area for which students felt unprepared was that of a medical social work environment” (Liley, 2003, p. 209).

Literature further indicates that current social work curricula is inconsistent in preparing social workers to practice in a healthcare setting and there is an increasing gap between curricula and medical social work practice; thereby creating medical social workers who do not have the required knowledge base or skills for medical social work practice (Bronstein, Kovacs, & Vega, 2007; DeBonis, Becker, Yoo, Capobianco, & Salerno, 2015; Mitchell, 2012; Mitchell & Joosten, 2014; Volland, Berkman, Phillips, & Stein, 2003). Kadushin and Egan (1977) evaluated the curricula of 94 MSW programs and concluded that content specific to medical social work practice was rarely included in course outlines. Kovacs and Bronstein (1999) further expanded on the gap between curricula and practice in their study of hospice social workers. Their study’s findings indicated a deficit in the preparedness of medical social workers, and that schools of social work should consistently offer courses that focus on social work practice in health care settings, family intervention and crisis intervention in health care settings, and interdisciplinary

collaboration (Kovacs & Bronstein, 1999). In a recent study by Mitchell and Joosten (2014) it was determined that social work curricula should include content on “policy relevant to direct practice in health settings” and content on “health care access, disparities, quality and safety, preventive care, mental health, ethics, professional standards, social service programs and eligibility criteria, safety net services, and healthcare reform” (p. 236). This study also reported a need for future medical social workers to receive course content on “home and community-based services for lesbian, gay, bisexual, transgender, questioning; minority; female; child; older adult; homeless; and veteran populations” (Mitchell & Joosten, 2014, p. 236).

In 1982 CSWE approved the development of concentrations, although structure and content of concentrations was left to the discretion of the school (Boyce & Scott, 1986). Since that time there has been a notable shift away from the medical social work curriculum that was established by the AAMSW. Furthermore, due to the variations in electives and field experiences little is known about how schools of social work prepare graduates to practice in a healthcare setting (Mitchell, 2012). Researchers agree that medical social work practice requires a specialized skill set that consists of effective communication, an ability to navigate through challenges associated with practicing in a host environment, an ability to work with medically vulnerable patients, interdisciplinary collaboration, and specific biomedical knowledge (Chaddock, 2016; Gregorian, 2005; Redmond, 2001; Reinhold, Otieno, & Bacon-Baguley, 2017; Silverman, 2008; Sims, 2011; Sweet et al., 2017; Zayas & Dyche, 1992). Literature past and present overwhelmingly suggests that generalist training is not sufficient for social work graduates who enter the field of healthcare, and that in order for social workers to have an impact on health and healthcare there must be “systemic improvement in the curriculum at every level

of education, including substantive increases in content in health, health care, health care ethics, and evaluating practice outcomes in health settings” (Browne et al., 2017).

### **Method**

This qualitative exploratory study was conducted using telephone and face-to-face interviews. Recruitment for the study was purposive via formal and informal social networks of medical social workers. A formal network of medical social workers were made aware of the study and invited to participate at the 2017 Tennessee Annual Medical Social Workers Conference in Jackson, Tennessee. Medical social workers who were not in attendance at the conference and who were known via informal social networks of medical social workers were contacted via email and made aware of the study and invited to participate.

### **Participant Criteria**

Participants were required to be currently employed as a medical social worker. Current medical social worker was defined as a social worker who is currently employed as a medical social worker in a healthcare setting (e.g., hospital, dialysis, oncology, Veterans Administration, primary care, hospice, outpatient clinic). The individual needed to possess a BSW (bachelor of social work) or a MSW (master of social work) degree and must be currently serving in the role of medical social worker, medical social worker administrator, medical social worker supervisor, or medical social worker case manager. Participants were not excluded based on age, race, ethnicity, health status, or length of time as a medical social worker. Exclusion criteria were as follows: participants were excluded if they were not currently employed as a medical social worker in a healthcare setting, and/or if they did not have a BSW (bachelor of social work) or MSW (master of social work) degree.

## Participants

Twenty-three medical social workers participated in this study. Twenty participants identified as female and three identified as male. Participants' ages ranged from 32-69 years old. Two of the twenty-three participants (9%) identified as Hispanic, eight (35%) as Caucasian, and thirteen (56%) as African American. Participants' state of practice included California, Illinois, Mississippi, Tennessee, and Texas. All participants possessed a MSW and of the twenty-three participants sixteen participants also possessed a BSW. All participants were licensed in their state of practice although two participants were licensed in an additional state. Level of licensure varied with fourteen (61%) participants being licensed as a Licensed Master Social Worker (LMSW), seven (30%) as a Licensed Clinical Social Worker (LCSW), and two (9%) as a Licensed Advance Practice Social Worker (LAPSW). Table 1 presents the MSW programs from which the participants in this study graduated.

Table 1

### *Participants' Graduating Institution*

Institution	Number	Percentage
Colorado State University	1	4.3
Jackson State University	1	4.3
Jane Addams College of Social Work	1	4.3
San Jose State	1	4.3
Union University	5	21.7
University of Houston	2	8.7
University of Memphis	2	8.7
University of Michigan in Ann Arbor	1	4.3
University of Southern Mississippi	1	4.3
University of Tennessee	7	30.4
University of Texas at Austin	1	4.3

Participants' years of experience as a social worker ranged from nineteen months to thirty years. Participants' experience as a medical social worker ranged from one year to twenty-five

years. Nine (39%) participants had less than five years of medical social work experience and the remaining fourteen (61%) participants had greater than five years of medical social work experience. Participants were employed as medical social workers in various healthcare settings. Table 2 presents the participants' settings.

Table 2

*Participants' practice setting*

Healthcare Setting	Number	Percentage
In-center Dialysis	11	47.8
Hospital	5	21.7
Hospice	2	8.7
Home Dialysis	2	8.7
Administration	2	8.7
Out-patient Cancer Center	1	4.3

**Protection of human participants.** This study was approved by Union University Institutional Review Board (IRB). Participants' identification was protected by assigning each participant a study ID number and by striping identifying information from all transcriptions.

**Procedures**

Participants were contacted via email and invited to participate in the study. The email contained a participant invitation letter and a consent form. The email encouraged participants to review the consent form and to contact me with any questions that they may have. Participants were also informed that to schedule an interview the consent form must be signed and returned to the researcher via email. Upon receipt of the participant's signed consent form the researcher signed and dated the informed consent form and scanned a copy via email to the participant along with the google calendar link to schedule his/her face-to-face or telephone interview. Once participants scheduled their interviews, the researcher contacted the participants via email to



confirm his/her interview date, time, location (if face-to-face interview), and contact number (if telephone interview). The researcher presented to the participant's desired location or contacted the participant via telephone on the day and time of the scheduled interview and conducted each interview by asking predetermined semi-structured interview questions. Each interview was audio recorded and the researcher took field notes during the interview, in an effort to record emerging themes. Each interview lasted thirty minutes to an hour. Interview recordings were transcribed verbatim by the researcher.

### **Data Analysis**

The data were analyzed by coding the participants' responses to the semi-structured interview questions and identifying themes. The semi-structured open ended interview questions focused on four specific topics: demographics, current work, medical social work educational preparation, and suggestions for preparing future medical social workers. The primary focus of this study was to gain insight from current medical social workers regarding the barriers to effective medical social work practice. Therefore, the interviews were coded for barriers.

The codes were organized into categories and themes were identified from the categories. The coding was done in two rounds. The first round of coding was done using Atlas Ti qualitative data analysis software. The data analysis software was utilized to assist with accuracy and organization of the coding. The second round of coding was done manually. The transcripts were printed, organized in a binder, each theme was assigned a color, and excerpts from the transcripts that represented the identified themes were highlighted with the corresponding color. Three significant themes emerged as barriers to effective medical social work practice: medical culture, lack of knowledge, and limited exposure. Results associated with each of these themes will be discussed in detail below.

## Results

### Medical Culture

Medical culture was a primary theme that emerged from participants' interviews. Participants identified medical culture as all the people and things that make up a complex health care system. Across interviews participants acknowledged that working as a medical social worker forces one to work in a host environment such as a hospital or an out-patient clinic that is fast-paced, time sensitive, heavily influenced by payor sources, and heavily-ridden with unfamiliar "lingo." In addition, Participants noted that when working in a healthcare setting there is an unspoken "expectation to know." Participants reported that medical professionals expect "answers" without a lot of deliberation, which is "foreign" to social workers. Participants also reported that often times social workers do not come into the environment receiving respect and have to earn respect from the other professionals (e.g. doctors, nurses, physical/occupational therapist). Safety in a healthcare environment was another issue that participants indicated as part of the medical culture that medical social workers often times are not prepared to navigate. As it relates to medical culture being a barrier for medical social workers, one participant stated the following:

In the hospital setting it is totally different. The doctor is the one who really runs the show and some of the doctors I have worked with look down on social workers, as if we are beneath them.

In discussing medical culture as a barrier, other participants made the following comments:

I think one of the main barriers is the doctors, some of the nurses, and even some of the therapists. They think that as social workers, all you do is discharge planning. You're just the discharge planner. For example, the therapist I'm working with now for some reason he thinks that I'm his secretary. I had to let him know that's not part of my job and I'm not doing that.

I need to be able to function in a fast-paced clinic setting... I have to be able to sit in a really busy room and be able to watch a board of like 40 patients that are scheduled and

know which ones I need to see, like the ones that I'm scheduled to see and also the prn issues that pop up. It's very fast paced. You have to be able to build rapport quickly with patients.

Social workers definitely aren't trained on how to keep themselves safe. A nurse will stand there and let a social worker go in a room that is on full contact precautions; where they suit up in body suits; but they will sit there and let us walk in.

Several participants identified the need to gain respect as an integral part of the medical culture. Participants indicated that medical social workers have to prove their value in healthcare settings and that the culture of medical environments make it extremely challenging for social workers to prove themselves and earn the respect of the medical team.

You have to earn respect... I know that's the case with any field, but because social work is not being viewed as an integral part of the hospital setting, you're not going to come in with respect. How you treat your patients, how you treat your physicians, your demeanor, your body language, all of those things affect your success in healthcare and how you're viewed as part of the team.

### **Lack of Knowledge**

Participants noted lack of knowledge as a major barrier for medical social workers. Several categories comprised lack of knowledge and out of those categories four major sub-themes emerged. The four sub-themes were terminology, understanding disease processes and treatment regimen, understanding insurance and payor sources, and understanding how to communicate effectively and the social worker's role on an interdisciplinary team.

**Terminology.** Participants openly discussed their lack of knowledge as it relates to medical terminology and not understanding what is being said or written about a patient.

Participants across interviews identified medical terminology as a barrier to effective medical social work practice. One participant stated:

You need to know some medical terminology to be effective as a medical social worker.

Other participants stated:

I was at a real disadvantage not knowing any of their (medical professionals) lingo.

A major barrier was... not knowing the medical terminology and having to go back and say, wait a minute; let me look this up.

I feel like medical terminology is not very well focused on in school, but it really helps to have some of that in your background when you come into the medical setting so that it's not all brand new to you.

BSW and MSW classes teach you all your theories and all that, but when you go into the medical field, you don't know the medical terminology. That's not taught in school. You just got to learn that on your own.

When it comes down to it, if you can't understand the jargon and the language where you're at, you're not going to be successful. So just a basic understanding of medical terminology is necessary.

**Understanding disease processes and treatment regimen.** When asked about the importance of understanding disease processes and treatment regimen, participants overwhelmingly reported that medical social workers should have some working knowledge of basic disease processes and treatment regimens, especially as it applies to the clients that they serve. Participants notably indicated that a barrier to effectively practicing as a medical social worker is lack of medical knowledge and basic understanding of disease processes and treatment regimens. Participants reported the following:

You definitely have to understand the diagnosis, all of those things go hand in hand, which is what's going to help you be able to help the patient.

I think that's pretty important. I think that that's certainly not something that I've learned in school, but that was certainly something you kind of get here on the job and I think that's really important.

These (disease process and treatment regimens) are not things that we (medical social workers) get to avoid. We have to know what's going on with the patient in order to provide appropriate social work services.

It's very important because a lot of your patients look for you to know and they usually talk to you, they dialogue with you on a regular. So, a lot of things, they're going to look for you to answer. They're going to come to you to know about the disease process, what can happen, the pros and cons, or what's going to be the barriers. They will come to you before they go to the nurse or their doctor. The doctor comes, they won't say anything; as soon as the doctor leaves they come to you with a list of questions. So, it's very important for you to be able to explain to them what's going on, what issues and how to resolve these issues or to just assist them in playing a role in their own healthcare.

**Understanding insurance and payor sources.** Participants agreed that having a foundational understanding of insurance and payor sources is essential to medical social work practice. Although one participant reported that understanding insurance and payor sources is a “double edged sword.” Participants’ responses indicated that social workers should not be the “insurance person” although having a lack of knowledge of insurance and payor sources can be a major barrier in assisting patients with getting the healthcare services they need. One participant summed up the impact and importance of understanding insurance:

It's very important because a lot of the questions we get, whether it's access to medication or full coverage for patients who are able to get full coverage or being able to act on a referral quickly enough to be in a time frame to get insurance. You have to have a basic working knowledge of insurance and I noticed that when I started 18 years ago we were the only persons doing insurance. So, it was something I had to learn... Newer social workers... struggle with helping the patients with basic (insurance related) things.

**Understanding how to communicate effectively and the social worker’s role on an interdisciplinary team.** Participants candidly discussed their roles on interdisciplinary teams within their current settings and the need for effective communication skills. Participants reported that lack of knowledge as relates to effectively communicating with medical professionals and understanding the social worker’s role on the interdisciplinary team (IDT) were primary barriers to being an effective medical social worker. One participant stated that:

Medical social workers have to be equipped to navigate “communication landmines.”

Other participants noted that new medical social workers often join the IDT and have no clue of their role on the team and they are unable to effectively articulate what they bring to the team, which ultimately results in new medical social workers having no “voice” or “seat” at the table. In addition, participants’ responses indicated that medical social workers are intimidated by other members or the IDT or feel inferior or less valuable to the team. Examples of those sentiments are listed below:

I think I was scared of the doctors for two years. Oh my gosh, you're a doctor, what do I say to you?

Learning to work with the team is an important piece. A lot of people (social workers) get intimidated, in that area; especially when working on the team with doctors and nurses and higher ups.

Normally social workers are able to work well with a team, but from my experience medical social workers often lack medical related knowledge which causes them to be intimidated by the doctors and nurses. Which in turn causes the doctor and nurses to think that the social worker is not knowledgeable.

A lot of social workers that I train are scared of doctors. They (new medical social workers) don't know how to interact with them (doctors) because they can come across as being a bully or being arrogant and they don't know how to deal with that.

### **Limited Exposure**

Participants noted limited exposure to medical social work practice in their BSW and MSW educational preparation across interviews. All participants indicated that their greatest learning about being a medical social worker occurred on the job. One participant stated:

It was honestly being in the charting room, sitting right next to the medical providers so that I can kind of learn on the job and also going into rooms, patient rooms with providers. I learned a lot about the medical, well best about the diagnosis and treatment plans and impacts on the body from working right alongside the medical team. I didn't receive any kind of specific social work training on that at all. It was really more on the job training, just learning as I go from the medical team.

Another participant that recalled her greatest learning about being a medical social work as such:

Just really on the job training I guess. Just by being in it and then having supervision. I was lucky and continue to be lucky to have a supervisor who is a medical social worker... In the beginning I relied on my supervisor to help think through scenarios and how to approach different issues that would come up, so I would say through supervision from my director, but also just from my colleagues, my medical colleagues... So I would just kind of say that I learned from working with my supervisor and from the medical team that I worked with every day.

Fifteen (65%) participants reported having a medical social work field practicum experience. Eight (35%) participants reported not having a medical social work field practicum experience. Regardless of practicum experience the majority of participants reported that medical social work content was not covered in their BSW or MSW classes. Participants reported that their BSW or MSW programs provided very limited exposure to medical social work practice, which ultimately resulted in a barrier to effective medical social work practice. In discussing their BSW and MSW programs' limited exposure of medical social work responses, participants' responses included:

There were six tracks that you could choose from and medical was not one.

My MSW program offered not one class on medical social work, not even an introduction to medical social work practice.

I don't really remember medical social work being a focus... I don't remember medical social work one of the four divisions within our program, I believe they were children and family. That was like one area within our program. Then there was the school setting and then there was mental health.

In addition to limited exposure to medical social work practice, participants acknowledged that their BSW/MSW programs provided limited exposure to understanding healthcare systems and insurance, disease processes and treatment regimen, and interdisciplinary

collaboration. Participants reported that their greatest learning regarding those things occurred on the job or in classes from other disciplines.

**Exposure to healthcare systems and insurance.** Participants indicated that their educational preparation did not adequately expose them to healthcare system and insurance, which is an essential component of medical social work practice. One participant stated:

We didn't learn about insurance in school, I didn't realize that would be one of my roles, until on the job as a medical social worker.

While others reported:

I definitely don't recall any specific education about how insurance works. I have gotten that education through workshops... not during the MSW program.

I had to learn about that the hard way. Just getting into the field, getting my feet wet and also just educating myself ... so I can educate the patient.

Very minimally went over Medicare, generally, the history of it; but not the specifics of what it actually covers. I really truly didn't learn that until my medical internship.

**Exposure to disease processes and treatment regimen.** Participants identified their psychopathology course and human behavior and the social environment (HBSE) courses as being the courses that provided content related to disease processes and treatment regimen. Participants reported the content in those classes was limited and that the content in psychopathology was related to mental health rather than physical health. Three participants had undergraduate degrees in the health sciences and reported being exposed to disease processes and treatment regimens during their undergraduate education. Participants across interviews reported very limited exposure to course content in their MSW programs that was related to disease processes and treatment regimen. Exemplar participants' responses include:



We talked about diagnosis, but mostly for mental health, psychopathology, but nothing medical.

On the medical standpoint, none, we didn't do that. We did mental health.

The only thing that I can really think of as far as well disease as it's called today was really addiction. That's kind of the focus that I remember because I don't recall anything being related to things other than, drug addiction, alcohol abuse. I mean that, that was it.

**Exposure to IDT participation and collaboration.** All participants identified as being members of an IDT and actively collaborating with medical teams consisting of, but not limited to; doctors, nurses, dieticians, physical/occupational therapists, and third-party service providers. Participants indicated that their first exposure to and IDT was on the job. Participants reported that they were not exposed to IDT content in their social work educational programs. Participants made the following remarks regarding their educational preparation for IDT participation and collaboration:

I don't feel like that there was education about working with an IDT. That was definitely something on the job.

I wasn't prepared at all to work with teams. Not at all as I can recall I wasn't prepared to work with teams at all, now that I'm thinking about it. Now my work history, I have worked with teaming, but as far as the school, not at all.

I don't feel like we had any interdisciplinary team type prep.

I don't know that it really did. There were certainly instances in social work school that we had to do group work. We had group assignments and working with the various individuals in the groups; you did get to work with students who came from different backgrounds, different ethnicities, different cultures, that sort of thing and did you got to deal with group interaction but that's the closest I came to interdisciplinary teamwork in school.

## Discussion

### Interpretation of Findings

Findings from this study are consistent with current social work literature regarding social workers' unpreparedness for practice in healthcare settings. Current medical social workers perceive three major areas as barriers for social workers' effectiveness in a healthcare setting. Those perceived barriers are identified as medical culture, lack of knowledge, and limited exposure.

**Medical culture.** A primary barrier faced by social workers in a healthcare setting is the "medical culture." Social workers tend to work in environments with other social workers who they can readily collaborate with, deliberate with, and confer with as needed. In addition, social work environments tend to be a little less fast paced. In a medical environment social workers are tasked with working in a fast-paced host environment that may not be receptive to social work practice, in addition to working alone or being the only social worker on the healthcare team. Consequently, there is less time to deliberate and confer with like-minded professionals and the social worker is solely responsible for the biopsychosocial needs of the patient, and there is an underlying "expectation to know." Furthermore, those interviewed spoke to how the hierarchy present in a medical environment is often times new to social workers and social workers tend to be at the bottom of the hierarchy and have to gain respect in order to move up the hierarchy. This in combination with social workers being intimidated by other healthcare professionals, especially the doctor, who in most cases is at the top of the hierarchy; presents a challenge to a social workers' effectiveness in a healthcare setting.

Safety is another complex issue within a healthcare setting that is challenging and was identified by this sample as a central concern for social workers. Current medical social workers

acknowledged having limited knowledge of how to protect themselves in a healthcare setting, especially as it relates to infectious disease and contact precautions. Social workers are trained on how to maintain safety in the field in relation to conducting home visits or how to arrange their office to maximize the ability to escape. Yet, social workers are not necessarily educated on basic safety precautions such as hand hygiene or proper hand washing, wearing protective personal equipment (PPE) when a patient is on contact precaution, avoiding airborne pathogens, and preventing contact with bodily fluids; which is essential knowledge in a healthcare setting and heavily embedded within the medical culture.

**Lack of knowledge.** Another primary barrier identified by participants in this study is lack of knowledge related to terminology, understanding disease processes and treatment regimen, understanding insurance and payor sources, and understanding how to communicate effectively and the social worker's role on an interdisciplinary team. Social workers enter into practice in healthcare settings with limited to no understanding of medical terminology. Current medical social workers in this sample noted that this lack of understanding inhibits the medical social worker's ability to understand and adequately communicate with the healthcare team.

In addition, current medical social workers are expected to understand healthcare systems and insurance and they are expected to help patients and their families not only understand healthcare systems and insurance, but to navigate through the larger medical system in an effort to get the best possible care and services. Social workers' expectation to understand insurance does not stop with patients and their families, this expectation extends to doctors and other members of the medical team. Medical social workers often time have to educate the medical providers they work with on what services and medications insurance will and will not cover. Despite understanding insurance and payor sources being an expectation for medical

social workers, current medical social workers admit to entering into medical social work practice with little to no understanding of insurance and payor sources.

The medical social workers in this study all agreed that some knowledge of basic disease processes and treatment regimens is necessary for medical social work practice. Although, they recognized that they entered into practice with very limited knowledge of disease processes and treatment regimens which presented a “learning curve” for them and served as a barrier to effective medical social work practice. Lack of knowledge, as well as communication and interdisciplinary collaboration proved to be barriers for current medical social workers in this study. Despite the social workers in this study reporting that they were trained to collaborate with others there was a consensus among participants that they entered practice as a medical social worker with inadequate communication and interdisciplinary collaboration skills regarding understanding and communicating their role on the team, being able to articulate the value they bring to the team, and ultimately being able to effectively navigate within a large complex team that is composed of various disciplines.

**Limited exposure.** The third primary barrier to medical social work effectiveness is limited exposure in regard to educational preparation. Study participants overwhelmingly noted that their social work educational programs failed to adequately prepare them for practice in a healthcare setting; whether it was through course content, field practice, or simply acknowledging healthcare as area of practice. The medical social workers in this study acknowledged that some content regarding disease processes and treatment regimens were covered in their psychopathology and HBSE courses, although this content was not identified by them as sufficient for effective practice as a medical social worker. Participants also noted that policy was the only course that covered insurance, yet the information covered was insufficient

for medical social work practice. These insufficiencies in combination with non-medical field placements and limited exposure to interdisciplinary collaboration as a social work student created a barrier for effective medical social work practice.

### **Implications for Social Work Education**

This study's data indicate that medical social workers experience *baptism by fire* when it comes to working in a health care setting. Medical social workers' greatest learning about medical social work practice is occurring in the field as a medical social worker rather than in the classroom as a student or in practicum as an intern. The findings in this study align with current literature which indicates that current social work curricula, broadly, is inconsistent in preparing social workers to practice in a healthcare setting, thereby creating medical social workers who do not have the required knowledge base or skills for medical social work practice (DeBonis et al., 2015; Mitchell, 2012; Mitchell & Joosten, 2014; Volland et al., 2003). Considering that medical social workers are often initially ill-prepared for practice in a healthcare setting as noted by this study and previous other studies there are several implications for social work education regarding reducing the barriers associated with being effective in a healthcare setting.

**Strengthening existing curricula.** Existing social work curricula can be strengthened in several ways although based on the findings of this study, the single most impactful way to strengthen existing curricula would be to develop an introduction to medical social work course. It is understandable that developing a medical social work course may not be feasible for all schools of social work, therefore schools of social work are encouraged to focus on infusing medical social knowledge throughout current courses. Infusion can occur in many ways across several content areas. For example, HBSE would be ideal for infusing biomedical knowledge related to basic and/or common diseases, disease processes, and treatment regimens. In addition,

policy courses can be avenues for exposing students to more in-depth information regarding healthcare policy and insurance. It is also important to note that practice courses are ideal for exposing students to course content that aims to provide students with a basic understanding of biological functioning and how impaired biological functioning impacts mental health and social functioning. Infusion can be achieved by inviting current medical social workers to participate in question and answer sessions with students, arranging for students to visit a healthcare setting and shadow a medical social worker, and by utilizing case studies, role plays, and simulations that focus on working with clients in a healthcare setting. Infusion can also occur by creating assignments and activities such as interdisciplinary simulations that require students to work with or partner with students from other disciplines.

**Healthcare practicums.** Evidence from this study clearly indicates that medical social workers most often learn how to be an effective medical social worker on the job, rather than in the classroom; therefore, developing healthcare related practicums is essential to social work education. Healthcare practicums will expose future medical social workers to tasks as well as the necessary knowledge that is required for medical social work practice. In addition, a medical social work field practicum will provide students an opportunity to be exposed to the “medical culture,” disease processes and treatment regimens, and insurance and healthcare systems. In addition, healthcare practicums provide students with an opportunity to practice conceptualizing the biological component of biopsychosocial assessments as well as serve as a member of an interdisciplinary team. Membership on an interdisciplinary team as an intern allows students to learn the roles and responsibilities of the various disciplines, in addition to practicing team dynamics with the support of a field supervisor. Findings from this study suggest that social work programs require students that are interested in medical social work practice to complete at

least one field practicum rotation in a healthcare setting. This requirement will reduce the *baptism by fire* that social workers are subjected to when they enter into a healthcare setting with no previous medical experience.

**Developing IPE opportunities.** Preparation for interdisciplinary collaboration should start in the classroom with the development of IPE opportunities and the infusion of IPE assignments into existing social work course content. IPE content can be infused into existing social work content through in-class role plays and assignments that highlight the purpose and importance of interdisciplinary collaboration. In addition, IPE infusion can occur by utilizing case studies that promote critical reflection on teamwork with professionals such as doctors, nurses, and pharmacists. Social work educators should be willing to work across departments and partner with other disciplines to develop IPE simulations that depict real-life medical scenarios and that force students to engage in team dynamics similar to those in a healthcare setting. This exposure would be dynamic and beneficial for all parties involved and would carry over into the field upon graduation.

### **Implications for Future Research**

Future research on medical social work education is warranted. Future studies should explore schools of social work that have a medical social work concentration and schools that offer medical social work courses. These programs as well as current medical social workers who graduated from these programs should be studied to gather more in-depth information regarding the benefits of being exposed to medical social work practice as a part of their program of study. It would also be helpful to analyze the course offerings of these programs to determine what courses are essential for the preparation of medical social workers. Additional research on the impact of medical social work field practicums and their role in preparing medical social

workers should be explored in more detail. Future research would also be well served in exploring the role of supervision and mentoring of new medical social workers and their successful acclimation to medical social work practice and thriving in a healthcare setting.

### **Limitations**

This study is limited by geographical factors and dominance of one area of medical social work practice. The study was not representative of the United States as a whole and was concentrated in a specific area. In addition, the majority of the participants were medical social workers in a dialysis setting, which is not representative of all medical social workers because medical social workers are employed in various other healthcare setting outside of dialysis.

### **Conclusion**

Scholars who write about medical social work education propose that social work curricula offers minimal content related to medical social work practice and that medical social workers enter the field without formal training in medical terminology, disease processes, biomedical knowledge, and biological functioning (Berkman, 1996; Gant & Toh, 2017). The results of this study support those findings. Medical social work is a specialized area of social work practice and based on the findings of this study, schools of social work are encouraged to commit to revising social work education to allow for better preparation of social work graduates for practice in a healthcare setting; rather than allowing them to be *baptized by fire*. Ultimately if schools of social work fail to better prepare future medical social workers, there could be severe consequences for the social work profession. Failure to properly prepare future medical social workers will very likely result in other allied health professionals, such as nurses, being hired for positions that are better suited for medical social workers.



## References

- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work, 41*(5), 541-551. doi:10.1093/sw/41.5.541
- Boyce, L., & Scott, V. (1986). Curriculum planning for social work in health care: The practitioner's view. *Australian Social Work, 39*(3), 37-43.  
doi:10.1080/03124078608549881
- Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work, 48*(3), 297-306. doi:10.1093/sw/48.3.297
- Bronstein, L., Kovacs, P., & Vega, A. (2007). Goodness of fit: Social work education and practice in health care. *Social Work in Health Care, 45*(2), 59-76.  
doi:10.1300/J010v45n02-04
- Browne, T., Keefe, R. H., Ruth, B. J., Cox, H., Maramaldi, P., Rishel, C., & ... Marshall, J. (2017). Advancing social work education for health impact. *American Journal of Public Health, S3*, S229-S235. doi:10.2105/AJPH.2017.304054
- Bureau of Labor Statistics, U.S. Department of Labor. (2018). *Occupational Outlook Handbook, Social Workers*. Retrieved from <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm>
- Cabot, R. C. (1909). *Social Service and the Art of Healing*. New York, NY: Moffat Yard and Company.
- Chaddock, R. (2016). Integrating early multi-disciplinary advance care planning into core social work practice: Social workers' bread and butter. *Journal of Social Work Practice, 30*(2), 129-138. doi:10.1080/02650533.2016.1168382

Council on Social Work Education (2017). *2016 Statistics on Social Work Education in the United States: A summary of the CSWE Annual Survey of Social Work Programs*.

Alexandria, VA: CSWE. Retrieved from:

<https://www.cswe.org/CMSPages/GetFile.aspx?guid=6e8bc9e7-ebd6-4288-bc7a-d2d427d68480>

DeBonis, J. A., Becker, M. A., Yoo, J., Capobianco, J., & Salerno, A. (2015). Advancing social work education: Lessons learned from piloting an integrated healthcare curriculum.

*Journal of Social Service Research*, 41(5), 594. doi:10.1080/01488376.2015.1081859

Education for Medical Social Work: The Curriculum Content. (1951). *American Association of Medical Social Workers Education Committee, Curriculum Content Subcommittee*.

Retrieved from University of Minnesota Social Welfare History Archives.

(NASW: AAMSW Box 31, Folder 381).

Grant, D. M., & Toh, J. S. (2017). Medical social work positions: BSW or MSW?. *Social Work in Health Care*, 56(4), 215-226. doi:10.1080/00981389.2016.1265633

Gregorian, C. (2005). A career in hospital social work: Do you have what it takes? *Social Work in Health Care*, 40(3), 1-14. doi:10.1300/J010v40n03 01

Horevitz, E., & Manoleas, P. (2013). Professional competencies and training needs of professional social workers in integrated behavioral health in primary care. *Social Work in Health Care*, 52(8), 752–787. <https://doi.org/10.1080/00981389.2013.791362>

Hospital Social Work. (1929). In *Social Work Year Book 1929* (Fred S. Hall ed.). Retrieved from <http://umedia.lib.umn.edu/node/542286>

Kadushin, G., & Egan, M. (1997). Educating students for a changing health environment: An examination of health care practice course content. *Health & Social Work, 22*(3), 211-222. doi:10.1093/hsw/22.3.211

Kovacs, P. J., & Bronstein, L. R. (1999). Preparation for oncology settings: What hospice social workers say they need. *Health & Social Work, 24*(1), 57-64. doi:10.1093/hsw/24.1.57

Liley, D. G. (2003). Bridging the gap between classroom and practicum. *Journal of Gerontological Social Work, 39*(1-2), 203-217. doi:10.1300/J083v39n01\_17

Medical Social Work. (1951). In *Social Work Year Book 1951: A Description of Organized Activities in Social Work and in Related Fields* (Margaret B. Hodges ed.).

Retrieved from <http://umedia.lib.umn.edu/node/542296>

Medical Social Work. (1960). In *Social Work Year Book 1960: A Description of Organized Activities in Social Work and in Related Fields* (Russell Kurtz ed., Fourteenth Issue).

Retrieved from <http://umedia.lib.umn.edu/node/542299>

Mitchell, J. A. (2012). Integrating education on addressing health disparities into the graduate social work curriculum. *Journal of Teaching in Social Work, 32*(5), 471-486.

doi:10.1080/08841233.2012.725458

Mitchell, K. R., & Joosten, D. M. (2014). Determinants of health concentration selection among university of southern California MSW students. *Health & Social Work, 39*(4), 230-237.

doi:10.1093/hsw/hlu033

NASW Center for Workforce Studies and Social Work Practice. (2011). *Social Workers in Hospitals and Medical Centers: Occupational Profile*. Retrieved from

<http://workforce.socialworkers.org/studies/profiles/Hospitals.pdf>

National Association of Social Work. (2016). *NASW standards for social work practice in healthcare settings*. Retrieved from

<https://www.socialworkers.org/LinkClick.aspx?fileticket=fFnsRHX-4HE%3D&portalid=0>

Redmond, H. (2001). The health care crisis in the United States: A call to action. *Health and Social Work*, 26(1), 54-57. doi: 10.1093/hsw/26.1.54

Reinhold, M.I., Otieno, S., & Bacon-Baguley, T. (2017). Integrating interprofessional experience throughout a first-year physician assistant curriculum improves perceptions of health care providers. *Journal of Interprofessional Education & Practice*, 6, 37-43. doi: 10.1016/j.xjep.2016.12.001

Report of the Committees on the Training of Hospital Social Workers. (1922). *The American Hospital Association: Presented to the Board of Trustees at the Convention of the Association*. Retrieved from University of Minnesota Social Welfare History Archives. (NASW: AAMSW Box 31, Folder 369).

Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K., Wyche, K., & Sliwa, S. (2017). *Profile of the social work workforce*. Retrieved from <https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx>.

Silverman, E. (2008). From ideological to competency-based: The rebranding and maintaining of medical social work's identity. *Social Work*, 53(1), 89-91. doi:10.1093/sw/53.1.89

Sims, D. (2011). Achieving collaborative competence through interprofessional education: Lessons learned from joint training in learning disability nursing and social work. *Social Work Education*, 30(1), 98-112. doi:10.1080/02615471003748056

- Sweet, B. V., Madeo, A., Fitzgerald, M., House, J. B., Pardee, M., Zebrack, B., ... Mueller, B. A. (2017). Moving from individual roles to functional teams: A semester-long course in case-based decision making. *Journal of Interprofessional Education & Practice*, 7, 11-16. doi:10.1016/j.xjep.2017.01.003
- Volland, P. J., Berkman, B., Phillips, M., & Stein, G. (2003). Social work education for health care. *Social Work in Health Care*, 37(4), 1-17. doi:10.1300/J010v37n04\_01
- Zayas, L. H., & Dyche, L. A. (1992). Social workers training primary care physicians: Essential psychosocial principles. *Social Work*, 37(3), 247-252. doi:10.1093/sw/37.3.247

Promoting Social Justice Through Effective Medical Social Work Practice: Closing the Gap

Between Classroom and Practice

Katrinna M. Matthews

St. Catherine University/University of St. Thomas

## Abstract

Social work students require adequate education that will allow them to be effective medical social workers who are able to work with all clients who enter the healthcare system and who are able to promote social justice through their practice. This presentation examines the deficits in social work education as it relates to preparing social work students for practice in a healthcare setting. Social work practice in a healthcare setting requires preparing social work students to be confident with the biological/physical aspect of biopsychosocial-spiritual assessments, interdisciplinary collaboration, and engaging social justice issues related to healthcare. This presentation provides implications for social work educators related to integrating interprofessional education (IPE) opportunities into existing course content, developing healthcare practicums, increasing biological content, and incorporating medical social work practice models and content targeted at addressing social justice issues in healthcare into existing course content. This presentation was given at the annual Association of Baccalaureate Social Work Program Directors (BPD) conference which was held in Jacksonville, FL, March 13 – 17, 2019.

*Keywords:* medical social work, IPE, interdisciplinary collaboration, healthcare, social justice, biopsychosocial-spiritual, social work education, deficits, social work educators

Promoting Social Justice Through Effective Medical Social Work Practice: Closing the Gap  
Between Classroom and Practice

The social work profession has a long-standing commitment to providing social work services to those impacted by illness and has maintained a strong position on universal provisions to healthcare (Owen, 2009). If the social work profession plans to maintain its solid standing in healthcare, by providing effective medical social work practice, taking a leading role in closing the health gap, advocating for and helping to implement socially just healthcare policies, and developing prevention initiatives; then schools of social work education must make medical social work preparation a priority and adequately prepare future social workers to thrive in a healthcare setting.

The purpose of this presentation is to increase awareness of the gap between medical social work practice and social work education, especially as it relates to social work education's limited focus on interdisciplinary collaboration and the biological aspect of biopsychosocial-spiritual assessment. Attention is also given to health disparities and the role of medical social work education in training medical social workers to address the social injustices in healthcare. The conceptual framework that grounds this body of knowledge is the author's lived experience as a medical social worker, Bronstein's Model for Interdisciplinary Collaboration, and the Biopsychosocial-Spiritual Model.

Due to the ever-changing landscape of the healthcare system, the human condition, and the increasing demand for medical social workers in the private and public sector; social work educators must realize that there is a need to integrate an increased focus on knowledge of biological functioning, interprofessional collaboration, and issues of social justice into existing social work course content and/or existing social work curricula. Therefore, this presentation will

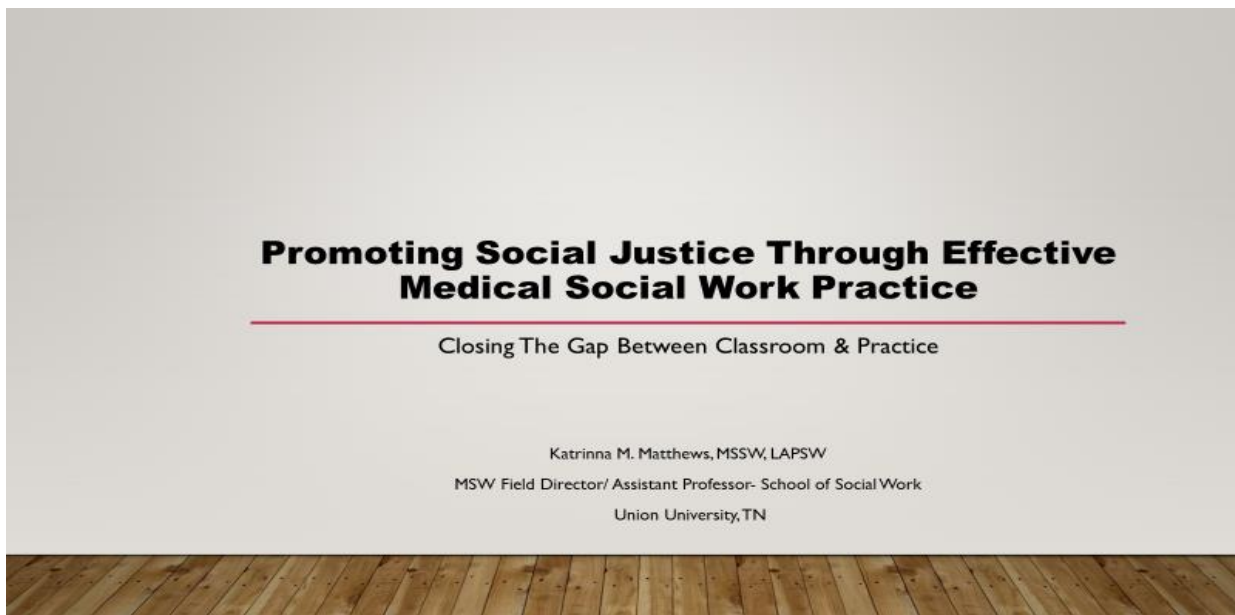


provide implications for social work education that will assist social work educators with better preparing future social work students to thrive in a healthcare setting while effectively addressing social justice issues.

### **Presentation**

This presentation is an adaptation of a conceptual paper that is part of a Doctor of Social Work (DSW) banded dissertation at St. Catherine University/University of St. Thomas. The presentation was given at the annual Association of Baccalaureate Social Work Program Directors (BPD) conference which was held in Jacksonville, FL, March 13 – 17, 2019. The presentation provided a detailed historical overview of medical social work education, addressed the current deficit in social work education as it relates to training future social workers for practicing in a healthcare setting and engaging social justice issues related to health and well-being, and provided implications for social work educators.

### **Presentation Slideshow**



*Figure 1.* Presentation slide one

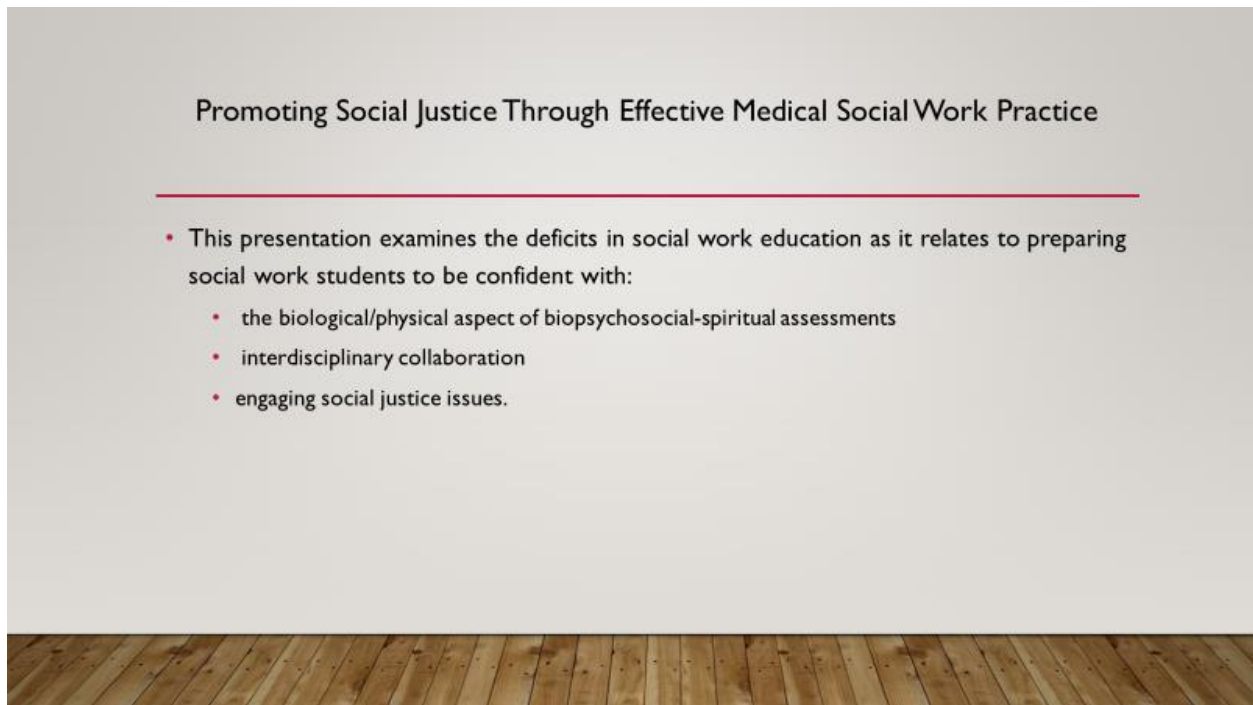


Figure 2. Presentation slide two

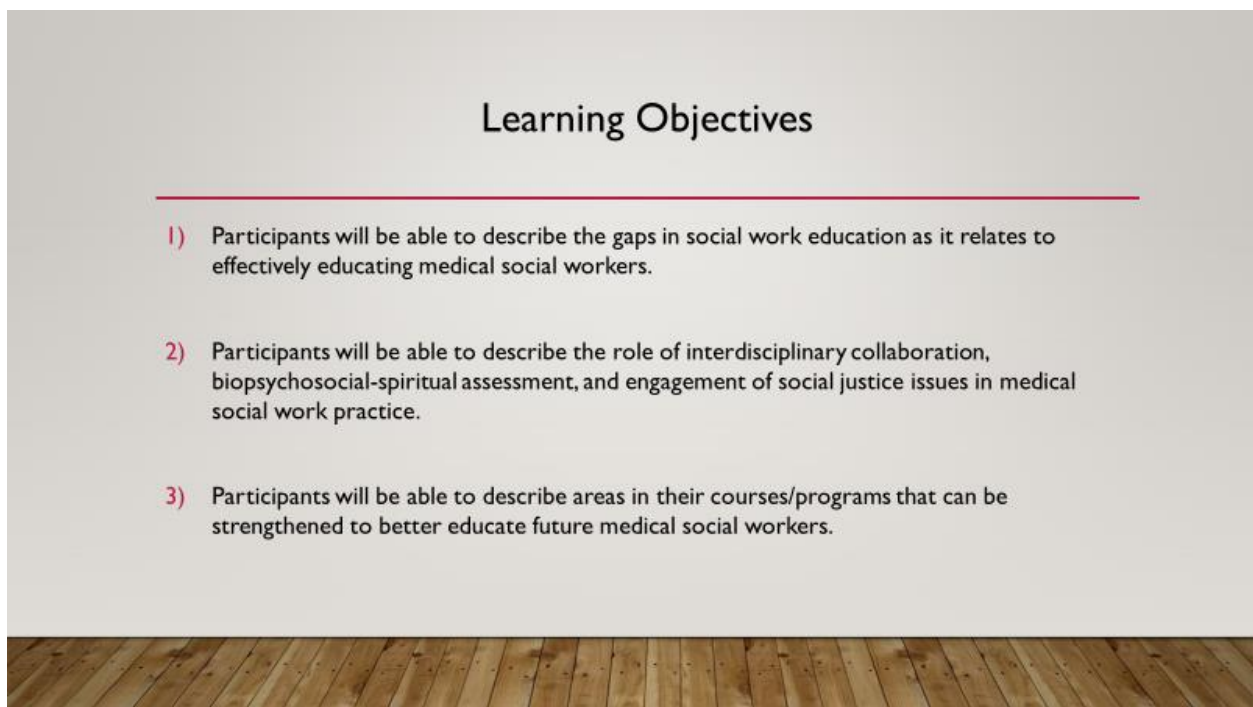


Figure 3. Presentation slide three

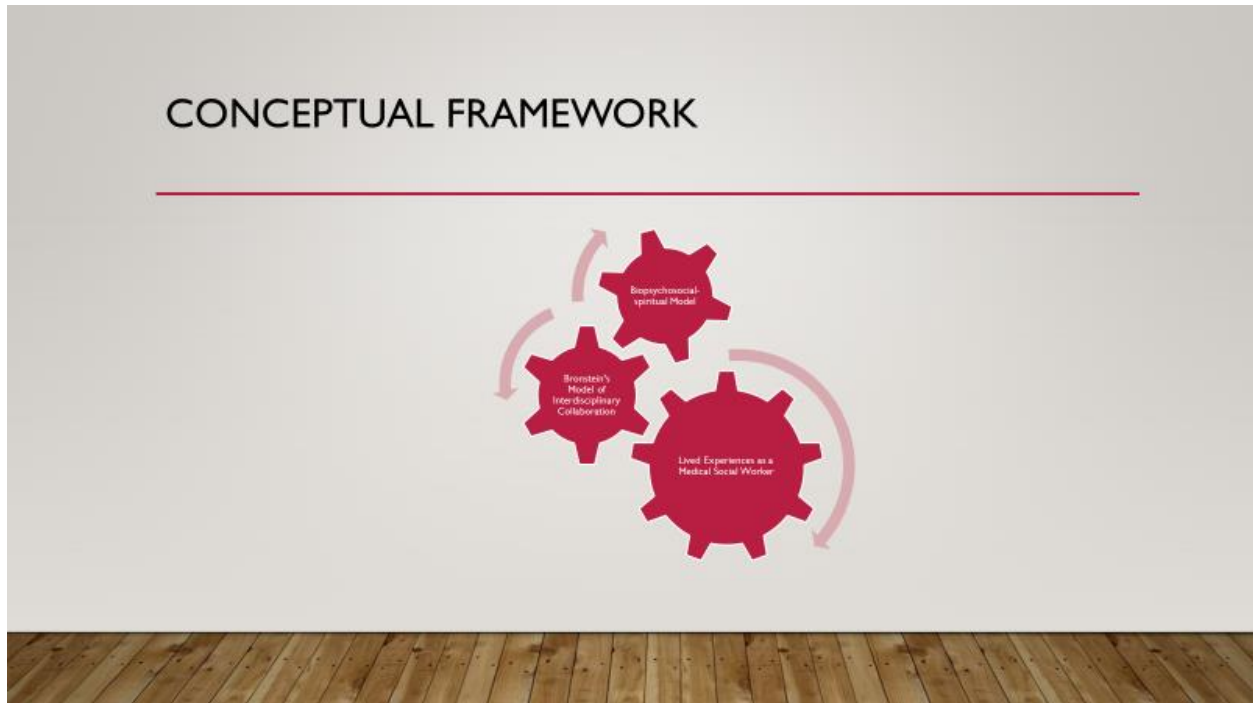


Figure 4. Presentation slide four

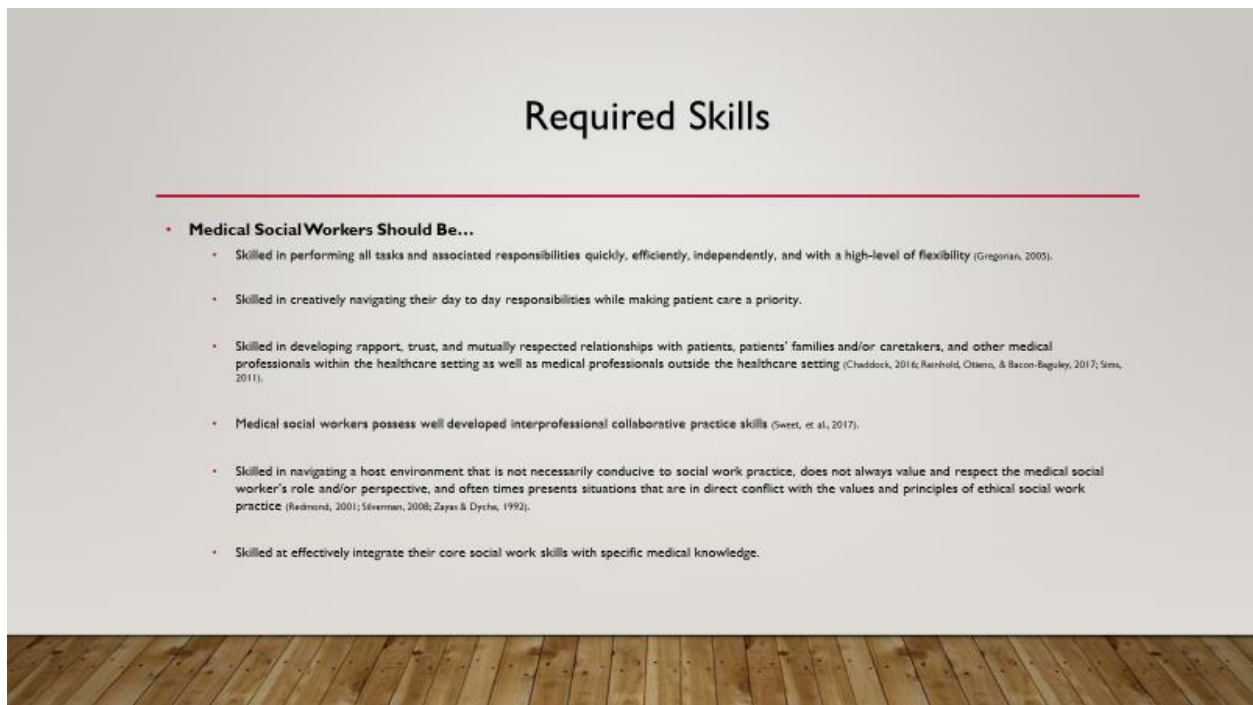
## Medical Social Work

- Medical social work is reportedly the fastest growing area of social work practice and it is anticipated that medical social work will grow an additional **20%** by **2026** (Bureau of Labor Statistics, 2018).
- **29%** of all social workers work in a healthcare related setting (Salsberg, 2017).
- National Association of Social Workers (NASW) recognizes medical social work as an "area of specialization within the social work profession..." and "requires a distinct skill set and knowledge base..." (2016, p.18).

Figure 5. Presentation slide five



*Figure 6.* Presentation slide six



*Figure 7.* Presentation slide seven

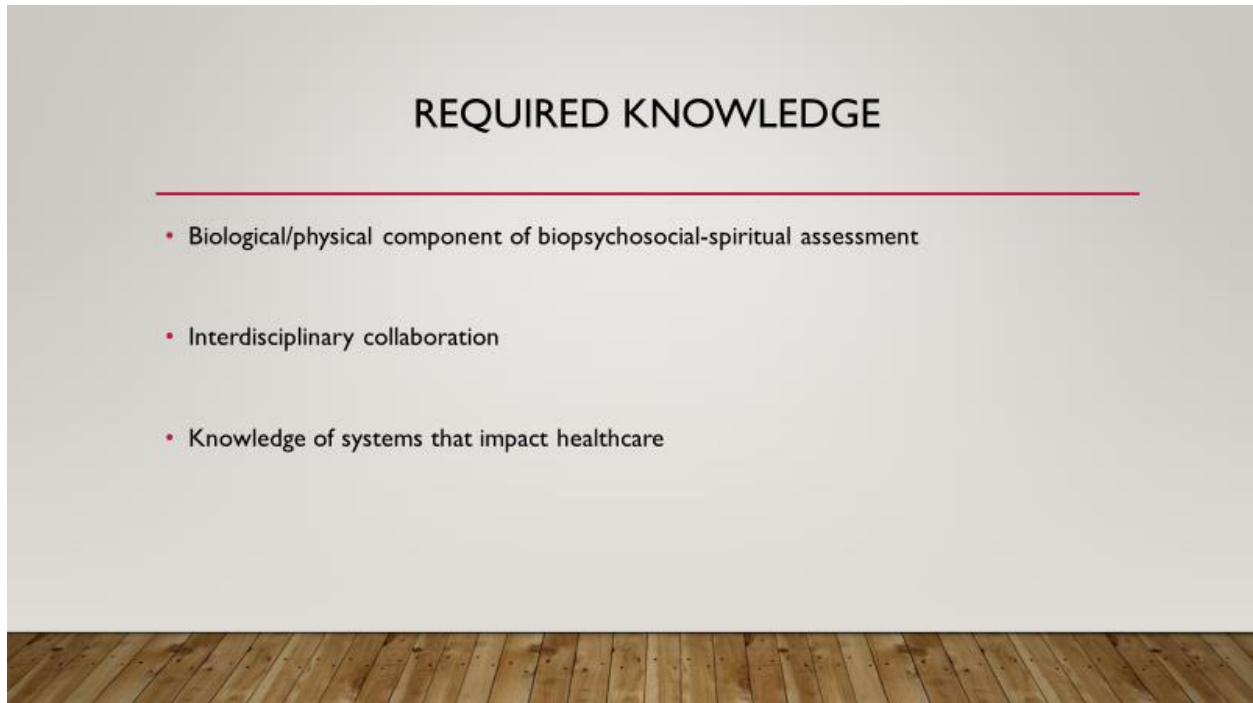


Figure 8. Presentation slide eight

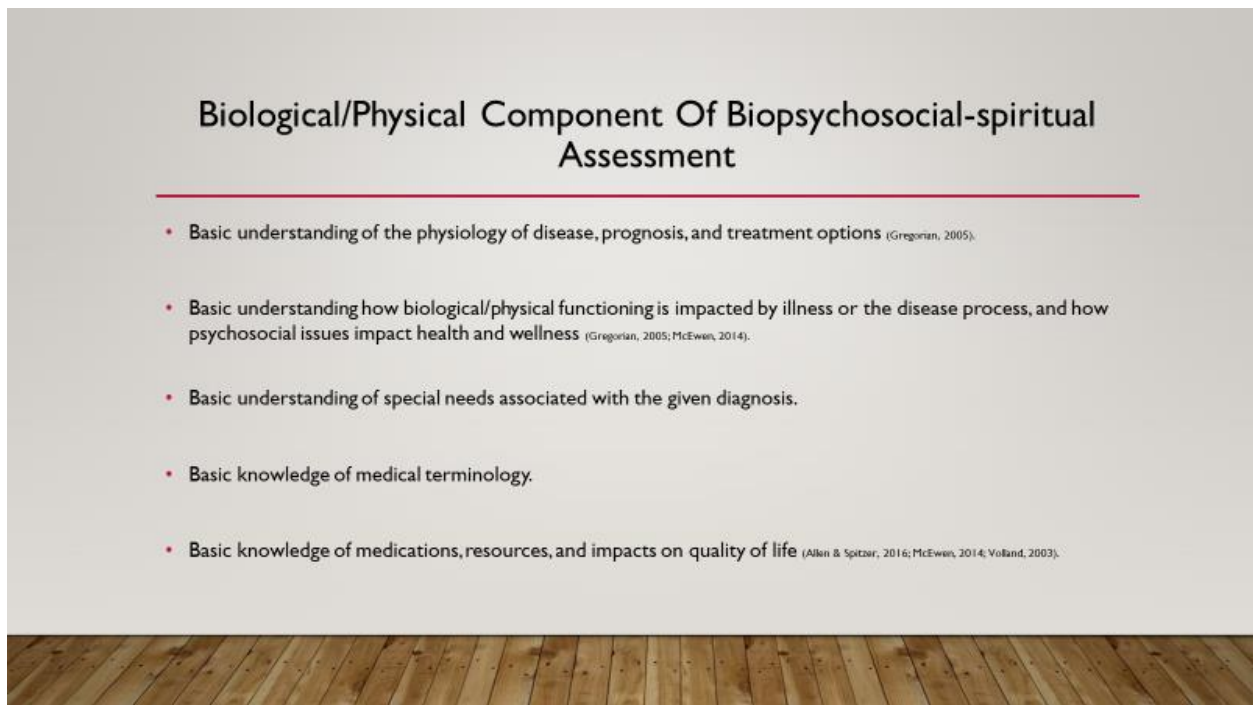


Figure 9. Presentation slide nine

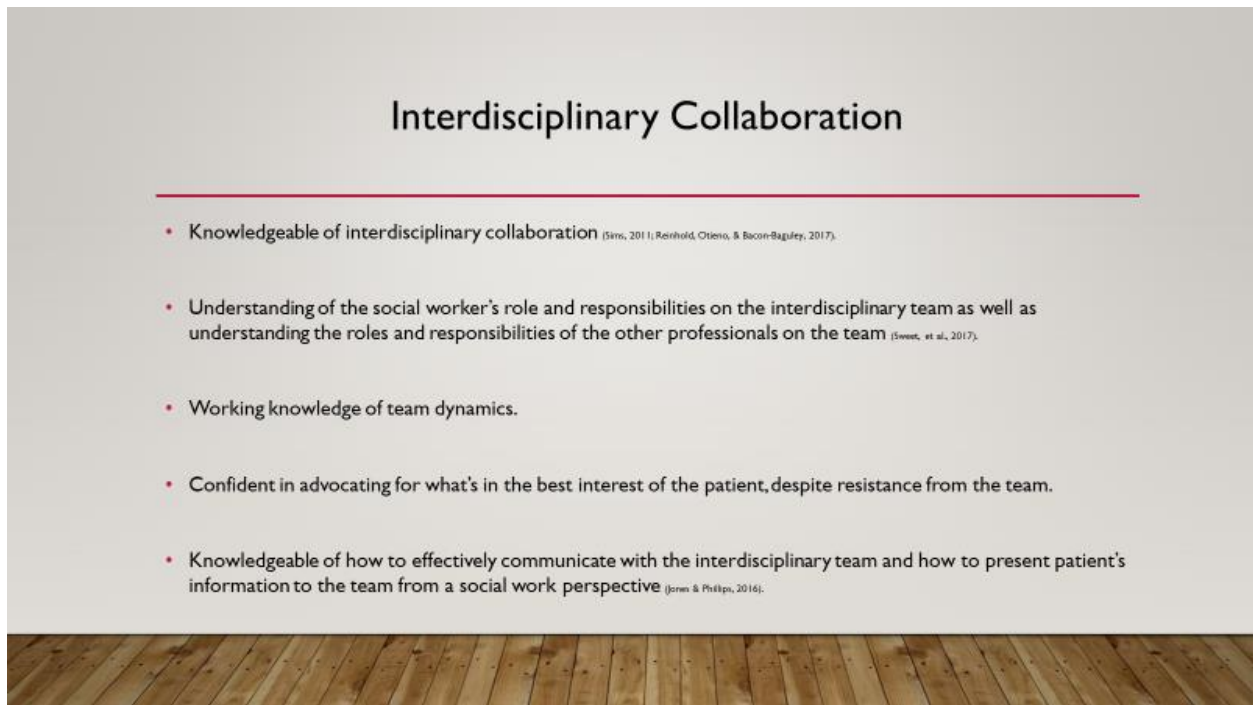


Figure 10. Presentation slide 10

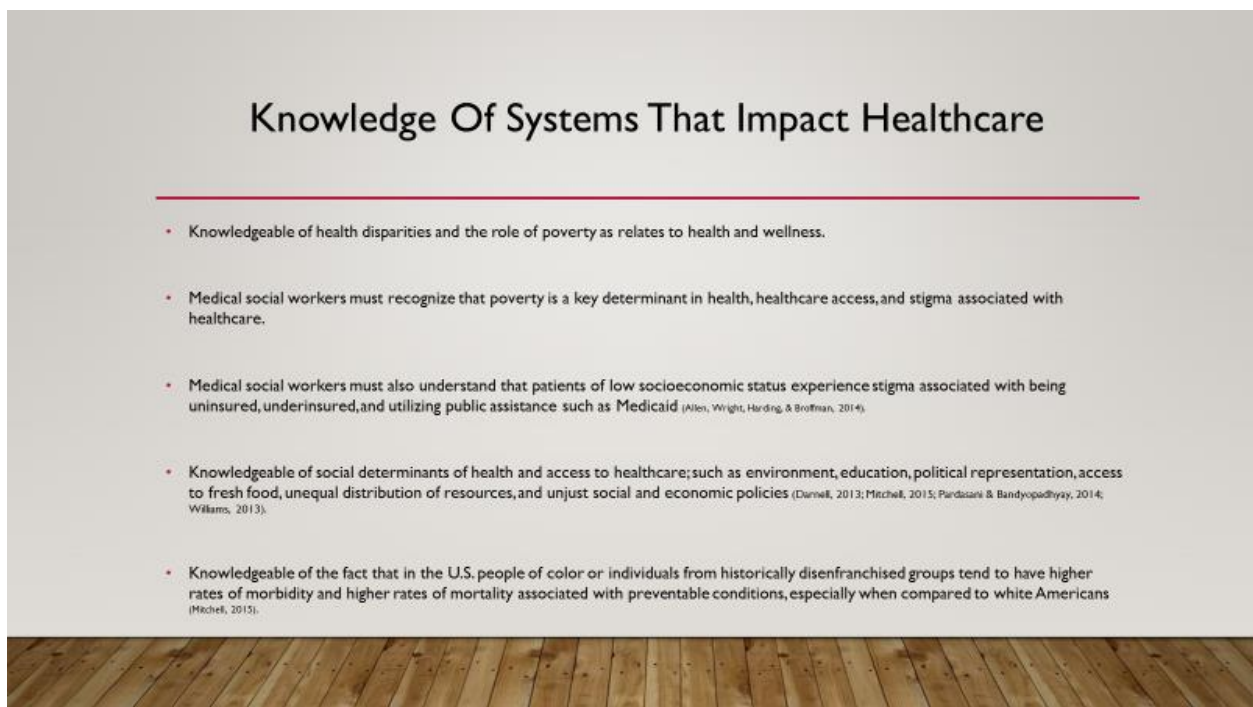


Figure 11. Presentation slide 11

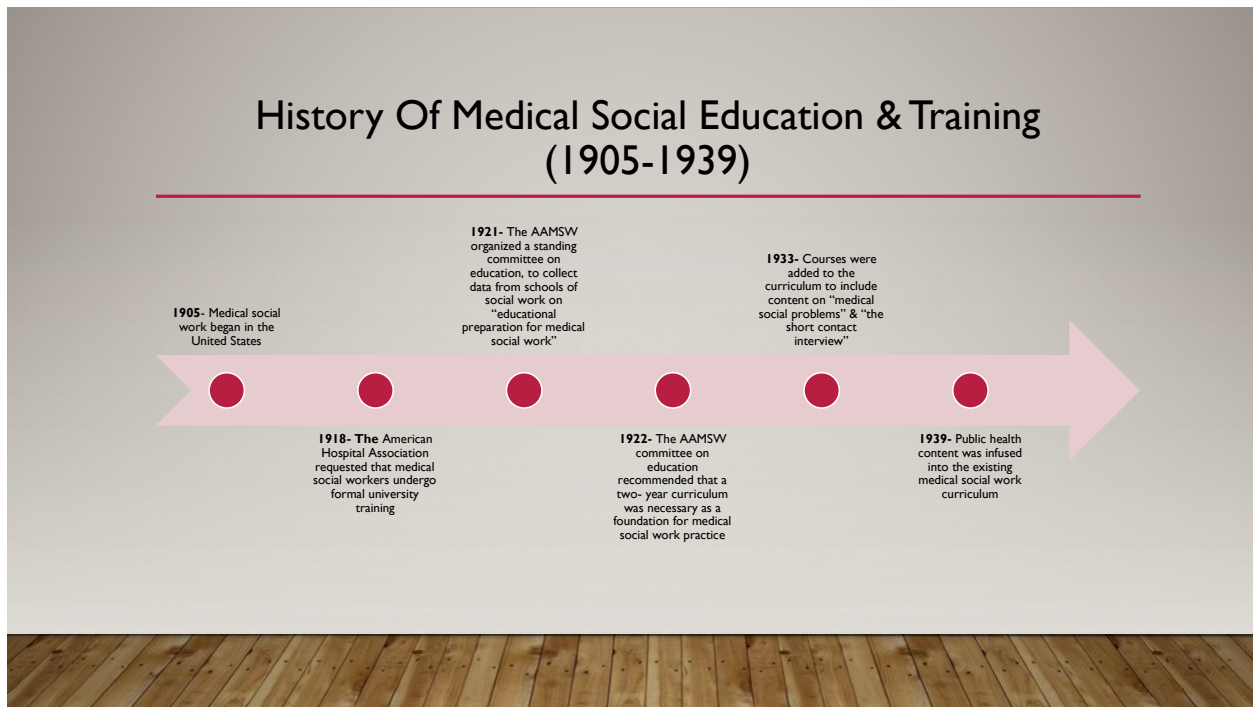


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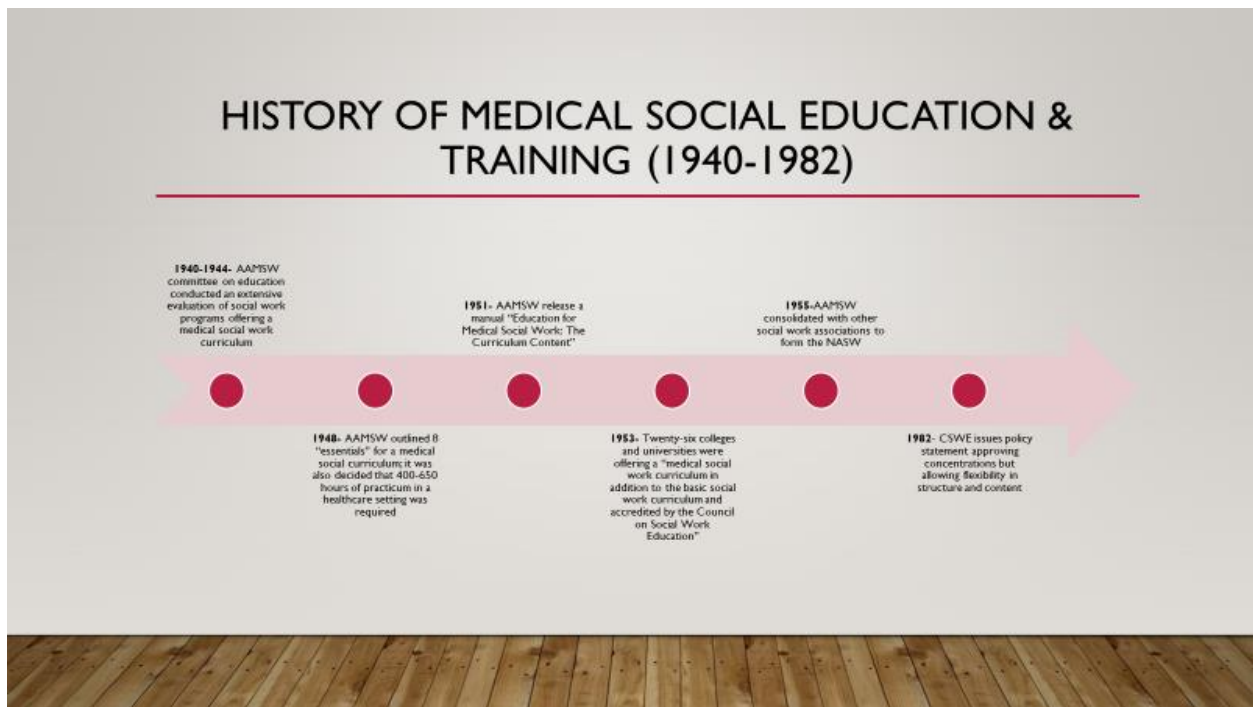


Figure 13. Presentation slide 13

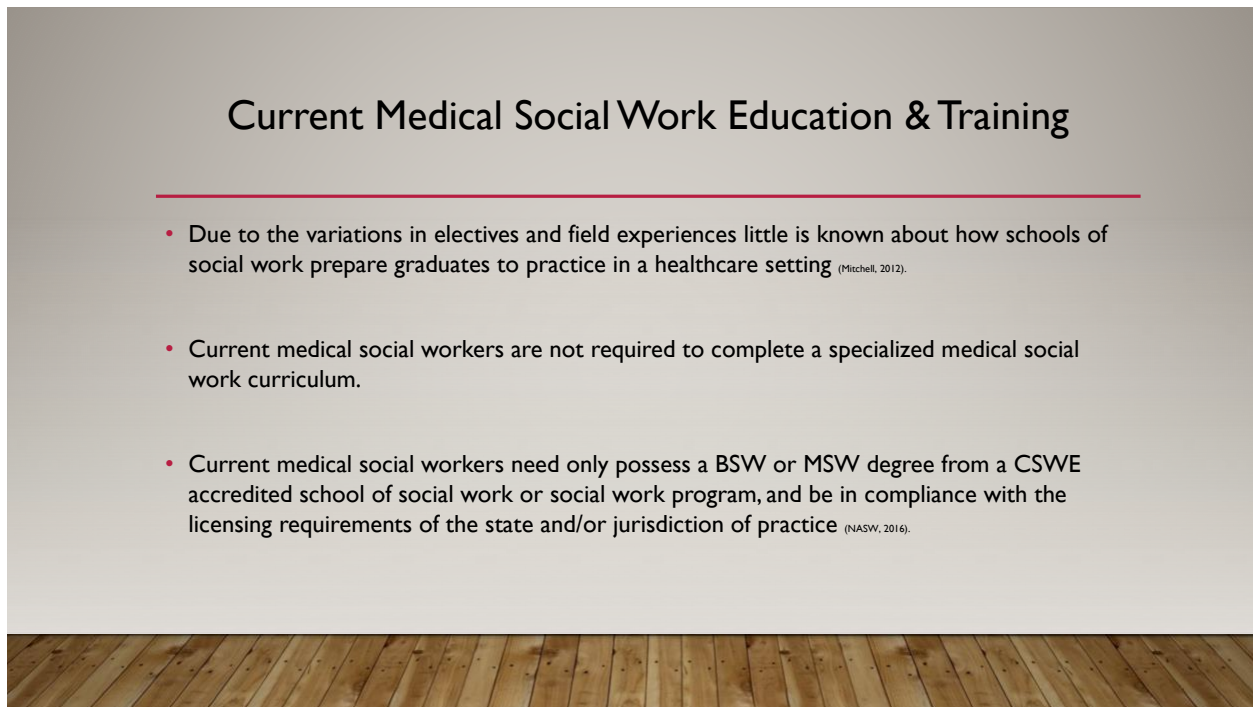


Figure 14. Presentation slide 14

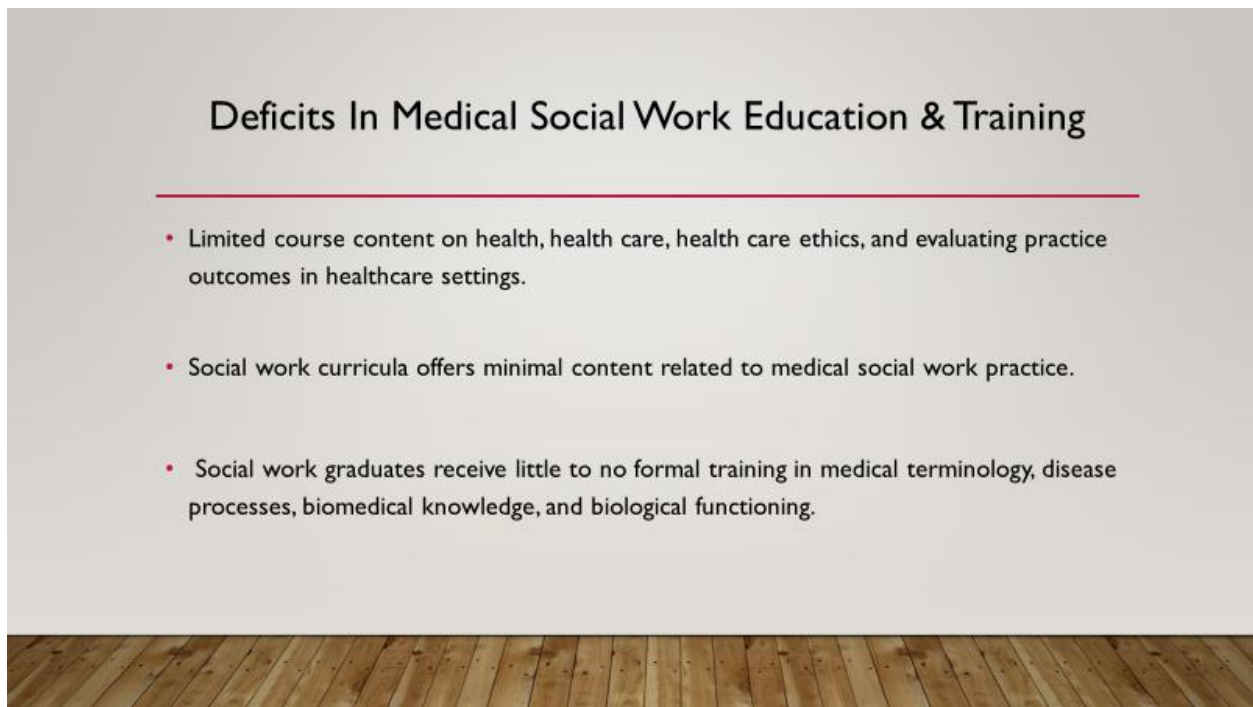


Figure 15. Presentation slide 15



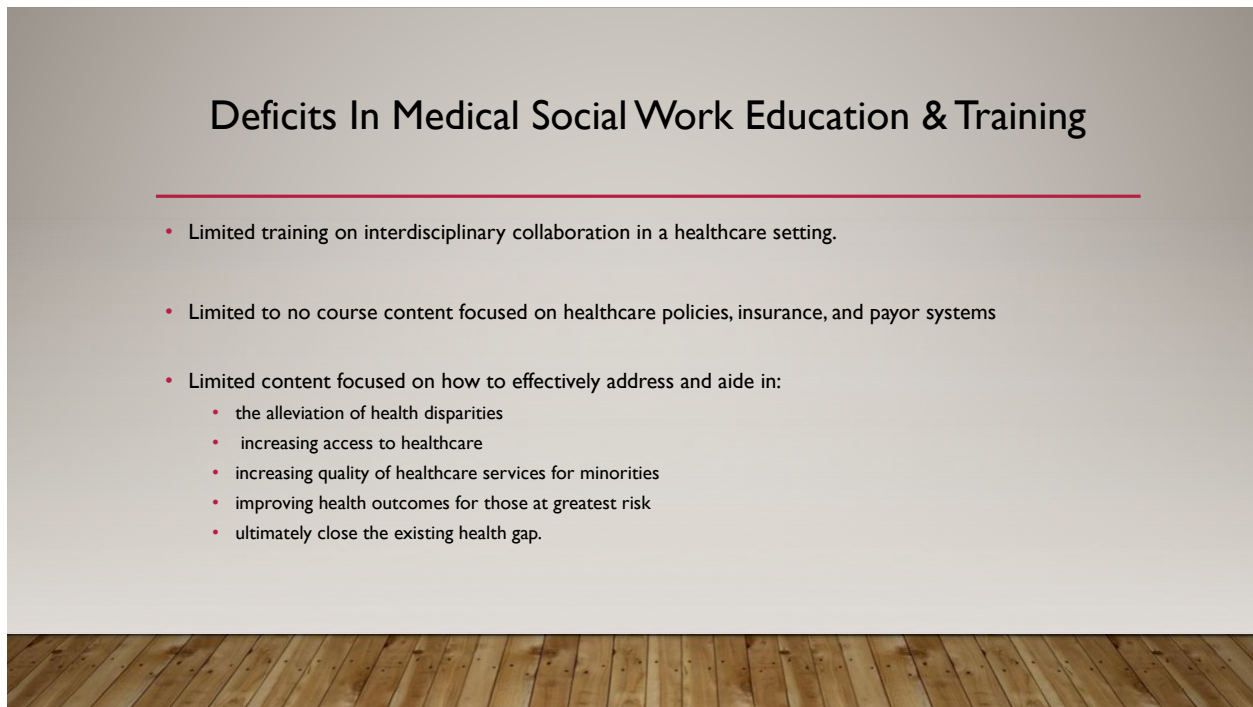


Figure 16. Presentation slide 16

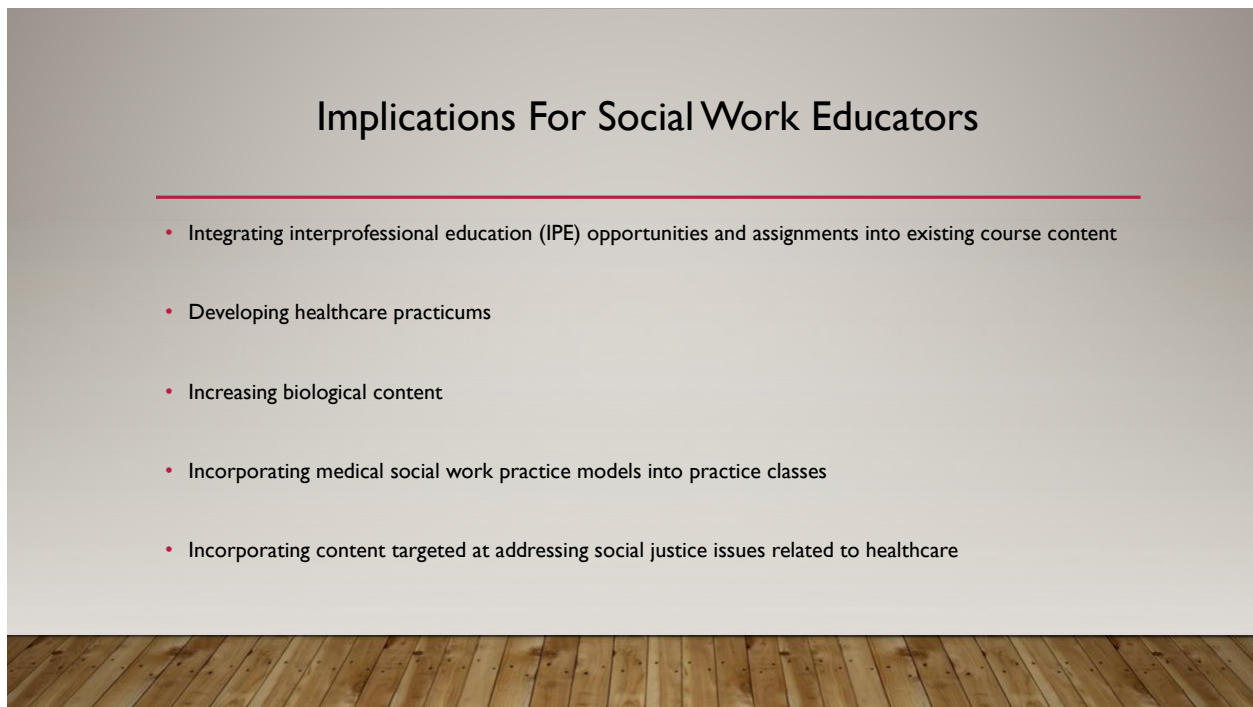
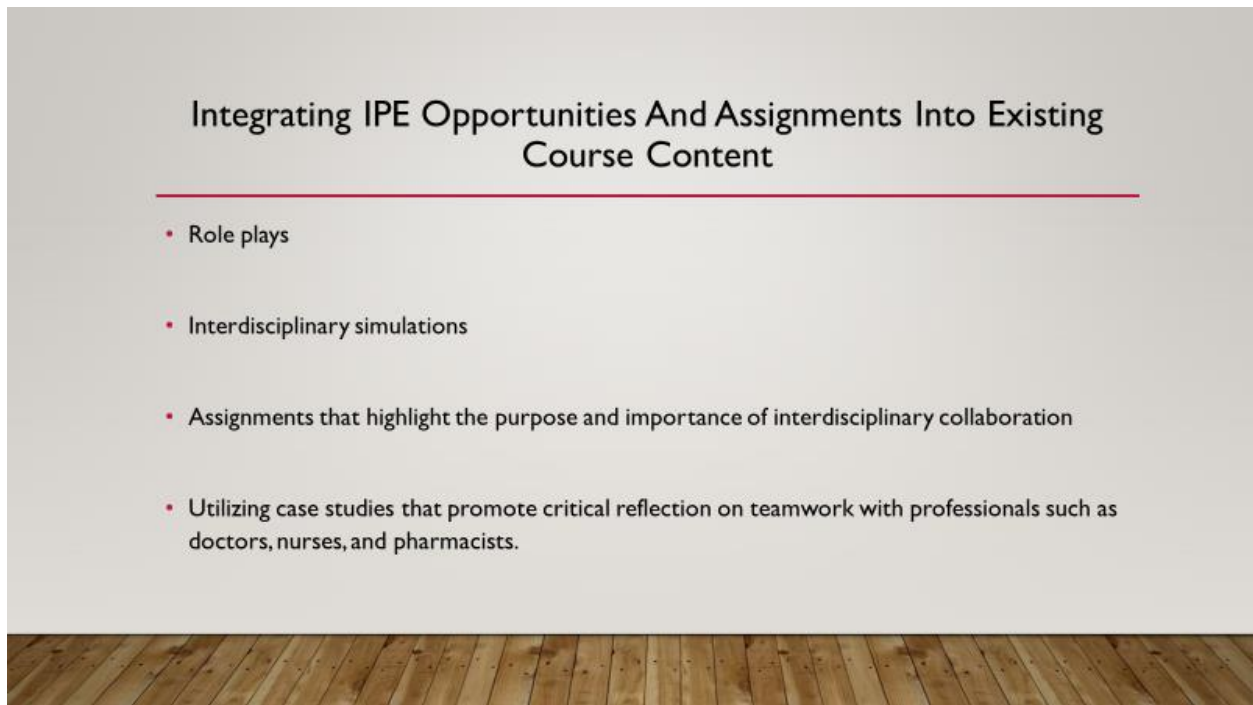
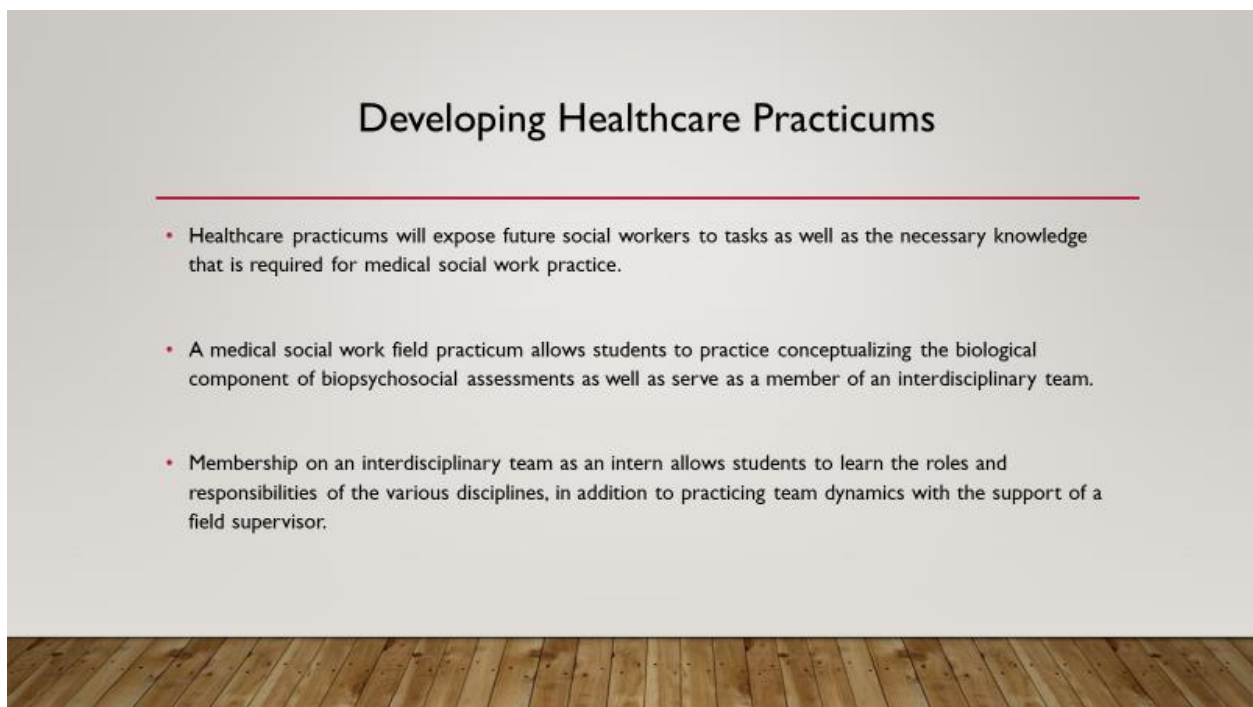


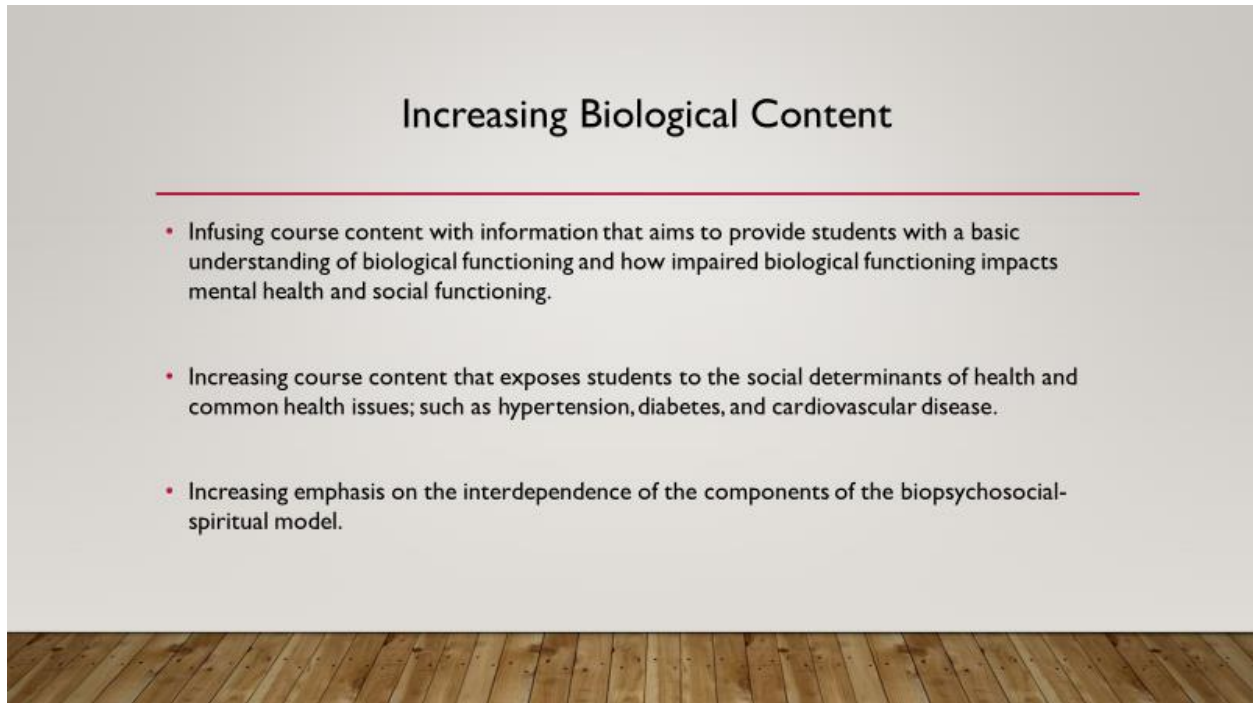
Figure 17. Presentation slide 17



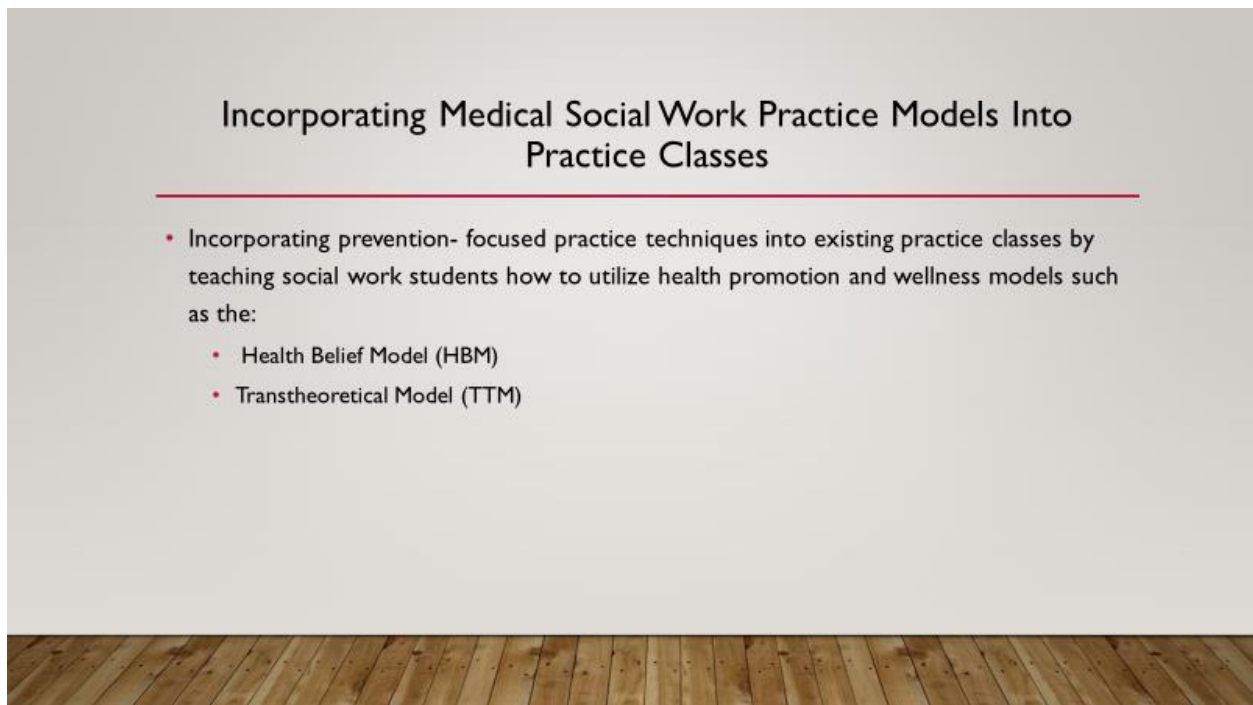
*Figure 18.* Presentation slide 18



*Figure 19.* Presentation slide 19



*Figure 20.* Presentation slide 20



*Figure 21.* Presentation slide 21



Figure 22. Presentation slide 22

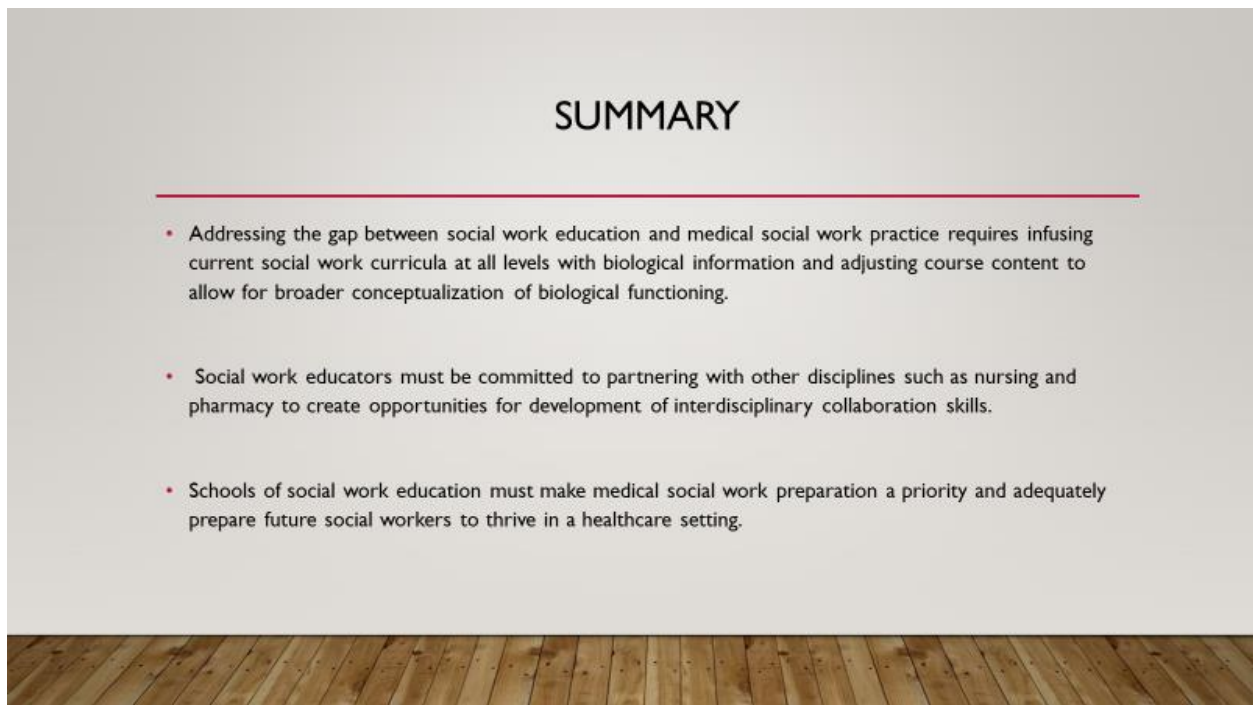


Figure 23. Presentation slide 23



Figure 24. Presentation slide 24

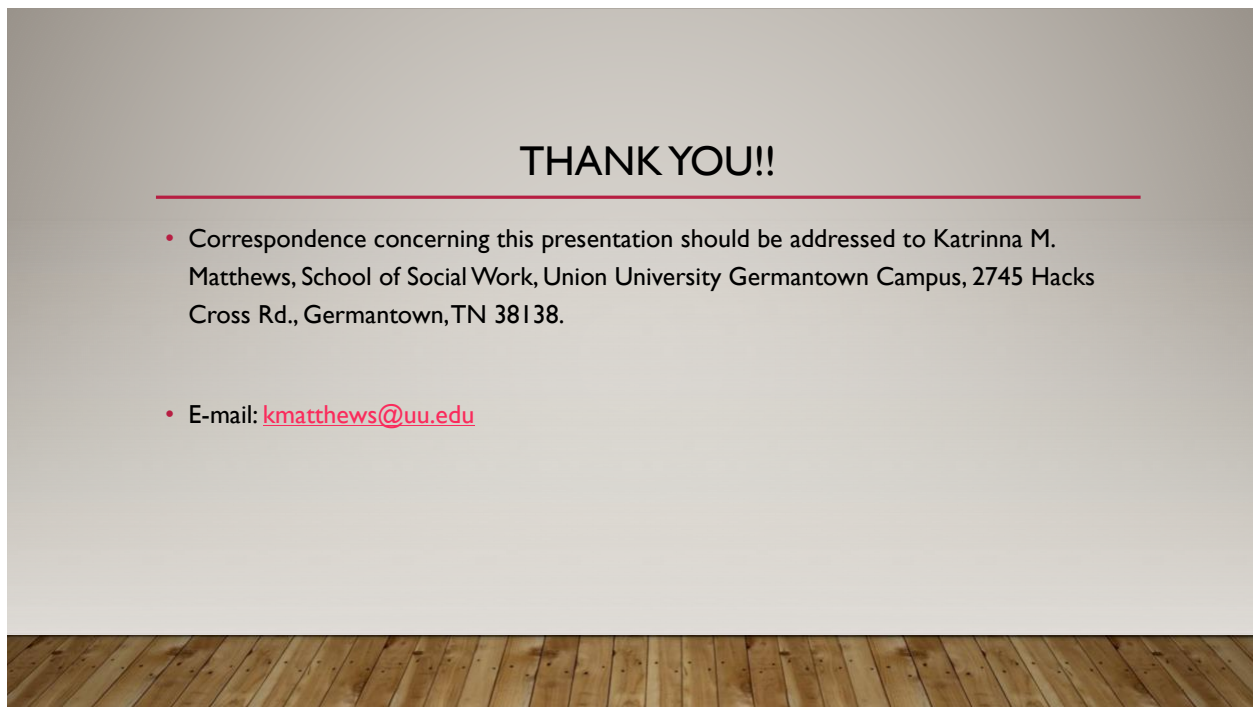


Figure 25. Presentation slide 25

## References

- Bureau of Labor Statistics, U.S. Department of Labor. (2018). *Occupational Outlook Handbook, Social Workers*. Retrieved from <https://www.bls.gov/tooh/community-and-social-service/social-workers.htm>
- Allen, H., Wright, B. J., Harding, K., & Broffman, L. (2014). The role of stigma in access to health care for the poor. *The Milbank Quarterly*, 92(2), 289-318. doi: 10.1111/1468-0009.12059
- Allen, K.M. & Spitzer, W. J. (2016). *Social work practice in healthcare: Advance approaches and emerging trends*. Thousand Oaks, California: Sage Publishing.
- Andrews, C. (2014). Unintended consequences: Medicaid expansion and racial inequality in access to health insurance. *Health & Social Work*, 39(3), 131-133. doi:10.1093/hsw/hlu024.
- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work*, 41(5), 541-551. Retrieved from <https://search.proquest.com/docview/215274993>
- Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, 48(3), 297-306.
- Browne, T., Keefe, R. H., Ruth, B. J., Cox, H., Maramaldi, P., Rishel, C., & ... Marshall, J. (2017). Advancing social work education for health impact. *American Journal of Public Health*, 107S229-S235. doi:10.2105/AJPH.2017.304054
- Chaddock, R. (2016). Integrating early multi-disciplinary advance care planning into core social work practice: Social workers' bread and butter. *Journal of Social Work Practice*, 30(2), 129-138. doi:10.1080/02650533.2016.1168382
- Cooner, T. S. (2011). Learning to create enquiry-based blended learning designs: Resources to develop interdisciplinary education. *Social Work Education*, 30(3), 312-330. doi:10.1080/02615479.2010.482983

Figure 26. Presentation slide 26

## References

- Education for Medical Social Work: The Curriculum Content. (1951). *American Association of Medical Social Workers Education Committee, Curriculum Content Subcommittee*. Retrieved from University of Minnesota Social Welfare History Archives. (NASW: AAMSW Box 31, Folder 381).
- Engel, G. L. (2012). The need for a new medical model: A challenge for biomedicine. *Psychodynamic Psychiatry*, 40(3), 377-396. doi:10.1521/pdps.2012.40.3.377
- Grant, D. M., & Toh, J. S. (2017). Medical social work positions: BSW or MSW?. *Social Work in Health Care*, 56(4), 215-226. doi:10.1080/00981389.2016.1265633
- Gregorian, C. (2005). A career in hospital social work: Do you have what it takes? *Social Work in Health Care*, 40(3), 1-14. doi:10.1300/J010v40n03\_01
- Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education*, 52(1), 18-29. doi:10.1080/10437797.2016.1112629
- Kovacs, P. J., & Bronstein, L. R. (1999). Preparation for oncology settings: What hospice social workers say they need. *Health & Social Work*, 24(1), 57-64.
- Mitchell, F. M. (2015). Racial and ethnic health disparities in an era of health care reform. *Health & Social Work*, 40(3), e66-e74. doi:10.1093/hsw/hlv038
- Mitchell, J. A. (2012). Integrating education on addressing health disparities into the graduate social work curriculum. *Journal of Teaching in Social Work*, 32(5), 471-486. doi:10.1080/08841233.2012.725458
- National Association of Social Work. (2005). *NASW standards for social work practice in healthcare settings*. Retrieved from <https://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf>
- Redmond, H. (2001). The health care crisis in the United States: A call to action. *Health and Social Work*, 26(1), 54-57. doi: 10.1093/hsw/26.1.54

Figure 27. Presentation slide 27

## References

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- Reinhold, M.I., Otiemo, S., & Bacon-Baguley, T. (2017). Integrating interprofessional experience throughout a first-year physician assistant curriculum improves perceptions of health care providers. *Journal of Interprofessional Education & Practice*, 6, 37-43.  
[doi: 10.1016/j.xjep.2016.12.001](https://doi.org/10.1016/j.xjep.2016.12.001)
- Salsberg, E., Quigley, L., Mehfood, N., Acquaviva, K., Wyche, K., & Sliwa, S. (2017). *Profile of the social work workforce*. Retrieved from <https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx>.
- Silverman, E. (2008). From ideological to competency-based: The rebranding and maintaining of medical social work's identity. *Social Work*, 53(1), 89-91.  
[doi:10.1093/sw/53.1.89](https://doi.org/10.1093/sw/53.1.89)
- Sims, D. (2011). Achieving collaborative competence through interprofessional education: Lessons learned from joint training in learning disability nursing and social work. *Social Work Education*, 30(1), 98-112. [doi:10.1080/02615471003748056](https://doi.org/10.1080/02615471003748056)
- Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social Work in Health Care*, 54(5), 383-407. [doi:10.1080/00981389.2015.1025122](https://doi.org/10.1080/00981389.2015.1025122)
- Sweet, B. V., Madeo, A., Fitzgerald, M., House, J. B., Pardee, M., Zebrack, B., ... Mueller, B. A. (2017). Moving from individual roles to functional teams: A semester-long course in case-based decision making. *Journal of Interprofessional Education & Practice*, 7, 11-16. [doi:10.1016/j.xjep.2017.01.003](https://doi.org/10.1016/j.xjep.2017.01.003)
- Zayas, L. H., & Dyche, L. A. (1992). Social workers training primary care physicians: Essential psychosocial principles. *Social Work*, 37(3), 247-252.  
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Figure 28. Presentation slide 28

## References

- Bureau of Labor Statistics, U.S. Department of Labor. (2018). *Occupational Outlook Handbook, Social Workers*. Retrieved from <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm>
- Allen, H., Wright, B. J., Harding, K., & Broffman, L. (2014). The role of stigma in access to health care for the poor. *The Milbank Quarterly*, 92(2), 289-318.  
doi: 10.1111/1468-0009.12059
- Allen, K. M. & Spitzer, W. J. (2016). *Social work practice in healthcare: Advance approaches and emerging trends*. Thousand Oaks, CA: Sage.
- Andrews, C. (2014). Unintended consequences: Medicaid expansion and racial inequality in access to health insurance. *Health & Social Work*, 39(3), 131-133.  
doi:10.1093/hsw/hlu024.
- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work*, 41(5), 541-551. doi:10.1093/sw/41.5.541
- Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, 48(3), 297-306. doi:10.1093/sw/48.3.297
- Browne, T., Keefe, R. H., Ruth, B. J., Cox, H., Maramaldi, P., Rishel, C., & ... Marshall, J. (2017). Advancing social work education for health impact. *American Journal of Public Health*, S3, S229-S235. doi:10.2105/AJPH.2017.304054
- Chaddock, R. (2016). Integrating early multi-disciplinary advance care planning into core social work practice: Social workers' bread and butter. *Journal of Social Work Practice*, 30(2), 129-138. doi:10.1080/02650533.2016.1168382



- Cooner, T. S. (2011). Learning to create enquiry-based blended learning designs: Resources to develop interdisciplinary education. *Social Work Education, 30*(3), 312-330.  
doi:10.1080/02615479.2010.482983
- Education for Medical Social Work: The Curriculum Content. (1951). *American Association of Medical Social Workers Education Committee, Curriculum Content Subcommittee*. Retrieved from University of Minnesota Social Welfare History Archives. (NASW: AAMSW Box 31, Folder 381).
- Engel, G. L. (2012). The need for a new medical model: A challenge for biomedicine. *Psychodynamic Psychiatry, 40*(3), 377-396. doi:10.1521/pdps.2012.40.3.377
- Grant, D. M., & Toh, J. S. (2017). Medical social work positions: BSW or MSW?. *Social Work in Health Care, 56*(4), 215-226. doi:10.1080/00981389.2016.1265633
- Gregorian, C. (2005). A career in hospital social work: Do you have what it takes? *Social Work in Health Care, 40*(3), 1-14. doi:10.1300/J010v40n03 01
- Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education, 52*(1), 18-29. doi:10.1080/10437797.2016.1112629
- Kovacs, P. J., & Bronstein, L. R. (1999). Preparation for oncology settings: What hospice social workers say they need. *Health & Social Work, 24*(1), 57-64. doi:10.1093/hsw/24.1.57
- Mitchell, F. M. (2015). Racial and ethnic health disparities in an era of health care reform. *Health & Social Work, 40*(3), e66-e74. doi:10.1093/hsw/hlv038
- Mitchell, J. A. (2012). Integrating education on addressing health disparities into the graduate social work curriculum. *Journal of Teaching in Social Work, 32*(5), 471-486. doi:10.1080/08841233.2012.725458

- National Association of Social Work. (2016). *NASW standards for social work practice in healthcare settings*. Retrieved from <https://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf>
- Owen, C. L. (2009). Consumer-Driven Health Care: Answer to Global Competition or Threat to Social Justice? *Social Work*, 54 (4), 307-315. doi:10.1093/sw/54.4.307
- Redmond, H. (2001). The health care crisis in the United States: A call to action. *Health and Social Work*, 26(1), 54-57. doi: 10.1093/hsw/26.1.54
- Reinhold, M.I., Otieno, S., & Bacon-Baguley, T. (2017). Integrating interprofessional experience throughout a first-year physician assistant curriculum improves perceptions of health care providers. *Journal of Interprofessional Education & Practice*, 6, 37-43.  
doi: 10.1016/j.xjep.2016.12.001
- Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K., Wyche, K., & Sliwa, S. (2017). *Profile of the social work workforce*. Retrieved from <https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx>.
- Silverman, E. (2008). From ideological to competency-based: The rebranding and maintaining of medical social work's identity. *Social Work*, 53(1), 89-91. doi:10.1093/sw/53.1.89
- Sims, D. (2011). Achieving collaborative competence through interprofessional education: Lessons learned from joint training in learning disability nursing and social work. *Social Work Education*, 30(1), 98-112. doi:10.1080/02615471003748056
- Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social Work in Health Care*, 54(5), 383-407.  
doi:10.1080/00981389.2015.1025122

Sweet, B. V., Madeo, A., Fitzgerald, M., House, J. B., Pardee, M., Zebrack, B., ... Mueller, B. A.

(2017). Moving from individual roles to functional teams: A semester-long course in case-based decision making. *Journal of Interprofessional Education & Practice*, 7, 11-16. doi:10.1016/j.xjep.2017.01.003

Zayas, L. H., & Dyche, L. A. (1992). Social workers training primary care physicians: Essential psychosocial principles. *Social Work*, 37(3), 247-252. doi:10.1093/sw/37.3.247