Perceptions of the Role of Social Workers in an Emergency Setting: An Ethnographic Study

By

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Final Dissertation

Presented to the Faculty of

The Graduate College of Social Work

University of Houston

Submitted In Partial Fulfillment of Requirements for the

Degree of Doctor of Philosophy

Under the Supervision of Luis Torres, PhD

Houston, Texas

May 2014

Dedication

It is with love and gratitude that I dedicate this work to my parents, Arthur L. Malbrough and the late Katie M. Malbrough. Because you created a home culture of unconditional love, nurturing and support, I became the person you see today…thank you.

Joy

Acknowledgements

"I did not get here by myself."

-Vernon Jordan

I give God ALL the glory for all things at all times. His son, Jesus, a holy high five for giving all He had for ME!!!!! This journey has allowed my faith to rise immeasurably, and I owe it all to the Father. I thank my family for years of understanding and support. Daddy, you have been my number one fan and loudest, yet most silent cheerleader and source of strength since my arrival that beautiful March day. I love you and want to be just like you when I grow up. Mommy, Heaven became a different place the day you moved there. The angels get a kick out of you every day, just as we did the years we were blessed to have you. For me you served as the consummate example of what a woman is supposed to be. Thank you for all you have given. How I miss you! Aunt Linda and Aunt Doche, I could say thank you every day for the rest of my days and would likely leave something out. You are more than just my aunts or my mother's sisters. You have become our family matriarchs and my Rocks. You, like mom, serve as models for me of all things pure in heart. Though not uttered enough, my love for you is beyond words. Erin Elizabeth, for entering this world just twelve days after my mom's departure and lighting up my life, thank you- NiNi loves you so very much.

To my church family, specifically the Lakewood Choir led by Pastors Michael and Fiona Mellett; your kindness, covering and prayers have made the difference. This is the type of divine connection we hear about all of the time!!! To my Fit Life friends and family, because of you, I am on my way to becoming half the woman I was when this journey began.

To my UnitedHealthcare family, thank you for allowing my passions to grow as I work with our members and endeavor to make a difference in the lives of others on a daily basis.

To my fellow classmates, past and present, I thank you for sharing laughs, tears, knowledge and experiences throughout my time here. Let's go make waves around this world. Melissa and Monique, I could not have made it without you. Though now retired, Mrs. Carolyn Brooks, I owe so much to you, my sanity being one of them. Thank you for your gentle and sometimes sharp brand of love…

To my Dream Team of a Committee. Drs. Sampson, Thompson and Williams-Jennings, I appreciate you saying yes to me and being willing to impart your wisdom upon me. I will forever look up to each of you, both individually and collectively.

To my beloved Chair, Dr. Luis Torres. Beloved is the appropriate term as, through the ups and downs, I have come to know you and have come to have the utmost respect for you. Your dedication and devotion to your family, your passion for scholastic growth and knowledge, and your care and concern for students is like none that I have ever seen before. It is unparalleled and I am honored to call you colleague, but blessed to call you friend. You have welcomed me into your family, and for that I am eternally grateful. I thank you for believing in me, mentoring me and seeing things that were not yet in focus for me. For never giving up on me, even when I was on the verge, lands you a special place in my heart. May you be blessed for the remainder of your days and may everything you set your sights upon, prosper.

To Dr. Rebecca Chaisson, the reason I even considered doctoral education. From the day I met you the first week as an MSW student at LSU, my life and view of the world has never been the same. To enter a classroom and see someone who looked like me was indeed a welcomed surprise. Your soft-spoken, brilliant nature struck a harmonious chord with me and continues to resonate to this day. Thank you for blazing a trail and for caring enough to give back. The work you do makes a difference and I am blessed to know you.

I am not certain if a candidate has ever opted to thank a four-legged friend, but I would like to publically thank Xena, who came into my life at such a critical time and transformed me and my outlook. Your unconditional love and devotion has truly made the difference.

To those who started this journey with me here on earth and now sit among the heavenly cloud of witnesses, I thank you. You serve as angels for me, encouraging and clearing the path. For your continued touch from above, I am honored.

To everyone who said a kind word, lifted me up, prepared a meal, wiped a tear, listened to a rant or shared a laugh throughout this journey, thank you. No deed has gone unnoticed.

As I move from this phase to the next, may my work honor the Father and bless those I encounter. This is my prayer…….Joy

Abstract

Social Workers play a critical role in emergency medical settings and their presence has been associated with a decrease in inappropriate emergency room use, and with a reduction in initial and repeated emergency room visits related to psychosocial stressors. However, the discussion continues—especially among emergency room professionals from other disciplines—as to whether social workers truly belong in the emergency setting. In the wake of these debates, many hospital social work departments around the country have been closed. This study qualitatively examined the perceptions of the role of the social worker in a Level 1 Trauma center setting from a multidisciplinary perspective with the use of ethnographic research methods. Three main constructs were explored: Role of the Social Worker, Function of the Social Worker and Value of the Social Worker within the ER Culture. To date, previous studies on role perception in this arena have been done quantitatively.

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Chapter 1: INTRODUCTION

Background of the Problem

Social workers play a critical role in emergency medical settings (Mason & Auerbach, 2009), yet the discussion of whether social workers truly belong in the emergency setting continues, especially among non-social work professionals (Garces, 2002; Gelhart & Brown, 2006). As a result, the social work role continues to be devalued and social work departments remain vulnerable to downsizing and elimination (Rizzo & Abrams, 2000; Auerbach & Mason, 2009). Increasingly, social work roles are being transferred to registered nurses, who lack the training necessary to handle social work tasks (Auerbach & Mason, 2010; Barth, 2003). With the majority of new hospital admissions originating from the emergency room (HCHD, 2008) and many of these admissions being related to psychosocial issues in addition to medical issues (Auerbach & Mason, 2010), the need for social workers in the emergency room is increasing. The presence of social workers in the emergency setting has been linked to a decrease in inappropriate emergency room utilization, and to fewer hospital admissions for social reasons (Auerbach & Mason, 2010).

The role of the social worker in the emergency setting is to perform numerous tasks, often simultaneously, and tend to receive referrals for patients with the most challenging dispositions (Mason & Auerbach, 2009). Social workers address issues such as intimate partner violence, child and elder abuse, sexual assault, suicidal ideations/attempts, discharge placement, and trauma. Social workers are also often called upon to remedy situations of an economic or social nature such as access to food, transportation and/or employment. The issues social workers are asked to address in emergency medical settings may hinder, delay or thwart the disposition process (Auerbach, Mason & Heft LaPorte, 2007). Emergency room social workers play a key role in the provision of services to marginalized communities and in the efforts to eliminate health disparities. However, their role in the emergency setting remains

debated and poorly understood (Garces, 2002; Rehr, Blumenfield, & Rosenberg, 1998). With 117 million visits reported in 2007, (an increase of 23% from 1997), (Niska, Bhuixa & Xu, 2010) emergency rooms are often the initial battleground in our Country's struggle to eliminate health disparities related to access. Most of the patients seen non-emergently in hospital emergency rooms are uninsured minorities with low incomes (Padgett & Brodsky, 1992; Rochovich & Patel, 2012).

Harris County, Texas, the 3rd most populous U.S. County, is home to more than 4 million people. Made up of 40% Hispanics, 35% White, non-Hispanics, 18% Blacks, and an unspecified 7%, Harris County has the largest concentration of uninsured or underinsured residents in the United States: 1.2 million people (HCHD, 2008). Houston, the seat of Harris County, is home to one of the busiest trauma centers in the United States with more than 108,000 emergency visits per year (including emergency psychiatry visits). The study setting is 4th largest public metropolitan health system in the Country and holds the elite status of Level 1 Trauma Center (ACS, 2010). It also serves as the County's largest provider to the uninsured and underinsured, and has a large social work department with a staff of over 30 social workers.

Social Workers in Medical Settings

Social workers have been present in United States medical settings since 1905. Massachusetts General Hospital (MGH) served as the impetus for this new profession. Hospital social work was the creation of Dr. Richard C. Cabot, MGH Chief of Medicine during this time. This formation coincided with the mass movement from caring for the sick at home to bringing them to the hospital to seek medical treatment (Beder, 2006). The purpose of the social worker in the medical setting, according to Dr. Cabot's vision, was to serve as helper to the physician. With an influx of patients presenting to the hospital with issues such as tuberculosis, syphilis, polio and unwed pregnancy, home visits were needed to assist the physician in understanding the other side of the patient's ailments (economics, state of mind) as a means to assist in

treating the patients and providing a cure. Early on, Dr. Cabot understood that a patient's home environment, relationships, work and living conditions and personal issues factored largely into their illness and recovery or lack thereof. These home visits, were not feasible for practicing physicians, but dealing with the social issues of patients was deemed as a necessary medical treatment plan (Beder, 2006; Bartlett, 1975). At that time, the role of the social worker was to assist in the non-medical factors of treatment (Gelhart & Browne, 2006; Cannon, 1923; Bartlett, 1934; Bartlett, 1957; Nacman, 1990), including living conditions and patient financial limitations. Additionally, Dr. Cabot wanted the role to include interactions with family members regarding length of stay and what to expect such as severity and future impact. Early social workers agreed and acknowledged that those they served were part of a larger family system and learning more about the inner workings of that system could play an important part in aftercare considerations based on the environment, habits and possible hazards related to post-hospital adjustments (Goldstine, 1954). Patients need to be seen as being one part of a whole system that includes home, family, work and community. This thought best encapsulates Cabot's vision of the role of the social worker in the hospital setting (Goldstine, 1954). His hope was that this bio psychosocial approach would allow physicians to increase their job effectiveness.

Since then, social workers have been successful in the reduction of patient readmissions and non-emergent visits to the emergency room through education and connections to critical community resources (Holliman, Dziegielewski & Datta, 2001). Unfortunately, the social work profession continues to struggle to be fully recognized as an important health profession (Rosenberg, 1998; Holliman, et al, 2001). This is due, in part, to social work's heavy association with poor and seemingly powerless clients/patients, along with the profession's lack of outcome data to aid in the development of best practices in the push to recognize a science of social work (Rehr, et al, 1998; Brekke, 2011).

The first appointed hospital social worker on record was, in fact, a nurse by the name of Garnet I. Pelton. She served as a liaison for hospital and community agencies as well as a go-between serving as the lay voice, explaining the medicals orders and directives of the physicians (Beder, 2006). One year later, Ida Cannon replaced Garnet Pelton at MGH. Dr. Cabot's vision of social workers in the hospital setting began to catch on as positions began to spring up around the country. Ida Cannon also came to the social work position with nursing experience. She came with experience conducting home visits and studied sociology and psychology in college. Cannon's educational background and work history afforded her insight on the associations between social problems and medical illness. Cannon took a patient-centered approach to care and stressed the importance of collaboration among the disciplines in an effort to achieve the best outcomes for the patient, hospital and the community as a whole. Though this collaboration showed great strides and improvement in patient care, Dr. Cabot had to raise funds on his own to support the department as it was not officially recognized by the Hospital's Board of Trustees until 1914 (Beder, 2006).

The new use of social workers in the hospital setting brought about the need for more social work schools to train and meet this growing need. Now, there are upwards of 500,000 social workers employed in hospital settings (Cowles, 2003) who are tasked to "implement social-health services…and emphasize their professional independence while they enter into sound collaborative and team relationships" (Rehr, 1998, p.18). Today, social workers can be found in every area of the health care delivery system, yet the role of the social worker in medical settings remains unclear (Dziegielewski, 2004). This lack of clarity is evidenced by the broad range in the types of referrals received by social work staff. For instance, requests to arrange transportation for patients and to assist patients with long distance telephone calls often outnumber and overshadow other types of referrals that would afford masters-prepared practitioners opportunities to make use of their clinical skills (Auslander & Schneidman, 1996; Edgan & Kadushin, 1995; Cowles, 2000; Rizzo & Abrams, 2000).

Discharge Planning and Managed Care

Discharge planning is a large social work function in the medical setting, including the emergency room. Discharge planning plays a critical role in a patient's length of stay and has an overall effect on the total cost of patient health care. A well-executed discharge plan can decrease a patient's hospital stay and reduce care costs for both the patient and the providing facility (Holliman, et al, 2001). The success of the discharge plan rests partly on the social worker's knowledge and understanding of the patient's case; including the patient's strengths and limitations, and local resources appropriate to the patient's post-discharge needs and eligibility. According to Garces (2002), discharge planning occurs in conjunction with the other members of the interdisciplinary treatment team. Social workers see their role as broad and concerning the patient as a whole to ensure the best results, where as other team members tend to see the role of the social worker in the emergency setting as more narrow and task-specific.

The onset of managed care brought with it more confusion about the need for and role of social workers in hospital settings. In an effort to reap more federal dollars, discharge planning and other duties became the responsibility of registered nurses. As this shift occurred, social work departments were devalued and grew increasingly vulnerable to downsizing and even dismantling (Rizzo & Abrams, 2000). This shift also brought about increased reporting by social workers to nurse managers causing many social work professionals to experience a void in leadership. The result of this shift in focus was a decreased sense of professional accountability and an increased struggle to maintain their professional identity (Berger, Cayner, Jensen, Mizrahi, Scesny, & Trachtenberg, 1996; Globerman, Davies, & Walsh, 1996; Globerman, White, & McDonald, 2002). Furthermore, the federal government's passing of the Tax Equity & Fiscal Responsibility Act in 1993 established the diagnosis-related group system (DRG). This system assigns a prescribed patient length of stay based on his/her diagnosis. If a patient's stay exceeds

the prescribed system limit, the financial responsibility becomes that of the hospital, not the patient. This DRG system has generated the fear of non-reimbursement for services rendered and has reduced the amount of time the social worker has to work with patients to develop a successful discharge plan (Cowles, 2000).

In the case of an emergency room social worker, medical staff may be prompted to initiate services in concert with the provision of medical treatment. This would allow for better outcomes where the patient is concerned. On the other hand, hospitals with dismantled social work departments may make an attempt to meet the psychosocial needs of the patient by delegating the task to someone lacking the proper training or skills (Garces, 2002) such as patient advocates.

The Role of the Social Worker in the Emergency Setting

While in the emergency setting, the social worker works closely with physicians and registered nurses as well as other allied health professionals. Action needed and taken in the emergency setting is often immediate as time is of the essence. The role of the social worker is to quickly identify and address the psychosocial needs of the patient and not focus solely on the patient's chief complaint or presenting problem (Kitchen & Brook, 2005; Salvatore, 1988). By working in this fashion, the social worker is contributing to the overall operational effectiveness of the emergency room and to the success of the patient's comprehensive discharge plan (Garces, 2002). The ultimate goal is to work with the healthcare team to provide the best health services to every patient presenting for treatment regardless of their ability to pay (Abramson & Mizrahi, 1987). Social workers can serve in the following capacities while in the fast-paced emergency room environment: patient advocate, resource broker, consultant, counselor, liaison, mediator, planner and teacher (Soskis, 1985; Cowles, 2000).

The types of patients seen in the emergency setting differ from case to case as opposed to cases seen by social workers assigned to a particular hospital unit where the patients are treated for the same or similar issues. Examples of the types of issues faced by professionals in the emergency setting are: auto accidents, sudden illness, substance abuse, psychiatric issues, sexual assault, domestic violence, child and elder abuse/neglect, and death. Social workers serve as the "main conduit" of vital information to families while their loved ones are being cared for, particularly in the wake of a traumatic event (Beder, 2006, p. 137). They must clearly and factually explain next steps to patients and/or family members whether the patient has passed away, is being admitted to the hospital, or is being discharged and is in need of community resources. In the case of death in the emergency setting, the social worker is considered the stabilizer and manager in the crisis of death (Holland & Rogich, 1980). For many social workers this is difficult, because contact in the emergency setting is typically a single episode, leaving no opportunity for follow up with members of the bereaved family. Unfortunately, however, the full range of social workers' skills has failed to be maximized due to the health care delivery system's lack of knowledge of the breadth of services offered by this group of helping professionals (Cowles, 2000). Social workers in emergency settings are able to use their skills to assist with decreasing stress-induced illnesses, reducing treatment non-compliance and educating loved ones regarding caregiver burnout. Social work professionals also work to decrease the number of inappropriate emergency room visits by those who use this setting as their medical home (Davidson, 1998). Instead, social workers are mostly tapped to perform more concrete and narrow tasks and services. This creates the perception of social workers as subordinated to physicians and registered nurses, rather than as an equal member of the interdisciplinary team (Garces, 2002).

The Anatomy of Emergency Medicine and Level I Trauma

Prior to the onset of organized emergency medicine, general practitioners were responsible for addressing the total medical needs of their patients, doing so with little clinical instruction (Zink, 2006). As medical advances were made, general practitioners became the predecessors of family practice and emergency physicians. In the 1950's, access to health care was the great equalizer among the races; only those with money could afford health insurance (regardless of color) and physicians had the right to refuse care for inability to pay (Zink, 2006). With the advent of Medicare and Medicaid in 1965, came an influx of emergency room visits. For many who before lacked access, their new opportunity for care would often originate in the emergency setting. Their thoughts were as follows: instead of trying to blindly navigate this new system of care, if the point of origin was the ER, the proper referral would be given for next steps (outpatient clinic, specialist referral, etc.). The boom in demand for emergency services and physicians led to the organization of emergency medicine as a separate discipline (Zink, 2006).

As emergency care progressed and more training was provided, trauma care began to organize as well. The American College of Surgeons Committee on Trauma (ACS-COT) created a system to verify the presence of resources necessary to maintain a trauma setting. ACS does not designate trauma centers, as this is the responsibility of empowered entities such as state governments. The *Resources for Optimal Care of the Injured Patient* is classified by types as far as necessity/urgency of the presence of a particular resource. Type I Criteria must be present and in place at the time of the site visit conducted by the Verification Review Committee (VRC). Type II, while also required is deemed by the Committee as being less urgent (ACS, 2011). Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy and social services must be available during the acute phase of care in Level I and II trauma centers (ACS, 2010).

Examples of Type I Criteria for Level I Trauma Centers include:

A level I trauma center must meet admission volume performance criteria (one of the following):

a) Admit at least 1200 trauma patients yearly
b) 240 admissions with an Injury Severity Score (ISS) of more than 15[1]
c) An average of 35 patients with an ISS of more than 15 for the trauma panel of surgeons (general surgeons who take trauma call).

This study's hospital ER has held the Level I designation since 1994 (HCHD, 2009).

Rationale for Study

This qualitative ethnographic study is pertinent and relevant as it incorporates several innovative elements in its approach. To date, studies on social work role perceptions in healthcare/emergency settings have utilized quantitative surveys/questionnaires to obtain the bulk of the research data (Carrigan, 1974; Garces, 2002). This entirely qualitative study examined perceptions within this culture using ethnographic methods to include interviews and participant observations. This allowed themes to emerge as interdisciplinary team members spoke freely concerning their perceptions of social work roles while rendering suggestions and critiques. Another methodological innovation involves the use of self as a non-stranger overtly reincorporating into the research setting (Adler & Adler, 1987). The researcher serves in the capacity as social worker in the proposed research setting on a part time basis.

The setting for the study itself also constitutes an innovative approach to the questions being examined. This Emergency Center is the ideal setting to examine the role of social workers because of the size and interdisciplinary nature of the medical teams, and because of

[1] ISS is a trauma assessment tool that provides a numerical description for the overall severity of persons who have sustained injuries to multiple parts of the body.

the diversity of the patient population it serves in terms of socio-economic status, race, ethnicity, health insurance status, reason for treatment and access to community care. Obtaining detailed descriptions of the perception of social work's role from each professional perspective in the multidisciplinary treatment team may aid in social work integration and process improvement. This could then inform social work influences for better patient outcomes, improved physician practices, fiscal responsibility by hospital administrations and a decrease in non-emergent visits to the ER by high end users.

Rationale for Qualitative Methods

The purpose of a qualitative research study is to bring understanding while providing an explanation of participant meaning (Morrow & Smith, 2000). According to Maxwell (2013), qualitative research, or "process theory", is interested in "people, situations, events and the processes that connect them" (p. 29). As previously mentioned, social workers in emergency settings have been studied quantitatively. This is not the considered the appropriate approach to use when studying people (Cicourel, 1964; Garfinkel, 1967). Interviews and participant observations provide a better understanding of the customs and the culture in its natural form (Maxwell, 2013). Prior to the late 1960's, quantitative research was used solely in the field of health care. The introduction of this "newer" qualitative approach came by way of anthropologists and sociologists.

Statement of the Problem

The study offered the opportunity to understand how social workers operate within the medical treatment team. A good first step was exploring the perception of social work roles in a medical treatment team as seen through the lenses of the various professional disciplines that form the team, and by delineating the strategies social workers use to gain equal footing with professionals from other disciplines. The successful incorporation of social work into the

medical organizational culture is significant in that it can increase favorable patient health outcomes, promote fiscal responsibility by hospitals and alleviate non-emergent emergency room visits among high-end users (Auerbach & Mason, 2010).

Research Questions

The primary aim of this study was to answer the following research question:

What is the role of a social worker in a Level I trauma center. This study also addressed the following sub questions:

How do members of the interdisciplinary treatment team view the social work function within the organization?

How is value ascribed by each discipline to the role of the social worker in the emergency culture?

Scope of the Study

This study utilized a qualitative design incorporating specific ethnographic techniques of in-depth interviews and participant observations (LeCompte & Schensul, 1999) to assess the perceptions of the role of the social worker in the emergency room setting. Ethnographic research suggests the way to learn about people, their lives or certain aspects thereof, is through their own perspectives and within the context of that life (O'Reilly, 2012). These examined perceptions came from social workers, physicians, registered nurses and hospital administrators.

Significance of the Study

Social workers in emergency settings address the social and emotional concerns of the patients, which in turn allow the other members of the treatment team to focus solely on patients presenting medical issues. Social workers, however, must also focus on patients presenting medical issues in addition to their psychosocial factors when working to create the safest, most effective plan for post-discharge care. This task is challenged by the vast number of patients seen daily that have little to no resources available to access the care necessary for optimal health outcomes. The number of uninsured non-elderly persons in the United States reached 50 million in 2009 (Kaiser Commission, 2010), stirring social workers to labor harder to ensure the success of their discharge plans. The motivation is based, in part, on the reality that uninsured patients are less likely to seek the assistance of a primary care physician for preventive care or an illness, reserving this for the more expensive emergency room when their symptoms have severely worsened. Social workers are also motivated by the reality that minorities (33% Hispanic, 23% Black) are more likely than Whites (14%) to be uninsured (Kaiser Commission, 2010). These implications tap into the core principles of social work practice, especially the principle of social justice. Social workers have been equipped with the unique skills to work with diverse clients/patients to provide the tools and techniques necessary to aid in goal attainment.

Chapter 2: Conceptual Framework

Organization Theory (OT) suggests that the study of organizations is done with an emphasis on identifying commonalities among themes for the purposes of problem solving, maximizing efficiency and productivity, and the meeting of stakeholder needs (Meyer, 1977). An organization is defined as a structured system comprised of groups of individuals who work together to meet agreed upon objectives and goals (Meyer, 1977). For the purpose of this study, the organization refers to the Emergency Department of a County Hospital located in a large metropolitan city

Classical Organization Theory

Organization Theory has classical roots in scientific management with F.W. Taylor. He was, in fact, called the father of this era and believed that formal communication processes between management and employees was the way to keep a business afloat. Workers were to be closely supervised and the rewards and punishments concept was used as a means to motivate and drive production (Taylor, 1917). Unfortunately, this method was thought to dehumanize the workers. Max Weber (1947) followed Taylor with his Bureaucratic Theory where the focus was now on the organization as a whole – as opposed to the previous school of thought which focused solely on the individual. Hierarchical structure was introduced during this time as a means to ensure stability and uniformity. He focused his efforts on the division of labor and labor specialization. The Administrative Theory of Management was later presented by Henri Fayol (1930) with the intentional thought that by using five management functions, his theory could be applicable on a universal level. Those functions are: planning, organizing, commanding, coordinating and controlling (Meyer, 1977). These classical views of the organization were fraught with criticisms calling the ideas rigid and lacking the belief that employees could be motivated to work by some force other than money. These criticisms came

with a consensus that an alternative to the static and rigid classical theory and encouraged that organization be seen as social systems (Daft & Sharfman, 1995).

Neoclassical Organization Theory

Known as the human relations movement, Neoclassical Organization Theory was seen to be the response to it classical predecessor. This approach was more theoretical than the previous empirical school of thought. Some of the giants of this time were Elton Mayo (1933), whose Hawthorne Studies explored changes in productivity based on changes in conditions. Chester Barnard (1968) focused on the functions of the executive, citing that it was the duty of management to create a cohesive and cooperative workplace environment and that conflict had no place in the organization. And lastly, Herbert Simon (1945) became known for his idea of limited rationality in regards to the Hawthorne Studies. He reported that regardless of the condition change during the study (positive or negative), worker production increased. Simon contributed largely to the notion of rigor by way of the scientific method to study organizations.

Also during this human relations movement, Abraham Maslow and his hierarchy of needs came into play saying that organizations are in existence to serve the needs of humans (from physiological to self-actualization), which opposed the earlier thought that believed the reverse. Maslow wanted to see organizations operate in concert with the environment (1954). Systems Theory (von Bertalanffy, 1971) came along after the Neoclassical Era, but was not used in the study of organizations until the mid-1970's (Kast & Rosenzweig, 1972). Systems can be seen as meaningful wholes kept alive by the relations or the interface of its parts. This would then classify systems theory as a set of principles concerned with the organization of the parts to ensure, maintain and improve the function of the whole system (Laszlo, 1972; Smith-Acuna, 2011). The origins of the theory dealt with biological phenomena in a holistic manner in an attempt to move scientific study in a forward, more progressive direction across disciplines (Smith-Acuna, 2011). Normal/dominant science is likened to the gold standard and anything

that does not fit this paradigm is marginalized or ignored until such time that sufficient evidence could be provided to revolutionize prior thought (Kuhn, 1970). Smith-Acuna took the idea of systems thinking and broke it down into seven concepts that make the theory more practical. The concepts are: context, causality, communication, change, structure, history and development, and social and cultural narratives (2011). The study focused on the concepts of context, communication and structure as they relate to the system of the emergency setting and the perceptions of social workers therein.

Systems Theory represents balance that incorporates both social and interpersonal aspects of a patient care plan. The goal of systems theory is achieving a social order that is strong and effective (Payne, 2005). In a health care setting, the systems interacting are the patients, health service providers, families and communities, all attempting to work in concert with the ultimate goal of achieving strong and effective outcomes for the patient.

Numerous additional theories related to organization have been created to address the particular concerns of particular organizations and their specific concerns. Social workers in health care organization introduce a different domain that influences patient care, the psychosocial component. This person- and family-centered approach is now seen as a supplement to the patient/symptom-focused medical model (Davidson, 1990; Cowles, 2000; Garces, 2002). Social workers in emergency settings continue to work with patients to connect them and their families with community resources that will improve overall functioning, both physically and psychosocially, ensuring positive outcomes post-discharge. For the purpose of this study, The Contingency Approach to Organization Theory was utilized to guide the proposed research.

The Contingency Approach to Organization Theory

The Contingency Approach seeks to understand the interrelationships "within and among the various parts of an organization," (Hellreigel & Slocum, 1976). This Approach speaks to the fact that each part of the organization can be analyzed separately or as an interacting piece of the group dynamic. A Contingency Approach "recognizes that subsystems within the organization are dependent upon and influence each other (pp. 7)." There are four major properties of this model: Environmental, Individual, Organizational and Group.

Environmental Properties

According to the authors, organizational success deals directly with the ability to identify and relate to the relevant environment. This can mean vendors, consumers and even competitors. Resources must be secured according to the needs of the environment in question. This property varies tremendously, but for this study, the relevant environment refers to the patients served in the research setting. Social workers operating in the emergency setting must have a vast and varied knowledge of available resources in the community to best service the needs of patients (environment) to promote optimal post discharge outcomes. This can come in the form of relationships with area vendors, churches, local health and health service providers, as well as other hospitals in the surrounding area.

Individual Properties

Representing the "core" of the Approach are the individuals. The primary level of analysis of interest for this study was that of the individual as stated in the central research question: what is the role of the social worker in the level 1 trauma setting. Under this property, the psychological and perceptual processes come into play as it relates to individual behavior. This study looked to the actual participants of the study in their individual roles (social worker, physician, registered nurse) and how those roles shape behavior within the organization. This

study examined the perceptions of the individual role of the social worker within the setting as well their function and value within the culture. This was accomplished by the other individuals that make up the ER treatment team. Boundaries within and between actors can also be defined here.

Group Properties

Group properties deal with the forces that influence the group behavior as a unit and the forces that influence behavior between other groups within the organization and/or the relevant environment. Some possible factors may be hierarchy and leadership. As stated at the top of this chapter, the goal is to understand the interrelationships within and among parts of the organization. This study, for the purpose of analysis, took the responses of the individual participants and looked at them from a group perspective. Meaning if individual registered nurses were interviewed, following the initial data reduction and display, the process would be repeated on a group level to look at all of the registered nurse responses for similarities, themes. The same would be done with each group of participants. This step was not ultimately necessary, as the interview responses coalesced among disciplines.

Organizational Properties

Organizational culture is said to be a cognitive framework made up of attitudes, values, behavioral norms and expectations shared by the members of the organization (Van Maanen, 1998). Hospital administrators represented the organization for this study as many cultural norms flow from the top down. Their input allowed for the understanding of the characteristics of leadership and its effect on employee motivation, production, beliefs, views, norms as well as performance. Throughout the literature there is little information and research exploring the contingency approach to organization theory ethnographically in an emergency room setting. There are studies that look at the contingency approach in triage departments (Aacharya et al,

2011). This study looked at the role of social worker through the lens of the Contingency Approach of Organization Theory, to gain an understanding of the interrelationships as well as within and among the environment, the individual, the group and the organizational properties.

Chapter 3: Research Methods

The study utilized an ethnographic approach to examine what it means to be a social worker in a level 1 trauma setting, based on the expressed perceptions of social work functions in the interdisciplinary team from the perspective of team members serving within the organization. Additionally, by using the tenets of Organization Theory, this ethnographic study explored how role value is ascribed within the Emergency Culture. The ultimate goal of this study was to see the culture and gain an informed understanding of how social work professionals operate in a predominately medical trauma team based on the knowledge gained, for the benefit of the population served. According to Hammersley and Atkinson (2007) define qualitative ethnographic approach as:

> usually involves the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts-in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry (pp. 3).

With ethnography, the focus is placed on understanding cultural rules along with the perspectives and worldviews of the people involved in the study (Seale, et al, 2004). Wolcott (1988) describes it as the picture of a "way of life" of a group of people. One of the main characteristics of the ethnographic approach, according to Punch, is the commitment to the "cultural interpretation." This is all about behavior, meaning understanding the symbolic and contextual aspects and their significance to the culture in question (1998).

There are several features involved when using the ethnographic approach. Uncovering and understanding shared cultural meanings is critical to understanding behavior. Researchers

should be sensitive to the members of the study culture as a true way to understand these shared meanings. In order to garner the most knowledge, the key to ethnographic research is that it must take place in the natural setting (this makes participant observation key). Ethnography is an evolving process and this evolution takes place throughout the entire study and new developments come forth as the study unfolds. This approach is eclectic in all areas, to include the collection of data and the data itself. The data collection process should continue until no new information is learned about the study culture (Punch, 1998).

Research Site/Setting

The research study took place in a major metropolitan city located in Southeast Texas in the heart of the world-renowned Texas Medical Center. This hospital serves as the flagship for a major public health system, the largest provider of public health care for the 3rd most populous County in the United States (HCHD, 2008). Made up of 40% Hispanics, 35% White, non-Hispanics, 18% Blacks, and an unspecified 7 %, Harris County is home to 4 million people, of which 1.2 million have no insurance or are under insured (HCHD, 2009). In addition to being a county/public healthcare facility, this research setting holds the distinction of being designated a Level I Trauma Center by the American College of Surgeons. The Trauma Center handles in excess of 100,000 visits annually and is the source of 80% of the hospital's admissions (HCHD, 2008). The Clinical Case Management Department at the study site has a staff of more than 30 social workers.

Subject Selection/Sampling

In order to gain multiple perspectives in the areas of role and role value, purposive sampling procedures (Patton, 1990; Seale, Gobo, Gubrium & Silverman, 2004) were used to seek out participants who met the inclusion criteria. That is members of the interdisciplinary team who have a direct interface with social work professionals in the emergency setting. The

study sample consisted of 16 emergency room personnel. Specifically, the following team members were targeted for inclusion:

1. social workers
2. social work student intern
3. physicians (faculty and residents)
4. mid-level providers (physician assistants)
5. registered nurses (including clinical nurse case managers)
6. hospital administrators

All team members were stationed at the research setting at the time of the study. As stated above, Creswell suggests choosing participants who "inform an understanding of the research problem and central phenomenon in the study" (2013, pp.156). Because of their proximity to the ER these professional roles were purposefully selected because of their interface with emergency room social workers.

Recruitment: In adherence to Harris Health System guidelines, I first approached supervisors to gain permission to access. For example, directors were asked during individual face-to- face meetings to allow researcher to invite staff members to participate via printed flyers and literature/announcements during staff meetings. Since the researcher had access to the Emergency Department, potential respondents were approached following face-to-face meetings with the Director of Clinical Case Management, the ER Nursing Manager and the distribution of the printed invitation/flyer. Presentations describing and promoting the study were held during nursing huddles (short meetings held prior to each shift).

Electronic and printed memorandums were sent to hospital administration then to the directors of the Clinical Case Management and Emergency Center Departments notifying them of the study with details of its purpose along with a copy of the IRB approval from the University

of Houston's Committee for the Protection of Human Subjects and administrative approval from the Harris Health System's Department of Research and Sponsored Programs. Attached was a study timeline for their review. The researcher also worked with Harris Health System's Department of Research and Sponsored Programs to create electronic and printed invitations regarding study participation of Emergency Department staff. These invitations were printed and posted in common areas for staff members, but were not distributed via email. All flyers displayed the researcher's phone and e-mail contact. The researcher fielded telephone calls and emails from interested staff who responded to the printed recruitment materials.

Completion of interviews was on a voluntary basis over a near three month period. Each interview was scheduled at a time that would best suit both researcher and participant. No incentives were offered for participation, but $10 Starbuck's gift cards were given in appreciation. Interviews did not take place during work hours, and occurred in a closed room. Participants were ensured that the information provided would be used for educational purposes only and that their identities would remain confidential.

Data Collection

Data collection consisted of 16 semi-structured one time, face- to- face interviews using ethnographic interviewing techniques (Hammersley and Atkinson, 2007). All interviews were audio recorded with the participant's permission. The purposive sampling procedures were used to gather specific data within each professional category, fill in gaps, and learn about variations in and among them. This also aided in saturating the categories. Interview participants consisted of members of the ER interdisciplinary team: 3 social workers, 5 physicians (attending and resident physicians), 3 registered nurses (to include one clinical nurse case manager), 2 physician assistants, 1 social work student intern and 2 hospital administrators. Each study participant was asked all of the questions from the Interview Guide (see "Tools" for a list of questions and Appendix 1 for a copy of the complete Guide).

Other methods of data collection included participant observations by the researcher. As discussed in the tenets of the Contingency Approach of Organization Theory by Hellreigel & Slocum, 4 separate sessions of researcher observations were conducted at four different locations to provide an in-depth observation of the different facets of social worker response in the ER. This process of researcher participant observations in group, individual and environmental "properties" is important to inform the interrelationships throughout the emergency organization (1976). Locations of immersed observations included: the emergency psychiatry area, hallway of trauma care, peer debriefing sessions, and patient consultations.

Description of Tools Used

An interview guide, which was created by the researcher, (see Appendix 1) was used with emergency room staff members and participant observations were conducted by this researcher. Interview guide questions were formulated based on the framework of Organizational Theory.

Ethnographic Interviews. The interviews were semi-structured and used an interview guide that focused on obtaining a comprehensive understanding of the role of the social worker in the emergency room setting based on participant perceptions. These perceptions were based on factors related to context, personal experiences or based on the culture of operating within the trauma setting. All interviews were conducted by the researcher. Each participant was interviewed separately and each interview was thirty to forty-five minutes in duration. Participants were informed of the purpose of the study and what participating in the study entailed. They were made aware that the interviews would be audio recorded, that breaks were allowable and that they could withdraw their participation at any time. Each participant then signed their Informed Consent and Consent to Record Forms (see Appendix). One interview guide was developed for this study. This guide consisted of six questions divided into three sections based on the corresponding research questions (role, perception and role value). In the area of role, participants were asked to describe, to the best of their

knowledge/experience, what an emergency room social worker does. To explore the perceptions of that role/function as it pertains to the organization as a whole, participants were asked to share when would be the appropriate time to consult or involve a social worker. They were then asked to provide an example of such time along with the result. Role value, as it relates to the emergency culture and how it is ascribed, was examined by asking the participants to provide the names of social workers on duty during their particular shifts. The follow up here was to give the steps to locate the social worker on duty if their names were not known along with the steps to place a consult for social work services. Lastly, each participant was asked to describe the emergency department void of social workers.

Each interview was accompanied by a demographic sheet purposed to identify the study sample. The demographic sheet inquired about age, gender, ethnic background, highest degree earned, current profession, years of emergency room experience as well as years of level 1 trauma experience. Notes were taken by the researcher as a complement to the audio recordings.

Participant Observations. Hammersley and Atkinson spoke explicitly about the importance of participant observations saying that even if the group or setting is familiar to the researcher:

> The participant observer is required to treat this as 'anthropologically strange,' in an effort to make explicit the presuppositions he or she takes for granted as a culture member. In this way, it is hoped, the culture is turned into an object available for study. Naturalism proposes that through marginality, in social position and perspective, it is possible to construct an account of the culture under investigation that both understands it from within and captures it as external to, and independent of, the researcher: in other words, as a natural phenomenon. Thus, the *description* of cultures becomes the primary goal (1995, pp. 9-10).

Observation periods were completed in conjunction with the recruitment phase while onsite. There were four (4) total sessions that coincided with recruitment dates, flyer display, interview scheduling or recruiting presentations. Each session captured a different type of interface with social work professionals in the emergency setting. Because occurrences in this setting are generally spontaneous in nature, the participant observer was open and subject to the encounter(s) during the observation periods. The four sessions covered the following areas: EC Psychiatry shift change and morning rounds, patient consultations, trauma, and peer to peer debriefing. The observations were recorded in the form of field notes and real- time assessments. The purpose of the participant observation was to gain additional knowledge about the culture of the emergency room and the operation of the social worker therein. To serve as an enhancement and add richness to the data findings gathered through the semi-structured interviews to affirm/negate/expand upon the depiction of role, culture and role value. These observations also helped to establish the trustworthiness of the data according to Lincoln and Guba (1985). While recruiting study participants for the interview process, the researcher was the sole person to gather data at the study site. Field notes were recorded to document daily emergency room observations focusing on the role of the social worker in the context of the overall setting and their interactions with members of the multidisciplinary treatment team. Again, observations were only taken during situations where the interface between social workers and other members of the treatment team were occurring. The field notes were informal yet descriptive and were done in 1-2 hour increments throughout the emergency center, as previously indicated. Notes included setting, characters and interactions. All data; interviews (transcribed and audio versions), observations, obtained archival and researcher's own experiences as a social worker in this setting were used to display findings for this study.

Documents. The researcher obtained a printed copy of the Social Worker/Case Manager II job description for use in conjunction with the interviews and observations. This was done to add another view of the role of the social worker as detailed by the Health System.

Personal notes or memos were used to provide a "rich vein for analysis," (Hammersley & Atkinson, 1995). All written resources available were used to aid in the documentation of participant behavior, context and significance (Spindler & Spindler, 1992).

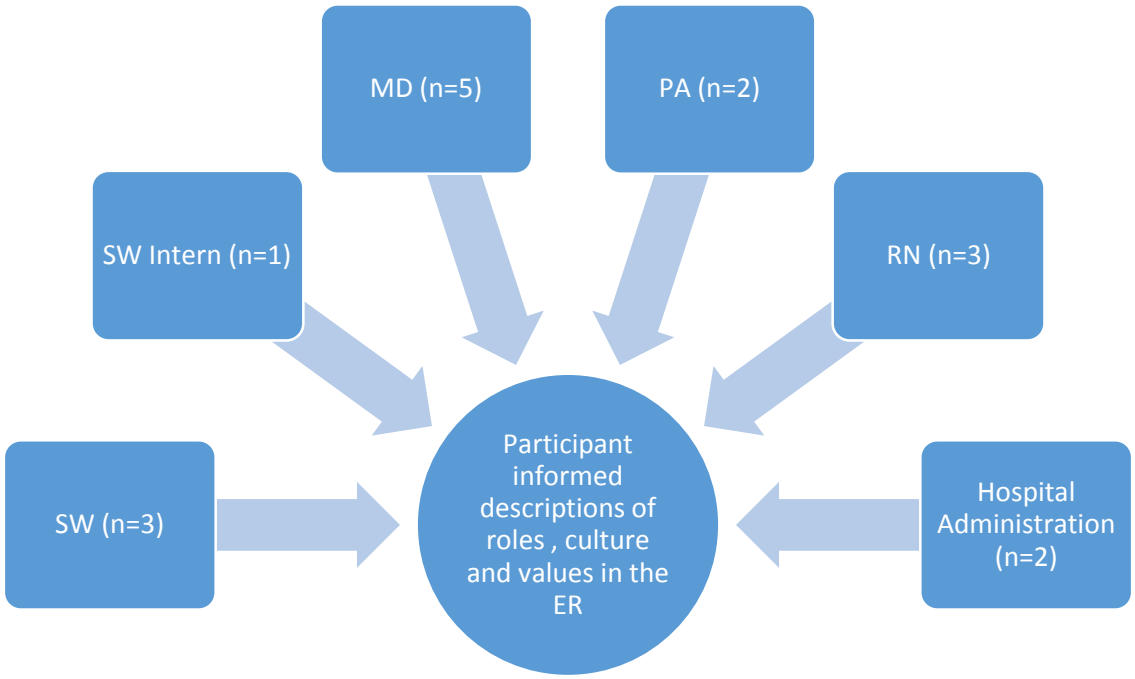


Figure 1: Visual of Data Flow Process.

Data Analysis

Prior to beginning the formal analysis process, all audio recorded interviews were sent via secure delivery to a professional transcription service. Interviews were transcribed verbatim allowing the researcher the opportunity to get reacquainted with the data. Data analysis was based on information gathered by the tools used for the study. The bulk of the data came from

the interviews where the respondents were able to speak freely concerning their perceptions of the role of the social worker in the emergency room based on their experiential interactions in the setting. The field notes, real time assessments and other documents were collected to enhance the bulk data by adding vivid descriptions and providing a pictorial context for the study.

Though there is no single right way or prescription to follow when analyzing qualitative data (Punch, 1998), aspects of the Miles and Huberman Framework for Qualitative Data Analysis and Wolcott's approach were used (1994; 1994). There are three main components to this framework: data reduction, data display and drawing and verifying conclusions. This falls in line with Wolcott's idea of describing, analyzing and interpreting the culture. These activities stream concurrently and take place throughout the analysis process. *Data reduction* consists of editing and summarizing the data and takes place throughout the analysis. Reduction also includes the creation of codes and memos where themes and patterns begin to appear. Later, data reduction is done in the form of conceptualization and explanation of abstract concepts found within the data. The objective here is to reduce the data to its purest form without losing significant information or context. In this study, a team of three were equipped with both the audio recordings as well as the interview transcripts for the reduction process. The team read through the data and uploaded it to NVivo for further analysis. Some of the data was analyzed using NVivo, but the bulk of the reduction and summary was completed using line by line coding, using the exact words of the respondents. Codes were created and were further reduced or gathered into themes as the patterns began to emerge.

Data display is essential and deals with the organization of the data. This step is helpful throughout all phases of analysis due to the sizeable content of interviews and observations. Miles and Huberman are of the thinking that the better the display, the closer the researcher is to a valid qualitative analysis (pp. 11). Displays come in several forms such as graphs and charts

and all are acceptable as long as it moves the analysis forward. This step, again, is valuable at all stages because it aids in focus and organization of the analysis, showing what has taken place and what steps still need to occur. Reducing and displaying rely heavily on coding and memoing to get the analysis moving and to capture substantive and theoretical concepts as they develop. These are seen as the building blocks of the analysis and continue to occur throughout the analysis process to allow for deeper abstraction and categorization. In this study, the researcher, using the codes and findings found by the team, continued to combine codes and themes and further reduce them, bringing them to their richest, purest form to best capture the description of the culture through the responses of the participants.

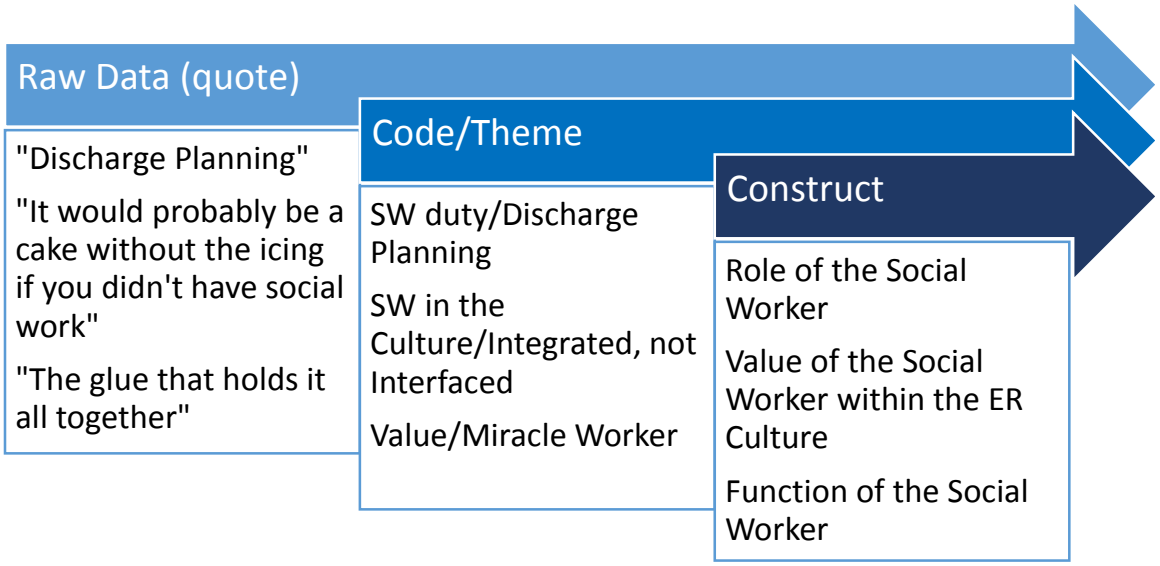


Figure 2: Sample of Data Display.

Drawing and verifying conclusions can be considered a culmination of the previous steps of reduction and displaying, but this step, in fact, takes place in concert. This allows for propositions and conclusions to begin forming early on, though nothing is finalized until all data has been mined. In this study, drawing and verifying conclusions was indeed the culminating step. This was where things began to come together allowing the researcher to take a step back

and see the big picture. As the questions were answered, the researcher began to draw meaning from the themes and constructs. Conclusions were drawn during this step as were implications and suggestions for further and future research.

All textual data (transcribed interviews, written field notes, assessments and journal entries) were to be entered into a computer software program for analysis. Demographic data was to originally be analyzed using a Statistical Package for the Social Sciences (SPSS) 18.0 or latest version. Due to the fact that the study size was small, hand counts and averages were able to be used in lieu of the software for frequencies and means for the demographic variables. The remaining data was loaded into NVIVO, which assisted the researcher/coding team in sorting, classifying and arranging the data. This allowed for clearer identification of themes that emerged during the process. Line by line analysis and coding were the primary sources for the interviews to provide the researcher with more intimate knowledge of the gathered data.

The Role of the Researcher, Researcher Bias and Reactivity

I have worked as a social worker in healthcare settings for twelve years. The research setting has served as my place of employment on a part time basis since 2006. My training began in the emergency room and flowed into other areas of the hospital organization. That being said, the emergency room at this hospital has been a large source of education for me throughout the years. It has also been a place where I have been given the opportunity to teach others (future social work professionals and resident physicians). My initial dissertation topic dealt with diabetes in a population made up of persons age 18-30, a group I called Generation Invincible. This study was to be completed using a secondary data set with the possibility of a few ethnographic interviews to add richness to the study. The more I researched the more cumbersome and frustrating. During this process, I was working more shifts in the emergency room and growing increasingly fascinated with the level of knowledge that could be gained on any given day, or night in my case. I was afforded the opportunity to work in one of the busiest

emergency rooms in the United States with some of the best physicians in their respective specialties. This was all taking place as I encountered different types of patients and presentations. I was in a dream land. Because of this work, I was asked to serve as guest lecturer on several occasions to BSW students at the University of Houston Clear Lake and Texas Southern University to discuss what I was fortunate enough to do to as a social work professional and the lessons learned. The shift in dissertation focus came when speaking with my Dissertation Chair and another professor in a casual setting about the ins and outs of my job and the experiences I have had, both good and bad within this culture.

From the outside looking in, it may appear as though I have a certain position on both the ascribed role value and the general perception of the social worker within the emergency culture. I am aware of my subjectivity as a social worker in the setting and how those feelings may play a role when analyzing and interpreting the data collected. Appropriate steps were taken to ensure the integrity of the study and make certain that there would be no negative bearing by using peer reviewers/coders along with other validation strategies. That being said, I am also cognizant of the fact that with the continual declining financial/social situations of patients serviced in this setting, more people will be presenting to the emergency room in search of having all of their needs addressed. My passion in life is health promotion (health and wellness strategies) and working with people to live their best and healthiest lives. I am a strong believer that small changes can yield big results. Since receiving my Master of Social Work twelve years ago, I have worked exclusively in health care. From a school-based health clinic, to hospice care and senior medicine, to general medical/surgical hospital care, home dialysis, trauma and the current service coordination for the sickest members of a Medicaid HMO, I have been blessed to both deliver and coordinate services for people in every population. During this time, I have been able to see the impact social work can have on patient and family outcomes, when used properly.

My future goals include increasing my knowledge in the areas of health policy and legislation to begin working to eradicate access disparities, (as it relates to housing, health care, life-giving/sustaining foods and education) in both my immediate area and beyond. To accomplish this through a position with my current company in the Department of Government Relations, Social Responsibility, or Health Services would be ideal. As a Company that services more than seventy million people, not including the seventy thousand employees, I will have the opportunity to effect change on a larger scale and at some point return to my love for Generation Invincible and the diagnosis (diabetes) that is destroying them.

Due to the fact that I am employed at the Hospital (though only in a less than part time capacity), I am aware that reactivity/reflexivity may be an issue. Since I am unable to eliminate the actual influence (Hammersley & Atkinson, 1995), my goal is to understand it and use it industriously.

Trustworthiness

The researcher employed the following to sustain the trustworthiness of the proposed study as assigned by Lincoln & Guba: long term/prolonged involvements (interviews and observations took place during a nearly three month period in a setting where the researcher has been employed for seven years). Triangulation, the use of the semi-structured interviews, participant observations and documents along with the fact that the interviews were conducted with different professional disciplines helped in the reduction of bias and invalidity. Peer debriefing took place with outsiders, with expertise in qualitative research. Member checks took place with participants to confirm their responses as it relates to conclusions drawn. Finally, persistent observation took place during the recruitment phase of the study as yet another way to confirm participant responses in accordance to yielded results (1985).

Ethical Considerations

All study participants were treated in accordance to the University of Houston Institutional Review Board and the Harris Health System Department of Research and Sponsored Programs. Since employees are considered vulnerable populations, participants were reminded that their decision to participate or to withdraw would not affect their relationship with Harris Health System. Additionally, all participants were treated equally, regardless of position held and the researcher worked to ensure the comfort by allowing each participant to initiate the seating arrangement when being interviewed. Respondents were also asked if they were comfortable prior to the start of the session and were reminded, as per the Consent form that they could pause and withdraw their participation at any time. The names and likeness of participants were not used for this study to both ensure and assure confidentiality.

Chapter 4: Research Findings

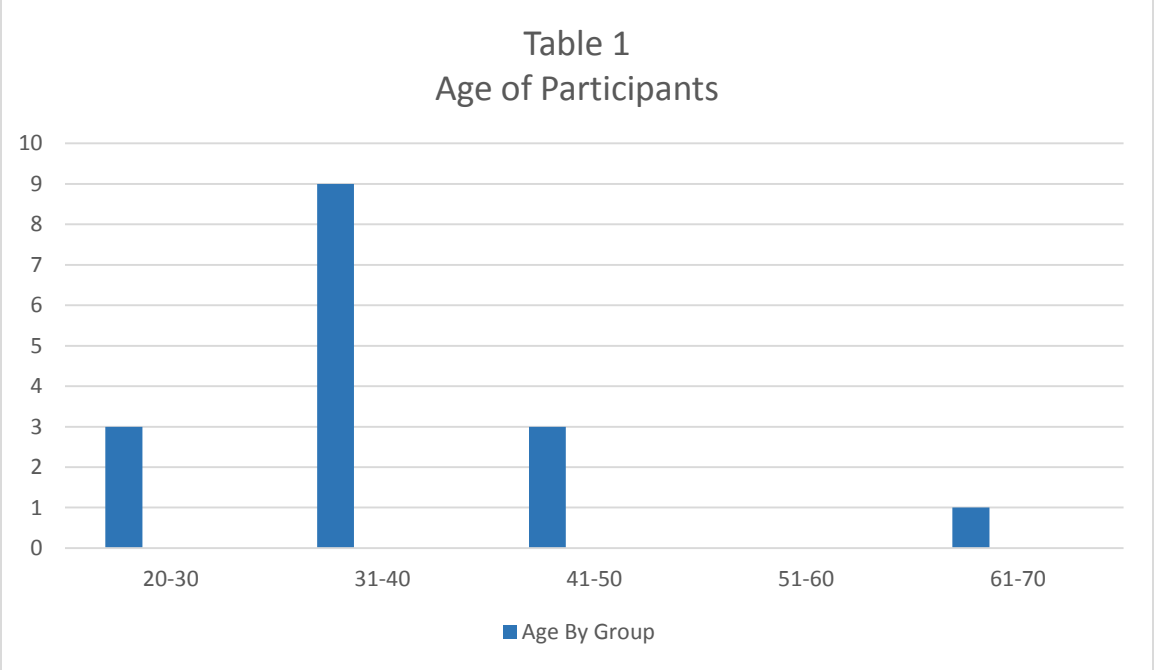
The purpose of this research study was to examine the role of a social worker in a level 1 trauma setting, based on the expressed perceptions of social work functions within the interdisciplinary team from the perspective of team members serving within the organization. Additionally, this ethnographic study aimed to explore how role value is ascribed within the Emergency Culture. The ultimate goal was to see the culture and gain an informed understanding of how social work professionals operate in a predominately medical trauma team based on the knowledge gained, for the benefit of the population served.

Study Participants

This study was conducted with the participation of 16 (n= 16) professional members of the emergency/hospital team. As detailed in Chapter 3, there were 3 social workers, 1 social work intern, 5 physicians (1 ER attending, 1 psychiatry attending, 2 ER residents, 1 psychiatry resident), and 2 mid-level providers; for this study they were physician assistants, 3 registered nurses (2 bedside and 1 clinical nurse case manager) and 2 members of hospital administration. The demographic makeup of the participants was as follows: The mean age for participants was 31-40 (n=9), followed by 20-30 (n=3), 41-50 (n=3) and finally 61-70 (n=1). Of the participants, ten (n=10) were female and six (n=6) male. There were eight (n=8) White, non-Hispanic respondents, seven (n=7) Black/African American respondents, and one (n=1) of Asian/Pacific Island descent. Among the study participants, two (n=2) held Associates, three (n=3) Bachelors, five (n=5) Masters and six (n=6) participants carried a Doctor of Medicine.

Each participant was asked two questions regarding their years of experience. The first question was surrounding their years of emergency room experience, followed by a question about their years of Level 1 Trauma experience as the study took place in a Level 1 Trauma Center. Four of the 16 respondents had less than 3 years of experience in the ER. The same number was reported for Level 1 trauma experience. There were 6(n=6) who had been in the ER

for 3-5 years, and 7 (n=7) who provided this range for their time in a Level 1 Trauma setting. Four (n=4) brought with them 6-10 years of emergency experience, while three (n=3) affirmed 6-10 in Trauma. There was one (n=1) response for each of the following time frames: 11-15 years for ER and for Trauma as well as 16 years or more for ER and for Trauma. See Tables 1-5 below. Individual/group descriptions of participants will not be provided as to not allow for participant identification.



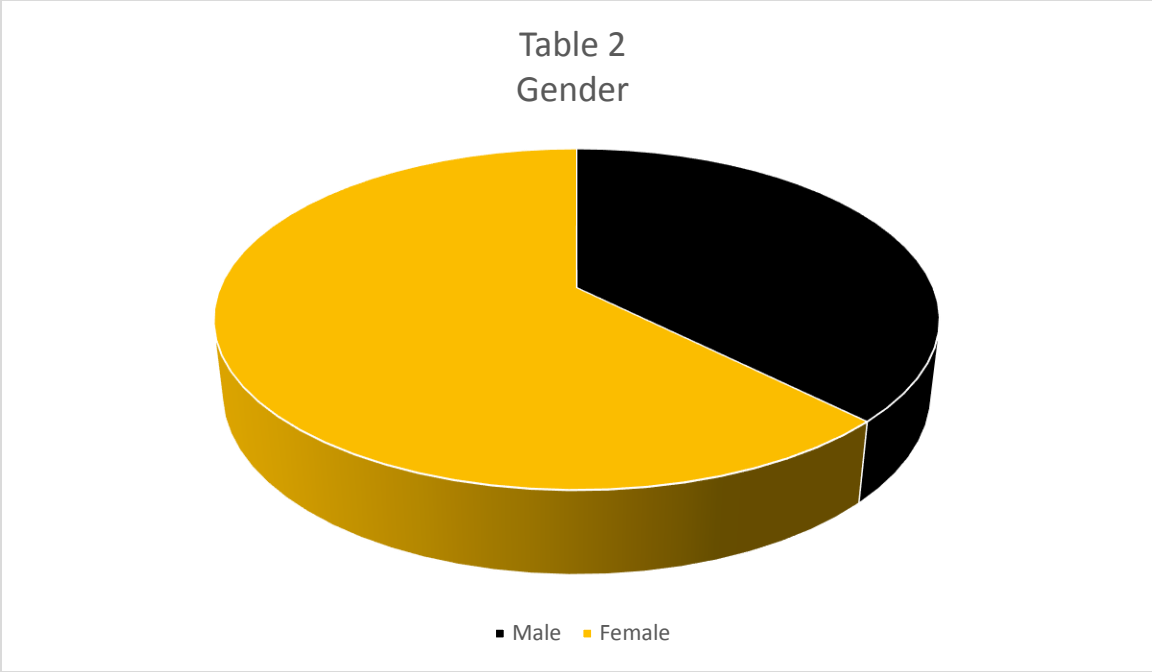


Table 2
Gender
Male
Female

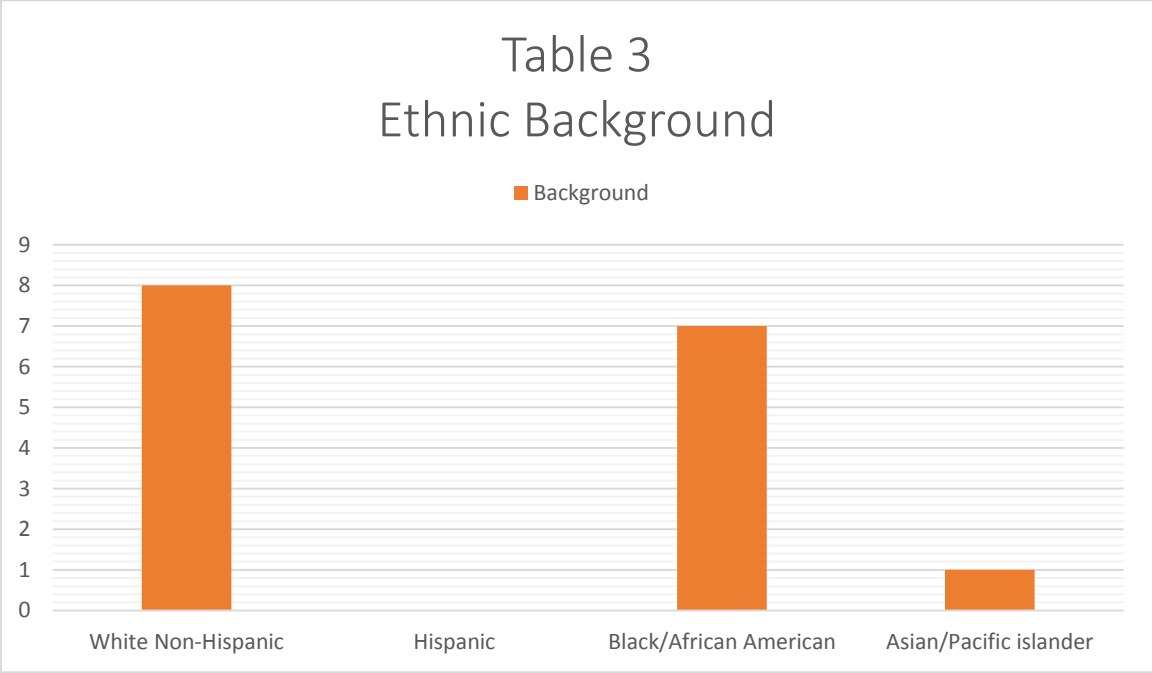


Table 3
Ethnic Background
Background
9
8
7
6
5
4
3
2
1
0
White Non-Hispanic
Hispanic
Black/African American
Asian/Pacific islander

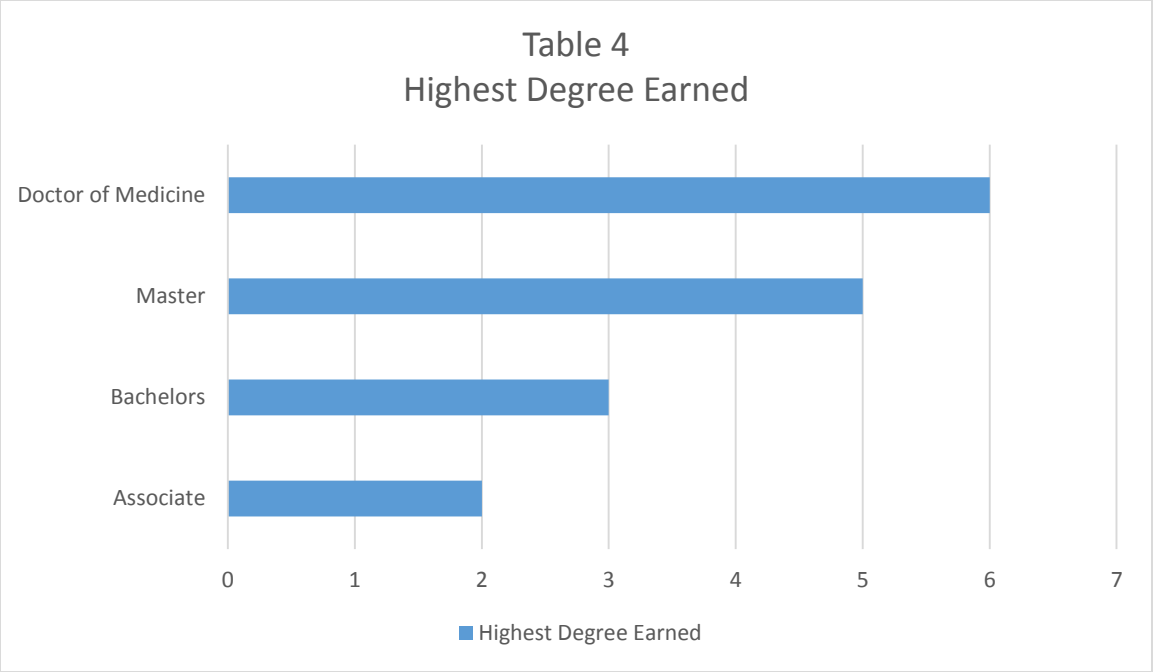


Table 4
Highest Degree Earned
Doctor of Medicine
Master
Bachelors
Associate
0
1
2
3
4
5
6
7
Highest Degree Earned

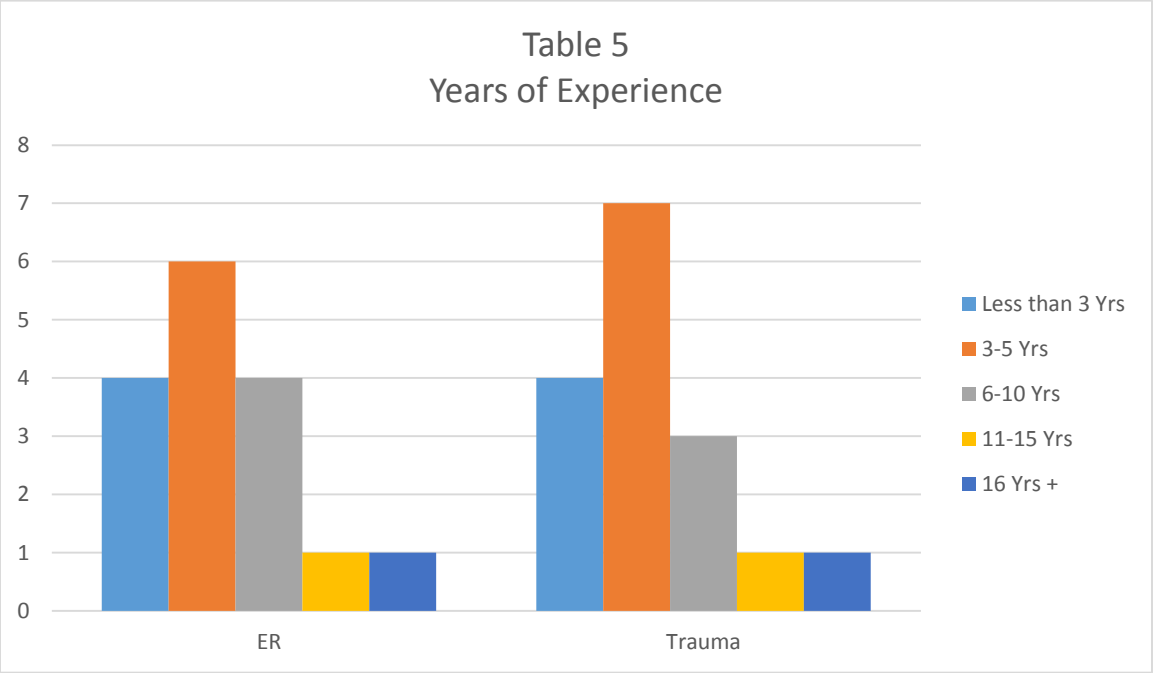


Table 5
Years of Experience
8
7
6
5
4
3
2
1
0
ER
Trauma
Less than 3 Yrs
3-5 Yrs
6-10 Yrs
11-15 Yrs
16 Yrs +

Summary

As a reminder, there were three research questions which were as follows: 1) what is the role of the social worker in a Level 1 trauma setting, 2) how do members of the interdisciplinary team view the social work function within the organization, and 3) how is value ascribed by each discipline to the role of the social worker in the emergency culture? Below are the presented findings organized by three major constructs based on the above mentioned research questions. The constructs are: Role of the Social Worker, Function of the Social Worker and Value of the Social Worker within the Emergency Room Culture. This decision was made because there were no real differences across disciplines, rather more commonalities in how participants responded to the questions. The team seemed to share the same view regarding the role of the social worker, function of the social worker and value ascribed to the social worker within the ER culture.

Role of the Social Worker

The interviews were completed over a span of just over 2 months and revealed that there were more similarities of thought than were differences. Again, the findings have been organized by constructs with the first being Role of the Social Worker (perceptions). In general, it was found that the role of the social worker was that of a discharge planner, community resource expert, lead detective and mental health professional.

Discharge Planner

One common theme was that social workers were discharge planners and is illustrated below:

I'm always thinking about discharge, even before I walk into the room. What is the person going to need to be successful, to be healthy at the time of discharge and if that requires a social work consult, then I put it in immediately.

-Physician Assistant

Social workers quarterback safe discharges.

-Hospital Administrator

Disposition is almost dependent on social work.

-ER Resident

Disposition, or where a patient will go upon discharge, is a large factor in when or whether a patient can leave the emergency room. Noted specifically were dispositions to shelters, skilled nursing facilities, inpatient psychiatric hospitals, personal care homes, with family, hospice, morgue, drug treatment facilities, jail, the hospital lobby or discharge to the street. And in order to get the patient to the appropriate level for their after care needs, patient assessments are required. Social workers, according to the data, are responsible for patient psychosocial assessments, crisis assessments, financial assessments, suicidal/homicidal ideations assessments, family assessments to obtain collateral information when patients are unable or unwilling to provide it. Social workers complete legal affidavits to accompany emergency detention orders if a patient is currently a danger to themselves or others. Interviews and assessments are completed to determine if other entities should be involved such as child and adult protective services or law enforcement for matters such as abuse, neglect, domestic violence, or if bodily injury was caused as a result of a crime.

Community Resource Expert

Another common theme found surrounding the role of the social worker dealt with their expertise and vast knowledge of community resources. Being well versed in available resources was touted as a top role and almost a requisite for emergency room social workers. Many adding the fact that countless numbers of the patients seen in this particular ER setting lack

certain basic necessities, such as housing, income, insurance, identification, clothing, transportation and food. According the respondents, their ability to provide quality care hinges on their ability to also assist in meeting the other needs of the patient.

> *Has the total good really been done if the patient leaves with no resources of where he can go to get food?...A lot of times, the largest part of the encounter is maybe that new information about community resources that the patient is leaving with...I have had encounters where I say, 'well let me let you talk with a social worker,' and 15 minutes later, some person from a shelter is coming to pick them up...I don't know what that patient maybe came to the ER for, but they're leaving with something way greater than probably was first anticipated.*
>
> -Physician Assistant

> *Social workers are able to get resources that would otherwise prevent patients from going home and collateral information, and kind of really organizing on a higher level than the docs are able to do, all of the things that go behind the scenes of making sure the patients are taken care of.*
>
> -ER Physician

Social workers are said to work behind the scenes, waving their magic wands, collaborating with other entities within the community to take care of the patients. And because it is often done so smoothly, it has admittedly become an expectation to add that piece to the puzzle. Based on participant experiences for this serviced population, the data showed the following as resource needs: shelters, single room occupancy rentals, personal care homes, legal assistance, community HIV/AIDS testing and assistance, insurance eligibility assistance, substance use/abuse resources and assistance, sexual assault, domestic violence, food pantries,

hot food serving lines, area clinics, bus routes to area resources, mental health resources and education, support groups, and transportation assistance.

Lead Detective

Common to the role of the social worker was the theme that investigative and detective work played a big part in the day to day duties in the ER. This role was not just for the purposes of resource allocation, but when it came to the trauma side of their ER work. There are times when patients arrive to the emergency room and the only known information is their current or presenting medical problem, such as a gunshot or stab wound, altered mental status (for a number of possible reasons), fall, motor vehicle accident, drug overdose, or even a natural disaster or industrial chemical spill. While the medical team works to stabilize the patient, the social worker works to identify the patient and locate/identify family to notify them of their loved one's arrival and need for emergency care. This is accomplished using several different avenues. When patients enter the critical care room, their clothing is removed and bagged. Social workers will often put on gloves if they need to go through the patient's belongings in search of anything that can help identify them or help find family (wallet, ID, cell phone, check stub).

> *We had a trauma case here where a lady was involved in a motor vehicle accident. This was a level one code- trauma code, which is the worst. This lady was coming from the airport in a taxi and was what we call T-boned where here vehicle that she was driving in…was hit broadside by another vehicle as she was going through an intersection. This lady was from another country, but was working here in the United States on some kind of project. And she came in and basically we had to do what I call- what I'd like to call detective work. We had to figure out who she was, where she came from, why she was here, and figure out how to reach her family or company and next of kin*

without her help, which involved us going through her personal effects looking for signs and clues of people we may call or contact in order to find out who this lady was…we were able to access her computer and figure out where she worked and was able to notify her company that she'd been involved in an accident. The company here in Houston was curious when she did not show up for her meeting that morning, but we were able to reach the company and resolve everything.

–Social Worker

Sometimes we have to search through pants, purses and wallets to identify a patient.

-Social Worker

Mental Health Professional

Another common theme found was social work's role regarding the mental health of the patients served in the hospital. This is an important finding as this setting is home to the only psychiatric ER for a community of more than 6 million people, reports one respondent. Social workers are involved in many, if not most psych ER cases. Doing what it takes to provide care to the patients encompasses assessing the situation through interviews with patients when possible and/or by obtaining collateral information to share with the treatment team to determine the best and safest course of action for the patient. This collateral information often comes from the patient's family, friends, personal care home staff, or sometimes the police. Patients may be brought to the hospital specifically presenting with mental health/psychiatric needs, but often have a co-occurring medical presentation that must be addressed and cleared prior to them moving into the psych ER, or 1 South as it is called, which is a locked unit. Social workers work with patients with suicidal ideations or attempts, homicidal ideations, psychosis, patients

needing new placements due to being banned from their current care home or are unable to return home with family. Patients with new diagnoses of schizophrenia with paranoid features, drug overdoses, or patients in various stages of detoxing. Social workers respond to whatever the needs are while collaborating with other members of the treatment team. Social workers are said to smooth over the gaps between psych and medical as reported by one respondent. Some cases take a long time to come to an acceptable resolution.

> *One of the cases that I worked on several days…was a mental health patient who had been mostly cared for by his mother. He had a history of mild MR and schizophrenia, had assaulted his mom, which is why he ended up in jail. While he was in jail, his mother dies. Was not able to go to the funeral. Also, while he was in jail, his disability got turned off. He had been in remission from drugs and alcohol for many years, but now is out of jail, has no place to stay, is staying in the park and no insurance anymore and no income. So he had been back and forth. He had come in…he had relapsed on some drugs and alcohol and had been having interventions, had been having conversations, being discharged and not remembering a thing and coming right back several days in a row. So, finally I was able to get with him and we made out a list. We wrote things down. We went over the things to make sure that when he discharged in the morning, he remembered exactly what we had talked about and had this piece of paper and where he was going and he had to get his disability reinstated and onto housing 'cause he didn't want to be back on the streets, was afraid he was going to hurt somebody or get hurt. And we had a positive outcome. The next morning he actually went. He did get his benefits turned back on and met with the people that he needed to help him do that. And we haven't seen him back here, so we think that was a good thing.*

–Social Worker

Social workers provide collateral information for our patients who present with psychosis, suicidal or homicidal ideations.

-Psychiatry Resident

When questions explored ideas about the role of the social worker within the ER setting, words such as multi-faceted, complex, comprehensive, holistic in approach, diffuser of intense situations, supportive, patient-focused, solution-driven, chaos manager, facilitator, and communicator were also noted as roles of the social worker based on their experiences.

The role of the social worker is to forge relationships with the patients and the team.

-Hospital Administrator

There was a time when social workers were thought of as the folks who always got the bus token or the cab fare for the patient or…the patient was in the trauma room and needed clothes, the social worker went to the clothing room and helped find clothes- not that that's not important, but the profession has changed much in terms of skill sets and expectations.

-Hospital Administrator

Though this change in skill set was mentioned and acknowledged by others, there were some respondents who focused their responses on transportation and some reported the social role included assistance with home health and durable medical equipment, both areas that are handled by the clinical nurse case managers.

A printed copy of the Social Worker /Case Manager II job description was obtained to add another view of the role of the social worker in an attempt to determine if the participant responses were in line with the Health System's expectations. This form was created in 2004 and was last revised in 2010. It was created in the form of a rubric, possibly for use for performance evaluations. It listed the responsibilities, their weight by percentage, performance standard and measurement methodology.

Nine responsibilities were listed in this job description:

1. Performs Psychosocial Needs Assessments & Reassessment, 15%
2. Plan of Care, Discharge Planning and Case Management, 15%
3. Demonstrates Professional and Clinical Expertise in the Practice of Social Work, 10%
4. Demonstrates Adherence to Department Guidelines and Policies and Procedures for the Provision of Client Services and the Effective Operation of the Department, 10%
5. Supports Departmental Professional Activities, 10%
6. Effective Use if Supervision, 10%
7. Demonstrates Cultural Competence, 10%
8. Patient Satisfaction, 10%
9. Service First Behavior, 10% (Friendliness, Integrity, Responsibility, Satisfaction, Teamwork)

Function of the Social Worker

A rich finding from this study was that in a high-intensity, high-stressed setting where hierarchy may occur, the opposite was found. The different disciplines were found to work or function together in an integrative nature. Though worded differently and spoken from different disciplines, the message came across the same; A patient-focused culture, one that is constantly improving from the days of being separated and one side placing the blame on the other, and being seen as the care center of last resort; to one of collaboration, integration, alliances, empathy, great understanding –the best of the best. The culture expressed in the data came and were delivered with a feeling or sense of pride as it related to the quality, safety and level of care provided to the patients and the accolades that came as a result of that care.

Rewarding! That reward is knowing that…I take pride in the fact that I do not have to ask insurance status for patients. I get to take care of everybody. I take pride in the fact that after another facility completely botches something, they send them to us and we fix it…that contributes to our culture and the way we approach our patients. –ER Attending Physician

It's not a job, it's THE job. – Hospital Administrator

It's a community -based health care system. –Registered Nurse

The very foundation of this Hospital System is about compassion and caring for the Harris County community. –Physician Assistant

[There is a] *common nationwide [mis]conception that people feel, that people who need to seek care in public hospitals are lucky to get what they get.*

-Hospital Administrator

I expected less caring because it's a county hospital, and it's quite opposite.

-Social Worker

Everyone wants to be here…everyone cares for the patients.

-Registered Nurse

Patients receive more compassion here than they would at other ERs.

-Social Worker

We are more than one person caring for the patient.

-ER Resident

If you're not passionate about what you are doing, I don't know what you're doing in the job…because you have to be to do the work we do.

-Registered Nurse

Requires appreciation of other disciplines' roles.

–Physician Assistant

Integrated, Not Interfaced

Chief among these findings was the fact that social workers were seen as the glue that kept things going in this setting, adding that social workers were actively engaged, serving as the heartbeat of the emergency center and not considered a separate entity within this ER. Seen as playing a vital role on both the treatment team and within the ER culture, with their work perceived as impressive and the manner in which they do it as respectful.

The social work cadre is absolutely critical. –Hospital Administrator

Harris Health System does a good job by making sure that social work is integrated into the entire system. –Clinical Nurse Case Manager

I can honestly say that I've learned to do some things from social workers in seeing how they address problems, approach patients, do their assessments.

-ER Attending Physician

There is no separation the culture includes social work.

-ER Attending Physician

> *If we want to truly heal the patient medically, we have to make sure that their social issues are not necessarily totally solved, but at least moving toward some type of being resolved- and that's where social work comes in as that glue.*
>
> - ER Resident

> *Social workers do functions that add to the total care of a patient that would probably get lost or not done otherwise.* –Clinical Nurse Case manager

> *I would say that in our culture because just point blank a hospital like this would not work without the level of social work interaction that we have on a daily basis.* –Hospital Administrator

One physician reported that when considering coming to work at this hospital, the fact that there were social work and language services available through the ER at all times, was a selling point and had a major impact on their final decision. Others added that social workers are always striving for social justice and come in to remind the team that the patient is a human life with feelings, by displaying a special sensitivity to their needs all while working to re-acclimate the patients to the real world.

Miracle Worker

A commonly noted response when detailing the function of the social worker within the culture was the fact that, among the other disciplines, it is uncertain how the social workers come up with the resources and contacts, but nevertheless, they do and it is greatly appreciated and adds to smooth workings in the emergency room.

> *A few weeks ago, I had a guy come in. I think his complaint was like dental pain, but there was something that he wanted to talk about. He was very apprehensive. It was my second time seeing him and he says… you can't believe*

what happened to me. He began to tell me that wherever he had been staying, he couldn't go back because he was staying with a friend- someone he thought was a friend- and the guy told him, he could not return unless he performed sexual on him/with him, whatever. And so, he had been like just walking around all night not wanting to go back home and so, that's when I said, 'oh , let me let you talk with a social worker, 'cause we got to figure this out, you can't- this is not gonna work.' And I left the Unit for 15 minutes and literally, when I got back, I mean, his whole demeanor had changed… and someone from some home like 20 minutes later was there to pick him up and take him to wherever and then the patient came back and he- he came back to thank me…I said, 'well it's my job' or whatever. But he just came back to say how nice the place was. It was Christian-based. He had his own room. The rent was like 400, - something he could afford, and yes, this was just a simple encounter. He had no idea what he was gonna leave with. –Physician Assistant

We know they have low resources. We know… they might not have any money and somehow the social workers will usually always find a way to get them somewhere. –Psychiatry Attending Physician

Value of Social Work within the ER Culture

Visibly Working Miracles

A value finding from this part of the study was that the social workers were never hard to find, they were always visible and accessible regardless of time of day. The terms varied slightly, but there was a general consensus of value and respect for the social workers in the emergency room at Hospital. Some valued specific tasks that they assist with, such as their knowledge of resources, the way they assist the homeless population or the efficient manner in which consults

were handled. Some respondents spoke to the higher level of organization and the ability to think critically in stressful situations as valuable. Social workers are said to have a myriad of resources and go behind the scenes to help the patient. The fact that they are flexible and available; not just for the patients, but for team members to collaborate and bounce stuff off of were listed as values of note by respondents during this study.

> *I think what I value the most is that they can always handle it and take care of it, regardless of what it is.* –ER Resident

> *The really good social workers are the ones that were able to really span the entire spectrum of the patient experience and that's the strength.*
>
> -Clinical Nurse Case Manager

> *I think our input on how discharge planning is handled is very valuable and I think the physicians and nurses alike will rely on us a lot more than I even anticipated they would.* –Social Worker

Nightmare on Taub Loop

Travesty, confusing, frustrating, incomplete and chaotic were responses given when asked to describe under this role value construct, the emergency room without social workers. Noted in some form by all respondents was the fact that without the presence of social workers, interventions would go missed and that patient needs would go unmet. The concept of throughput would be disrupted, decreasing the number of patients seen daily.

> *10 times harder without social work.* –ER Resident

> *I would not be working here if there was no social work.*
>
> –ER Attending Physician

We would not be able to pick up the slack. –Registered Nurse

A big headache. –Registered Nurse

No, I cannot imagine the emergency department without social workers.

-Physician Assistant

The absence of social workers in the emergency room would negatively affect the culture. –ER Attending Physician

Nurses, residents, patient advocates, providers, pastoral care and trained volunteers were said to likely assume the roles and duties barring the presence of social work. Everybody would be looking to somebody else, passing the buck with no consistency.

[Nurses] are not skilled in identifying and understanding the nuances of community resources and the connections that exist within our communities.

-Hospital Administrator

Social Workers Help With the Bottom Line

Social work input in the emergency room, as reflected in the data, was said to play an important role in discharges, readmissions and admissions for social reasons. Length of stay and patient wait times, according to one reply, would be ridiculous without social work as their work is attributed with preventing wrongful admissions and decreasing recidivism rates. The social work input enhances the continuity of care for the patient. Similarly to outcomes, the importance of the social work input to the team was seen as vital and respondents were not hesitant to speak to that fact. Several respondents noted that their jobs would be impossible to do without the assistance of social work and went a step further by saying that when everything was working well, it was clear that social work was involved. Some participants reflected the

under appreciation of the social worker and the fact that sometimes they could be taken for granted or even dumped upon, assuming that they could just handle everything by waving those imaginary wands. It was found that the idea of interdisciplinary versus multidisciplinary team was the preferred term, seeing the team or the system incapable of functioning without the social work facet.

Also seen as a valuable finding, was the impact the social worker had on the patients served. Social work input was deemed as important to patient's overall well-being and that this input was considered vital to their success post discharge. Education, information, advice and advocacy were said to make the patient experience complete and provided the patient's with the sense that they were being provided with an extra level of care when they were visited by the social worker.

> *No one looks at it the way that the social worker does when they're looking at the family and the patient and the whole element of things that are only being looked at incrementally or in a small way with respect to the disease…the social worker is the one person that I've seen for years, the one person the patients know is an advocate…it's just an unspoken truth. The patient knows that the social worker is going to be an advocate and the social worker is not going to judge them if they don' want to do something. The social worker is not going to be critical of- they may have a conversation about compliance and education and whatever, but it's always directed in a positive and healthy fashion toward, you know, what's best for the patient…It's someone they can trust who's going to look out for their best interest who's not gonna walk away saying, no I can't do that right now or go ask your nurse…they're going to work with them until they get it worked out or do everything they can to get it worked out, you know. And the patient's gonna be satisfied that they've done everything they can do.*

-Clinical Nurse Case Manager

I sleep better at night knowing someone else saw the patient and helped me make a decision on what to do. –Physician Assistant

If they knew what social work was capable of doing?

-Social Work Intern

Patients seen here have 1-2 active problems and 20+ inactive problems.

-Hospital Administrator

You can't treat people if you can't keep people moving.

–Social Worker

Social workers are lagniappe, the extra that makes things better.

-Social Worker

Outtakes

No Appointment Necessary

As part of the ethnographic interviews, participants were asked to describe the ER setting for this Hospital. Though not a major finding of the study at large, these descriptions and depictions work to inform the themes and constructs regarding the role, function and value of the social worker in the emergency culture. The researcher was asked on several occasions to picture a facility designed more than 20 years ago to accommodate 45,000 patients annually that now actually sees 105,000+ patients, averaging 280-350 daily encounters with more than 100 daily hospital admissions from the ER alone. By response, this is a Level 1 trauma center

where 15-17% of the workload is said to come from traumas. This ER consists of a triage area, where based on acuity level, patients are sent to certain areas or Cores for treatment. These areas/Cores have assigned alphabets, A,B,C…but refer to express care, urgent care, a 60 bed holding area, with no private rooms, close observation area (with psych techs), pediatric emergency area, and psych ER. The setting has been likened to a third world country at first impression, and a war zone with a battlefield medicine mentality. Safety net was used to describe the ER and the hospital in general as a place for both emergent and primary care for those who feel as though they have no other care option, or just simply prefer to return to a system in which they have learned to navigate.

Descriptions were given of some of the patients served in this ER. One respondent noted that Hispanics make up 60% of patients seen with several having Spanish as their first and sometimes only language. Patients from the Middle and Far East (Cantonese speakers) were mentioned. To this was the remark that language services are available in the ER 24/7 to meet patient needs and decrease barriers to care caused by language. This ER was described as a place where people can come with very serious injuries and in very grave conditions and receive care. Homeless patients, undocumented patients, substance abusers, patients with comorbidities.

The most common terms used to describe this ER setting was fast-paced, followed by chaotic, crowded, extremely busy, demanding, intense, complex, quick patient turnover, high energy, stressful, and ginormous. The reported need for roller skates was used to give context to the pace and volume of people that come through the ER on a daily basis. Another reported flying by the seat of their pants as a result of the pace. Treatment team members say they are constantly working to put out fires and work quickly to stabilize a patient's condition. Sometimes that stabilization takes place in the hallway if all of the critical care rooms are occupied. This brought about the decreased sense of privacy.

Patients seen here have 1-2 active problems and 20+ inactive problems.

-Hospital Administrator

You can't treat people if you can't keep people moving.

-Registered Nurse

The ER setting at Ben Taub consists of open bay type of beds where all the beds are open. There's no privacy, per se. There's a curtain that you can halfway close, but you can't close it all the way, because of course, the nurse has to still be able to see their patient. All of the beds are in somewhat close proximity. So your ability to get in close maybe to hear the patient can be a little cumbersome just because if you get in closer that means your butt may be in another patient's face. So you have those confined spaces. Also when a trauma comes in, a code, then that's in one of the critical care rooms and although it is a room, it is, again, open. And it is open with multiple disciplines in there as well and you have to find your way up to where the patient is to get the needed information. It also entails the hallway. Sometimes there is not enough space in either the holding area or the critical care area and you are assisting the patient literally in the hallway. -Social Worker

It smells. I know they can't help it. It smells. Whenever I go in there, I have this sense of like sadness, 'cause everyone in there is hurting physically or mentally. They're confused half of the time. A lot of them are angry. -Social Work Intern

The Eyes Have It

As noted in Chapter 3, observations were completed as part of this study to enhance the data received by way of interviews and printed data. Observation periods or sessions took place

during the recruitment phase to maximize time spent at study site. Observations were taken on four different dates and were 1-2 hours in duration. Each session captured a different type of interface with social work professionals in the emergency setting. Because occurrences in this setting are generally spontaneous in nature, the participant observer was open and subject to the encounter(s) during the observation periods. The four sessions covered the following areas: EC Psychiatry shift change and morning rounds, patient consultations, trauma, and peer to peer debriefing. Notes were taken during each session and included the setting, characters involved and interactions noted. The focus was the social work interface and observations reflected this effort.

Session 1: Trauma Anyone?

Observation taken in the Critical Care Area, formerly known as Shock Room Hallway. The Critical Care Areas consists of 5 critical care rooms, stocked with state of the art equipment to handle whatever medical situation that arrives, usually with little notice. Each room has a stretcher, computer, x-ray equipment, monitors, fluids, sheets, bandages, gauze, gloves and other supplies. There is actually an Observation Deck (a raised area) in rooms 1 and 2 where people can get a better view of the care being provided without interfering with that care. This Care Area also includes the hallway where care is often provided when necessary. Along this hallway is an elevator bank that can take the Team along with the patient to the operating room quickly. Further down this hall is the assistant nurse manager's office and next to it is the Pyxis or medication system for quick access to meds necessary to assist the patients. Rooms 1 & 2 are primarily designated for trauma, while the remaining rooms are typically used for more medical emergencies, such as heart attacks and strokes. This does not exclude all five rooms from being filled with patients with traumatic injuries. Moving throughout the halls on this date were people dressed in scrubs in an array of colors to correspond with their role. There were emergency medicine attending physicians and residents, medical students, x-ray technicians,

registered nurses, certified nursing assistants and clerks. Physician Assistants were nearby as was the Spanish Interpreter on shift. The social worker was present as was the guest of honor, the patient, accompanied by EMS professionals. The Team was notified of the upcoming arrival via trauma pager as well as an overhead page that gave the code level, this was a Code 2 (in the middle as far as severity) and a brief description of the situation (stab wound, upper right quadrant) or my personal favorite- man versus train or man versus pole. Lastly, the estimated time of arrival, 10 minutes was announced. While the information is being announced, team members maintain their current positions, but were seen pausing to catch an ear of the particulars, to what looked like a means to prepare themselves for what was coming while wrapping up their present task, or at least bringing it to point where they could safely move to the next need. Upon the arrival of the awaited guest, which was in less than 10 minutes, the responding team members are in place and receive a report from EMS that included patient presentation upon their arrival and what was done in the field to stabilize, if possible, their condition until their arrival to the trauma center. There is a charting nurse who is writing down numbers as they are called out. These numbers were for vital signs, needle sizes, types of neck stabilizing collars used, amount of any drug administered in the field and en route to the hospital. After EMS concludes, the social worker is observed asking a member of that team their Unit, Ambulance or Medic number to add to the record. Also, the location of the pickup was asked to provide collateral, should it be pertinent at a later time. EMS had the patient's name and identification, information that was shared with the social worker. While this is taking place, the charting nurse continues to take down numbers being called out by other members of the team. Doctors calling out numbers in response to their physical exam of the patient and their responses to questions or inability to respond. A resident with scissors is more than excited to cut the patients clothes off to get a better look at the situation and better assess the wound(s). The Chaplain is in the room and is taking a copy of the patient sticker that provides the name and medical record number of the patient, also age with date of birth. After the

situation calms a bit, the social worker approaches the patient, making introduction and asking if there is a family member or friend they would like to be notified of their arrival to the emergency room- then asking permission to make contact and if needed, share information after obtaining name and contact information. This patient was able to consent and provide a name, but was lost when it came to the phone number. Patient said that the number was located in the cell phone located in their pants pocket….the same pants that were cut off the patient and placed into a belongings bag. The social worker donned a pair of gloves, retrieved the cell phone and with the verbal assistance of the patient, was able to find the number and made contact with the next of kin selected by the patient. After making the call, the social worker returned to the critical care are to update the patient that their loved ones were indeed notified and were to be en route. Patient verbalized understanding as the nurse was taking them to CT scanning area to get a better look at the extent of the damage. The social worker returned to work area to document the occurrence. This was the same for other members of the team who would not continue working directly with the patient upon their return from the scanner, they returned to their previous post and continued caring for their patients.

Session 2: Early Morning Psych

Observation taken in the Emergency Psychiatry Unit (also known as 1 South). This took place early in the morning- before, during and after shift change. This observation also included a morning staffing meeting with patient rounds. Present were 2 social workers, a social work intern, 2 off going psychiatry residents, 2 oncoming psychiatry residents, 2 psych nurses, 1 faculty attending and 2 medical students (in a not so large space). All eyes were on "The Board." The Board is just that, a whiteboard that holds the information for all the patients in the EC Psych area as well as the name of patients referred for a psychiatry follow up located across the hall in the Holding Area (Cores A and B). The name, age and gender of the patient, along with medical record number, and bed number are placed here. There are also codes to determine

whether or not the patient has been seen (and by whom), needs to be seen, has been cleared, or other disposition status. A brief description of why member is in the emergency center and other consults are listed; such as social work, INSIGHT (substance abuse team). If patient is awaiting blood work or other testing, this can also be placed on the board. On this date, The Board looked "good" according to team comments. Some team members were completing documentation as they prepared to end their shift, while others were arriving and preparing to begin their workday. People were moving in and out. Housekeeping and food services knock and were able to enter the Unit to fulfill their duties for the morning. The Board is being cleaned up to reflect updates, such as discharges, transfers and cancelled consults as appropriate. Social workers are observed checking both the Board as well as the electronic medical record for open referrals. Staff is prepping to round on the patients remaining on the Board. Each patient was briefly presented and if there was a social work consult noted, the results of that consult were reported. The meeting was led by the Faculty Psychiatrist with major updates presented by the resident who worked the overnight shift. Discharge planning, dispositions, barriers to discharge or successful aftercare were all discussed as appropriate for each listed patient. This was an early day and the mood in the room reflected that. There was a distinct difference in the people coming on and the people who had spent several hours working and were ready to leave. On the other side of the Unit, registered nurses and psych techs were taking vitals, giving breakfast and also preparing for shift change and giving/receiving report. Patients are moving from their beds to the day room area, where there are tables, chairs and a television. There are about 5 rooms with 4 beds to each room, bathroom in the hallway, and at the end of the hall, an interview room next to 2 locked doors. At the other end of the hall, there are 2 locked rooms used for patients needing to be de-escalated in a safe room. These 2 rooms are separated by a staff restroom.

Session 3: Patient Consultations

This observation took place at night. This particular night was not a heavy trauma night, that being said, the consults were steady. Shortly after the observation period began, referrals began to come in through more than one avenue. The first was viewed on the psychiatry board with an official consult for the same patient placed in the computer system. The consult was for an assessment for a patient with suicidal ideations. While the social worker was reviewing the patient chart, a resident from the medicine team came over with a sticker (containing patient name and medical record number). This particular consult was for a patient who was ready for discharge, but need transportation home. The patient, who has a chronic illness, came to the emergency room via ambulance and needed to return the same way. Patient was wheelchair bound and the chair did not accompany the patient to the hospital and family did not have access to transportation to safely secure the patient. The consult was specifically for ambulance transport home. Shortly after that, another consult came for transportation for a patient who was brought to the emergency room directly from one of the Health System's Community Clinics. This patient was experiencing severe chest pains and was brought in for evaluation.

The social worker was observed taking the information being reported and decided to handle the cases in the order in which the consult was received. Prior to getting up to see any patients, all charts were reviewed to obtain information regarding presentation, treatment and support, if any. The initial patient interview was the SI assessment. It was determined that the patient did not have a plan and was currently going through a bad break up and was having a difficult time coping with the situation. The social worker worked with the patient, offered immediate support counseling and assessed interest and willingness to seek continued assistance upon discharge, patient was willing and received education and resources for counseling and other community based support services.

Next stop was to the holding area to see the patient in need of ambulance transportation home. Social worker asked the patient to verify their address and inquired as to whether or not there was someone home to receive them upon arrival. The patient affirmed, giving the social worker the name and number of the loved one who would be in the home. There is an online request system for the Health System's ambulance transport/dispatcher, but since it was after hours, a paper form was completed at the bedside and reviewed with the patient for accuracy in preparation for faxing. The social worker conferenced with the patient's nurse to ensure all discharge matters where in order, explaining that when the form was received and ambulance unit could arrive for pick up in as few as fifteen minutes, and the goal was to have the patient ready. The nurse asked the social worker to wait a few minutes as they were waiting for a prescription to be filled (a tech to script to pharmacy on the patient's behalf). The social worker agreed to wait and decided to see the next patient on the list. Another request for transportation, but this time it was looking as though this would be for a cab. According the treatment team, patient did not live along a bus route and was unfamiliar with how to travel via bus with transfers. The patient was up in age and for safety purposes, the social worker felt more comfortable with sending the patient home via taxi cab, but only after an assessment was completed. Patient did not have the funds to pay for the trip, but could provide the address and produced his house keys to let himself into the home upon arrival. The social worker obtained a cab voucher, placed a call to the contracted cab rates operator, corporate account number, voucher number, the hospital address, patient's address with zip code and the name of the patient (this was done so the cab driver would know who to expect). This information was also written of the voucher to later be presented to the driver. The social worker again spoke with the patient's nurse, inquiring about readiness and added that there are often cab drivers in the area and they can be onsite within 5 minutes of being called. The nurse reported that the member was ready and even had the tech ready with a wheelchair to take the patient to the entrance to await transport. Social worker quickly made the call and escorted the patient and

tech to the entrance, handing over the voucher to the driver, who was pulling up just as the patient made it to the designated area.

This social worker made it back to the holding area where the ambulance transport was pending. Upon return, the social worker was informed that the medications had been filled and released to the patient and that all discharge instructions and follow up information had been explained to member. Social worker faxed the transport request, called to confirm receipt and was given an estimated time of arrival. This time was then shared with the patient, nurse and resident. When the patient was picked up, the social worker then placed a call to the family informing them that the patient was returning home and to be available to let them in. Social worker then returned to computer to document the three cases.

Session 4: Peer-to-Peer Debriefing

This observation took place in the morning in the Psych ER, where many of the emergency room social workers are housed. Two social workers are present during this time. Observation began with a lot of typing and very little interaction. Then a fellow social worker came from another post (this social worker is located in another part of the emergency room) came into the area to discuss a case and obtain additional resources to assist a patient. The other social workers listened attentively as the case was presented and immediately began to offer suggestions and bounce ideas off of one another. This went on for a few minutes until a good set of options were available to share with the patient. The conversation then changes to the events of the week; cases seen heaviness of the week's workload. Each took a turn sharing a memorable case of the week or an encounter with a frequent flyer. There was a comment on how good the psych board was looking and how things appeared to finally be under control, allowing them a bit of a breather for a change. As soon as that last comment was uttered, a psych nurse appeared along with the psych resident and a medical student. They were all coming to get some assistance with developing a plan for a patient who did not quite meet

inpatient criteria, but definitely needed follow up care in the community. While the team began deliberating, it was brought up that the fact that the patient also would be in need of a place to stay, had been neglected. Not to show frustration, all of the social workers paused, looked at one another, and began to laugh. It was back to the drawing board. A consult was requested so the patient could be assessed to determine the full extent of the needs, along with additional barriers.

Flashbacks

While serving in the capacity of researcher and participant observer, there were times when thoughts of shifts past would come to mind. For every case recalled during the data collection; memories of trauma codes, family notifications and not so pleasant smells flooded the mind. Several stick out, but one remains the most memorable. There is a saying that you never forget your first time. This can mean many things, but for these purposes it refers to the first solo death this researcher (in the role of emergency room social worker) responded to. It was a Friday night and the Trauma Pager went off….CODE 3 (at this time Code 3 referred to the most critical case, that has now changed and Code 1 now holds that distinction). The Pager said GSW and the overhead page voice chimed in and said CODE 3, GSW TO THE HEAD. 5 MINUTES OUT. There was no one to take this Code or to assist…this social worker was all alone. Shortly following the initial overhead page, there was another notification, CODE 3 ON THE BACK DOCK. It was show time. All disciplines were in place and ready to take care of this patient. He was a 21 year old male with black curly hair. Since the call said he was shot in the head, the eyes automatically went there first. It was clear almost immediately that this patient would not be able to verbally assist with providing contact information for next of kin. Though there was no cell phone, EMS had the patient's information and date of birth from his State ID Card. With only this to go on, this social worker asked if family was on the scene and if anyone was on their way to the emergency room. It was then explained that the patient was found at a

hotel…alone. Quickly to the office, this social worker entered the patient's information to see if he had ever been treated at any of the hospitals or clinics in the System. It was discovered that the patient was born at this hospital (according to the DOB, patient just celebrated his 21st birthday) and had some other historical information, but not enough to really work with. Social worker began to look to see if patient could possibly be a Jr. and whether or not his father could possibly be identified. Nothing. Other internet resources were attempted, but there was not much to work with and Homicide detectives had not yet arrived to the ER. Intermittent checks into the shock room (now called critical care room) were made to see how the patient was doing. Again since the wound was to the head, the eyes went instantly to his curly black hair. His head was noticeably larger and there was a steady trickle of blood from his head to the floor.

After about an hour of exhaustive searching and unsuccessful detective work, there was another overhead page for the social worker to report to the triage area. A security officer informed that there were people claiming to be family members of the patient in the lobby. After meeting with them and asking initial questions regarding name, date of birth, relationship to patient and identifying characteristics (someone mentioned that he had black curly hair), the social inquired as to how they were made aware of patient's whereabouts. The patient's brother responded that someone saw it on the news and knowing that the patient liked to go to this particular hotel, he called the brother to tell him patient had been shot in the head and taken to this hospital. This social worker went from not being able to locate anyone, to being face-to-face with the patient's mother, father, sister and two brothers. They were immediately placed into the Family Room, which is a small consultation room with a sofa, lounger and side table with phone. Social worker made introductions, now joined by the Chaplain, and explained what we knew at this time (meaning that the patient was brought via ambulance and was being treated for wounds sustained). They were told that the team would be notified of their arrival and that a doctor would soon be in to provide them with an update. A few minutes passed and now added to the family room was the assistant nurse manager, attending surgical physician and security,

who was right outside of the door to control foot traffic in this area. The attending went through the course of events following the patient's arrival to the trauma center. The report included details of the care provided upon arrival and ended with the doctor informing the family that despite their attempts, they were not able to survive his injuries. The small room went from quiet to loud and violent in a matter of seconds. The patient's mother was so overcome with grief and anger that she pushed her daughter against wall, knocking her to the floor. She was quickly detained, removed from the room and the daughter was attended to. Family members began to scatter as they each reacted in their own way to the news. A lot of things transpired after this moment, but what sticks in the mind is the fact that the mother wanted to call her employer to let them know that she may be late for work the following day and needed someone to open the restaurant for her. When asked about this decision, she said it was the only thing she knew to do at the time, but after a while she realized what actually transpired and she made another phone call, explaining the situation and was told not to worry about coming in. She was taken to the restroom to wash her face and she stopped this social worker in the hall to make a statement. She reported that this was her fault because she and her husband just told the patient 2 days prior that if he continued to live his life the way he was, that he would find himself either in jail or dead. She then said words that have been remembered to this day. She said that when she left the hospital tonight that it would be the first night that she would go to bed knowing where her son was. The social worker was able to begin the healing process with her, but knew that this would take time. The Chaplain was able to take over with this process as well as logistical steps regarding what would happen after the conclusion of the police investigation.

Chapter 5: Discussion

Study Summary

The purpose of this research study was to examine the role of the social worker in a Level 1 Trauma setting, based on the expressed perceptions of social work functions within the interdisciplinary team from the perspective of team members serving within the organization. Another aim of this ethnographic study was to explore how role value is ascribed within the Emergency Culture. The ultimate goal was to see the culture and gain an informed understanding of how social work professionals operate in a predominately medical trauma team based on the knowledge gained, for the benefit of the population served.

Three research questions staged the study:

Research Question 1: What is the role of the social worker in a Level 1 trauma setting?

Research Question 2: How do members of the interdisciplinary team view the social work function within the organization?

Research Question 3: How is value ascribed by each discipline to the role of the social worker in the emergency culture?

The three constructs or focus areas in this study per the findings were: (1) *Role of the Social Worker,* (2) *Function of the Social Worker and* (3) *Value of the Social Worker within the ER Culture.* A qualitative design was selected to allow the researcher/participant observer the opportunity to operate within the emergency room culture without disrupting the normal behavior or routine of the participants or other members and actors at the research site. The site for the study was the emergency center at Level 1 Trauma Center in Southeast Texas. Over a near three month period data was collected from social workers (interns), physicians (residents), registered nurses and physician assistants. Disciplines were observed during

rounds (team meetings on patient presentations, status and plan), trauma codes, peer-to-peer debriefings and patient consultations. Archival data was reviewed and inspected for comparison to interview data gathered through discourse.

The research questions provided guidance and focus for the interviews and observations. The participants were the center throughout the study. Their words, behaviors and observed interactions formed the foundation upon which meanings could stand. The interpretations that emerged can be discussed in relation to the study's major findings. Chapters 4 and 5 display the findings as related to the role of the social worker in a Level 1 trauma setting, their interface/function within the described cultural environment and their ascribed role value based on the perceptions of members of the treatment team operating within this same emergency culture. This Chapter will continue as follows: Findings and Interpretations, Recommendations, Researcher Reflections, Suggestions for Further Research and Summary and Conclusion.

Findings and Interpretations

Role of the Social Worker

Among non-social work professionals, do social workers belong in the emergency setting (Garces, 2002; Gelhart & Brown, 2006)? This was the question that created the spark for the study. According to the data collected, the non-social work professionals interviewed responded overwhelmingly that not only did social workers belong in the emergency setting, but their absence (in this setting, in particular) would have negative effects that would be felt throughout the emergency room and hospital at large. Chapter 1 also introduced literature regarding social work's impact on admissions and rate of return ER visits (Auerbach & Mason, 2010). This information was affirmed through the data collected in the study. Interestingly, some of the statements rendered almost read verbatim to the literature. For example, when the researcher asked who would assume the roles/duties if social work was no longer available within the

setting, several respondents said the duties would fall to nursing and some added, just as the literature suggested, that registered nurses lacked the training to handle social work tasks (Auerbach & Mason, 2010; Barth, 2003). Regarding role- there was little, if any variation from the literature in terms of responses for role and types of consults for ER social workers as noted by (Auerbach, Mason & Heft LaPorte, 2007).

Discharge Planning, a major theme noted both in the literature and by respondents as to the function of social workers in the emergency setting. *Broad* and *holistic* were used to describe the social work approach, contrasted by other members of the treatment team who report seeing their role as more narrow and task specific (as medical providers), (Garces, 2002; Kitchen & Brook, 2005; Salvatore, 1988). This being said, social workers are commonly consulted for narrow, concrete tasks, limiting the use of their full range and scope of their skill set (Garces, 2002). A social worker's connection to critical community resources has aided in their success reducing patient readmission and non-emergent visits (Holliman, Dziegielewski & Datta, 2001). Soskis and Cowles (1985; 2000) reported that one of the roles of social workers in the ER setting is that of resource broker.

Throughout the study, participants spoke of the important role good resources play in a successful discharge disposition for patients. The right resources can determine whether a homeless person has a place to live at discharge, or if a substance abuser can enter into a rehabilitation program. This is an important area for social workers, as it requires them to stay engaged in the community with their fingers on the pulse of changes as they happen in order to best serve the patients as well as the members of the treatment team.

According to the literature, social workers serve as the main conduit of vital information to include community resources (Beder, 2006; Holland & Rogich, 1980). Community resources and discharge planning, in the opinion of the researcher, go hand in hand. Unless the discharge is straightforward/routine and includes a patient returning to their home environment with

strong and loving family support via private transportation from the hospital and back for their follow up appointments, resources that are accurate and up to date are central. The same can be said regarding the social worker being seen as a mental health professional. Upon completion of their specific assessment- connecting the patient, their family and the treatment team with the appropriate resource(s) to take the patient to the next step is vital. The role of the lead detective in the ER has a similar function, in that this is often where critical thinking and creativity come into play. The use of resources are essential to be successful, but are used in a different way. When trying to identify a patient or locate next of kin, a social worker must use whatever is at their disposal. Time is often of the essence during these trauma codes. A patient may come into the critical care area, receive a quick physical assessment while the team receives a report from the EMS team, after which the patient and the team disappear to the operating room. Social workers often try to obtain information from EMS, patient belongings, the electronic medical record (if they have been in the hospital before), and the internet (to include social media). As someone who has served in the position of lead detective, this role can be both rewarding and frustrating. There are times when one trauma case can take up an entire shift as social workers labor to find a patient's loved ones after a tragic accident. The reward comes when the social worker has employed creative and unconventional methods and have been able to find family and safely get them to the hospital. The down side to that is having to inform them of the critical, or fatal condition of their loved one and initiating with them the grieving process.

As patterns and themes emerged from the data surrounding the role of the social worker, the researcher could not ignore the striking resemblance the participant responses had to the values, principles and standards prescribed in NASW's Code of Ethics. Service, social justice, dignity and worth of the person, the importance of human relationships, integrity and competence were all mentioned among the disciplines.

> The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective…ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence (NASW, 1999).

The data has shown that patients, interdisciplinary team members, and of course, the social workers care and are impacted by the input of the social worker in the emergency setting. But when looking from a global perspective, the role of the social worker has a positive impact on hospital administrators/leaders as well. The final probing question posed to participants made inquiries as to the importance of social work input to the hospital. According to the literature and supported by the data, social workers aid in the reduction of hospital readmissions and return visits to the ER. This is important for many reasons, but with the Patient Protection and Affordable Care Act (ACA) which was signed into law March of 2010, social work input is not the only thing that will impact the hospital. ACA was created to provide quality health care that is affordable to all Americans and do so in an efficient manner. The Law is also pressing for transparency from hospitals, such as the study site, that benefit from 501 c (3)/ tax exempt status. Accountability among health care institutions have increased to include greater requirements to obtain this status. Hospitals must now complete a Community Health Needs Assessment every three years to ensure that they are continuing to meet the needs of their service area while providing quality outcomes for their patients (Health Capital Consultants, 2011).

Due to a bundled payment system associated with ACA, ERs have already began changing triage/care procedures as to decrease wait times as noted in Chapter 4 when participants were describing the ER. The study setting operates under a Core System (express

care, urgent care, medical/surgical holding areas, etc…) all based on level/severity of patient acuity. Due to the ACA insurance mandate, more people will be entering the market, but the question and possible area for future research is whether or not their healthcare behaviors, patterns and habits change (ER as primary care). Based on the new reimbursement rules along with new spell of illness regulations with Medicare and Medicaid, hospitals are working to reduce readmission rates. And just to reemphasize, the literature, supported by the collected data confirm social worker's role in such a reduction. Making good use of those skills could have a positive impact on patient outcomes as well as reimbursement rates.

The focus of the Reform changes are accountability, efficiency and quality. This may leave hospitals in a bit of a strange place- more patients with coverage, but stricter guidelines and reduced reimbursement rates. Education, preventive care, community care and involvement become key. Social workers play a vital role in patient education regarding resources available, presenting an opportunity for social workers as well to become better acquainted with community providers as they roll out new services and make practice changes in response to health care reform. This could be accomplished through the offering of CEUs sponsored by local agencies to educate and promote available services along with eligibility requirements. HMOs could possibly sponsor educational events as their members are in emergency rooms and the accountability, efficiency and quality cornerstones have not been set up for hospital alone- HMOs are also effected. This adds another opportunity for community collaboration for information exchanges.

As a current employee for an HMO, the researcher has first-hand knowledge that the goal is to allow members to live and operate in the least restrictive environment possible, which in most cases is their home environment. If member's leave the hospital with a skilled need, more than likely that need can be met with home health care and physical therapy. These services come at a decreased cost in the home than if rendered in a hospital or skilled nursing

facility. These services also serve another purpose. It serves as another set of eyes with multiple contacts and can prevent readmissions or return ER visits when there is a change in condition as the care staff report to the member's primary care physician and can be given orders for in home care.

Function of the Social Worker

The Contingency Approach to Organization Theory

The general premise of Organization Theory, as noted in the Conceptual Framework, is that the study of organizations is done with an emphasis on identifying commonalities among themes for the purposes of problem solving, maximizing efficiency and productivity, and the meeting of stakeholder needs (Meyer, 1977). Meyer went on to define an organization as a structured system comprised of groups of individuals who work together to meet agreed upon objectives and goals (1977). The emergency organization at the study site is made up of disciplines charged to treat and repair patient stakeholders in a safe, efficient and productive manner. The Contingency Approach to Organization Theory seeks to understand interrelationships "within and among the various parts of an organization," (Hellreigel & Slocum, 1976). Each part of the organization can be analyzed separately or as an interacting piece of the group dynamic. A contingency approach '"recognizes that subsystems within the organization are dependent upon and influence each other (pp. 7)."

To apply the Contingency Approach to this study, social workers are an independent discipline with core values and standards that drive the level of care provided to their clients or patients. And as shown through the data, social workers are considered to be an integral part of the emergency culture with key roles in the total throughput of patient care process, and are seen as a "major cog in the wheel." This Contingency Model also plays a part in ACA and the impact on hospitals. There are four major properties of this Model: Environmental, Individual,

Organizational and Group. For this chapter, the researcher will focus on environmental and individual properties as they flow into the organizational and group.

Environmental

Vendors, consumers and competitors would fall into this category. Resources must be secured according to the needs of the environment in question. Initially, the researcher considered the patients only when working through environmental properties. This initial interpretation shifted after data collection and analysis. In order for the organization to be and remain successful through the ACA mandates and with advances in general, relationships in the community (home health, skilled nursing, durable medical equipment, health maintenance organizations, other ERs) must be intact and truly cohesive. Secured resources, per researcher interpretation and based on participant responses can come in the form of more qualified social work staff to better meet the patient needs while complying with government regulations.

Individual

The overall goal of the Contingency Model is environmental success. To this point, caring for the patients is central, but in order do that, each discipline must do double duty. That is, work in their lane by staying up to date with the latest tools and techniques to do their best work, while at the same time coming together across disciplinary lines, forming a joint set of values, behaviors and practices to serve their stakeholders. According to the data, when participants were asked about social work interface within the ER culture, respondents spoke of social justice and the values that make social work unique as a discipline. They continued to add that though unique in their knowledge and skill set, it was those same characteristics that formed the glue that held the team together and contributed to the positive outcomes experienced by patients on a daily basis.

The Study, as previously stated, began with the question do social workers have a place in the emergency room? Based on the participant responses regarding the fast–paced, war zone, complex natured culture of this ER and social work's fit and integration therein, it appears that these social workers have created a place for themselves within this environment. Solidified by answers that suggesting that an ER without this faction would make this place of battlefield medicine much harder to navigate and would be seen as a travesty for both the team, for which they are a part and the stakeholders for which they serve.

Value of the Social Worker within the ER Culture

To refer again the question posed at the top of the study; do social workers belong in the emergency room. Research Question 3 looks into the value ascribed to the role of the social worker by each discipline in the emergency setting. Participants answered this question by listing that the input of the social worker in this setting affects unnecessary hospital admissions from the ER for social reasons such as lack of suitable discharge disposition. Also, the number of readmissions and return visits, per participant response, is reduced and has been partly attributed to the valued role of social workers in the setting. Each respondent was able to speak to their thoughts on the importance, if any, of the input of the social worker to the team, the patient and the hospital. The findings were in favor of contributions made as each entity was said to benefit from social work input. Telling, were the responses given when asked to describe this ER setting void of social workers? The replies were mostly immediate and the tone definitive. There was almost a tenor of resentment that the words were even uttered for recorded response. The question seemed to have caught participants off guard. No one responded in the affirmative as if things would continue as normal should social work services no longer be offered in the this emergency center, rather; hospital administrators, physicians, physician assistants, registered nurses and social workers alike spoke to the difficulty maintaining the quality level of care currently provided. When asked, each discipline provided a

replacement to assume the duties, but added that the skill set and knowledge base could not compare to that of the social worker, stating that everyone would essentially pass the buck and look to someone else to handle to matter/issue typically covered by the social worker.

Researcher Reflections

This research study was both a labor of love and an eye-opening experience. The labor of love refers to highlighting the social work profession and the professionals who make this challenging role look like second nature. The researcher has served in the capacity of a social worker/case manager II on an on/off PRN (as needed) basis since 2006. Training side-by-side in the ER with some who still hold their positions to this date. As a fellow professional it is difficult not to be impressed by the wealth of knowledge each social worker possesses, their individual personalities and flow that distinguishes one from the other, and the sheer grace and finesse by which they seem to glide and operate within this hectic environment. To address up-front the issue of bias, the researcher purposely took time away from the ER to be able to come inside with a bit of an outsider feel. This actually worked and contributed to the eye-opening experiences. Procedural changes had taken place, to include the ER nomenclature that the researcher had to adjust to during the recruitment and data collection phases of the study. To sit with members of the different disciplines, ask questions and await the responses was exciting, but came with uncertainty-not knowing what would be said.

The interview scheduling was at the convenience and availability of the participants. The first interviews of any project typically set the tone and will inform whether or not the Interview Guide is effective. They also tell if the questions flow in a logical manner and if it gets to the heart of what is trying to be discovered or uncovered. For this study, the first two interviews, coincidentally, were conducted with members of hospital administration. Both participants spoke, unsurprisingly, with such elegance and like artists, painting pictures and scenes with every word of every given response. They understood the role of the social worker

and the capabilities held within. Both spoke about relationships forged onsite and within the community. They also added, from their perspectives, the detriment that would be caused should this ER be void of social work as a consulting/team option. These initial interviews showed that the Guide was well constructed, providing initial excitement regarding potential results, but also created a small sense of fear that these would be the only two positive encounters as administrators do not have a daily hands on function in the ER. The researcher thought back to years past where social work's place/position was not always celebrated and was sometimes even seen as a nuisance or after thought.

As the interviews continued, it was refreshing to see that the changes made in the ER appear to include social work into its model. One resident physician in the Emergency Medicine Residency Program reported that consulting social work has been engrained into them, so assessing for the need for social work intervention and then making the consult has essentially become part of their comprehensive patient assessment. Hearing from a faculty member/attending physician about his thoughts surrounding social work and his trust in their assessments along with the level of care and concern they bring to the team-not just to the patients, but to the entire team. This, along with the fact that there was social work available in the ER 24 hours a day was one of the deciding factors when considering where to work. As a social work researcher who also actively practices, these types of comments make the years of education worthwhile- now if only something could be done about the pay. That being said, social work positions in health care typically come with better wages (at least this has been the researcher's experience with a 12 year post graduate work history exclusively in health care).

When speaking of researcher bias, there was the initial thought that the medical team members would be pleasant due to the fact that the researcher is a social worker, but would not be able to provide the information in an in-depth manner regarding role and interface. Conversely, it was feared that the social work participants would take this as an opportunity to

bash other disciplines and possibly complain about poor treatment. Neither took place to the surprise of this researcher. The medical disciplines were able to list several social work duties based on their experiences and were hard pressed to imagine maintaining the current daily patient load /care quality without the assistance and input from their social work colleagues. Fellow social work professionals used their participation as an opportunity to highlight and articulate the many ways in which they add to the team dynamic as well as the team's success with their contributions. Many added how the fact that the doctors rely so heavily upon their input was a surprise to them too, but a welcomed one. The study reaffirmed the love for the decision to pursue a career in social work, though this profession is not one that can be chosen, rather, it chooses you- all you can do I accept the calling and decide to educate yourself and strive to improve and devote your life to bettering the lives of others.

Changes have been made to improve the working conditions of these social workers-all shifts now have double coverage for most, if not the entire shift. This differs from a time when working an entire shift alone as the norm. If working alone during an overnight shift, the social worker was not only responsible for the ER in this 8/10/12 hour time period, but would also care for the entire for social work needs of the entire hospital. Though improved, there are still opportunities for growth and fine tuning- additional staff is always welcomed to allow for ease when needing to request time off. Also for staff working Registry (part time or PRN) an increase in the hourly rate would be an incentive. Upon being hired until today, the rate has increased $1.50 since 2006. This does not encourage qualified people who receive no benefits to apply for open positions. This is unfortunate, because this remains, in the researcher's opinion, one of the most interesting places to work, learn and grow. Every shift is different. This researcher's ability to conduct a comprehensive assessment in any situation, under treacherous circumstances and unrealistic time constraints is attributed to the training received in this facility. This researcher is also able to attribute an increased level of empathy along with a

greater appreciation to the lives and living situations of others, and the work done by all professionals within this system, respectively.

Suggestions for Future Research

This research study could serve as a foundation for future research. For example, one year following the full implementation of the ACA health insurance mandate (which affords access to health care to all Americans), this study could be repeated to explore the changes, if any, to the role and function of the social worker in the emergency setting. This mandate may impact the daily census at this County/safety net facility, leading to an increase in the number of professionals needed to provide quality care. Also based on the value construct, a longitudinal study could be conducted to track study participants as their careers progress. For example, if following the careers of the social work interns and resident physicians, inquiring about the influence of their training on their employment decisions as well as the integration models of their current employer.

The study could be extended to include a neighboring emergency room. This facility also holds Level 1 status, it is a non-profit private hospital system with a community-based hospital board. This hospital is also in an urban city in Southeast Texas and is actually located next door to the study site. The study could compare the perceptions between the Systems to explore differences/similarities in role perception and types of consults received. Culture and role value would be studied as well. The patient perspective regarding the role of the ER social worker could also be explored. Purposive sampling could inform the participant pool from chart reviews of patients with social work interventions-then expand this to the other Level 1 facility for comparison. Replication could also take place in a Level 2 or 3 emergency room to explore the culture, role, function and value.

Limitations

The study took place inside of one Level 1 Trauma center in an urban city in Southeast Texas and may not be representative of other centers in the State of Texas or on a larger scale. The study used as convenience sample and the perceptions provided by the respondents were based on their personal experiences and again may not be representative of the entire population of ER staff. The convenience sampling and the progressive/integrative nature of the research setting may have influenced the research and outcomes. Participant bias, in favor of social work professionals, may have also influenced recruitment response and outcomes. The Interview Guide was developed by the researcher specifically for use in this study, though useful for this research, it may not serve as suitable in other health care environments. Other environments may not have the same social work interface/interdisciplinary team arrangement as this particular Level 1 Trauma setting. The researcher was the sole person to collect data for the study and also serves in the capacity of social worker in the study setting.

While steps to decrease bias were taken, subjectivity may still exist. The researcher used the anthropologically strange approach to the research setting as one means to decrease bias. Triangulation and peer debriefing, the use of multiple data collection tools, along with the industrious use and understanding of actual reactive and reflexive influence.

Summary and Conclusion

While conducting this study, thoughts began to arise regarding the results, what they mean and how those meanings could be used to best move the data forward. In the area of social work practice, the results of this study show that though the term is not explicitly used, members of this ER disciplinary team are operating under an integrated health model. According to SAMHSA-HRSA's (CIHS) Center for Integrated Health Solutions, integrated primary and behavioral health services better address the needs of individuals with mental

health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings (SAMSHA-HRSA, 2013). They have developed an integration continuum in the efforts to form a standardized framework for research and outcomes for best practices in patient care. The levels range from minimal collaboration, where there is a separation in systems and facilities, communication is rare and there is a lack of appreciation of each other's cultures. The other side of the continuum is close collaboration in a fully integrated system where all care professionals have shared expectations, systems and facilities, great appreciation of roles and cultures, and routine collaborations that occur smoothly (SAMSHA-HRSA, 2013).

In the area of policy, the implementation of current policy that would allow for the expansion of social work services in the emergency setting that would make full use of the education garnered by these professionals. As listed throughout, the Affordable Care Act would be a great place to start being that this monumental law is rolling out over the next several years with the potential to effect the lives and livelihoods of social work professionals while expanding access to healthcare to people Nationwide.

As it relates to social work education, greater emphasis could be placed on medical social work at both the BSW and MSW levels- encouraging students/future practitioners to consider health care as the avenue by which their passion can be expressed. With the changes coming from healthcare reform, there can be an opportunity for medical social work certifications/concentrations with a dedicated field component for those with medical social work interests.

Research opportunities can and will continue to come as changes are made as a result of the reform and as institutions work to accommodate those regulations as passed. Studies regarding the gateway that is the emergency room in reference to number of admissions, length of stay and health habits post the ACA insurance mandate. The researcher is interested to see if the Reform will actually bring about change in favor of the patient as designed or will fear; of

change, the unknown or even progress prevent progress from being made? Hopefully, as integrated health models develop and strengthen, social workers can take on a larger role, leading the charge to form a seamless bio psychosocial web.

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Appendix 1

Demographic Data Sheet & Ethnographic Interview Guide

Background Information (please circle your response)

Age

- 20-30
- 31-40
- 41-50
- 51-60
- 61-70
- 71 or older

Sex

- Male
- Female

Ethnic Background

- White non-Hispanic
- Hispanic
- Black/African American
- Asian/Pacific Islander
- Other, please specify
  _____

Highest Degree

- Associate
- Bachelors
- Masters
- Doctorate

Years of Emergency Room Experience

- Less than 3
- 3-5
- 6-10
- 11-15
- 16 or more

Years of Level I Trauma Experience

- Less than 3
- 3-5
- 6-10
- 11-15
- 16 or more

Profession

- Social Worker
- Physician
- Registered Nurse
- Mid-Level Provider
- Intern
- Hospital Administrator

The following guide purposes to obtain a comprehensive understanding of the role of the social worker in the emergency room setting based on the perceptions of the participant. These perceptions (using one's senses to acquire information about the surrounding environment or situation) can be based contextual factors, personal experiences and/or the cultural factors associated with working in a fast-paced trauma setting.

An open ended question will be asked to begin the interview and each subsequent topical section and will follow the schedule listed below. Since the format is that of a semi-structured interview, "loosely follow" is more accurate.

All interviews will be digitally recorded for later transcription, archival and analysis.

All information gathered will be held strictly confidential.

Interview Questions (IQ) are organized by Research Question (RQ)

RQ 1: What does it mean to be a social worker in a Level 1 trauma setting?

IQ: Based on your knowledge/experience, tell me what a social worker in the emergency department does.

RQ 2: How do members of the interdisciplinary treatment team view the social work function within the organization?

IQ: Tell me when you would involve or consult a social worker.

IQ: Recall for me an instance/scenario when you consulted a social Worker and what was the result?
(is this a professional approach or a personal practice?)

RQ 3: How is value ascribed (hierarchically) in the emergency culture?

IQ: Name the emergency department social worker(s) for your normal shift. If not certain, how would you go about finding out?

IQ: What is the process for consulting a social worker?

Describe the emergency department without social workers?

Appendix 2

UNIVERSITY OF HOUSTON
CONSENT TO PARTICIPATE IN RESEARCH

Perceptions of the Role of Social Workers in an Emergency Setting: An Ethnographic Study.

You are being invited to participate in a research project conducted by Joy J. Malbrough, LMSW from the Graduate College of Social Work at the University of Houston. As a doctoral student, this project is being conducted in partial requirements for completion of the doctoral dissertation process and is being conducted under the supervision of Dr. Luis Torres, sponsoring faculty member.

NON-PARTICIPATION STATEMENT

Your participation is voluntary and you may refuse to participate or withdraw at any time without penalty or loss of benefits to which you are otherwise entitled. You may also refuse to answer any question. As a student researcher, your decision to participate or not, or to withdraw your participation will have no effect on my standing. Your employment will not be affected in any way, whether or not you take part in this research study.

PURPOSE OF THE STUDY

This study purposes to describe the role of the social worker in a level I trauma setting. Also, to examine the perceptions of the social work function in the interdisciplinary team from the perspectives of social workers and social work team members. Lastly, the purpose of this study is to discover strategies used by social workers to gain equal footing for their professional contributions in a primarily medical treatment team. The duration of the entire study is 6 months.

PROCEDURES

You will be one of approximately _15_ subjects to be asked to participate in this project. This project is taking place solely in the Emergency Center at Ben Taub General Hospital.

- Your participation will consist of a one (1) time face-to-face interview

- Your participation will NOT take place during work hours

- Your participation will take place in a closed room

-Your responses will remain confidential

-You will only be asked to complete a follow up interview if absolutely necessary

- Total time commitment will be 45 minutes

CONFIDENTIALITY

Your participation in this project is anonymous. Please do not write your name on any of the research materials to be returned to the principal investigator.

RISKS/DISCOMFORTS

There are no foreseeable risks, discomforts, or inconveniences involved in participating in this project. Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with Harris Health System.

BENEFITS

While you will not directly benefit from participation, your participation may help investigators better understand the perceptions on the role of the social worker in the emergency setting.

ALTERNATIVES

Participation in this project is voluntary and the only alternative to this project is non-participation.

INCENTIVES/REMUNERATION

As a token of appreciation for participating in the study, participants may receive a $10 Starbuck's gift card upon completion of interview.

PUBLICATION STATEMENT

The results of this study may be published in professional and/or scientific journals. It may also be used for educational purposes or for professional presentations. However, no individual subject will be identified.

If you have any questions, you may contact Joy J. Malbrough, LMSW at 281-431-6290. You may also contact Dr. Luis Torres, faculty sponsor, at 713-743-8512.

ANY QUESTIONS REGARDING YOUR RIGHTS AS A RESEARCH SUBJECT MAY BE ADDRESSED TO THE UNIVERSITY OF HOUSTON COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS (713-743-9204).

Principal Investigator's Name:

_____

Signature of Principal Investigator:

_____

Appendix 3

CONSENT TO RECORD

Perceptions of the Role of Social Workers in an Emergency Setting:

An Ethnographic Study

The undersigned consents to the recording of his/her voice by Joy J. Malbrough, LMSW, acting under the authority of the University of Houston, for the purposes of the research project entitled "Perceptions of the Role of Social Workers in an Emergency Setting: An Ethnographic Study." The undersigned understands that the material recorded for this research may be made available for educational, informational, and/or research purposes to such use.

_____ _____

Participant **Date**

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing this consent form did so freely and with full knowledge and understanding of its contents.

_____ _____

Representative of the University of Houston **Date**

Appendix 4

Research Study Involving Emergency Room Staff
University of Houston
Graduate College of Social Work

You are invited to participate in a study examining the role of the social worker in an Emergency Room setting. The study will be conducted by Joy Malbrough, Doctoral Candidate at the University of Houston's Graduate College of Social Work.

Who is Eligible?

Social Workers
Social Work Student Interns
Physicians
Registered Nurses
Nurse Practitioners
Physician Assistants

What will you be asked to do?

The study involves ER observations and one (1) face-to-face interview lasting one (1) hour where you will be asked questions about the contributions made by social workers in the emergency room

Compensation

You will receive a Starbuck's Gift Card for your participation in this study

If you have any questions or are interested in participating, please contact:

Joy Malbrough, Principal Investigator at
(337)-xxx-xxxx
or Email: joymalbrough@aol.com

This research is conducted under the direction of Dr. Luis R. Torres, Graduate College of Social Work, and has been reviewed by the University of Houston Committee for the Protection of Human Subjects (713)743-9204 and the Harris Health System Research & Sponsored Programs (713)566-6914.

Appendix 5

Hello,

I am a graduate student at the University Of Houston Graduate College Of Social Work. I am in the process of writing my doctoral dissertation and am collecting data for that purpose. For my dissertation, I am very interested in learning more about how the members of the interdisciplinary treatment team view the functions of social workers in the hospital emergency room. My research study is titled, "Perceptions of the Role of Social Workers in a Hospital Emergency Setting: an Ethnographic Study."

You are receiving this email because you are a member of the multidisciplinary team (social worker, physician, registered nurse, nurse practitioner, etc.) in the Emergency Room Harris Health System's Ben Taub General Hospital. This project has been reviewed by the University of Houston Committee for the Protection of Human Subjects (713) 743-9204 and has been approved by the Harris Health System Research & Sponsored Programs Department.

I invite you to take part in this study. This study involves observations of social work interactions with other members of the ER multidisciplinary team in addition to speaking directly with you about your view of the functions of social workers in the ER. This will take the form of a one-time only interview, which will be held at a time and date of your choosing and will last about one hour.

As an expression of my appreciation for your involvement in this study, I would like to offer you a Starbucks gift card at the end of the interview.

If you are interested in participating or have any questions about the study, please email joymalbrough@aol.com or call 337-xxx-xxxx.

Thank you for your time and assistance.

Sincerely,

Joy J Malbrough, LMSW

Joy J. Malbrough, LMSW
Doctoral Candidate
Principal Investigator
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