

# Understanding Collaboration Between Social Workers and Physicians: Application of a Typology

Julie S. Abramson, PhD  
Terry Mizrahi, PhD

**ABSTRACT.** This article builds on prior analyses of data collected from a qualitative study of 50 pairs of social worker-physician collaborators in. This article presents the elements of a typology of collaborators from both professions developed from those analyses. The typology was also applied to the entire sample and each respondent characterized according to type (traditional, transitional or transformational). Further analysis was done to evaluate the relationships between type and collaborative perspectives. The sample was primarily transitional (56%-58%) and there were more traditional social workers (22%) and transformational doctors (24%) than anticipated. Social workers, as a group, were much less satisfied with the doctors than the doctors were with them although both groups of traditional respondents were the most dissatisfied. Both groups were least transformational in relation to control over decision making. *Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2003 by The Haworth Press, Inc. All rights reserved.*

---

Julie S. Abramson is Associate Professor at the School of Social Welfare, University at Albany, 135 Western Avenue, Albany, NY 12222 (E-mail: jal99@albany.edu). Terry Mizrahi, is Professor at the Hunter College School of Social Work, 129 East 79th Street, New York, NY 10021 (E-mail: tmizrahi@hunter.cuny.edu).

This research project received support through faculty research awards from the University at Albany to Julie Abramson and from the Professional Staff Congress of the City University of NY to Terry Mizrahi as well as from a grant to Julie Abramson from the Silberman Fund.

Social Work in Health Care, Vol. 37(2) 2003  
<http://www.haworthpress.com/store/product.asp?sku=J010>  
© 2003 by The Haworth Press, Inc. All rights reserved.  
10.1300/J010v37n02\_04

**KEYWORDS.** Interdisciplinary collaboration, healthcare professions, social workers, physicians, teamwork, professional socialization

Social workers and other health care practitioners are providing care to patients in a health care environment that is undergoing rapid change (Redmond, 2001). The dominance of managed care, re-engineering, downsizing, cross training and other market-based, profit-driven approaches to reduce costs (Rayburn, 1999; Nauert, 2000; Lown, 2000) have had major impact on the roles and relationships among health care providers (Callister, 2001; Sigmond, 1995; Abdellah, 1997). Collaboration and interdisciplinary teams have become central to many of the newer endeavors undertaken by health care systems, such as the development of continua of care or horizontal integration of services (Dunevitz, 1997; Raiwet, Halliwell, Andruski & Wilson, 1997; Proenca, 2000).

In addition, collaboration is a key element of recent expansion of comprehensive primary care services and community health initiatives (Rock & Cooper, 2000; Resnick & Tighe, 1997; Badger, Ackerson, Butell & Rand, 1997; Steele, 2000). Such efforts are more likely to emphasize shared solutions and multiple perspectives based on the recognition that effective health prevention and treatment approaches require resources and competencies that go beyond the expertise of any one profession or organization (Minkler, 1997; Lasker, 1997; Welton, 1997). Thus, as collaborative models have become prevalent, it becomes more important to understand the complexities of interdisciplinary relationships so that social workers can become even more skillful and influential collaborators (Lymberg, 1998; Keigher, 1997; Graham & Barter, 1999).

This paper builds on our prior analyses of data collected from a qualitative study of 50 pairs of social worker-physician collaborators in 12 acute care hospitals (Authors, 1996; Authors, 2000). Here, we present all elements of a typology of social worker/physician collaboration drawn from that data. While other typologies have depicted the interaction between physicians and patients (Szasz & Hollander, 1956; Campbell, Mauksch, Neikirk & Hosokawa, 1990; Emanuel & Emanuel, 1992), we have developed a typology that addresses professional behavior between colleagues.

### **LITERATURE REVIEW**

For the purpose of our study, we defined interdisciplinary collaboration as the process by which the expertise of different categories of professionals is communicated and coordinated in order to address clients' needs. The literature on interdisciplinary collaboration has tended to focus more on obstacles to collaboration than its benefits. Obstacles include: unequal status of participants and continued physician dominance (Abramson & Mizrahi, 1986; Abramson, 2001; Faulkner Schofield & Amodeo, 1999); inattention to the teaching of collaborative skills in professional education (Hilton, 1995; Lawson & Sailor, 2000); competing values and approaches to patient care that result from different professional socialization processes (Mizrahi & Abramson, 1985; Abramson, 2001; Julia & Thompson, 1994) and even personality difficulties of participants (Drinka & Streim, 1994).

While the strengths of collaborative models have been articulated, there has been little empirical validation of the positive impact of collaboration on patient care (Baggs, Ryan, Phelps, Richeson & Johnson, 1992). However, there is general agreement that multiple professional orientations make distinct contributions to the definitions of problems and their resolutions (Payne, 2000; Julia & Thompson, 1994; Nandan, 1997; Schmidt, 1994), through communal experience and reflection. Lawson and Sailor (2000) refer to this process as "generativity." Such a process is especially needed in treatment of the poor, chronically ill and aged individuals whose psychosocial problems are too complex to be managed within the narrow boundaries of the traditional medical model (Simmons, 1994; Paris, Thompson, Riher, Quisenberry, & Cooper, 1996).

Some studies of collaboration between physicians and social workers were conducted, beginning in the 1960s, that compared social work and physician perceptions of the social work role (Olsen & Olsen, 1967, Carrington, 1978; Lister, 1980). In those studies, physicians did not identify the breadth of roles for social work that social workers did for themselves, particularly in relation to the provision of counseling and mental health services. In more recent studies, increasing numbers of physicians acknowledged the social work role in counseling patients and families (Gross & Gross, 1987; Salvatore, 1988; Cowles & Lefcowitz, 1992 & 1995; Badger, Ackerson, Buttell & Rand, 1997; Netting & Williams, 1996 & 1998; Egan & Kadushin, 1997). They also understood and appreciated the social work role in coordinating community resources but no longer identified it as an exclusive social work function.

None of these studies examined the way physicians view their role in relation to the psychosocial problems of their patients. The few studies of physician attitudes toward this aspect of care have documented limited physician awareness of patients' psychosocial needs and even less readiness to provide assistance to address those needs (Mizrahi, 1986; Eisenthal, Stoeckle & Erlich, 1994; Sheff, Rand, Patterson, Ellis & Weeks, 1994; Robinson & Roter, 1999; Franks, Williams, Zwanziger, Mooney & Sorbero, 2000). However, there is some indication that physicians recognize their limitations in this area (Eisenthal et al., 1994), more often attend to psychosocial issues the longer they have been in practice (Franks et al., 2000) and already are, or would be, interested in integrating psychosocial services into their practices (Badger et al., 1997; Wesson, 1997).

Rarely have studies of collaboration between the two professions been grounded in specific collaborative experiences nor have they sought participants' views of their interactions with other professionals. The analysis discussed in this paper is based on actual shared collaborative experiences of social worker/physician collaborators. Our previous empirical findings provided the foundation for the development of this typology of physician/social worker collaboration and thus are summarized below (Abramson & Mizrahi, 1996, 2000).

### ***Key Findings from Our Prior Work***

We found that perspectives on the social work role differed between social workers and physicians in relation to the counseling function of social work. Social workers identified this role more than physicians in their shared case, particularly where there were issues related to adjustment to illness; however, close to half of the physicians did identify a counseling role for social work. Physicians understood and accepted the social work role in linking patients to services as reported elsewhere (Lister, 1980; Netting & Williams, 1998); surprisingly, however, many did not acknowledge the common social work role in negotiating the hospital system or advocating for and coordinating resources (Abramson & Mizrahi, 2000).

Our findings led us to question the readiness of many physicians to relinquish control or share aspects of patient care decision making since only 12% of the physicians in the shared cases identified the social worker as case coordinator, while they laid claim to this role in 55% of the cases. Social workers saw themselves as case coordinators even more often (in 68% of the cases), while they rarely identified the doctor

as coordinator (in only 3% of the cases). However, since little conflict was reported, it is likely that both professionals did their part in the case without overt claim to leadership (Abramson & Mizrahi, 2000).

Moreover, our data indicated that a subset of physicians expressed an egalitarian and interdependent orientation to interdisciplinary practice. Markers of this more collaborative model included emphasis by some physicians on shared responsibility and by most on active communication with social workers; almost a third also saw decision making as shared or team-based. Many physicians also recognized importance of addressing patients' psychosocial problems with social workers.

In assessing positive and negative collaborative experiences with the other profession (Abramson & Mizrahi, 1996) both physicians and social workers agreed on many of the factors that contribute to positive outcomes: respect for the collaborator, similar perspectives on the case, and good quality communication. However, physicians, overall, emphasized competency more often than social workers, while the latter group valued indicators of positive interaction and relationship more highly (Abramson & Mizrahi, 1996).

In this paper, we apply a typology that emerged from the process of data analysis to our whole sample to evaluate its utility for identifying patterns of collaborative practice.

## **METHODS**

### ***Development of the Typology***

The typology was generated through review of approximately 25% of the transcripts from the sample of 100, as part of a grounded theory analysis that identified themes for coding (Abramson & Mizrahi, 1994; Glaser & Strauss, 1967; Strauss & Corbin, 1990). The transcripts reviewed were distributed equally between social workers (13) and physicians (13). We focused particularly on the responses to certain questions related to key components of collaboration (e.g., Who was central to decision making? Who coordinated the case? Was the team helpful? What were the psychosocial problems in the case? What was the social work role?). This approach helped us to uncover the dimensions of collaboration that seemed most central to understanding the perspectives of social workers and physicians (see Abramson & Mizrahi, 1994 for details on how we constructed our analytic framework).

The dimensions which we used for purpose of analysis, are: (1) views about the psychosocial aspects of care (ranging from a limited focus on concrete needs for discharge to strong emphasis on a breadth of psychosocial concerns); (2) the definition of the social work role (ranging from one that is limited to provision of services to one that incorporates counseling and adjustment to illness); (3) attitudes about communication with the other profession (ranging from minimal interest and little contact or even avoidance to strong interest and active role); (4) emphasis on teamwork (ranging from avoidance of team participation to strong appreciation of the contributions of other team members); and (5) control over decision making (ranging from emphasis on ultimate physician authority to strong support for shared decision making).

### *Sample*

Our non-random sample of 50 physicians and 54 social workers worked in internal medicine, surgery or related subspecialties in 12 hospitals in New York City, Albany, NY and Western MA. These specialties were chosen in order to study the largest and most influential branches of medicine. The hospitals were selected to achieve diversity of size and location. The sample was obtained by first securing participation from social workers with medical/surgical assignments in the various hospital departments. Each social worker identified a complex case where extensive collaboration (3 or more contacts) with a physician took place. We successfully recruited 50 of these 54 physicians and limited our analysis to 50 pairs of collaborators. We assumed that these atypical cases would be more likely to shape professional perspectives than would routine experiences.

Almost all of the social work subjects were MSW's (41) except nine BSW or BA level workers located in hospitals outside of New York City. Most physicians (68%) were trained in internal medicine or related subspecialties, while 28% were trained in surgery and 4% in family practice or rehabilitation medicine. Both groups were predominantly white (83.3% for SWs & 90% for MDs). The social work sample was overwhelmingly female (87%) while the physician sample was primarily male (88%). Approximately 48% of the respondents worked in large hospitals (600+ beds), 39% in medium sized (300 to 600 beds) and 13% in small hospitals (under 300 beds).

FIGURE 1. Traditional, Transitional and Transformational Models of Social Work/Physician Collaboration

TYPE:	TRANSITIONAL PERSPECTIVE	
DIMENSIONS	PHYSICIANS	SOCIAL WORKERS
Psychosocial (PS) Aspects of Care	<ul style="list-style-type: none"> <li>• Sees PS as optional or a necessary evil</li> <li>• Views PS as outside MD jurisdiction</li> <li>• Limits understanding of total patient</li> <li>• Gives priority to hospital's administrative &amp; financial concerns</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes importance but not addressed</li> <li>• Accepts or alternatively is frustrated with MD's limited focus</li> <li>• Gives priority to hospital's administrative and financial concerns</li> </ul>
Definition of the Social Work Role	<ul style="list-style-type: none"> <li>• Limits to discharge/disposition</li> <li>• Blames SW for system obstacles</li> <li>• Does not understand or accept SW counseling role</li> <li>• Emphasizes outcome over process</li> </ul>	<ul style="list-style-type: none"> <li>• Limits to discharge planning/disposition; does not include clinical aspects</li> <li>• Minimizes patient/family involvement</li> <li>• Emphasizes outcome over process</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Keeps to minimum</li> <li>• Resents requests for on-going communication</li> <li>• Avoids or limits to one way from (MD to SW)</li> <li>• Resists meeting with patient, family &amp; SW</li> </ul>	<ul style="list-style-type: none"> <li>• Keeps to minimum</li> <li>• Stays with MD agenda</li> <li>• Communicates narrow SW role</li> <li>• Limits chart notes</li> </ul>
Teamwork	<ul style="list-style-type: none"> <li>• Views contact with other professions as a necessary evil</li> <li>• Functions independently</li> <li>• Resists participation in meetings</li> <li>• Views non-MDs in a hierarchical/non-reciprocal manner</li> </ul>	<ul style="list-style-type: none"> <li>• Uses information from other professionals for assessment? Participates in team</li> <li>• Views role as subordinate to MD's</li> <li>• May provide limited leadership</li> </ul>
Control over Decision-Making	<ul style="list-style-type: none"> <li>• Owns patient &amp; controls decisions</li> <li>• Resents regulatory or other intrusions into MD autonomy</li> <li>• Rejects independent SW case finding</li> <li>• Grants SW autonomy or responsibility in areas where MD has no interest</li> </ul>	<ul style="list-style-type: none"> <li>• Accepts MD control of patient care</li> <li>• Limits independent assessment</li> <li>• Accepts MD definition of problems</li> <li>• Functions independently in those areas where MD has no interest</li> </ul>

FIGURE 1 (continued)

TYPE: TRANSITIONAL PERSPECTIVES		
DIMENSIONS	PHYSICIANS	SOCIAL WORKERS
Psychosocial (PS) Aspects of Care	<ul style="list-style-type: none"> <li>• Recognizes but rarely addresses PS issues</li> <li>• Appreciates that SW handles PS aspects of care</li> </ul>	<ul style="list-style-type: none"> <li>• Gives priority to hospital's administrative &amp; financial concerns</li> <li>• Assesses psychosocial complexities, but limits counseling intervention</li> </ul>
Definition of the Social Work Role	<ul style="list-style-type: none"> <li>• Emphasizes discharge planning as primary</li> <li>• Refers for SW assessment</li> <li>• Emphasizes counseling more if part of team</li> <li>• Blames SW for system obstacles</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasizes discharge planning, but may vary role depending on service</li> <li>• Separates counseling and provision of concrete services</li> <li>• Reframes role for MD priorities</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Makes referrals</li> <li>• Requests information</li> <li>• May share psychosocial information to assist SW assessment</li> <li>• Focuses communication on MD concerns</li> <li>• Attends meetings with patients, family, and SW, sometimes reluctantly</li> </ul>	<ul style="list-style-type: none"> <li>• Communicates about discharge planning on chart or in person</li> <li>• Shares some psychosocial information</li> <li>• Omits information on process of activities</li> <li>• Educates actively or withholds information, depending on MD receptivity</li> </ul>
Teamwork	<ul style="list-style-type: none"> <li>• Views MD as team leader</li> <li>• Values others' contribution to care</li> <li>• Has hierarchical view of relationships with other professionals</li> <li>• Respects skills of other professionals</li> <li>• Cooperates in interest of efficiency and outcome</li> </ul>	<ul style="list-style-type: none"> <li>• Actively participates as team member</li> <li>• May provide situational leadership</li> <li>• Communicates with other professions (e.g., RN) in addition to or in lieu of MD</li> </ul>
Control of Decision Making	<ul style="list-style-type: none"> <li>• Assumes role of team leader</li> <li>• Makes decisions with consultation from others</li> <li>• May delegate decision when others are viewed as expert and competent</li> </ul>	<ul style="list-style-type: none"> <li>• Accepts MD authority</li> <li>• Practices independently in areas of SW expertise</li> <li>• Provides consultation to MD and other professions</li> </ul>

TYPE:	TRANSFORMATIONAL PERSPECTIVES	
DIMENSIONS	PHYSICIANS	SOCIAL WORKERS
Psychosocial (PS) Aspects of Care	<ul style="list-style-type: none"> <li>Integrates PS aspects into own role and view of patient care</li> <li>Views PS as pivotal to medical care</li> <li>Shares responsibility with SW</li> <li>Seeks &amp; shares PS information with SW</li> <li>Sees therapeutic value of PS component</li> </ul>	<ul style="list-style-type: none"> <li>Emphasizes clinical aspects of patient care</li> <li>Educates and involves MD on PS issues</li> <li>Actively involves patient/family in decision making</li> <li>Shares PS responsibility with MD</li> </ul>
Definition of Social Work Role	<ul style="list-style-type: none"> <li>Involves SW for broad range of psychosocial tasks with patients and families</li> <li>Accepts SW role in dealing with adjustment to illness and mental health assessment</li> <li>Refers private patients for SW treatment</li> <li>Does not blame social worker for system obstacles</li> <li>Understands complexities of SW assessment and intervention</li> </ul>	<ul style="list-style-type: none"> <li>Defines discharge planning role broadly</li> <li>Integrates clinical and concrete service provision functions</li> <li>Emphasizes adjustment to illness in working with patients &amp; families</li> </ul>
Communication	<ul style="list-style-type: none"> <li>Actively communicates</li> <li>Seeks psychosocial information and SW assessment</li> <li>Initiates and willingly attends meetings with social worker, patient and family</li> </ul>	<ul style="list-style-type: none"> <li>Actively communicates</li> <li>Regularly provides PS information and assessment</li> <li>Actively educates MDs and others</li> </ul>
Teamwork	<ul style="list-style-type: none"> <li>Contributes actively to team</li> <li>Sees team as responsible for patient care</li> <li>Shares responsibilities</li> <li>Functions interdependently</li> <li>Assumes egalitarian, non-hierarchical/ reciprocal relationships</li> </ul>	<ul style="list-style-type: none"> <li>Contributes actively to team</li> <li>Provides leadership on patient care and team process</li> <li>Shares responsibilities? Functions interdependently</li> <li>Assumes egalitarian, non-hierarchical/reciprocal relationships</li> </ul>
Control of Decision Making	<ul style="list-style-type: none"> <li>Shares ownership of patient with other professionals</li> <li>Makes decisions jointly</li> </ul>	<ul style="list-style-type: none"> <li>Shares responsibility</li> <li>Stresses competence</li> <li>Makes decisions jointly</li> <li>Functions interdependently</li> </ul>

### *Method for Applying the Typology to the Whole Sample*

We evaluated all 100 respondents for type by first characterizing them within dimensions as *traditional*, *transitional* or *transformational*; using this information, we then assigned each respondent to one of the three types. Since all typologies are gross means of classifying complex data, we were not surprised that 20 of the 100 respondents were not consistent by type across all five dimensions; we labeled them as “straddlers.” By then giving extra weight to the dimensions of teamwork and control over decision making, based on their importance to the collaborative process, we assigned straddlers to one of the three types for purpose of comparative analysis. In addition, we did quantitative analyses using chi-square tests to identify the variables that might be associated with type of collaborator for each profession. Since this is an exploratory and qualitative study, we selected a significance level of less than .10 to capture trends in the data.

## **FINDINGS**

### *Elements and Illustrations of the Typology*

Figure 1 provides a description of each type by each dimension. The following section presents a composite of each type of social worker and physician, including representative quotes from our interviews.

*Traditional* physicians (N = 9) demonstrated little understanding of psychosocial issues, saw social workers primarily as providers of concrete services, did not understand or accept a counseling role for social work, kept communication and teamwork to a minimum and emphasized physician control over patient care. As one doctor noted, “We have the ultimate responsibility for the patient’s care . . . sometimes the social worker may not appreciate that. They may not have a full understanding of the relationship the patient has with the physician.” Another said, “There are certain tasks that need to be done . . . that is a kind of drudgery to me [such as] . . . sorting out where somebody is going to go and what is going to happen to them. So that is what gets delegated [to the social worker].”

*Traditional* social workers (N = 11) also defined a limited psychosocial role that emphasized service provision and did not include counseling. They followed administrative and physician priorities and limited independent assessment. They communicated minimally with

the physician although they drew on information provided by other health care professionals. One social worker commented, "I tend to listen to physicians when they're giving me orders . . . I'll kind of agree with them. It's hard at times because I haven't really completed my assessment, so I go by what the doctor is telling me." Another noted: "The bulk of what we do here is nursing home placement . . . We got rid of a lot of people last month."

*Transitional* physicians (N = 29) were characterized by greater acceptance of the social worker as discharge planner and provider of concrete resources to their patients; however, they also had limited understanding of the social work counseling role. They were more appreciative of the contributions of other professionals to the care of their patients but saw themselves as team leaders who were willing to delegate some aspects of patient care to social workers. These physicians wanted social workers to provide information and were willing to share psychosocial information about their patients; however, they preferred focused communication related to physician priorities. Here are representative comments from four physicians:

My primary function in this case is captain of the ship. You guide the patients, you guide the family, you administer medication and call in consultants . . . you work with social services and everybody in the totality of patient care . . . but you are the captain.

You find yourself depending on the social worker to give you some insight into the family dynamics . . . because we don't always have time or interest to find out who all the family members are.

The social worker is a tremendous asset to the physician . . . I feel comfortable when I have a social worker in the case because there's a lot of work otherwise I would have to do which is para-medical . . . It takes part of my burden which is great.

Social workers need to understand the time constraints doctors are under, just keep the lines of communication open and try to anticipate problems rather than to react to them.

*Transitional* social workers (N = 28) identified and often addressed a range of psychosocial issues; however, in conceptualizing their roles, they tended to separate the provision of so-called "concrete" services

from counseling. They participated fully in teams, communicated actively and often strategically with physicians and other professionals. Some seemed to “work around” or even evade direct communication with physicians as they sought autonomy or simply avoided those physicians they saw as difficult collaborators. They accepted the physician’s primary responsibility for decision making but often attempted to influence outcomes through their assessments of patient/family circumstances.

One social worker lamented, “One frustrating part of the job is that so much of it is discharge planning . . . a lot of it is not therapy . . . more concrete than clinical, by far.” Another said, “I’d contact them {doctors} to explain that this is what we’re dealing with . . . This is why she {the patient} can’t go home without help.” A third commented, “I would avoid them and speak with the nurse. Doctors are always . . . on the run . . . It’s infuriating and frustrating so I learned other ways to get information.” Commenting on her collaborative strategy, a different social worker said, “A lot of time, it helps if you approach them {physicians} in such a way that they feel that they’re the ones who are making the decisions. You can tell them, this is my impression, and ask, what are your suggestions? Making them feel like they are in control helps . . . A lot of doctors have that need.”

*Transformational* physicians (N = 12) and social workers (N = 11) were more alike in their characteristics than either *traditional* or *transitional* respondents. Both had a broad view of the social work role, emphasizing integration of service provision with counseling. Both viewed the psychosocial aspects of care as central to medical outcomes. Many *transformational* physicians attended directly to the psychosocial aspects of patients’ lives rather than delegating that role completely to social workers. Both were active team members and sought communication with the other profession. They functioned interdependently, shared responsibility for patient care decision making and often used the pronoun “we” in describing their collaborative activities.

One *transformational* physicians said, “I think that the inter-relationship here is one of shared responsibility . . . to get families through times of stress . . . we all bring our perspective to a family situation and discuss how we can help each other to help the families.” Another noted, “Everyone looks at the problem differently . . . The social worker is coordinating things plus all the psychodynamic things that go on with the family. Everyone sees a different angle to the same problem. I think the social worker puts it together and addresses things on longer term.” Still another physician reflected, “When someone is acutely ill . . . the pa-

tient's medical needs must be met . . . so the social worker can be in the waiting room with the family while the doctor is trying to keep the patient alive. Then the case evolves and the social worker takes a larger role."

A *transformational* social worker described her role: "It was to work with the family as a support system . . . supporting their view and helping them work through the stages of denial, doing some concrete services for them, negotiations and advocacy. We moved through the system and got what we wanted." Another elaborated, "Here on the floor, I'm the liaison between the nurses, doctors and the patients. I'm the instrument to help the patient understand the diagnosis and treatment plan . . . to help the patient adjust to the illness, to work with the family, doing a lot of counseling as well as making concrete arrangements." A third social worker discussed her communication style, "I let doctors know that I'm available to discuss any situation."

### ***Application of the Typology to the Whole Sample***

When the typology was applied to the entire sample for coding purposes, we found an almost even distribution for each profession across the three types. Although the sample was primarily *transitional* (56% of the social workers and 58% of the doctors), there were more *traditional* social workers (22%) and *transformational* doctors (24%) than we anticipated from our beginning conceptualization of collaborative roles (Abramson & Mizrahi, 1985; Abramson & Mizrahi, 1986). At that point, we had recognized sources of strain in the collaborative relationships between the two professions and articulated strategies for collaboration based on a view of the social worker as a resource for the physician. We see with hindsight that we were then describing what we now label as the *transitional* social work type and as the *traditional* physician type. The broader range of collaborative types only became apparent to us when we analyzed the data of actual collaborative experiences between the two professions.

### ***Relationship Between Collaborative Type and Dimensions***

We examined how respondents were typed within each dimension to see if they varied or were consistent across the five dimensions (see Table 1 for distribution of sample by type across the five dimensions). Both groups were least *transformational* in regard to decision making; only 20% of the physicians were *transformational* on this dimension

TABLE 1. Dimensions of Collaboration by Types of Social Worker and Physical Collaborator

DIMENSION	TRADITIONAL COLLABORATOR				TRANSITIONAL COLLABORATOR				TRANSFORMATIONAL COLLABORATOR				GROUP MEAN FOR EACH DIMENSION* (Range 1-5)	
	N = 9		N = 11		N = 29		N = 28		N = 12		N = 11		MD	SW
	MD		SW		MD		SW		MD		SW			
N	%	N	%	N	%	N	%	N	%	N	%	(N=50)	(N=50)	
Psycho-Social Factors	10	(20)	8	(16)	24	(48)	27	(56)	16	(32)	15	(30)	2.12	2.14
Social Work Role	7	(14)	11	(22)	27	(54)	24	(48)	16	(32)	15	(30)	2.18	2.08
Control over Decision-Making	10	(20)	13	(26)	30	(60)	29	(58)	10	(20)	8	(16)	2.00	1.99
Teamwork	7	(14)	7	(14)	24	(48)	31	(62)	19	(38)	6	(12)	2.24	2.10
Communication	8	(16)	17	(38)	25	(50)	22	(44)	17	(34)	11	(22)	2.18	1.88**

\* Using a t Test, comparing means for the two professions

\*\*  $t = 2.289$ ,  $df = 49$ ,  $p = .026$

while over 30% of the physicians fell into this type on the other four dimensions. Social workers also were less likely to be *transformational* on this dimension than on any other except for teamwork. Surprisingly, more doctors were *transformational* than social workers on the teamwork dimension. Also unexpectedly, social workers were both more *traditional* and less *transformational* than their physician counterparts in relation to the communication dimension. To see if there were statistically significant differences between the two professions within particular dimensions, we assigned each type a value along a continuum (*traditional* = 1; *transformational* = 2; *transformational* = 3). Then we calculated the dimension means for each group and used a paired sample t-test to compare the two groups. Communication was the only dimension to show significant differences ( $t = 2.289$ ,  $p = .026$ ) between physicians and social workers, with the physician mean closer to *transformational* than the mean for social workers.

### ***Relationship Between Collaborative Type and Respondent Characteristics***

To account for the differences among types, we used chi square tests to examine the relationship between various background characteristics of the subjects and type by profession. These included gender, level of experience, education and specialty; In addition, a chi-square test was

used to analyze the relationship between exposure to teamwork and type by profession. None of these variables showed statistically significant differences by type except in relation to social work education ( $p = .009$ ); a significantly higher percentage of BSWs than MSWs were *traditional*.

### ***Relationship Between Type and the Collaboration Process***

Chi-square analyses did not reveal significant differences by type in relation to which professional was identified by the collaborator as case coordinator, intensity of collaboration on the shared case, level of satisfaction with case outcome or whether something should have been done differently by the other profession. We did find that type of collaborator was significantly associated with ratings of collaboration ( $X^2 = 27.807$ ,  $df = 6$ ,  $p = .000$  for MDs;  $X^2 = 11.128$ ,  $df = 6$ ,  $p = .084$  for SWs). Fifty-six percent of the *traditional* doctors and 73% of the *traditional* social workers were dissatisfied with their collaborator in strong contrast to *transitional* respondents; only 10% of MDs & 37% of SWs were dissatisfied. No *transformational* doctors and many fewer (only 27%) *transformational* social workers were dissatisfied.

Also using chi-square tests, we found few significant differences by type of collaborator in relation to most aspects of respondents' views of their own and the others' roles. Physician type was significant for only one aspect of the social work role, doing psycho-social assessments ( $X^2 = 6.576$ ,  $df = 2$ ,  $p = .037$ ). Almost twice as many *transitional* and *transformational* physicians identified this role as did *traditional* physicians. Physician type was related to two aspects of their own role: planning for discharge ( $X^2 = 5.05$ ,  $df = 2$ ,  $p = .064$ ) and referral for social work assessment ( $X^2 = 7.073$ ,  $df = 2$ ,  $p = .029$ ). Again, these were identified by many more *transitional* and *transformational* doctors.

When social workers discussed their role, some aspects did vary significantly by type; these included the social work role in patient counseling ( $X^2 = 7.564$ ,  $df = 2$ ,  $p = .023$ ), in family counseling ( $X^2 = 5.954$ ,  $df = 2$ ,  $p = .054$ ), in educating the physician ( $X^2 = 9.091$ ,  $df = 2$ ,  $p = .011$ ), and in defining their role to the doctor ( $X^2 = 9.118$ ,  $df = 2$ ,  $p = .010$ ). With all these aforementioned roles, many more *transitional* and *transformational* social workers recognized them than did those who were *traditional*. Even in the seemingly more traditional discharge planning role, half the traditional and transitional social workers named this function, while all but one *transformative* social worker

identified it ( $X^2 = 4.949$ ,  $df = 2$ ,  $p = .084$ ) as part of her collaborative repertoire.

### ***Impact of Type on Collaboration by Pairs of Colleagues***

To answer questions about the compatibility of various types of collaborators, we divided our sample into those who collaborated with a professional of the same type and those who collaborated with a different type. When groups of similar and dissimilar types were compared using chi-square tests, there were almost no significant differences in relation to their agreement about the roles each collaborator assumed, the appropriate outcomes in the case and the responsibility each took in working on the case. The one exception related to agreement about approach to the case. For that variable, there were significant differences between the professions with respect to whether they were same type ( $p = .092$ ) or different type ( $p = .002$ ). Social workers working with a same type physician disagreed about the approach only 38% of the time compared with 58% of those with a different type collaborator. Physicians in both groups indicated a very high level of agreement with their social work counterpart about the approach to the case.

### ***Relationship of Collaborative Type to Advice Given About Collaboration***

Finally, we asked respondents to give advice to both social workers and physicians about how to collaborate successfully with their own colleagues and with those of the other profession. We developed categories or kinds of advice from the data, using the same grounded theory approach of reviewing approximately 25% of the transcripts and identifying themes. Guided by the typology and its dimensions, the two primary investigators then independently assigned each kind of advice to one of the collaborative types (see Tables 2 and 3 for frequencies of kind of advice by type of collaborator) with 85% initial agreement.

Given that our sample was composed of primarily *transitional* social workers and physicians, it follows that most of the advice they offered to each other was of a *transitional* nature. We used chi-square tests to examine the relationship between type of social worker and physician and particular categories of advice. No social work advice to physicians varied significantly by type except "to make an early referral" ( $X^2 = 5.390$ ,  $df = 2$ ,  $p = .068$ ). Social workers of all types stressed that physicians should be respectful to social workers, value their role and com-

TABLE 2a. Social Workers' Advice to Social Workers

SOCIAL WORKERS' ADVICE TO SOCIAL WORKERS	TRADITIONAL SOCIAL WORKERS (n = 11)		TRANSITIONAL SOCIAL WORKERS (n = 28)		TRANSFORMATIONAL SOCIAL WORKERS (N = 12)			
	N	(%)	N	(%)	N	(%)	N	(%)
TRADITIONAL ADVICE								
Acknowledge Md Authority**	7	(64)	6	(21)	4	(33)	17	(34)
TRANSITIONAL ADVICE								
Communicate Actively	5	(45)	14	(50)	8	(66)	27	(54)
Individualize MD	8	(73)	13	(46)	5	(42)	26	(52)
Take Initiative	3	(27)	13	(46)	6	(50)	22	(44)
Build Relationships Proactively	4	(36)	11	(39)	6	(50)	21	(42)
Communicate SW Role***	0	(00)	13	(46)	7	(58)	20	(40)
Demonstrate Competence*	2	(18)	11	(39)	7	(58)	20	(40)
Be Visible**	0	(00)	13	(46)	6	(50)	19	(38)
Be Assertive	4	(36)	8	(29)	5	(42)	17	(34)
Focus Communication	3	(27)	10	(36)	4	(33)	17	(34)
Have Empathy for MD	1	(9)	11	(39)	4	(33)	16	(32)
Use Self as Resource for MD**	0	(00)	10	(36)	6	(50)	16	(32)
Educate About Patient/Family/Sys	1	(09)	8	(29)	1	(8)	10	(20)
TRANSFORMATIONAL								
Present Self as Equal*	1	(09)	8	(29)	6	(50)	15	(30)
Include Psychosocial Content*	0	(00)	6	(21)	4	(33)	10	(20)

\* = significance < .10

\*\* = Significance < .05

\*\*\* = Significance < .01

TABLE 2b. Social Worker's Advice to Physicians By Type

	N	(%)	N	(%)	N	(%)	(IN RANK ORDER BY TYPE)	
TRADITIONAL ADVICE								
PROVIDE MEDICAL INFORMATION	0	(0%)	4	(14%)	1	(8%)	5	(10%)
TRANSITIONAL ADVICE								
Be Respectful to SW	4	(36)	12	(43)	7	(58)	23	(46)
Value Role of SW to Pa- tients	5	(45)	10	(36)	5	(42)	20	(40)
Value Role of SW to MD	2	(18)	13	(46)	4	(33)	19	(38)
Communicate Actively	3	(27)	12	(43)	4	(33)	19	(38)
Use SW Assessment	3	(27)	6	(21)	5	(42)	14	(28)
Make Early Referrals	3	(27)	2	(7)	4	(33)	9	(18)
Be Visible and Available	1	(09)	7	(25)	1	(8)	9	(18)
TRANSFORMATIONAL ADVICE								
Define SW Role Broadly	4	(36)	17	(61)	8	(67)	29	(58)
Understand the Whole Pa- tient	3	(27)	7	(25)	6	(50)	16	(32)
Treat SW as Equal	2	(18)	7	(25)	5	(42)	14	(28)
Understand System Obsta- cles	1	(09)	9	(32)	2	(17)	12	(24)

\* = Significance &lt; .10

\*\* = Significance &lt; .05

\*\*\* = Significance &lt; .01

TABLE 3a. Physicians' Advice to Physicians by Type

PHYSICIANS ADVICE TO PHYSICIANS	Traditional MD (N = 9)		Transitional MD (n = 29)		Transformational MD (N = 12)		Total Advice by Physicians (N = 50)	
	N	(%)	N	(%)	N	(%)	N	(%)
TRADITIONAL ADVICE								
Provide Medical Information to Social Worker	3	(33)	9	(31)	2	(17)	14	(28)
TRADITIONAL ADVICE								
Value Role of SW to Patients ***	2	(22)	26	(90)	11	(92)	39	(78)
Value Role of SW to MD **	3	(33)	24	(83)	9	(75)	36	(72)
Active Communication	5	(56)	17	(59)	6	(50)	28	(56)
Use SW Assessment **		1	(11)	19	(66)	8	(67)	28
Be Respectful to SW **	2	(22)	13	(45)	10	(85)	25	(50)
Make Early Referrals **	2	(22)	17	(59)	2	(17)	22	(44)
Have Empathy for SW	0	(00)	5	(17)	4	(33)	9	(18)
TRANSFORMATIONAL ADVICE								
Treat SW as Equal **	1	(11)	16	(55)	8	(67)	25	(50)
Define SW role Broadly ***	1	(11)	14	(48)	10	(85)	25	(50)
Share Information	1	(11)	10	(34)	3	(25)	14	(28)
Share Responsibility	1	(11)	6	(21)	5	(42)	12	(24)
Understand the Whole Patient *	1	(11)	4	(14)	5	(42)	10	(20)

\* Significance = &lt; .10

\*\*\* = &lt; .01

\*\* = &lt; .05

TABLE 3b. Physicians' Advice to Social Workers by Type

PHYSICIANS' ADVICE TO SOCIAL WORKERS	Traditional MD (N = 9)		Transitional MD (N = 29)		Transformational MD (N = 12)		Total Advice by Physicians (N = 50)	
	N	(%)	N	(%)	N	(%)	(In Rank Order)	
TRADITIONAL ADVICE								
Acknowledge MD Authority ***	5	(56)	15	(17)	0	(0)	20	(40)
TRANSITIONAL ADVICE								
Be An Active Communicator	5	(56)	20	(69)	9	(75)	34	(78)
Take Initiative *	2	(22)	19	(66)	6	(50)	27	(54)
Be Visible *	5	(56)	15	(52)	2	(17)	22	(44)
Demonstrate Competence **	1	(11)	12	(41)	9	(75)	22	(44)
Educate about Patient/Family/System **	0	(0)	13	(45)	6	(50)	19	(38)
Communicate SW Role **	1	(11)	7	(24)	7	(58)	15	(30)
Use Self as Resource for MD	2	(22)	9	(31)	4	(33)	15	(30)
Be Link to Family	3	(33)	7	(24)	5	(42)	15	(30)
Be Assertive	1	(11)	10	(34)	4	(33)	15	(30)
Focus Communication	3	(33)	9	(31)	2	(17)	14	(28)
Have Empathy for MD	1	(11)	8	(28)	2	(17)	11	(22)
TRANSFORMATIONAL ADVICE								
Include Psychosocial Content **	0	(00)	13	(45)	6	(50)	19	(38)
Present Self as Equal	0	(00)	8	(28)	8	(67)	13	(26)
Use MD Psychosocial Information **	4	(44)	5	(17)	0	(00)	9	(18)

\*Significance = &lt; .10

\*\* = &lt; .05

\*\*\* = &lt; .01

municate actively with them. However, some kinds of advice by social workers to their social work colleagues did differ significantly by type. For example, almost twice as many *traditional* social workers advised other social workers to acknowledge physician authority as either *transitional* or *transformational* social workers ( $X^2 = 6.305$ ,  $df = 2$ ,  $p = .043$ ). Half or more of the *transitional* and *transformational* social workers advised social workers to actively communicate their role while none of their *traditional* colleagues did so ( $X^2 = 10.376$ ,  $df = 2$ ,  $p = .006$ ). Both *transitional* and *transformational* social workers gave *transitional* advice but *transformational* social workers gave *transformational* advice more often than either of the other types. The latter were also more likely to advise social workers to present themselves as equal ( $X^2 = 5.471$ ,  $df = 2$ ,  $p = .065$ ), to include psycho social content ( $X^2 = 4.627$ ,  $df = 2$ ,  $p = .099$ ) in their communication with physicians, and to be visible ( $X^2 = 7.924$ ,  $df = 2$ ,  $p = .012$ ).

When we examined the advice given by physicians to physicians and social workers, we found more variation by type, although communication was important to all types of physicians. Generally, *transitional* and *transformational* physicians were more likely than their *traditional* colleagues to give *transitional* advice to other physicians; these included advice to value the social work role with patients ( $X^2 = 19.919$ ,  $df = 2$ ,  $p = .000$ ) and for themselves ( $X^2 = 8.393$ ,  $df = 2$ ,  $p = .015$ ), to be respectful to social workers ( $X^2 = 8.421$ ,  $df = 2$ ,  $p = .015$ ), to use social work assessment ( $X^2 = 8.980$ ,  $df = 2$ ,  $p = .011$ ), and to make early referrals ( $X^2 = 6.570$ ,  $df = 2$ ,  $p = .037$ ). *Traditional* doctors rarely gave any *transformational* advice while *transformational* physicians gave *transformational* advice three times as often as “transitional” ones; for example, treat the social worker as an equal ( $X^2 = 7.088$ ,  $df = 2$ ,  $p = .017$ ); define the social work role broadly ( $X^2 = 10.812$ ,  $df = 2$ ,  $p = .004$ ); and understand the whole patient ( $X^2 = 4.664$ ,  $df = 2$ ,  $p = .097$ ).

When physicians gave advice to social workers, *traditional* physicians were much more likely than the other two types to emphasize the need to acknowledge physician authority ( $X^2 = 10.249$ ,  $df = 2$ ,  $p = .006$ ), which we label as *traditional* advice. They also were much less likely than *transitional* or *transformational* physicians to advise social workers to take the initiative ( $X^2 = 5.285$ ,  $df = 2$ ,  $p = .071$ ), be visible ( $X^2 = 4.828$ ,  $df = 2$ ,  $p = .089$ ), include psychosocial content ( $X^2 = 6.823$ ,  $df = 2$ ,  $p = .033$ ), demonstrate competence ( $X^2 = 8.712$ ,  $df = 2$ ,  $p = .013$ ), educate the doctors about the patient and family ( $X^2 = 6.823$ ,  $df = 2$ ,  $p = .032$ ) or communicate the social work role ( $X^2 = 6.591$ ,  $df = 2$ ,  $p = .037$ ); *transformational* doctors were more likely than either of the other types

to give the latter two kinds of advice. It is interesting to note that we classified the social worker's use of the physician for psycho-social information as a transformative strategy because it implies a role for physicians on that dimension; however, more *traditional* than *transitional* physicians suggested it, and no *transformational* physicians did ( $X^2 = 6.90$ ,  $df = 2$ ,  $p = .032$ ).

We did find that type of collaborator was significantly associated with ratings of collaboration ( $X^2 = 27.807$ ,  $df = 6$ ,  $p = .000$  for MDs;  $X^2 = 11.128$ ,  $df = 6$ ,  $p = .084$  for SWs). Fifty-six percent of the *traditional* doctors and 73% of the *traditional* social workers were dissatisfied with their collaborator in strong contrast to *transitional* respondents; only 10% of MDs & 37% of SWs were dissatisfied. No *transformational* doctors and many fewer (only 27%) *transformational* social workers were dissatisfied.

Also using chi-square tests, we found few significant differences by type of collaborator in relation to most aspects of respondents' views of their own and the others' roles. Physician type was significant for only one aspect of the social work role, doing psycho-social assessments ( $X^2 = 6.576$ ,  $df = 2$ ,  $p = .037$ ). Almost twice as many *transitional* and *transformational* physicians identified this role as did *traditional* physicians. Physician type was related to two aspects of their own role: planning for discharge ( $X^2 = 5.05$ ,  $df = 2$ ,  $p = .064$ ) and referral for social work assessment ( $X^2 = 7.073$ ,  $df = 2$ ,  $p = .029$ ). Again, these were identified by many more *transitional* and *transformational* doctors.

When social workers discussed their role, some aspects of their role did vary significantly by type; these included the social work role in patient counseling ( $X^2 = 7.564$ ,  $df = 2$ ,  $p = .023$ ), in family counseling ( $X^2 = 5.954$ ,  $df = 2$ ,  $p = .054$ ), in educating the physician ( $X^2 = 9.091$ ,  $df = 2$ ,  $p = .011$ ), and in defining their role to the doctor ( $X^2 = 9.118$ ,  $df = 2$ ,  $p = .010$ ). With all these aforementioned roles, many more *transitional* and *transformational* social workers recognized them than did those who were *traditional*. Even in the seemingly more traditional discharge planning role, half the traditional and transitional social workers named this function, while all but one *transformative* social worker identified it ( $X^2 = 4.949$ ,  $df = 2$ ,  $p = .084$ ) as part of her repertoire.

### ***Impact of Type on Collaboration by Pairs of Colleagues***

To answer questions about the compatibility of various types of collaborators, we divided our sample into those who collaborated with a professional of the same type and those who collaborated with a differ-

ent type. When groups of similar and dissimilar types were compared using chi-square tests, there were no significant differences in relation to their agreement about the roles each collaborator assumed, the appropriate outcomes in the case and the responsibility each took in working on the case. The one exception related to agreement about approach to the case. For that variable, there were significant differences between the professions with respect to whether they were same type ( $p = .092$ ) or different type ( $X^2 = 10.058, df = 1, p = .002$ ). Social workers working with a same type physician disagreed about the approach only 38% of the time compared with 58% of those with a different type collaborator. Physicians in both groups indicated a very high level of agreement with their social work counterpart about the approach to the case.

## DISCUSSION

Although the typology presented here was generated from a non-probability sample and cannot be assumed to be representative of all social workers and physicians in similar settings, the sample did include hospitals of different sizes and communities. Also, the respondents were selected from key branches of medicine and the patterns of their responses were consistent across 12 different hospitals. Our findings indicate that social workers and physicians can be located on a continuum of collaboration ranging from *traditional* to *transitional* to *transformational*. The patterns that emerged have implications for collaboration between the two professions.

First, both groups of respondents were primarily *transitional* in their collaborative attitudes and behavior. Given the traditional hierarchical nature of the medical model, the extent to which physicians in the sample demonstrated *transitional* and *transformational* collaborative behavior and attitudes appears to represent a substantial paradigm shift for the profession. The preponderance of *transitional* social workers in the sample may be, in part, a result of the collaborative strategies used by social workers to work with both *traditional* and *transitional* physicians. In other words, it may be that the need to employ such strategies makes it difficult for social workers to be inherently *transformational*, while *transformational* physicians may be less likely to adjust their collaborative strategies when working with different types of social workers. Due to the power differential between the two professions, it may not be possible for social workers to be *transformational*, even if so inclined, without a *transformational* collaborator.

We were surprised at the high proportion of *traditional* social work respondents (20%). Clearly, professional education was a key variable since a disproportionately high percentage of the BSW level social workers were *traditional*. Social workers also may develop *traditional* collaborative approaches in response to pressures in many hospitals to put administrative and financial agendas ahead of patient interests. Under such circumstances, some social workers may give priority to providing concrete services without embedding them in a professional, clinical approach. Such a *traditional* approach to collaboration and patient care may not serve clients or the social work profession well, especially with the massive changes taking place in health care.

The findings related to the social work role dimension were similar to findings of more recent studies (Netting & Williams, 1996 & 1998; Cowles & Lefcowitz, 1992 & 1995; Egan & Kadushin, 1997; Badger et al., 1997) in reflecting increased understanding and acceptance by many physicians of the contributions of social workers to counseling patients and families. Yet, it was surprising that neither *traditional* nor *transitional* physicians understood the social work role in negotiating the hospital system and advocating for services for patients and families. Clearly, the continuing lack of understanding by many physicians of the breadth of the social work role remains a source of dissatisfaction and strain for *traditional* and *transitional* social workers. It is clear that social workers need to continuously educate physicians about the range of social work skills including counseling patients and families and coordinating complex cases. At the same time, by recognizing that increasing numbers of doctors already value such competencies, social workers can engage those doctors in the process of educating more *traditional* physicians about the contributions of social work and the benefits of a more collaborative model.

The emphasis by all types of physicians on the communication dimension of collaboration suggests that social workers need to reexamine their approaches to communicating with physicians, particularly in relation to the psychosocial dimension of care. Although all *traditional* and most *transitional* doctors focused more on concrete arrangements for patients, *transformational* and many *transitional* doctors were interested in receiving psychosocial information as well. Active provision of such information by social workers to all types of physicians can help less psychosocially-oriented physicians utilize the social worker to deepen and expand their understanding of their patients. Social workers should assume that physicians want to communicate with them and act accordingly (Roter, Stewart, Putnam, Lipkin, Stiles & Inui, 1997).

Ironically, they also may need to manage tensions that could arise from sharing the psychosocial domain with *transformational* physicians, a domain that was once exclusively theirs.

The high levels of dissatisfaction found in *traditional* respondents when collaborating with any type of colleague may indicate that the *traditional* model of collaboration is inherently less satisfying to both professions. However, social workers, as a group, were much less satisfied with physicians than the physicians were with them, regardless of type. This finding is particularly disturbing in that many social workers rated the collaboration on the shared case as more positive than the norm, primarily because it was more intense and took place over a longer length of stay than is typical.

To reduce frustration, social workers may need to have more realistic expectations of *traditional* and *transitional* physicians. Given the continuing prevalence of the medical model, physician authority and legal accountability, it is not surprising that collaborative behavior has changed less in relation to control over decision making than for other dimensions. Thus, it may be necessary, at times, for social workers to work autonomously without directly challenging physician authority. At the same time, many physicians indicated that their own collaborative behavior had become more *transitional* or *transformational* over time. Together with *transformational* physicians, social workers can educate more *traditional* and *transitional* physicians about the positive impact of shared responsibility on outcomes for patients and improved collaborative relationships.

### ***Issues Related to Typology Development and Application***

While the typology did emerge from the comments of both social workers and doctors, it is important to recognize that we brought a social work perspective to its discovery. Physician researchers might have perceived other dimensions in the data. Any typology is innately an artificial construct that cannot completely reflect the range of individual responses (Szasz & Hollander, 1956). For that reason and also because professional practice is evolving in a rapidly changing health care environment, we found practitioners who “straddled” types across various dimensions. Reflecting back on our earlier conceptualization of factors influencing collaborative behavior (Authors, 1994), we also found a number of respondents (particularly social workers) who noted that their behavior varied with type of service or setting (institutional factors), or varied according to individual with whom they were collabo-

rating (interactional factors); still others in both professions described themselves as always conducting themselves using one particular style or framework (intrinsic factors). Even though we believe that social workers need to develop a *transformational* approach to collaboration, it is essential that social workers retain the capacity to respond differentially and strategically to various settings and collaborators. Conceptual clarity about the professional aspects of their role will assist social workers to remain confident when confronted with pressures to function in more *traditional* ways.

Although our primary intention in this study was to characterize and compare collaborative behavior of physicians and social workers, we clearly value the markers of a *transformational* approach to collaboration; these include recognition of the importance of psychosocial factors, shared responsibility with other professionals and egalitarian collaborative relationships. We think they lead to better outcomes for patients, a more productive and satisfying work environment and greater compatibility with the changes taking place in health care. However, we wonder if it is realistic to expect all practitioners to function within this paradigm? After all, the traditional medical model with its emphasis on paramount physician authority is deeply embedded in our society.

Yet, forces for change do exist (Callister, 2001) as physicians confront a changed regulatory environment that has seriously reduced their autonomy. Their motivation to collaborate with social workers has been enhanced by increased recognition that psychosocial interventions can enhance medical outcomes and improve quality of life for their aged and chronically ill patients (Cook, Freedman, Freedman, Arick & Miller, 1996). In addition, shared responsibility and increasing interdependence, could reduce frustration, provide mutual support, and, ironically, protect all professional autonomy from inappropriate corporate and government encroachment.

### CONCLUSION

This typology can provide a conceptual framework for understanding collaboration between social workers and physicians. It can assist practitioners in developing collaborative strategies based on assessment of their own and others' collaborative style or type. It also can increase awareness of the importance of collaborative skill development to successful practice in health care settings and thus influence curriculum in schools of social work and medicine. In addition, it provides a useful

mechanism for educating students within each profession and in inter-professional education programs about the collaborative process.

Further research is needed to see if the typology is applicable to other physician specialties as well as to non-hospital settings. Studying specialties such as family medicine and pediatrics that stress psychosocial factors to a greater extent may reveal more extensive *transformational* collaborative behavior. The impact of professional status differences could be further explored by examining collaboration between social workers and professionals closer in status such as teachers or nurses (Schmitt, 1994).

No doubt, certain challenges are inherent for social workers in collaborating with a higher status, dominant profession whose priorities and socialization have been traditionally different from social work. Social workers need to accept that such tensions are an integral part of the collaborative process and seek other sources of support and affirmation. In addition, these tensions can be managed effectively through use of collaborative strategies that address differences in type of physician. As the professions of medicine and social work move to a more *transformational* approach to collaboration, patients and families dealing with serious health problems will obtain the interdisciplinary care that best meets their needs.

Manuscript Received: 01/09/02

Accepted for Publication: 07/09/02

## REFERENCES

- Abramson, J. S., & Mizrahi, T. (1986). Strategies for enhancing collaboration between social workers and physicians. *Social Work in Health Care*, 12(1), 1-21.
- Abramson, J. S., & Mizrahi, T. Interdisciplinary team practice. In G. Greene & A. Roberts (Eds.). *Social worker's desk reference*. Oxford University Press.
- Abramson, J. S., & Mizrahi, T. When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. *Social Work* 41, 270-283.
- Abramson, J. S., & Mizrahi, T. Examining social work/physician collaboration: An application of grounded theory methods. In C. Riessman (Ed.). *Qualitative Studies in Social Work Research*, pp. 28-47, Thousand Oaks, Ca.: Sage Publications.
- Abramson, J. S., & Mizrahi, T. (2000). Social work and physician collaboration: Perspectives on a Shared Case. *Social Work in Health Care*, 31 (3).
- Abramson, J. S., & Mizrahi, T. (1994). Collaboration between social workers and physicians: An emerging typology. In W. J. Reid & E. Sherman (Eds.). *Qualitative Research in Social Work* (pp. 135-151). New York: Columbia University Press.

- Abdellah, F. G. (1997). Managing the challenges of role diversification in an interdisciplinary environment. *Military Medicine*, 162 (7):453-458.
- Badger, L. W., Ackerson, B., Buttell, F., & Rand, E.H. (1997). The case for integration of social work psychosocial services into rural primary care practice. *Health and Social Work*, 22 (1), 20-29.
- Baggs, J.G., Ryan, S., Phelps, C., Richeson, J.F., & Johnson, J. (1992). Collaboration in critical care: The association between interdisciplinary collaboration and patient outcomes in a medical intensive care unit. *Heart & Lung*, 21 (1), 18-24.
- Callister, R.R. (2001) Conflict across organizational boundaries: Managed care organizations versus health care providers. *Journal of Applied Psychology*, 86 (4), 754-755.
- Campbell, J., Mauksch, H., Neikirk, H., & Hosokawa, M. (1990). Collaborative practice provider styles of delivering health care. *Social Science & Medicine*, 30 (12), 1359-1365.
- Carrigan, Z. (1978). Social workers in medical settings: Who defines us? *Social Work in Health Care*. 4(2), 149-164.
- Cowles, L., & Lefcowitz, M. (1992). Interdisciplinary expectations of the medical social worker in the hospital setting. Part I, *Health & Social Work*, 17, (1), 57-65.
- Cowles, L., & Lefcowitz, M. (1995). Interdisciplinary expectations of the medical social worker in the hospital setting. Part II, *Health & Social Work*, 20 (4), 57-65.
- Drinka, T., & Streim, J. (1994). Case studies from purgatory: Maladaptive behavior within geriatrics health care teams. *The Gerontologist*, 34 (4), 541-547.
- Dunevitz, B. (1997). Collaboration in a variety of ways creates health care value. *Nursing Economics*. 15 (4), 218-19.
- Egan, M., & Kadushin, G.(1997). Rural social work: Views of physicians and social workers *Social Work and Health Care*, 26 (1), 1-24.
- Eisenthal, S., Stoeckle, J.D., & Ehrlich, C. M. (1994). Orientation of medical residents to the psychosocial aspects of primary care: Influence of training program. *Academic Medicine*, 69 (1), 48-54.
- Emanuel, E., & Emanuel, L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association*, 267 (16), 2221-26.
- Faulkner-Schofield, R., & Amodeo, M. (1999). Interdisciplinary teams in health care & human services settings: Are they effective? *Health & Social Work*, 24 (3), 210-219.
- Franks, P., Williams, G.C., Zwanziger, J., Mooney, C. & Sorbero, M. (2000). Why do physicians vary so widely in their referral rates? *Journal of General Internal Medicine*, 15 (3), 163-168.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Adline.
- Graham, J.R. & Barter, K (1999). Collaboration: A social work practice method. *Families in Society*, 80 (1), 6-13.
- Gross, A.M. & Gross, J. (1987). Attitudes of physicians and nurses towards the role of social workers in primary health care: What promotes collaboration? *Family Practice*, 4, 266-270.

- Hilton, R. (1995). Fragmentation within interprofessional work. A result of isolationism in health care professional education programs and the preparation of students to function only in the confines of their own discipline. *Journal of Interprofessional Care*, 9 (1), 33-40.
- Julia, M.C., & Thompson, A. (1994). Group process and interprofessional teamwork. In Casto, R. M., Julia, M.C., Platt, L., Harbaugh, G., Thompson, A., Jost, T., Bope, E., Williams, T., & Lee, D. (Eds.). *Interprofessional care and collaborative practice* (pp. 35-41) Pacific Grove, CA: Brooks/Cole.
- Keigher, S.M. (1997). What role for social work in the new health care practice paradigm? *Health and Social Work*. 22 (4): 479-484.
- Lawson, H., & Sailor, W. (2000). Integrating services, collaborating and developing connections with schools. *Focus on Exceptional Children*, 33 (2), 1-24.
- Lasker, R.D., & the Committee on Medicine and Public Health. (1997). *Medicine & public health: The power of collaboration*. The New York Academy of Medicine.
- Lister, L. (1980). Role expectations for social workers and other health care professionals. *Health and Social Work*. 5 (2), 41-49.
- Lown, N. (2000). Market health care: The commodification of health care. *Philosophy and Social Action*, 26, 1-2, 57-71.
- Lymberg, M., (1998). Social work in general practice: Dilemmas and solutions. *Journal of Interprofessional Care*, 12 (2), 199-208.
- Minkler, M. Ed. (1997). *Community Organizing and Community Building in Health*. New Brunswick, N.J.: Rutgers University Press.
- Mizrahi, T., (1986). *Getting Rid of Patients: Contradictions in the Socialization of Physicians*. New Brunswick, NJ. Rutgers University Press.
- Mizrahi, T., & Abramson, J. S. (1985). Sources of strain between physicians and social workers: Implications for social workers in health care settings. *Social Work in Health Care*. 10 (3), 33-51.
- Nandan, M. (1997). Commitment of social services staff to interdisciplinary care plan teams: An exploration. *Social Work Research*, 21 (4), 249-259.
- Nauert, R. C. (2000). The new millennium: Health care evolution in the 21st century. *Journal of Health Care Finance*. 26, 3, 1-13.
- Netting, E.F., & Williams, F.G. (1996). Case manager-physician collaboration: Implications for professional identity, roles and relationships. *Health and Social Work*, 21 (3), 216-224.
- Netting, E.F., & Williams, F.G. (1998). Can we prepare geriatric social workers to collaborate in primary care practices? *Journal of Social Work Education*, 34 (2), 195-209.
- Olsen, K.M., & Olsen, M.E. (1967). Role expectations and perceptions for social workers in medical settings. *Social Work*, 12, 70-78.
- Paris, W., Thompson, S., Riher, T., Quisenberry, M., & Cooper, D.K. (1996). A Comparison of Transplant Patient and Social Work Attitudes in Regard to Transplant Patient Psychosocial Selection Criteria, Role Expectations, and Communication Style. *Social Work in Health Care*, 23 (1), 39-52.
- Payne, M. (2000). *Teamwork in multiprofessional care*. Chicago: Lyceum Books.

- Proenca, E. J. (2000). Community orientation in hospitals: An institutional and resource dependence perspective. *Health Services Research, 35* (5), 210-218.
- Raiwet, C., Halliwell, G., Andruski, I., & Wilson, D. (1997). Care maps across the continuum. *Canadian Nurse, 93*, (1), 26-30.
- Rayburn, L.G. (1999) Hospital survival in a managed care environment. *Management Accounting, 80* (7), 50-53.
- Redmond, H. (2001) The health care crisis in the United States: A call in action. *Health & Social Work, 26* (1), 54-57.
- Resnick, C., & Tighe, E.G. (1997). The role of multidisciplinary community clinics in managed care systems. *Social Work, 42* (1), 91-98.
- Robinson, J.W., & Roter, D. L. (1999). Psychosocial problem disclosure by primary care patients. *Social Science Medicine, 48* (10), 1353-62.
- Rock, B., & Cooper, M. (2000). Social work in primary care: A demonstration student unit utilizing practice research. *Social Work in Health Care, 31* (1), 1-17.
- Roter, D., Stewart, M., Putnam, S., Lipkin, M., Stiles, W., & Inui, T. (1997). The patient physician relationship: Communication patterns of primary care physicians. *Journal of the American Medical Association, 277* (4), 350-356.
- Salvatore, E.P.(1988). Issues in collaboration and teamwork: A sociological perspective on the role definition of social work in primary health care. *Research in the Sociology of Health Care, 7*, 119-139.
- Schmitt, M.H. (1994). Focus on interprofessional practice, education, and research. *Journal of Interprofessional Care, 8*, 9-18.
- Sheff, R., Rand, W., Patterson, J.C., Ellis, G., & Weeks, S. (1994). Psychosocial problems in primary care: Pilot study of a new taxonomy. *Journal of Family Practice, 38* (4), 393-99.
- Sigmond, R. (1995). Learning the ghost of health care past: Doing more with less through collaboration and coordination. *Healthcare Forum Journal, (Nov./Dec.)*, 14-19.
- Simmons, J. (1994). Community-based care: The new social work paradigm. *Social Work in Health Care, 20*, 30-46.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*: Newbury Park, CA: Sage.
- Steele, J. (2000). Leading the way with community health partnerships. *Healthcare Executive (Sept/Oct.)*, 15 (2) pp. 20-25.
- Szasz, T., & Hollender, M. (May, 1956). A contribution to the philosophy of medicine. *Archives of Internal Medicine, 97*, 585-592.
- Welton, W.E., Kantner, T.A., & Katz, S.M. (1997). Developing tomorrow's integrated community health systems: A leadership challenge for public health and primary care. *The Milbank Quarterly, 75* (2), 261-288.
- Wesson, J.S. (1997). Meeting the informational, psychosocial & emotional needs of each ICU patient & family. *Intensive Critical Care Nursing, 13* (2), 111-118.

Copyright of *Social Work in Health Care* is the property of Haworth Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.