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# Dual practices of the institutional social work role: a hospital ethnographic study

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## Abstract

**Introduction:** *Social work plays an important role within hospital institutions and has had a diverse professional development in the world.* **Objective:** *To analyze the role of social workers in a public specialized care hospital in Mexico City.* **Methods:** *This is a qualitative study based on a hospital ethnography with semi-structured interviews, non-participant observations, and a review of historical data on this professional activity in Mexico. Atlas.ti software was used for coding and subsequent interpretative analysis from medical anthropology.* **Results:** *The activities of 17 social workers were observed. Three important themes were identified: social work functions, staff working conditions, and participation with the health team. The work dynamics reflect traditional models of intervention in the relationship with the hospital institution, with other health professionals and patients; these dynamics are in the process of transformation. There is evidence of duality in the professional practice, with a high administrative burden that affects their role to intervene in the social problems of patients.* **Conclusions:** *Social work is a central activity to overcome the socioeconomic barriers that patients may have in accessing care. In this way, it would contribute to mitigating the social inequalities and inequities in the health of the population served.*

***Keywords:*** *Social work. Dual practices. Institutional role. Public hospital. Mexico.*

## Introduction

Social work (SW) plays an important role in the interdisciplinary health group and has had diverse professional development worldwide[1,2]. The inception of SW in Mexico dates back to charitable work as a care activity linked to the evangelization process in Latin American countries. Social work emerged as a professional activity in the early 20th century[3,4], associated with public assistance institutions and the advent of the welfare state[4,5]. The feminization of the profession from its origins responded to the construction of the social role of women as universal caregivers, within the institutional and social context, considered a peripheral activity of other professions, often performed without being paid or with low wages[6].

The practice of SW is based on theoretical-methodological models rooted in sociological, psychological, and administrative perspectives, which help understand the social environment in which people live, the origins of practices, and social issues[7-9]. These models can be applied at different levels of care (individual, group, and community)[10] to generate a diagnosis and social intervention in contexts such as hospitals[11].

At Hospital General de México Dr. Eduardo Liceaga (HGM), SW has evolved from an informal activity to a

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more complex organizational structure as the Department of Social Work and Public Relations (DTSRP). In recent years, its activities have been impacted by changes in public health policies[3,12]. The patients attending this institution are mostly low-income individuals with low education levels, coming from Mexico City and nearby states (Guerrero, Hidalgo, Puebla, Oaxaca, and Veracruz), with health issues generally already addressed in their regions. Considering this context, the objective of this research was to explore the functions performed by SW and the institutional barriers from the staff's perspective.

## Method

### Design

This is a qualitative ethnographic research conducted from the perspective of medical anthropology, hospital ethnography as a methodology to describe and analyze the experiences of social actors within the hospital context from a sociocultural viewpoint[13]. Non-participant observations of the dynamics in DTSRP, waiting rooms, and hospitalization wards were conducted, along with semi-structured interviews guided by a interview guide by the research team. The guide included the following topics: personal experiences and opinions on work dynamics; description of the population served, including those in vulnerable conditions; work conditions and problems, as well as suggestions for improving their work in the institution. Interviews were conducted in a private place in the hospital, lasting an average of one and a half hours, and were audio-recorded for subsequent transcription and analysis. Additionally, documents on the history of SW in Mexico were reviewed. The study was conducted from 2016 through 2017, with an update period during 2022, lasting a total of one year; this latter period was due to the pandemic and changes in health policy promoted since 2020.

### Participants

SW personnel of any age, sex, and experience level from services meeting the following criteria were asked to participate: high demand for care, high presence of vulnerable populations, and feasibility of participation. The number of participants was determined by a process of saturation and richness of information related to the stated objectives[14].

### Analysis

A thematic analysis was conducted to organize and hierarchize information (interviews and field notes) to guide the researchers' interpretative process. This organization involves grouping the ideas expressed by participants through codes, assigning a common label or title to similar content, and subsequently associating these labels into families of codes and more general themes to categorize all narratives[15]. For these purposes, Atlas.ti software (version 7) was used. Through triangulation activities with other researchers (anthropologist and social workers), the analysis, synthesis, and interpretation of the information were conducted from the perspective of medical anthropology.

### Ethical considerations

This work is part of a larger project, which was reviewed and approved by the hospital ethics and research committees (Registration DI/16/404-A/04/085). All participants (SW) read and signed and gave their written informed consent, and although patients were not interviewed, they also signed the document to allow observation of their consultation in the department.

## Results

Seventeen people aged between 29 and 72 years, with a 1-to-28 year working experience agreed to participate. Of these, 16 were women and 1 man (Table 1), who performed their work in geriatrics, gynecology, rehabilitation, outpatient, oncology, and pediatrics services. During the observation process, changes in attitudes and practices were noted: initially, SW personnel felt uncomfortable with the researcher's presence, thinking their job performance was being evaluated. However, once reminded of the research objectives, participants interacted extensively, explaining matters related to procedures, and even expressed experiences or difficulties from their work. Interactions with patients also became more natural, following usual dynamics.

In the analysis of interviews and field notes, 3 major themes were identified: 1) SW functions; 2) SW staff working conditions; and 3) participation with the health team.

### Functions of social work

The first encounter of patients with SW revolves around verifying eligibility, conducting a socioeconomic

**Table 1.** Participating social work personnel

| P | Age (years) | Education | Service | Work experience (years) |
|---|---|---|---|---|
| A | 52 | Professionalization* | Pediatrics | 1 |
| L | 50 | Professionalization* | Gynecology | 26 |
| E | 36 | Professionalization* | Oncology | 8 |
| S | 38 | Bachelor's Degree | Geriatrics | 10 |
| D | 29 | Technician | Oncology | 5 |
| R | 47 | Bachelor's Degree | Outpatient | 26 |
| Es | 49 | Technician in process of professionalization | Oncology | 5 |
| Li | 29 | Technician in process of professionalization | Outpatient | 2 |
| M | 36 | Bachelor's Degree | Outpatient | 14 |
| G | 49 | Bachelor's Degree | Rehabilitation | 28 |
| An | 52 | Professionalization* | Gynecology | 10 |
| Ma | 37 | Bachelor's Degree | Oncology | 14 |
| Do | 49 | Technician in process of professionalization | Outpatient | 23 |
| N | 26 | Bachelor's Degree | Pediatrics | 6 |
| Ra | 72 | Technician | Outpatient | 27 |
| C | 50 | Professionalization | Outpatient | 27 |
| Mc | 45 | Bachelor's Degree | Outpatient | 19 |

*Studied a technical career more than 10 years ago while working in an administrative position at the hospital.

study, and hospital admission. Other interactions depend on the service area, addressed through social studies, case follow-ups, home visits, health education, interinstitutional coordination for referral, and support management. Participants recognize significant needs in the population served at HGM, linking their work directly to supporting patients in coping with their specific problems (Table 2).

## *Working conditions of social work personnel*

The working conditions of SW personnel impact how activities are developed, and services are provided to patients and their families:

- Level of training: The various levels of professional training of SW personnel (university or technical, for example) are reflected in daily practices and communication methods with patients and families (Table 2).
- Facilities and equipment: The layout and architecture of some DTSRP spaces may limit the type of care required by the population (in terms of privacy); environments that allow for quality and inclusive care with the family group.
- Work overload: The high demand for patient care reduces the time available for the optimal development of SW activities, leading to emotional fatigue and dissatisfaction with personalized care (Table 2).
- Administrative functions: The demand for administrative activities hinders the fulfillment of the SW social role because paperwork represents a significant time consumption, preventing the desired quality of care (Table 2).
- SW daily life: In-depth analysis of the patients' socioeconomic situation through social studies is recognized by participants as fundamental for understanding the needs of the users (Table 2).

As a result of changes in organizational processes, the hospital has strengthened the positioning spaces of SW, with greater presence in institutional training actions, an increase in practicing students, involvement in collaborative social research projects, and rethinking SW procedures according to current regulatory policies. However, there are areas of opportunity for improvement

**Table 2.** Topics and comments from participants

| Topics | Quotes |
|---|---|
| Functions of social work within the hospital | "Colleagues comment that it seems like patients there [in oncology] are very demanding, but it's important to understand their condition, as they are mostly chronic degenerative patients, often terminal. and it reflects on their financial, emotional well-being, and the wear and tear of both the patient and the family." (E, 36 years old, 8 years of work experience.) |
| | "Most people are low-income… I'd say about 80%. they are low-income people, although we have some who aren't and come because all the specialties they need are here; also, appointments aren't scheduled too far out." (R, 47 years old, 26 years of work experience.) |
| | "I see that several patients can't even read, what other issues besides financial? . disabilities, many patients arrive in wheelchairs or due to their poor health, they can't take care of themselves and arrive without family members. they get hospitalized without family." (D, 29 years old, 5 years of work experience.) |
| Working conditions of social work personnel Level of training | "We can see colleagues treating patients in a short and dismissive manner as done in administrative settings to move to the next patient. there's no real interest, the treatment is bureaucratic and distant. in some cases, when they attempt to approach people and their situation, they can make very unfortunate interventions, with very colloquial language, for example, in a case of violence, which are numerous, they might say, 'Don't let yourself be abused, don't be stupid!'" (C, 50 years old, 27 years of work experience.) |
| Work Overload Administrative functions | "[We need] more staff, because the population is very large… I don't think you can provide optimal care, the commitment is there, but they ask for quality and warmth, and often it's not possible, people come already emotionally, financially, and health-wise worn out, so it's difficult to give them the care they deserve because the demand is overwhelming, there are too many people to attend to, and you can't give them the time you would like to." (A, 52 years old, 1 year of work experience). |
| | "Yesterday, for example, the head nurse called me and said, 'Guess what? A patient was admitted… I saw he came with family and they were pampering him, and I thought, 'Oh, how nice!' But now during the physical exam, the family is gone, and they left me a note saying the patient has some mental delay and they were leaving because they didn't have a 24-hour permit. So they left their phone numbers. but that wasn't in the socioeconomic study." (M, 36 years old, 14 years of work experience.) |
| | "Sometimes we, as colleagues, are very despotic, sometimes very rude, and patients get disappointed, but if they fall into more protective, more understanding hands, it changes their mindset a bit, especially if we guide them or clear up their doubts." (Ra, 72 years old, 27 years of work experience.) |
| | "Well, there are more administrative than care activities that prevent us from doing care activities, and research too." (G, 49 years old, 28 years of work experience.) |
| | "Recently, I had a patient who was abandoned, he had children who didn't want to know about him. The situation was that the gentleman asked me to take him home; he had been there for over a month. So I arranged everything to take him home, as I had managed to get his brother to receive him; I went to the [hospital] administration to get the document signed. When everything was ready, they told me, 'No, that's not the right protocol.' I said, 'But he's an abandoned patient, so it's equivalent to this and this,' 'But that's not the protocol, we can't lend you the ambulance,' 'But I have everything ready, they're going to receive him over there'; 'No, go back to the service.' I lost everything, I lost the day, the contact with the brother who was going to take responsibility for him, I had contacted a person who coincidentally helps people and was going to do me the favor of checking on him, and they didn't let me take him out, he had to wait another week. So you think, 'Well, it costs money, it costs my time, well, not my money, but time, the effort of doing all the paperwork, I think the institution could help by having people with more vision for the patients.'" (S, 38 years old, 10 years of work experience). |
| Daily life of social work | "No matter how much you want it, to individualized care is not possible, no matter how much you want to do more intervention, you can't. At best, you can interview the mother, explain the hospital dynamics, delve a bit into the family dynamics, how the child's environment is. It's difficult to verify data because you would need to do a home visit, a whole case development." (A, 52 years old, 1 year of work experience.) |
| | "I believe it is possible to do social work in the hospital, it takes organization, commitment, and clarity in the purpose of the intervention; I feel that in many spaces there has been a gradual genuine recognition of the profession contributions, but there is still much to do to change the perception of what a social worker in a hospital can or should do." (Mc, 45 years old, 19 years of work experience.) |
| | "The functions of social work in the hospital have been impacted by changes in policies and processes. I constantly hope that we can exclusively focus on the social aspect, but it is complex, as the system depends on us for other tasks that are more administrative." (Mc, 45 years old, 19 years of work experience.) |
| Participation of social work in the health team | "I remember doctors running to me because they urgently needed the socioeconomic study sheet to admit the patient, others [professionals] came with concerned because the patient had a certain socioeconomic level, but I wonder: how many of them read the socioeconomic study sheet to learn a bit about the patient's and family's situation?" (Mc, 45 years old, 19 years of work experience.) |

related to simplifying administrative tasks, allowing for greater complexity in SW activities, thereby increasing SW personnel satisfaction (Table 2).

### *Participation with the health team*

SW personnel perform most of their activities from their offices. Health team members approach this space to present situations requiring support for patients or families (Table 2), often referred by other professionals, on issues such as verifying eligibility and economic-related arrangements. However, recent institutional changes have enabled more active participation in health teams through clinical sessions, medical committees, medical ethics committees, and case discussions.

## Discussion

The role of SW in the hospital combines different components: attending to a socioeconomically vulnerable population, professionals with heterogeneous levels of training, historically feminized roles within a hierarchical system, a particular physical and professional context, and daily interactions with healthcare professionals and patients.

### *Relationship between the profession involved and institutional structure*

Guillén[16] states that the functions of SW have become a mediator between state resources and the needs of the users who demand them. This research shows a discrepancy between the roles that should be fulfilled and those that are actually performed, with functions designated by other organizational entities, such as administrative activities, limiting a more person-centered intervention focused on the social aspects of illness and moving away from the ethical-political and ideological principles that constitute it[17-21].

We should mention that the current procedural changes at HGM that have allowed SW to dedicate more time to social intervention, though activities still tend to align with the operability of institutional policies.

The health system has been characterized by hierarchical relationships, which do not favor horizontal decision-making shared with the hospital health team[18,22-24]. This form of institutional interaction has historically shaped the functions of SW, designated to be the bridge between institutional aspects and users, turning SW into a practice that often does not align with the profession's objectives. Despite this scenario, there is a search for balance between independent professional practice and supporting institutional needs, positioning SW in the health field as a fundamental component for the management of the general population, and particularly for those in vulnerable conditions[18,25].

The concept of health as a state of complete physical, mental, and social well-being should be reflected in patient care, integrating the perspective provided by SW[26]. Although SW participation depends on the specific situations of each patient, more active and permanent participation spaces are currently opening within health teams, diagnosing "social issues" and structuring comprehensive action plans aimed at health recovery[19].

SW intervention is primarily focused on immediate socioeconomic issues, perpetuating the separation of health care from a biologically-centered approach without including the sociocultural components associated with health and care processes in a multicultural country[27]. These practices are like the threshold to introduce social aspects into health and illness processes, limiting care from a biopsychosocial and human rights perspective[28]. For example, the central instrument of SW -the socioeconomic study- has been seen as an administrative requirement for hospital admission rather than an instrument containing information on the patient's socio-family and cultural environment, allowing health professionals to take actions to mitigate socioeconomic aggravating factors and promote patient well-being. It is necessary to build horizontal communication pathways among health personnel to enable knowledge exchange, interdisciplinary dialogue, and the development of specific action strategies built from complementarity[25,29,30].

### *Relationship between social work and patients*

Flores and Martínez[21] recognize that distant practices have created representations of the profession that affect its image; as a result, people may not receive optimal services, affecting the hospital ability to maintain a positive outcome in care quality, resulting in encounters that hinder the creation of bonds with users for effective and appropriate social intervention based on their needs and particularities[25]. The follow-up that SW is involved with since patients are admitted to the hospital until their reintegrated into the family or the community after hospital discharge favors the development of this association between professional and user, the satisfaction of people, and the hospital image as a place to regain health[28].

The findings of this study show the execution of administrative roles and the transformation of

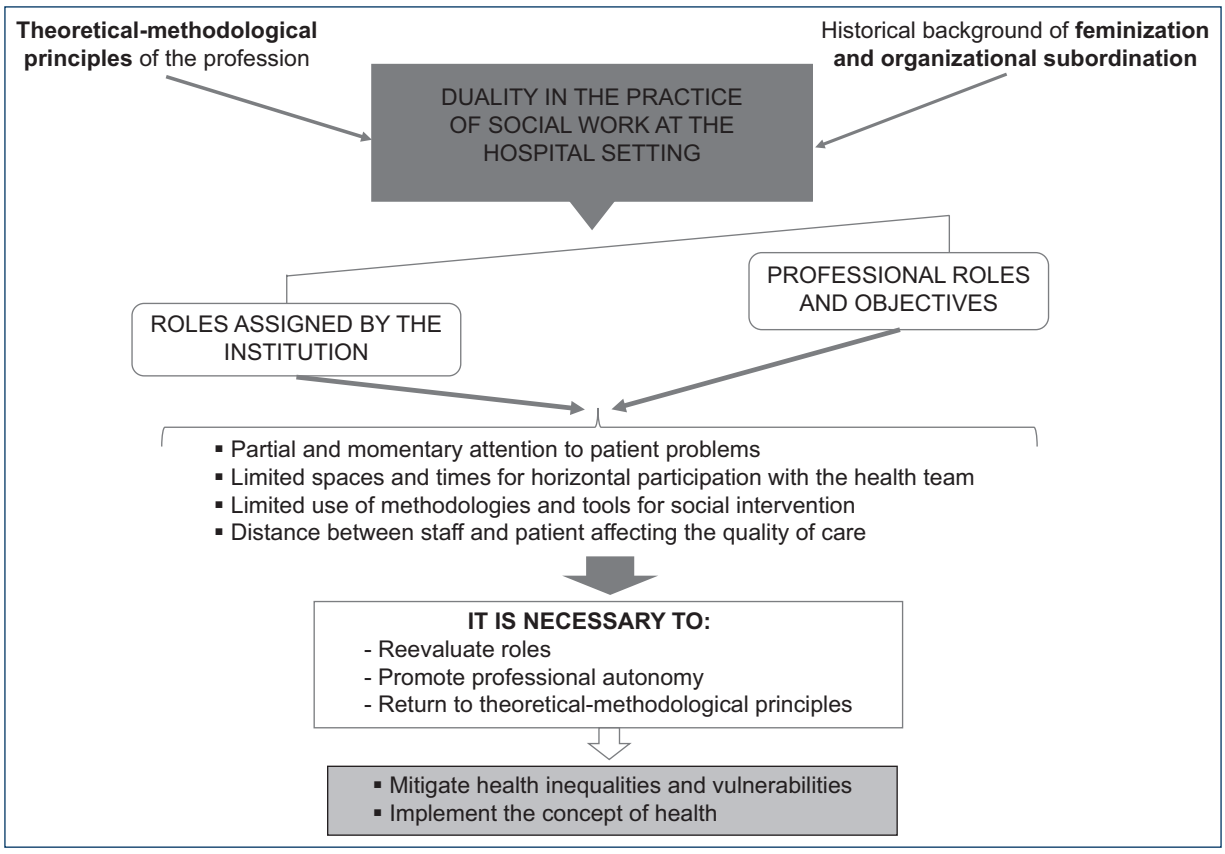


**Figure 1.** Duality of the social work role at the hospital setting. Effects and needs for transformation. Analysis of the problem.

addressing the patients' social and emotional needs into norms and administrative procedures, stemming from a historically and institutionally modeled traditional practice that harms the legitimacy of our profession. However, this has changed with recent policy changes governing the hospital[28,31].

These dual and ambivalent practices of SW relate to the lack of knowledge of SW professional competencies in the hospital context and the reinforcement of traditionally established functions in the institution.

A restructuring of current hospital activities is required, where SW social care covers all the stages patients and their families go through, while still being the relevant institutional connection in this hospital. This rethinking would allow for the recognition of SW as the profession responsible for studying the social issues that affect the health-disease-death process.

Research, social education, promotion, and prevention in health allow for the identification of support networks and the management of available resources for each person or family, as well as specific interventions individualized to the needs of vulnerable populations, to promote well-being and health recovery[19,32].

More broadly, SW is a central activity for overcoming barriers patients may face in accessing care, helping to mitigate social health inequalities and inequities in the population. Fig. 1 schematizes the analysis of the studied problems.

### *Study limitations*

This study presents several limitations: 1) the participants were mostly women, reflecting the gender distribution of this profession; 2) the experiences of social workers (SW) in services with lower demand could show differences; and 3) expanding the experiences to include other health professionals who interact with SW, as well as SW personnel from other healthcare institutions, could complement the understanding of the roles of this profession in the health field.

## Conclusions

The analysis of the experiences of SW professionals allows for the recognition of the diversity of their care and administrative roles within the public hospital context, serving as a link between users and the institution.

Various structural, historical, and internal factors of the DTSRP members have resulted in a duality in SW practice, undergoing persistent transformation in response to changes in hospital organization.

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## Conflicts of interest

The authors declare no conflicts of interest.

## Ethical disclosures

**Protection of human and animal subjects.** The authors declare that no experiments were performed on humans or animals for this study.

**Confidentiality of data.** The authors declare that no patient data appear in this article.

**Right to privacy and informed consent.** The authors have obtained the written informed consent of the patients or subjects mentioned in the article. The corresponding author is in possession of this document.

**Use of artificial intelligence for generating text.** The authors declare that they have not used any type of generative artificial intelligence for the writing of this manuscript, nor for the creation of images, graphics, tables, or their corresponding captions.

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