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Introduction

Role ambiguity for social workers working in a secondary setting has long been identified, particularly in hospitals. However, studies of this kind had not been undertaken previously in Hong Kong. One possible reason is that there are few medical social workers so engaged. This is partly accurate, but medical social work is expanding in the health care field; the majority of hospitals in Hong Kong have a department of medical social work to cater for non-medical needs and problems of patients and their family.

The strange thing about medical social work is that it is an extension of medicine to the practice of social work as well as an extension of social work to the practice of medicine. In other words, medical social workers may face a dilemma of allegiance: whether to be loyal to the hospital where they serve their clients or to the social work profession that is the source of their ethical beliefs and professional expertise. Thus stands an issue of role ambiguity and, perhaps, role conflicts with other health care professionals in the setting of the hospital.

In this study, we aim to identify the specific and distinct role of the medical social worker in Hong Kong hospitals. Two more factors are added to discern whether role ambiguity is affected by the line of authority and the interaction patterns. A self-administered questionnaire was followed by interviews with selected respondents, medical social workers, doctors and nurses. These were conducted to gather subjective perceptions about the role of

medical social workers and the interaction modes amongst the three groups of health care professionals under study.

Role Ambiguity of Medical Social Workers in Hospitals

Medical social workers in the hospital setting have a consistently uncomfortable sense that their roles are misunderstood and misinterpreted by other health care professionals. One study reports that the perceived lack of understanding about the role of medical social workers is their most serious problem (Schlesinger and Wolock, 1982). Discussions of the perceived role conflict of medical social workers have appeared in the social work literature since at least the mid-1950s (Cowles and Lefcowitz, 1992, 1995; Roberts, 1989; Schilling and Schilling, 1987; Mizraki and Abramson, 1985; Bergman, Contro and Zivetz, 1984; Black, Morrison, Snyder and Tally, 1977; Mailick and Jordan, 1977; Nacman, 1975; Olsen and Olsen, 1967). At the same time, several studies have been conducted to discern what differences exist between the views of medical social workers and medical professionals concerning the role of the former (Cowles and Lefcowitz, 1992, 1995; Egan and Kadushin, 1995; Lister, 1980; Carrigan, 1978; Philips, McCulloch, Brown and Hambro, 1971; Olsen and Olsen, 1967).

According to these studies and other discussions of the issue, medical social workers expect their role to have more to do with counseling (Carrigan, 1978; Mizraki and Abramson, 1985), psychotherapy (Olsen and Olsen, 1967), psycho-social problems (Philips et al., 1971) or emotional and behavioural problems (Nacman, 1975) than what medical professionals expect of their role. Concomitantly, medical professionals expect medical social workers to be environmental manipulators (Philips et al., 1971), who perform instrumental tasks, such as providing assistance for transportation and locating a nursing home (Nacman, 1975); they are to be active in the area of concrete service provision (Carrigan, 1978; Mizraki and Abramson, 1985); and they are to perform such

activities as arranging for post-hospital care and making referrals to community resources (Olsen and Olsen, 1967).

In other words, it seems that the role of medical social workers in hospitals is ambiguously defined. Non-social work professionals would expect and perceive medical social workers to be providing concrete services, whilst medical social workers are likely to define their role as serving psycho-social care functions. There exist great conflicting expectations regarding the appropriate role of medical social workers between medical social workers and non-social work health care professionals. This variance in role perception and expectation has great implications for the professional development of medical social work in hospitals. For instance, medical professionals' lack of a clear understanding of the services that medical social workers can provide; this may preclude their requests for patient services from medical social workers or limit patient expectations of medical social work services.

Admittedly, medical social workers in the secondary setting of hospitals have limited control over their job — many of their services are referred to by other health care professionals, particularly by doctors. In this regard, there are two major reasons underlying the need to clarify the ambiguity around the role of medical social workers in hospitals. First, in the hospital, medical social workers primarily respond to expectations defined by or in tandem with non-social work health care professionals. The doctor is usually the first and certainly the most important person to decide what is the problem of the patient, how it should be treated, and what other health care professionals need to become involved (Enos and Sultan, 1977). In this regard, doctors play a critical role in securing and defining services for patients and patients' families; this role may be characterized as that of a "gate-keeper" (Pray, 1991:184). Given this gate-keeping role, the knowledge doctors have of medical social work is critical for the service provision by medical social workers in hospitals. In this way, the professional autonomy of medical social work is somewhat distorted by the referral system in hospitals where the gate-keeper is, in general, the doctor. In other words, the clarity of medical social work

roles and the interaction pattern between medical social workers and other health care professionals become essential issues for the effective performance of medical social workers.

Secondly, under the impact of the knowledge explosion, health care professionals of different expertise in the hospital setting increasingly share a common knowledge base. Coupled with the trend, hospitals are seen less as an arena for professional practice and more as an instrument of cost effective health care delivery. This has led to a weakening of the traditional claims for professional domain and an increased competition amongst various professions for limited resources. Nurses, psychologists, psychiatrists read the same books, undergo similar training (to a certain extent) and share many of the same skills as medical social workers. These disciplines aggressively look for opportunities to market their skills and claim access to hospital resources. In the eyes of these competitors, the "psycho-social" is by no means the exclusive domain of medical social work. In such a competitive climate, more medical social workers in hospitals are finding themselves practising in an arena where the traditional support for their professional role definition is weaker and where other members of the interdisciplinary team are more aggressive in their claim for aspects of health care traditionally allotted to medical social work (Donnelly, 1992). For instance, the study by Egan and Kadushin (1995) of the role of medical social workers in hospitals concluded that medical social workers were perceived by nurses as only having an exclusive role in assessing and arranging the concrete, after-care community services. The nurses, in their study, expanded their professional domain into areas traditionally considered within the sphere of medical social work, such as the overall role of discharge planning, psycho-social assessment and intervention. The potential for role overlapping between the two professions is obvious, particularly in the area of assessing social and emotional problems of patients and their family members.

Thirdly, effective interaction and frequency of professional contact are important factors affecting the role relations of different professions within an organization. Interaction means "the opportunities and requirements presented for formal and informal social and professional contact during working hours and non-working hours" (Stamps and Piedmonte, 1986:18). Effective and frequent interactions between different professionals can increase mutual understanding about their practice, roles and responsibilities and facilitate the appreciation of each other's contributions. Interaction is critical to any organization because it is the process of information exchange, by which members of the organisation are motivated for action, and this is crucial for any decision-making. However, effective interaction is far more difficult to achieve than it is sometime realized in the hospital setting (Butrym, 1967). It is because the structure in hospital is characterized by a rigid status hierarchy that almost insures against conflict between lower and higher level professionals (Stamps and Piedmonte, 1986). Hence, in order to promote the domain of medical social work amongst health care professionals and to reduce the latter's misconception and misunderstanding, it is absolutely essential and necessary to explore the current interaction patterns and contact networks between medical social workers and other health care professionals, doctors and nurses in particular.

The Roles of Medical Social Workers in Hong Kong

Apparently clear, the definition of roles of medical social workers in hospitals is extremely essential and needs urgent clarification for their professional identity and professional performance. However, there is no empirical study of this kind in Hong Kong. This research is the first empirical attempt to clarify the roles of medical social workers and the interaction patterns of medical social workers with other health care professionals in the hospital setting. We select medical doctors and nurses as the other two groups of health care professionals for our study. We know from our brief discussion in the above section that medical social work-

ers expect their role to have more to do with counseling than tangible services. However, their non-social work colleagues in hospitals often think otherwise. The essential areas of conflicting view are about psycho-social task performance. Again, we know that the boundaries between medical social workers and nurses in hospitals nowadays are not fixed yet. More nurses expect to expand their career concern into areas traditionally defined as social work tasks, such as assessing and arranging for concrete services, after-care community services and even psycho-social assessment and intervention. In other words, we need to include these in our study of the role of medical social workers. On the basis of the above discussion, psycho-social assessment, psycho-social intervention, tangible assistance and mobilisation of new community resources seem to be the four key areas which are related to the respective roles of assessor, counselor, provider and organiser fundamental to medical social workers' role performance in the hospital setting.

In addition to these, we want to know more about whether role performance is affected by the interaction between medical social workers and other health care professionals in the hospital setting. As we have mentioned, doctors are the gate-keepers in hospitals, apart from their often unchallenged commanding role in the hierarchical authority structure. Henceforth, we postulate a few interaction modes for each category of medical social work role activities. Then, we further ask whether role expectation amongst health care professionals about medical social workers is affected by the mode of interaction and whether it can be identified.

In brief, this study aims to explore which roles are distinct and granted specialist status to medical social workers in the hospital setting. It is hoped that the findings of this study will increase the understanding of the role expectations of medical social workers in hospitals and facilitate the resolution of any confusion and differences about the role and function of medical social workers in the hospital setting. Moreover, the findings can be used to generalise the recommendation of strategies to improve participation in the interdisciplinary team work and improve the quality of medical social services as a whole, not only the services rendered by medical social workers.

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

When the Hospital Authority, which is a statutory body, was established on 1 December 1990 under the Hospital Authority Ordinance, it took over the management of all government hospitals and government-subvented hospitals. The Hospital Authority is independent of, but accountable to, the Hong Kong Government (or the Special Administration Region after 1 July 1997) through the Secretary for Health and Welfare who is responsible for the formulation of health policies and for monitoring the Authority's performance.

Under the management of the Hospital Authority, public hospitals are divided into two schedules. Schedule I hospitals represent all ex-government hospitals and Schedule II hospitals represent all ex-subvented ones. At present, medical social work in Schedule I hospitals is provided by the Social Welfare Department whereas medical social work in Schedule II hospitals is provided by the Hospital Authority. In other words, there are two systems of medical social work services in Hong Kong hospitals. Henceforth, the difference in terms of line of authority may be a factor needing attention in our study of the role of medical social workers. Apparently, this is about authority structure, a factor external to the social work profession itself.

The Research Method

This study aims to identify the specific and distinct role of medical social workers in the secondary setting of hospitals. By this, it discerns the different expectations of medical social workers, doctors and nurses about the role of the former. Line of authority by schedule of hospitals and role relations by the interaction modes amongst medical social workers, doctors and nurses are used to explore whether these two new variables affect role expectations of medical social workers. It is worth noting that line of authority is included in this study of role ambiguity of medical social workers. It is because role ambiguity may not only be a matter of misperception or misunderstanding. Hospitals are often structured by a rigid hierarchy that insures against conflicts between different levels of professionals (Stamps and Piedmonte, 1986). The study is conducted in two stages.

Stage 1: Quantitative Study Method by a Questionnaire Survey

The quantitative approach is chosen to generate information on the general view of the study samples. Accordingly, a cross-sectional survey on the expected and actual roles of medical social workers and the pattern of interaction between doctors, nurses and medical social workers are constructed. The study sample includes doctors, nurses and medical social workers of Group 1 hospitals.[1] These are the general acute-service hospitals with 24-hour accident and emergency services, usually with larger sizes of staff and services. In addition, it is the group with the largest number of hospitals, a total of 11 at the time the study was undertaken. Moreover, it is assumed that the larger the size of hospitals, the less understanding there might be amongst different groups of professionals. Hence, there likely is a greater discrepancy in role expectations. It would be ideal to obtain a more comprehensive picture on the role of medical social workers and other health care professionals if opinion from other non-social work health care

professionals, other than doctors and nurses, could be drawn. However, taking into account that there are many kinds of non-social work health care professionals, it is difficult to decide which one is to be asked. Besides, since the major users of medical social workers' service are nurses and doctors, other non-social work health care professionals were deliberately not included in the study. At the end, the study sample includes 270 doctors and 270 nurses selected by the systematic random sampling method from the human resources database from the Hospital Authority. Whilst the population of medical social workers is much smaller, all of the 184 medical social workers (i.e., the whole population) were included. It is assumed that the responding rate of doctors and nurses should be smaller than that of medical social workers in a study primarily not about their own. In other words, uneven quotas are allocated to these three professional groups. It is expected the size of the returned sample allows us to conduct an effective statistical cross-tabulation. Admittedly, limited resources and manpower also restrict us from having a larger sample size.

A self-administered close-ended questionnaire with instrument packet was designed in early 1997, based on four key working areas of medical social work and team activities commonly taking place among different groups of health care professionals in hospitals. As mentioned in the above sections, doctors, nurses and medical social workers have different role expectations of medical social workers. We want to see the commonalities and variations amongst them in terms of psycho-social assessment, psycho-social intervention, tangible assistance and mobilisation of new community resources. These are four major categories of task performance activities, each with two to four questions, indicating the respective roles of assessor (diagnostician), counselor, provider (resource developer) and (community) organiser by medical social workers. Table 1 illustrates the respective statements of activities performed by medical social workers for each of their roles in the questionnaire. It is assumed that each of the statements within a category represents the respective role of medical social workers. A scale is constructed to identify the

Table 1 Roles and Activities Performed by Medical Social Workers

Roles	Activities for the respective role
Assessor/ Diagnostician	Psycho-social assessment activities:
	1. Assessing patients' need for tangible social service.
	2. Assessing the psychological status of patients.
	3. Assessing the psycho-social functioning and role of patient in the community in relation to their illness.
Provider/ Resource developer	Tangible assistance activities:
	4. Assisting patients to make financial arrangement for medical and other needs.
	5. Assisting patients to make accommodation arrangement.
	6. Making referrals to community services for patients.
Counselor	Psycho-social intervention activities:
	7. Helping patients with emotional problems through individual counseling.
	8. Helping patients with emotional problems through therapeutic groups.
	9. Helping families of patients through individual counseling.
	10. Helping families of patients through therapeutic groups.
Organiser	Mobilisation of new community resource activities:
	11. Liaising with the community for new social services.
	12. Organising self-help or support groups.

respondents' view about the extent of importance attached to each activity.[2]

Then, four modes of interaction are formulated to identify the patterns amongst medical social workers, doctors and nurses. According to our researchers who are medical social workers, "written correspondence only," "one-to-one discussion" via ward rounds, direct contact or telephone contact, "group discussion" through team meeting or case conference and "transfer of skills" with or from the team members are four common modes of inter-

action in the hospital setting. These four modes reflect different interaction patterns. "Written correspondence" indicates the absence of close and interactive communication amongst doctors, nurses and medical social workers. These health care professionals are supposed to deal with each other in quite a formal manner. "One-to-one discussion" mode implies a closer encounter amongst health care professionals through a two-way communication. "Group discussion" suggests a more formalised interactive pattern, in which all health care professionals are supposedly actively involved in the interaction mode. Lastly, "transfer of skills" mode suggests a hierarchical relation amongst health care professionals with one acting as the instructor whilst the other as learner. As a result, the particular professional would be equipped with skills from another discipline. Respondents were asked to indicate the commonest mode of interaction for each of the four categories of task performance activities.

Stage 2: Qualitative Study Method by Interview

In stage 2, interviews were carried out immediately after the survey questionnaires were collected to obtain respondents' opinion with regard to medical social workers' roles and their interaction with doctors and nurses. The samples were one doctor, one nurse and one medical social worker from each of the 11 hospitals chosen at stage 1. In total, there were 33 respondents. They were recommended by the medical social work department of the hospitals concerned. Each hospital nominated three respondents from its own hospital. The criterion for nomination of doctors and nurses was that these health care professionals should have experience of cooperating with medical social workers. With regard to the criterion for selecting medical social workers, three or more years of working experience in hospitals was used. Concerning the interview questions, semi-structured questions were asked. As to the structured survey questionnaire, a total of 724 copies were distributed (doctors: 270, nurses: 270, medical social workers: 184) with a response rate of 57.3% (415 responses). At the end, the

number of valid questionnaires analyzed were 400 (doctors: 106, nurses: 177, medical social workers: 117). The Wilcoxon rank sum test was used to test the mean expectation and mode of interaction between the groups. The goodness of fit test was used to compare the medical social worker's expected and actual roles within the groups. The findings of the interviews were incorporated into the findings of the survey to try to explain the phenomenon identified.

The Findings

The Expected Roles of Medical Social Workers

We first analyze the expected roles of medical social workers from the perception of three groups of professionals (Table 2). This helps us to know the extent of role ambiguity between these three groups of hospital professionals.

About one-quarter (25.8%) of doctors and one-fifth (21.0%) of nurses considered that medical social workers had sole responsibility for psycho-social assessment. Whereas two-fifths (39.0%) of medical social workers thought that this task should be solely taken up by themselves. A significant difference in the perception of role is found in this aspect of professional practice. It appears that doctors and nurses consider that this task could be shared by other health care professionals, while medical social workers view this as of such importance that it can only be taken up by themselves.

Amongst the four categories of activities, tangible assistance was the category of activity that had the highest acceptance by all of the three groups of professionals. Three-fifths (61.3%) of doctors, one-half (51.7%) of nurses and nearly seven out of ten (65.6%) medical social workers opined that this task should be of most importance and that it could only be taken up by medical social workers. In interviews at the second stage of the study, doctors

Table 2 The Expected Roles of Medical Social Workers (MSW)

		Score (%)					Mean score	Conclusion
		1	2	3	4	Score		
Psycho-social assessment	Doctor	25.8	52.5	18.9	2.8	1.99	2	Reject Ho
	Nurse	21.0	50.5	23.4	5.1	2.13	2	Reject Ho
	MSW	39.0	47.6	9.1	4.3	1.79	2	—
Tangible assistance	Doctor	61.3	25.2	7.2	6.3	1.59	1	Accept Ho
	Nurse	51.7	33.1	9.8	5.3	1.69	1	Reject Ho
	MSW	65.6	19.5	9.7	5.2	1.55	1	—
Psycho-social intervention	Doctor	10.6	53.5	31.6	4.2	2.29	2	Reject Ho
	Nurse	8.0	53.2	31.0	7.8	2.39	2	Reject Ho
	MSW	38.9	47.5	8.2	5.4	1.80	2	—
Mobilisation of new community resources	Doctor	24.1	50.9	19.3	5.7	2.07	2	Accept Ho
	Nurse	22.3	48.0	23.4	6.3	2.14	2	Reject Ho
	MSW	34.9	41.8	17.7	5.6	1.94	2	—

Notes: Percentages may not add up to 100 because of rounding.
Ho = Null hypothesis.
Score:
1 = of most importance and can only be taken up by MSW.
2 = of importance and can be shared by other health care providers.
3 = of slight importance and can largely be achieved by other health care providers.
4 = of least importance and can solely be taken up by other health care providers.

and nurse gave quite definite answers about the sole responsibility of medical social workers for this category of activities.

It is worth noting that nurses still had lower percentage points than doctors and medical social workers in regard to the tangible assistance category of activities. In the interviews, some nurses expressed that they wanted to help patients with tangible services as well. They thought that, if they had information about tangible services, they could deliver them to patients immediately, in particular when patients were ready for discharge. They asked for information on concrete services, such as elderly nursing homes. Nurses felt that it would be more efficient if they could handle the enquiry on the spot. In such a case, it would save patients', theirs as well as medical social workers' time, if no referral was needed.

The largest discrepancy existing between medical social workers and the other two groups of professionals was about the role of medical social workers in performing psycho-social intervention. Only one-tenth (10.6%) of doctors and 8% of nurses gave the response that medical social workers should be the sole service provider for psycho-social intervention. In contrast, near two-fifths (38.9%) of medical social workers thought that this should be their reserved domain. Admittedly, these three groups of professionals had the largest variation of opinion about who should be the sole provider of psycho-social intervention activities. This is also very distinct from their different choices on the score of "of slight importance" attached to this category of activities. Three out of ten doctors (31.6%) and nurses (31.0%) respectively thought that this task could be shared by other health care professionals, whilst less than one-tenth (8.2%) of medical social workers agreed on this score.

The last category of activities is about the mobilisation of new community resources. Similar to psycho-social assessment and psycho-social intervention, medical social workers had different opinions about it from those of doctors and nurses. Only one-quarter (24.1%) of doctors and more than one-fifth (22.3%) of nurses responded that medical social workers should be the sole providers of this category of activities. Again, more medical social

workers (34.9%) rated themselves as having the most important role in delivering this category of services.

In general, tangible assistance was the category of activities that attracted the higher endorsement rates by the responding three groups of health care professionals. Despite this, it is worth noting that nurses still scored lower when comparing doctors and nurses. This suggests an underlying tension between nurses and medical social workers, even in the supposedly least contested domain of medical social work practice. This confirms the findings elsewhere (Egan and Kadushin, 1995) that nurses had a tendency to expand into areas traditionally considered within the sphere of medical social work. In other words, given other factors being constant, tensions between doctors and medical social workers are less likely than those between the latter and nurses in the hospital setting.

For the other three categories of activities, the ratings by doctors and nurses on the importance of medical social workers' role were far from impressive from the perspective of medical social workers. Our interviews also confirmed this finding. Most of the interviewees from the other two professions stated that medical social workers were important in providing psycho-social care to patients. Nonetheless, other members of the health care team should equally have a role to play.

The slightly more positive rating by doctors over nurses might be explained by the fact that doctors tended to concentrate their job on the physical care of patients and make referrals to medical social workers on non-medical tasks. Whereas nurses might think of their important role in helping patients with tangible services, psycho-social care and even community organising. Some nurses who were interviewed also stated that they were eager to help in solving the patients' psycho-social problems. As a result, role conflicts between medical social workers and nurses would be higher than that between medical social workers and doctors.

Lastly, it is important to stress that medical social workers themselves only chose one out of four categories of activities

under the "of most importance" order in rank (mean score 1, i.e., tangible assistance). Most of them ranked the other three categories of activities in the second order (mean score 2) in our scale. This means that such activities were "of importance" but could be shared with other health care providers. This finding is essential for the explanation of role ambiguity amongst medical social workers in the hospital setting as partly arising within the social work profession. Fundamentally, this reflects the nature of the profession; unlike the medical professions, social work cannot *fully* control its job. In other words, this could be seen as the internal source of role conflicts of medical social workers in the hospital setting.

In brief, our findings are consistent with what we have identified from the literature about role ambiguity of medical social workers in the hospital setting. Medical social workers had a higher expectation of their importance in the three roles of assessor, counselor and organiser than what were expected of them by doctors and nurses. However, amongst the four categories of activities, more compatibility of role expectation between doctors and medical social workers were identified in two of them: tangible assistance and resource mobilisation. Tensions were consistent throughout all four categories of activities between nurses and medical social workers in this study. In other words, medical social workers are not safe, even in the working domain (i.e., tangible assistance) which is traditionally recognised as within their control. The role ambiguity of medical social workers is partly attributed to their inadequate control of their job.

The Expected Roles as Compared with the Actual Practice of Medical Social Workers

Ambiguity of role is probably arising from a discrepancy between ideal expectation and actual reality. Therefore, it is worth identifying whether the actual practice of medical social workers is consistent with the expectation put on them. We add the factor of the line of authority in this area of study. As mentioned in the above

section, in Hong Kong, medical social workers in the hospital setting have two lines of authority — one from the Social Welfare Department (for Schedule I hospitals) and the other from the Hospital Authority (for Schedule II hospitals). The Social Welfare Department, as a "professional" government department, seems to symbolise an authority outside the hospital setting. In other words, the difference between medical social workers under different lines of authority may indicate the difference in allegiance or management control mechanism. Apparently, this may also affect the effectiveness of the communication amongst doctors, nurses and medical social workers in the hospital. For example, under the same hierarchical structure of the Hospital Authority, medical social workers in Schedule II hospitals may have better communications than their professional counterparts in Schedule I hospitals. In other words, we expect more matching of role expectations between doctors and nurses with medical social workers in the former setting than in the latter.

We go to Table 3 to examine this phenomenon first on doctors' matching of roles between ideal expectation and actual practice of medical social workers. In connection with the above assumption, it is found that, from the perception of doctors, medical social workers in Schedule I hospitals did more than the doctors' expectation in all categories of activities, except tangible assistant services. But, these great discrepancies (in terms of statistical significance) in role expectation and actual practice did not repeat in Schedule II hospitals in terms of all categories of activities performed by medical social workers. This suggests that medical social workers with allegiance or line of authority outside the hospital tend not to practice in accordance with doctors' expectation.

Now, we turn to Table 4 to examine the nurses' perception of medical social workers' role as compared with that of their actual practice. A similar pattern of discrepancy in role expectation between doctors and medical social workers by line of authority is also identified in the findings on nurses. Medical social workers did more than what was expected of them from the perception of

Table 3 Doctors' Perception of MSWs' Roles as Compared with Actual Practice of MSWs

	Hospital	Matching pattern (%)							
		Exact match	Relative match		Relative unmatch		Exact unmatch		Conclusion
			+ve	-ve	+ve	-ve	+ve	-ve	
Psycho-social assessment	Schedule I	61.4	24.1	5.1	8.9	—	—	0.6	Reject Ho
	Schedule II	76.9	15.4	3.8	3.8	—	—	—	Accept Ho
	Don't know	58.0	29.6	7.4	4.9	—	—	—	Accept Ho
	Total	64.4	23.3	5.4	6.6	—	—	0.3	Reject Ho
Tangible assistance	Schedule I	69.8	20.1	3.8	5.0	—	1.3	—	Accept Ho
	Schedule II	71.8	14.1	9.0	—	3.8	1.3	—	Accept Ho
	Don't know	66.7	25.9	2.5	4.9	—	—	—	Accept Ho
	Total	69.5	20.1	4.7	3.8	0.9	0.9	—	Reject Ho
Psycho-social intervention	Schedule I	55.7	30.7	6.6	5.7	—	1.4	—	Reject Ho
	Schedule II	67.3	22.1	2.9	4.8	1.0	1.9	—	Accept Ho
	Don't know	57.4	30.6	—	12.0	—	—	—	Accept Ho
	Total	59.0	28.5	4.0	7.1	0.2	1.2	—	Reject Ho

Table 3 Doctors' Perception of MSWs' Roles as Compared with Actual Practice of MSWs (Continued)

Mobilisation of new community resources	Schedule I	54.7	33.0	0.9	8.5	—	2.8	—	Reject Ho
	Schedule II	65.4	21.2	7.7	3.8	—	1.9	—	Accept Ho
	Don't know	50.0	33.3	—	16.7	—	—	—	Reject Ho
	Total	56.1	30.2	2.4	9.4	—	1.9	—	Reject Ho

Notes: Percentages may not add up to 100 because of rounding.
Ho = Null hypothesis.
Exact match : Rank of actual practice = Rank of expectation.
Relative match +ve (or -ve) : Rank of actual practice - Rank of expectation = +1 (or -1).
Relative unmatch +ve (or -ve) : Rank of actual practice - Rank of expectation = +2 (or -2).
Exact unmatch +ve (or -ve) : Rank of actual practice - Rank of expectation = +3 (or -3).

Table 4 Nurses' Perception on MSWs' Role as Compared with Actual Practice of MSWs

	Hospital	Matching pattern (%)							Conclusion
		Exact match	Relative match		Relative unmatch		Exact unmatch		
			+ve	-ve	+ve	-ve	+ve	-ve	
Psycho-social assessment	Schedule I	56.2	28.8	9.0	3.9	2.1	—	—	Reject Ho
	Schedule II	50.5	31.4	14.3	3.8	—	—	—	Accept Ho
	Don't know	55.7	28.2	8.6	4.0	3.4	—	—	Reject Ho
	Total	54.9	29.1	10.0	3.9	2.1	—	—	Reject Ho
Tangible assistance	Schedule I	63.6	22.9	7.2	5.1	1.3	—	—	Reject Ho
	Schedule II	47.6	37.1	10.5	3.8	1.0	—	—	Accept Ho
	Don't know	61.6	27.7	7.9	1.1	1.7	—	—	Accept Ho
	Total	59.7	27.4	8.1	3.5	1.4	—	—	Reject Ho
Psycho-social intervention	Schedule I	51.0	31.6	5.5	9.4	2.3	—	0.3	Reject Ho
	Schedule II	54.6	27.7	9.9	5.7	0.7	0.7	0.7	Accept Ho
	Don't know	49.6	28.2	6.8	13.2	1.7	—	0.4	Reject Ho
	Total	51.2	29.6	6.9	9.9	1.8	0.1	0.4	Reject Ho

Table 4 Nurses' Perception on MSWs' Role as Compared with Actual Practice of MSWs (Continued)

Mobilisation of new community resources	Schedule I	43.2	32.9	9.0	11.0	3.9	—	—	Reject Ho
	Schedule II	58.0	24.6	2.9	8.7	1.4	2.9	1.4	Reject Ho
	Don't know	46.2	34.2	6.0	12.0	0.9	0.9	—	Reject Ho
	Total	47.2	31.7	6.7	10.9	2.3	0.9	0.3	Reject Ho

Notes: See Table 3.

nurses in all four categories of activities in Schedule I hospitals. Line of authority plays a dominant part with regard to medical social workers' role performance in Schedule II hospitals in terms of three categories of activities but not of the category of mobilisation of new community resources. This may suggest that nurses were particularly keen on extending their work domain to organise additional community resources for patients. Their expectation in this category of activities even surpassed the factor of the source of allegiance in team membership. Interviews also confirmed this finding, some nurses indicating the expectation of developing joint programmes with medical social workers to better identify and meet the needs of patients. They thought that, at present, medical social workers were too independent and not inclined to cooperate with them in joint efforts.

Next, we come to the examination of medical social workers' own discrepancy between ideal expectation and actual practice in Table 5. Here, we identify a pattern of complete consistency between the two levels across schedules of hospitals in all four categories of activities performed by medical social workers. This suggest that medical social workers in this study had a very clear mind about what they did and what they should do for their patients in hospitals. Judging singly on this factor, role ambiguity of medical social workers in the hospital setting seem to be originating from sources outside the profession.

Despite this finding, we can also identify a discrepancy between ideal expectation and actual practice of all medical social workers (discounting the factor of schedules of hospitals, that is rejecting (the null hypothesis *Ho*) in both categories of activities) in psycho-social intervention and mobilisation of new community resources. This may suggest that medical social workers are eager to perform more in these two categories of activities. In the interviews, some of our social worker respondents expressed the view that they wanted to increase their role as counselor. However, the pressing demands of services had deprived them of the choice to allocate more time to this. In other words, the discrepancy between expectation and actual practice in these two categories of

Table 5 MSWs' Perception of MSWs' Role as Compared with their Actual Practice

	Hospital	Matching pattern (%)								Conclusion
		Exact match	Relative match		Relative unmatch		Exact unmatch			
			+ve	-ve	+ve	-ve	+ve	-ve		
Psycho-social assessment	Schedule I	75.6	15.9	8.5	—	—	—	—		Accept Ho
	Schedule II	70.4	25.2	3.1	0.6	0.6	—	—		Accept Ho
	Don't know	63.0	14.8	11.1	—	11.1	—	—		Accept Ho
	Total	72.3	20.0	6.3	0.3	1.1	—	—		Accept Ho
Tangible assistance	Schedule I	79.3	5.5	12.2	—	3.0	—	—		Accept Ho
	Schedule II	82.4	8.2	8.2	—	1.3	—	—		Accept Ho
	Don't know	73.1	11.5	15.4	—	—	—	—		Accept Ho
	Total	80.2	7.2	10.6	—	2.0	—	—		Accept Ho
Psycho-social intervention	Schedule I	63.7	20.9	11.2	2.8	0.5	0.9	—		Accept Ho
	Schedule II	56.4	31.3	6.6	4.7	—	0.9	—		Accept Ho
	Don't know	52.8	5.6	33.3	5.6	2.8	—	—		Accept Ho
	Total	59.5	24.5	10.8	3.9	0.4	0.9	—		Reject Ho

Table 5 MSWs' Perception of MSWs' Role as Compared with their Actual Practice (Continued)

	Hospital	Matching pattern (%)							Conclusion
		Exact match	Relative match		Relative unmatch		Exact unmatch		
			+ve	-ve	+ve	-ve	+ve	-ve	
Mobilisation of new community resources	Schedule I	63.0	15.7	16.7	3.7	0.9	—	—	Accept Ho
	Schedule II	61.9	23.8	11.4	2.9	—	—	—	Accept Ho
	Don't know	52.9	23.5	11.8	5.9	5.9	—	—	Accept Ho
	Total	61.7	20.0	13.9	3.5	0.9	—	—	Reject Ho

Notes: See Table 3.

activities is basically arising from high expectation inside the profession.

In brief, the addition of the factor of line of authority by schedules of hospitals in Hong Kong to the study of role ambiguity of medical social workers is rewarding. It is found that, from the perspective of doctors and nurses, the actual practice of medical social workers in general matched with what they expected of them in Schedule II hospitals. This matching pattern between role expectation and actual practice of medical social workers is not repeated in Schedule I hospitals where medical social workers were accountable to a "professional" government department outside the hospital setting. We have also identified that, even in Schedule II hospitals, from the perspective of nurses, medical social workers did more than they were expected to in the role of organiser for additional community resources. This reflects role ambiguity, perhaps role conflict, that might be arising from a competing profession for the control of the job. This seems to suggest that there is an underlying tension, not necessarily a rivalry, existing between nurses and medical social workers in hospitals. Lastly, we have also identified medical social workers as being of a very clear mind about what they did and what they should do about their job in hospitals. Nevertheless, we have also identified some slight discrepancy between role expectation and actual practice, but that has basically arisen from medical social workers' own enthusiasm about doing more than what they could do at the right moment. In other words, from our study of the matching between role expectation and actual practice of medical social workers, the sources of role ambiguity amongst medical social workers basically are external to the profession. Nevertheless, it does not mean that there is no definite relation between external and internal factors.

Modes of Interaction Amongst Medical Social Workers, Doctors and Nurses

Now, we turn to incorporate modes of interaction amongst doctors, nurses and medical social workers in the hospital context for our analysis of role ambiguity of medical social workers (Table 6). About half (50.2%) of doctors use only "written correspondence" as the communication tool with medical social workers in the psycho-social assessment category of activities. But, the commonest mode for nurses and medical social workers in this category of activity is "group discussion" (42.2% for nurses and 55.7% for medical social workers). It appears that doctors tend to make referrals to medical social workers by formal and uni-directional means. In the interviews, some respondents from the medical profession believed that referral by written correspondence should be sufficient, especially in regard to tangible services. However, the nursing professionals did not share this view about the interaction with medical social workers; they preferred further discussion in a "one-to-one" mode, such as ward rounds or face-to-face conversation.

For the mode of interaction by "group discussion," such as in team meeting or case conference, it was the second least embraced mode by all three groups of professionals. Only 7.6% of doctors, 12.5% of medical social workers and 17.0% of nurses chose this mode for interaction with the other two professional groups in the psycho-social assessment category of activities. Lastly, "transfer of skills" was the least preferred mode of interaction, especially in the case of medical social workers (no responding rate).

A more consensual view about the commonest mode of interaction by medical social workers, doctors and nurses was reached in activities categorised as tangible assistance services. Seven out of ten doctors (73.4%), nearly half of the nurses (46.9%) and about half of medical social workers (50.6%) selected "written correspondence" as the commonest mode of interaction with each other. It is understandable because the nature of tangible services is more straightforward, then, no further interaction by other

Table 6 Modes of Interaction between MSWs, Doctors and Nurses

		Mode of interaction (%)					Mode
		a	b	c	d	e	
Psycho-social assessment	Doctor	50.2	30.2	7.6	0.6	11.4	a
	Nurse	25.3	42.2	17.0	2.7	12.8	b
	MSW	28.9	55.7	12.5	—	3.0	b
Tangible assistance	Doctor	73.4	16.1	7.0	0.6	2.8	a
	Nurse	46.9	34.4	11.5	2.5	4.7	a
	MSW	50.6	40.8	4.3	0.9	3.4	a
Psycho-social intervention	Doctor	37.6	21.8	8.4	1.2	30.9	a
	Nurse	13.5	36.1	14.1	5.3	30.9	b
	MSW	14.8	43.9	13.5	0.9	27.0	b
Mobilisation of new community resources	Doctor	32.5	15.8	10.5	2.4	38.8	e
	Nurse	16.8	28.4	16.2	7.8	30.7	e
	MSW	11.9	36.1	16.7	1.3	33.9	b

Notes: Percentages may not add up to 100 because of rounding.
Mode of Interaction:
a = Written correspondence only, e.g., referral, memo, etc.
b = Discussion in ward rounds or via face-to-face conversation, telephone contact, etc.
c = Group discussion in team meetings, case conference, etc.
d = Transfer of skills to or from the team members, e.g., teaching other team members to perform one's job.
e = Not applicable.

mode is normally required. Nevertheless, we need to be reminded that doctors expressed the highest percentage points in this mode of interaction, and consequently, they did not prefer other modes of interaction (e.g., 16.1% for "one-to-one discussion" and 7.0% for "group discussion"). It is worth noting that nurses are the group of professionals that ranked the highest about the "group discussion" mode with the other two groups (11.5% for nurses as compared with 7.0% for doctors and 4.3% for medical social workers) in terms of tangible assistance activities.

In regard to the psycho-social intervention category of activities, still more doctors than the other two health care professionals preferred the "written correspondence" mode in interaction with members of the other two professions. Nearly forty per cent (37.6%) of doctors had written correspondence as the commonest interaction mode, but only 13.5% of nurses and 14.8% of medical social worker's preferred the use of written correspondence in this category of activities. Unsurprisingly, fewer doctors (21.8%) than nurses (36.1%) and medical social workers (43.9%) preferred the "one-to-one discussion" mode in regard to activities categorised as psycho-social intervention tasks. Similarly to the previous two categories of activities, nurses were the professionals who had the highest preference among the three groups of professionals regarding the use of the "group discussion" mode of interaction for psycho-social intervention tasks (14.1% as compared with 13.5% of medical social workers and 8.4% of doctors).

For doctors, the commonest mode was the "written correspondence" category (32.5%) for the mobilisation of new community resources; for medical social workers and nurses, the commonest mode of interaction for the respective category of activities was individual discussion (28.4% and 36.1%, respectively). Nevertheless, a relatively significant portion of respondents across professions found it not applicable to have interaction in this category of activities. They might think that they could handle the situation by themselves and no interaction was required. A similar pattern developed for psycho-social intervention.

In brief, for doctors, the commonest mode of interaction was "written correspondence," especially in the provision of tangible assistance services. Nevertheless, they were still concerned about the progress and wanted to have a feedback from medical social workers. The commonest mode of interaction for medical social workers was "one-to-one discussion." Whereas for nurses, they had a mix of modes but were skewed towards "one-to-one discussion" (three for this and another one for "written correspondence" regarding tangible services). It is also worth noting that nurses were the only group of professionals that had the highest ranking, as compared with the other two, about the "skills transfer" mode. It can be suggested that doctors and medical social workers might think that they were already well equipped with the required skills. In contrast, nurses might want to expand their knowledge base. This inference is consistent with our finding about the tendency of nurses to extend their professional domain when we examined data about the role ambiguity of medical social workers. Interviews with nurses also confirmed this finding. They expressed the wish to acquire simple skills for psycho-social intervention as well as factual information, such as the list of private nursing homes, so that they could handle patients immediately without the need to refer patients to medical social workers.

All in all, the interactions amongst the three groups of professionals were highly concentrated in formalised written communication, such as memo, and one-to-one discussion. Group discussion was infrequently used. And, the mode of skill transfer was rarely engaged in by doctors, nurses and medical social workers.

Conclusion and Discussion: The Nature of Role Ambiguity of Medical Social Workers

We started with the premise that medical social workers in the hospital setting have their roles misunderstood and misinter-

preted. We employed three factors to check out how and why the roles of medical social workers were ambiguously understood in the hospital setting. They were, first, the expected roles of medical social workers; secondly, their line of authority; and thirdly, the interaction modes in hospitals.

About the first factor dealing with the expected roles of medical social workers, we identified that, in general, medical social workers had different expectations of their roles from those of doctors and nurses, the latter in particular. Doctors' expectations of the roles of medical social workers as counselor and community organiser were fairly matched with those of medical social workers' self expectation. However, nurses mismatched with medical social workers in all four categories of roles. Amongst the four categories of roles, the tangible assistance category of activities attracted the highest endorsement rates by all three groups of professionals. In this category, half of nurses (51.7%) and three-fifths of doctors and medical social workers (61.3% and 65.6% respectively) supported that the tangible service provider role should be the most important and that it could only be taken up by medical social workers. In this light, what are distinct and specialised medical social workers' roles, as highly endorsed by doctors and nurses, are not complementary from the perspective of medical social workers at all. What medical social workers expected to do more of, and which they regretted as showing the gap from the ideal, was the role related to psycho-social care.

About the second factor regarding the line of authority, we identified a clear difference between Schedule I and II hospitals in terms of medical social workers' role relations with doctors and nurses. In general, under the same line of authority, medical social workers did what were expected of them by doctors and nurses. Social work is basically a profession working within an organisational setting. The case of medical social work is particularly clear, for it is primarily working in a secondary setting. The unique situation here in Hong Kong in this study is that medical social workers have two lines of authority, and one of them comes

from a "professional" department with its own line of thinking about social work.

The third factor is about the interaction modes amongst doctors, nurses and medical social workers in hospitals. We identified a phenomenon whereby the members of these three health care professions can hardly be assumed to be an interdisciplinary team operating in close interaction. Doctors relied heavily on "written correspondence," whereas medical social workers took the "one-to-one discussion" mode as their primary means to interact with others. Nevertheless, it does not mean that the prevalent pattern is not effective in the delivery of medical and social welfare services to patients.

Our primary concern in this study is about the identification of any distinctive and specialised roles of medical social workers in Hong Kong hospitals. In essence, our premises about role ambiguity of medical social workers has primarily arisen from a discrepancy between ideal and reality. This is about the different expectations about the roles of medical social workers by medical social workers themselves and the other health care professionals in hospitals. Role ambiguity stands in this sort of discrepancy is supposedly about inadequacy of communication and understanding. For instance, some medical social workers expected themselves to underscore more the role of counselor but were restricted by the heavy workload. Another example in the interviews, some doctors and nurses told us that they were also involved in counseling services, such as offering advice to patients on drug treatment and basic parenting skills. Nevertheless, they understood that these were of a different kind from the counseling offered by medical social workers. Counseling services offered by medical social workers were of the more complicated and in-depth kind. Indeed, there were incidences of this sort leading to role ambiguity. On this, the absence of the assumption of conflict of interests is clear. But, our findings unveil a tendency by the nursing profession to extend their working domain into those traditionally recognized as of a social work nature. Nurses in our study regarded medical social workers as doing more than they were expected to

in all four categories of activities. This is a concern going beyond concrete and after-care community services, two traditionally recognised domains of social workers, as identified in Egan and Kadushin's (1995) study about the expectation of medical social workers by nurses. In other words, the service domain of medical social workers is open to re-negotiation, from the perspective of nurses.

In addition to the negotiable boundaries of medical social work in hospitals, we found that the role ambiguity around the social workers could be substantially reduced if they were put under the same line of authority. This begs a serious question about the professional autonomy of social workers in a secondary setting. In hospitals under Schedule II, medical social workers were well integrated in the host setting under the leadership of doctors in the hierarchical structure of the Hospital Authority in Hong Kong. In this light, medical social workers were able to match more of the expectations of doctors and nurses than those of their counterparts who were under the line of authority of the Social Welfare Department. This is an issue larger than that of the medical social workers' limited control of their jobs arising from doctors as gate-keepers of clients of medical social workers, as we mentioned in a previous section. Apparently, the old question relating to professional autonomy of social workers is at stake (Smith, 1970; Hugman, 1991).

Medical social workers working under a line of authority outside the hospital have the advantage of stronger ground for professional autonomy. Medical social workers may have more opportunity, as social workers, to be rotated to other social work jobs and acquire generic knowledge of different clienteles and problems. However, this practice would pose obstacles to the development of trust and understanding with other health care professionals in the hospital. In contrast, medical social workers under the same line of authority could have the advantage of being specialised in social work practice in the medical field. Nevertheless, the absence or inadequacy of professional patronage of their own kind in such a scenario may mean that medical

social workers may perpetuate themselves as junior partners of the medical professionals in a setting where the latter hold the gate-keeper role. Moreover, they would increasingly face the challenge from the nursing profession. Apparently, there is no clear cut answer to the choice between these two different approaches of the medical social work practice in the secondary setting of hospitals. The essential consideration is to strike a balance between professional autonomy and allegiance to the host agency.

Apart from the above considerations, there are some technical suggestions that could be considered for improving the performance of medical social work in hospitals, particularly in regard to effective interaction, suggested by respondents in the interviews. They are as follows:

1. Decentralizing medical social work services: Nurses and doctors suggested that every unit in hospitals should be served by a medical social worker. They felt that this decentralization strategy of allocating medical social workers could increase communications between medical social workers and other health care professionals.
2. Transfer of skills: If skill transfer can facilitate the delivery of services to patients, medical social workers should teach other health care professionals, nurses in particular, some simple tasks as a means to streamline the work process of meeting patients' need. Henceforth, medical social workers could focus on in-depth psycho-social care services.
3. Increase in efforts to better communications in team work and become more client oriented: Medical social workers should actively promote their services to other health care professionals, especially those who are new comers to the hospital. There is suggestion of the need for medical social workers to be provided with modern communication equipment, such as pagers, so that they could be accessible in case of emergency. Preferably, medical social workers should work in hours somewhat correspondent to doctors' off-hour ward rounds

and patients' visit time, so that they can be more accessible to doctors and patients' family.

Notes

1. All hospitals under the Hospital Authority are categorised into five groups according to the Executive Information System. Apart from Group 1, Group 2 hospitals have a mix of acute and non-acute services; Group 3 is non-acute or infirmary hospitals; Group 4 is psychiatric hospitals whereas Group 5 is acute hospitals of special nature, e.g., eye hospital.
2. The full statements are:
    1. Assessment of patients' need for existing social services, e.g., financial support, housing assistance.
    2. Assessing the psychological status of patients in relation to their illnesses, disabilities or impending death.
    3. Assessing the psycho-social functioning and role of patients in the community in relation to their illness, disabilities or impending death.
    4. Assisting patients to make financial arrangement for medical, social and other needs.
    5. Assisting patients to make accommodation arrangement, e.g., housing elderly home (public or private) placement for medical, social and other needs.
    6. Referring patients to community services after their discharge from hospital, e.g., home help, day care, etc.
    7. Providing counselling to individual patients with emotional or adjustment problems related to their illnesses, disabilities or impending death.
    8. Organising therapeutic groups for patients with emotional or adjustments problems related to their illnesses, disabilities or impending death.
    9. Providing counselling to family members of the patients with emotional or adjustment problems.
    10. Organising therapeutic groups for family members of the patients with emotional or adjustment problems.
    11. Mobilising new community resources to meet the needs of patients and their families.
    12. Organising self-help or support groups.

    The code of 1 stands for "of most importance" which means the task can be taken up by medical social workers only. Code 2 stands for a sharing of task with other health care providers. In this light, the code 3 stands for a task that can be largely achieved by other health care providers. This assumes that medical social workers performance of the task is supplementary to other team members. The code 4 stands at the lowest end of the scale indicating a task by medical social workers as of least importance. This is a reverse of the code 1 (i.e., of most importance) as the task performance of medical social workers is in principle dispensable. In other words, a choice of the lower end of the scale implies that the task, indicating a respective role, is solely a medical social worker role; and vice versa for the higher end.

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The Role of Medical Social Workers and their Relationship with Doctors and Nurses in Hong Kong Hospitals

Abstract

Role ambiguity for social workers working in a secondary setting has long been identified, particularly in hospitals. However, studies of this kind had not been undertaken previously in Hong Kong. Our primary concern in this study is the identification of the distinctive and specialized roles medical social workers perform in Hong Kong hospitals. We also include medical doctors and nurses in our study to see whether role ambiguity for medical social workers is related to the differences in role expectations. Furthermore, medical social workers in the hospital setting are members of an interdisciplinary team; thus, the interaction modes amongst these members of the team are also examined. Lastly, we look into authority structure as another possible factor because medical social work in Hong Kong is operated under two different lines of authority: by Schedule I and II Hospitals. In sum, this study explores whether role expectations, interaction modes and authority structure affect the roles of medical social workers and their relations with doctors and nurses in the secondary setting of hospitals.

香港醫院醫務社工的角色及與醫生和護士的關係

王卓祺　陳志英　談德榮

（中文摘要）

社會工作者在從屬背景下工作常會導致角色的含糊，其中尤以醫院爲然。此問題雖備受關注，但是，香港卻未有這方面的研究。本研究的主要目的便是找出香港醫院的醫務社工是否擁有獨特及專門的角色。我們的研究對象也包括醫生及護士，期能藉此探索角色期望的差異會否做成醫務社工的角色含糊。此外，由於醫務社工是跨科際隊伍的成員，我們亦檢視醫院內醫務人員之間的交往方式。最後，因爲香港的醫務社工分別隸屬於兩種不同的醫院計劃（Schedules I & II），我們亦分析權力結構此因素的影響。總而言之，這項研究旨在探索角色期望、交往方式及權力結構此三項因素對醫務社工的角色及其與醫生和護士的關係的影響。