

ALC:
HOW HEALTH RESTRUCTURING
IS CHANGING THE SOCIAL WORK ROLE

**ALTERNATE LEVEL OF CARE:
HOW HEALTH RESTRUCTURING
IS CHANGING THE SOCIAL WORK ROLE**

By

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ABSTRACT

Social workers who are employed in a medical environment function in a situation that presents unique challenges to the profession. Currently the medical field in general and hospital settings specifically are experiencing extreme pressure to modify the manner in which they provide services. One manifestation of the current pressures that especially affects hospital social workers is alternative level of care (ALC). This thesis will examine the interplay of contemporary pressures on healthcare organizations, and social workers' professional practices. I will explore hospital social workers' perceptions of the transformation of their roles resulting from the intersection of organization and professional expectations using ALC as a back drop.

Although previous research has examined this concern from a more theoretical approach, little attention has been paid to the day to day experiences of front line workers. This study, based on a focus group with hospital social workers, extends our understanding of the impact of organizational influences on the role social workers occupy within health care organizations.

The changes in social work practice were understood in a range of ways by the focus group participants. In the most positive framing, any changes that were acknowledged were seen to be "instrumental." At the same time, group participants identified many potentially problematic changes in the actual practice of social work associated with ALC. Focus group members provided some insights as to how organization influences impacted on social work's apparent change in focus and practice.

It is my contention based on this study that contemporary organizational influences fundamentally change the manner in which the profession operates. If these organizational pressures are left unchallenged, social workers risk losing the ability to serve either the individual or greater good, making moot the debate surrounding our most appropriate role.

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INTRODUCTION

Social workers who are employed in a medical environment function in a situation that presents unique challenges to the profession. Unlike in child welfare, where social workers play a primary role, medical social workers are required to function as part of a multi-disciplinary team. In this situation a number of tensions exist. In a medical setting, differences in the professional status of various team members may impact on a social worker's ability to carry out her or his duties. The theory base informing team members' practices may often be at odds with a social work perspective. The "tools" that are applied to patients' concerns may differ drastically between diverse professional approaches. The goals and expected outcomes of any particular patient/professional interaction can be expected to differ as a result.

Currently the medical field in general and hospital settings specifically are experiencing extreme pressure to modify the manner in which they provide services. A great deal of the focus in today's acute care environment is directed toward cost reduction, effective practice and the efficient use of resources. As agents of the employer social workers are directly affected by these changes. The challenge faced by the profession is to decide how best to respond to the tensions inherent to the situation.

One manifestation of the current pressures that especially affects hospital social workers is alternative level of care (ALC). ALC is a patient designation created by the Canadian Institute for Health Information. "An alternate level of care patient has finished the acute care phase of his/her treatment but remains in the acute care bed," (Discharge Abstract Database, 2006, p. 10-1). In other words a doctor has decided that a patient has sufficiently recovered from the acute condition that caused a patient to be hospitalized, but something is preventing her or him from being discharged.

This thesis will examine the interplay of contemporary pressures on healthcare organizations, and social workers' professional practices. I will explore hospital social workers' perceptions of the transformation of their roles resulting from the intersection of organization and professional expectations using ALC as a back drop.

LITERATURE REVIEW

The literature review will unfold in the following manner. At the outset, information pertaining to the contemporary environment in which social work operates will be presented. A general overview of the historical determinants resulting in the current situation will be provided to ground the discussion with an assessment of the concerns raised for the profession. This will be followed by an examination of concepts related to the designation of ALC, concluding with a review of the problems experienced at both an organizational and professional level as a result. An examination of the profession's internal identity struggle will then unfold through review of social work's ongoing 'casework versus social justice' debate. An investigation of the organizational influences as they relate to the profession will then be presented including social workers' responses at the clinical level.

THE TRICKLE DOWN EFFECTS OF RESTRUCTURING

A cursory review of the social work literature informs us that the profession currently operates in a drastically different landscape in the last twenty years. Today's environment is typified as being re-engineered, downsized, restructured and requiring fiscal restraint. The literature suggests that social workers are in an intense battle for their survival, that competition for their roles is rampant and that if left un-addressed the threat to the professional role may be terminal, (Davis, Milosevic, Baldry & Walsh (2005); Karger & Hernandez (2004); Leahy & Lording; (2005); Sulman, Savage & Way (2001). Understanding the process that led to these concerns is of prime importance.

The practice and organization of health care in Canada has undergone unprecedented retooling in the last couple of decades. Shifts in financing, accountability, responsibility and delivery of service have been realized in all program areas. Historically the federal government has played a pivotal role in defining the nature, financing and the delivery of health care services Canadians receive. In 1995 that changed. In an effort to achieve deficit reduction, the Federal government initiated the Canada Health and Social Transfer (CHST). The idea behind this initiative was to create a shift in responsibility to allow the provinces greater flexibility in funding and in setting program priorities in health and social services (Canadian Council on Social Development, 2004, p. 1). While the provinces gained decision making authority, the financial costs of this initiative were significant. From 1995 through 1998 the "provinces lost \$7 billion in federal transfers," (Canadian Council on Social Development, 2004, p.1). In essence the Canada Health

and Social Transfer, "brought with it, less money, less flexibility and less transparency," (Canadian Council on Social Development, 2004, p.1).

The provincial response was swift. Under the ruling Conservative government the people of Ontario faced massive changes to both the funding and organization of health care, social services, income benefits and education. One initiative that began in 1996 witnessed the creation of the Health Services Restructuring Commission (HSRC). Its four year mandate was in part to "facilitate and expedite the process of hospital restructuring," (Ontario Health Services Restructuring Commission, 2000, p. v). With respect to hospital restructuring the goals of the Commission were clear. Specifically the Commission was responsible for "directing hospitals to amalgamate, transfer or accept programs, change their volumes, cease to operate or make any other changes considered to be in the public interest," (Ontario Health Services Restructuring Commission, 2000, p.1).

In 2006 similar yet greater change was legislated into the health care system. With the introduction of the Local Health System Integration Act the government created 14 Local Health Integration Networks (LHINs). Responsibility for key areas of health care within the province, were shifted from the Provincial Ministry, to each area LHIN. The work undertaken by the LHINs focused on five main areas. They include "accountability, integration and service co-ordination, funding and allocation, local health system planning, and local community engagement," (Ministry, Bulletin No. 30, 2007). The planning aspect of the LHINs work appears to be a pivotal component of the work to be undertaken. Through data collection and planning the changes envisioned by the LHINs may be rationalized and presented to the community. To that end the LHINs began to focus on the "identification and understanding of patterns of health care utilization," (Baigent, Loomer, Sarkella & Zago, 2006, p. iii). One area that has been targeted for such attention by the LHINs is acute care hospital use. Within the subset of acute care a further focus has been directed toward patients designated as Alternate Level of Care (ALC).

A couple of studies reflect the impact of these changes on the social work profession. Heinonen, MacKay, Metteri and Pajula (2001), undertook an examination of the impact of restructuring in Finland and Canada from the perspectives of hospital based social work staff. The authors review the impact of restructuring on clinical practice providing examples of how social workers have adapted and continue to attempt to adapt to the changes they encounter. The authors purposively surveyed social workers (15 in Canada and 35 in Finland) recording their views on the impact of changes within the social services. In a very general sense the authors attribute the impetus of restructuring to a political and organizational focus directed toward the reduction of service costs and an increase in efficiency. They note that globally many countries are undergoing similar experiences, the effects of which include a restriction in

social assistance eligibility and compensation coupled with an increase in restrictive unemployment benefits. They highlight as accompanying trends a reduction in the state regulation of social service matters, an increase in the regionalization of services, the emergence of private service providers, the introduction of service user fees and an increased expectation placed on families to fill service gaps. Specific to social work, the authors indicate a change in managerial practice which, "stress(es) fiscally-oriented management by objectives and specific budgeting approaches ...which has ... contributed to a focus on techniques and mechanics of measurement and away from a policy of comprehensive health provisioning," (Heinonen et al, 2001, p. 75). Practically, this has resulted in the need to focus on shorter lengths of stay, rapid assessments and greater time spent on discharge planning.

Overall the authors note in their findings that as a by-product of restructuring social work staff faced an increase in patient volumes, decreased lengths of stay, more rapid discharges, changes in staffing patterns, and bed closures. The authors also note that "social workers have tended to remain inside hospital faculty walls, resulting in the implicit adoption within their organizational culture of the medical model and hospital structure" (Heinonen et al, 2001, p. 78). Of the multiple recommendations made by the authors, a central focus revolved around the need for the profession to increase efforts toward research and program evaluation.

In the second study, Jane Aronson and Sheila Sammon (2000) examined concerns associated with restructuring in the province of Ontario, specifically detailing the effects of funding cuts and organizational changes on what they term "good practice." The authors carried out a qualitative study detailing social workers' (7 from health and 7 from child welfare) experiences related to the changes encountered in the work place in the preceding five years. Individual, semi-structured interviews were administered, with transcripts being reviewed to highlight emerging themes and tensions. Similar to the study noted above the authors indicate overall changes related to cost cutting, privatization, and emerging managerial techniques.

The authors indicate that as a result of restructuring, changes directly affecting service recipients included an overall curtailment of services, a decrease in social assistance benefit levels, and decreased access to subsidized housing and healthcare services. Social workers reported a shift to program management within health care, the need for defensive paperwork (paperwork detailing accountability), a focus on rapid discharges, a decrease in the scope and depth of practice, the standardization of work procedures and a fragmentation of labour. Aronson and Sammon (2000) report that the study participants further identified a decreased ability to develop meaningful relationships with clients, a decrease in preventative work (going from crisis to crisis), a decreased ability to advocate for clients and a inability to approach their duties in a reflective manner.

Pockets of resistance were noted by the authors and they indicate that workers often went above and beyond the call of duty. The authors found that social workers often relied on the use of close collegial contacts to secure services for clients. Social workers as well acted in covert manners selectively presenting information in hopes of meeting client needs. All too often these acts appeared somewhat idiosyncratic and the authors state that "in this restrictive context, good work and success are highly individualized ... there is little or no acknowledgement of the systemic insufficiencies that frame them," (Aronson & Sammon, 2000, p. 178).

The authors' findings extend as well, to the interactions experienced by social workers acting as field placement supervisors. In discussing the issue, the participants identified positives and negatives in the situation that both mirror and are motivated by the changes being discussed. The authors suggest as such it is imperative that social workers adopt a critically conscious approach to adequately understand and deal with the difficulties they encounter.

As a process, restructuring has both directly and indirectly impacted all levels of social services and it is in this evolving situation that social work continues to try to firm up its professional identity. Presented below is an overview of the debate that has and continues to unfold with respect to social work's primary role.

WHAT SHOULD WE DO AND HOW SHOULD WE DO IT?

Historically the debate surrounding the role of the profession has revolved around casework versus social justice approach. At the casework end of the spectrum efforts are best directed toward the individual. Typically the focus is directed at ensuring individuals comply with societal norms or obtaining access to the services for individuals which provide for basic needs. Examples include assisting someone in obtaining disability benefits. With a social justice approach, efforts take a more collective slant. Here a social worker's attempt to invoke changes that affect the greater good. Examples might include advocating for more affordable housing or reducing barriers to services for marginalized populations. Within social work the most appropriate role for profession has been and continues to be debated extensively within the literature and in practice settings.

One of the more entertaining yet informative presentations comes from Karen Haynes (1998). Here Haynes "debates" Harry Specht, Former Dean of the School of Social Welfare, University of California, Berkeley and co-author of *Unfaithful Angels*. The author notes that in light of Specht's absence as keynote speaker at the 1994 NASW Texas Conference she agreed to step in on his behalf. She indicates that she has used

excerpts from the speech Specht was to give to assist in framing her discussion. Haynes indicates that the debate surrounding social works' role continues to unfold and is as important today as in times gone by. She suggests that the profession has in the recent past been less attuned to the public arena as a vehicle for legitimate intervention. Haynes concludes that casework and social justice are not and need not be, treated as mutually exclusive domains and that the strength of the profession lies in its ability to harness the power of both approaches simultaneously.

The central theme of the Haynes (1998), presentation is picked up again in a 2004 article by Karger and Hernandez. Here too the authors review the absence of social work in the public domain. The authors opening line suggests that currently the profession exerts "little influence on the pressing social issues of the day," (Karger & Hernandez, 2004, p. 51). They suggest that as a profession, social work is noticeably absent from current social debates and they account for this trend on a number of fronts.

The authors identify that the profession's location, as employees inhabiting positions predominantly in the public sector, as being problematic. At an organizational level there appears some fear that speaking out on social issues could result in program cutbacks that would lead to a further deterioration of the services available to offer those in need. They explain that in the current arrangement social workers may wrestle with speaking out against those responsible for paying their salaries worrying about job loss or resource reduction as a result. The authors find that even where pockets of resistance exist, today's restricted, financially efficient institutions have left workers with increased caseloads, poor working conditions, increased stress and by extension little time to do anything more than focus on the immediate tasks that face them.

Karger and Hernandez (2004), next turn their gaze to social work's continued march toward increased professionalism. Here they suggest that in the past many of social works' most prominent public commentators were not by definition social workers at all. They were drawn from a wide array of disciplines including economics (Wilburn Cohen), education (Jane Addams), and journalism (Paul Kelly), as examples. They argue that efforts directed toward enhancing social works' image through the practice of licensing has resulted in an increasing environment of professional exclusivity at the expense of varied intellectual input.

The authors suggest that the pursuit of professionalism includes pairing the profession with psychiatry, specifically in social workers' adoption of elements of the Diagnostic and Statistical Manual of Mental Disorders. For the authors this resulted in a number of trade-offs including skill building versus critical thinking, credentialism versus competence and exclusivity versus inclusiveness

Karger and Hernandez (2004), locate some of the professional zeitgeist in the educational institutions responsible for training social workers. The authors suggest that currently educators focus more on the technical and vocational aspects of profession at the expense of the development of critical thinking and theory generation. They see research as being turned inward focusing more on the strengths and weaknesses of the profession and less so on social justice issues. For these authors, research has become overly reliant on quantitative measures in a pursuit of best practices. Research proposals are dictated by funding bodies and the research activities being pursued are tied to grant monies made available

In proposing solutions Karger and Hernandez (2004), suggest that now more than ever, the profession needs to address social workers apparent absence in the public domain. They argue that currently the profession operates in an environment typified by shifting political alliances which seem to be obsessed with models of efficiency, economic recession and stagnant job growth. The authors point to research activities as one method to effect change. Examples of solutions put forth include disseminating research findings in "non-traditional" ways including the use of newspapers, television and magazine articles. They suggest as well that tenure and promotion within educational institutions "should be tailored to enhance its relevancy to the social justice mission of the profession," (Karger & Hernandez, 2004, P. 65).

In the final study to be presented in this section Silvia Fargion (2008), examines Italian social workers' perceptions of the profession. Specifically the author looks at the balance of the individual and social; scientific versus humanistic and theory adoption versus theory generation aspects of the profession. The study focuses on the views of Italian social workers, using a qualitative approach, to capture information relevant to participant's definition of social work and good practice as well as intervention methods used in daily practice. Overall focus group members indicated that they take a "holistic approach," in carrying out their duties. Participants spoke of relating to individuals as being a crucial component of their job. Interventions include obtaining resources, advocating for clients and negotiating relationships. Study members also spoke of joining individuals and communities and addressing social goals.

Discussions of good practice appeared to reveal some rifts within the group and the participants' opinions spilt on the scientific nature of social work. While there was an acknowledged need for a technical approach to assessments, the participants seemed to play this off against the need to "build" relationships with clients, suggesting a non-scientific stance. A similar split was evident in the discussion focused on theory. Participants felt it was important to relate existing theory to practice as a way of highlighting the professional status of social work yet they also called for continued flexibility, adaptation and negotiation of practice methods. Interestingly the authors note that overall participant responses demonstrated little awareness of the structural nature

of social problems. Participants made minimal references to issues related to social justice or social policy. The author further suggests that a "lack of attention to issues of power and oppression," (Fargion, 2008, p. 212), could be identified in participants replies.

The ongoing debate about social work's most appropriate role becomes even more important when applied to practice issues. As theory and practice combine, we are afforded the opportunity to better observe the current direction and emphasis the profession is taking. ALC provides one such vantage point and will be reviewed below.

ALTERNATE LEVEL OF CARE

Shaped by the forces of politics, policy, economics, and resource availability ALC has a direct effect on patient care and by extension those who administer ALC procedures. This of course includes social workers. In Canada information about ALC is captured, manipulated and disseminated by the Canadian Institute for Health Information (CIHI). In their 2009 Analysis in Brief they inform us that the public consciousness has embraced the idea that hospital beds are being occupied by patients who no longer need acute care services, using expensive resources while they wait to be discharged to a more appropriate setting (p. 1).

CIHI notes that the situation presents a "sizeable challenge for the hospital system," (Analysis in Brief, 2009, p. 3). The report suggests that overall trends related to ALC patients indicate that these individuals are female, with a median age of eighty years, who enter hospital with multiple medical concerns and are admitted through the emergency department. At time of discharge ALC patients are overwhelming likely to be waiting to be transferred to a long-term care or rehabilitation facility.

Interestingly ALC is not a new concern, nor is it specific to one geographic area. Data from the United Kingdom can be found to exist as far back as 1982 when Hall and Blythway attempted to define the problem of "the blocked bed," (p.1). Subsequent studies have addressed concerns related to the delayed discharge of mental health patients (Lewis, 2006; Paton, Fahy & Livingston, 2004) and in one study patient perspectives related to discharge practices was reviewed (Swinkels, 2008).

In 1981, Shapiro and Roos presented Canadian data that looked at institutional and patient concerns related to elderly patient's lengths of stay in medical facilities. Their data is drawn from a study undertaken in the province of Manitoba between the years 1972 and 1976. From an organizational perspective the authors suggest that the problem of the long stay patient resulted in the inappropriate use of hospital resources

and increased costs. Patients experienced decreased self esteem, increased isolation and further physical deterioration. Families felt increased pressures to assist in dealing with the situation.

Shapiro and Roos indicate that at the time, attempts to address the concern included; increasing the number of rehabilitation and custodial care beds within the healthcare system; increasing the level of and access to home care programs; streamlining patient transfer procedures and re-allocating portions of in hospital acute care beds to rehabilitation and or chronic care services. They note that despite instituting the majority of these changes little positive effect was realized. In their analysis the authors indicate that the single most identifiable cause responsible for the continuing concerns could be traced back to difficulties in the patient transfer process. For example the authors note that at that time patients had the right to wait in hospital until the nursing home of their choice became available. Nursing homes providers retained the right to accept or reject placement candidates as they saw fit. Finally, nursing home reimbursement schedules were structured to make patients needing the least amount of care most attractive to care providers.

Shapiro and Roos offer a number of solutions to the concerns noted above. At one level they advocate for the development of a central processing agency responsible for assessing patient need and charged with the authority to require care providers to accept patients on a priority basis. A second option would require patients to accept the first available bed, with the option of moving to their preferred choice as dictated by availability. Another scenario would require the reallocation of beds within the hospital system from acute care to long-term care needs. The last option suggested by the authors is to do nothing. In this case they suggest that system pressures would continue to increase to the point that an inevitable redistribution of health care dollars would flow toward geriatric needs.

The study of the long stay, delayed discharge or ALC patient continues. In 2000 Victor, Healy, Thomas and Seargeant reviewed the concerns associated with elderly patients inappropriately occupying acute care hospital beds in the United Kingdom. Specifically they were interested in better understanding how, what they termed, individual and organizational factors lead to increased lengths of stay. The authors conducted a retrospective case note review of patients seventy five years of age or older admitted to three different healthcare sites in England. Of particular interest to the authors was the

relative contribution of ... individual and organizational factors ... detailed as ... predisposing factors (such as age), enabling factors (availability of family care), vulnerability factors (dependency and multiple pathology) and organizational/institutional factors (referral for services, type of team undertaking assessments, (p.443).

Overall the authors found that in an environment marked by resource reduction and cost analysis, predisposing and vulnerability factors had little influence. They suggest that patients who lacked familial support or who lived alone were most at risk for lengthy hospital stays. As well they suggest that organizational factors had a large impact on the situation. The authors further subdivide organizational concerns into team makeup and referral processes. With respect to team composition, the authors indicate that in the hospital that used nursing staff as the primary referral source, patients were more likely to experience delays in discharge. In the other two sites where social workers and occupational therapist made placement referrals, patients fared much better. They account for this phenomenon by noting nursing staff's reluctance to use a wide variety of team members in planning for patients discharge. As well the authors indicate that complications in the referral process, requiring the need to use multiple and divergent services providers bogged down the process and resulted in further delays.

ALC is a long standing concern that is of particular importance to the organization as patient flow impacts on the type of services that can be provided and the number of people they can be provided to. As a policy ALC defines the parameters of service delivery and the manner in which services will be delivered. As such ALC provides one example of the effects of organizational pressures on the profession of social work.

ORGANIZATIONAL IMPERATIVES AND THE IMPACT ON SOCIAL WORK

Currently professionals in various situations are confronted daily with organization messages that reshape the manner in which they work. In social work a subtle but persistent lexicon has entered the work force that directs the profession's focus toward organizational need. Workers are reminded of the importance of operating in a manner that is both responsible and accountable. Performance measures and benchmark indicators provide verifiable proof that workers are doing their job in an organizationally prescribed manner. Three examples of studies which review this issue will be presented below.

The first illustration comes from the study undertaken by Janet Rankin and Marie Campbell with respect to the changes experienced by hospital based nursing staff. The authors provide an explanation of "adjusting the mindset of nurses," (Rankin and Campbell, 2006, p. 65), which is instrumental in effecting change. The authors identify a number of "restructuring technologies," (Rankin and Campbell, 2006, p. 66) which directly and indirectly affect clinical practice. They suggest that these technologies are operationalized in texts (documents commonly used in the setting) and have the purpose

of advancing the appropriate use of hospital resources by standardizing treatment protocols within fixed timeframes. In the process nurses begin to develop an "organizational consciousness that is aligned with institutional restructuring priorities," (Rankin and Campbell, 2006, p. 66). The authors provide as an example the use of clinical pathways on hospital units. Clinical pathways are textual supports designed to assist staff in defining medical concerns and outcomes, establishing standards of care and tracking patient progress. The authors argue that they operate as well to ensure the efficient provision of service. At one level, clinical pathways provide increased scrutiny of the work being performed. They monitor for variance from standard methods of practice, which is taken as evidence of procedural mismanagement requiring corrective measures and as such also operate as a tool to enhance staff compliance. "Clinical pathways ... organize nurses to see and accept as a nursing concern, the timely and efficient handling of organizationally determined goals," (Rankin and Campbell, 2006, p. 69). This can include the need for rapid discharge and or responding to bed pressures as examples. In the process, nursing staff experience conflict between the education, training, and experience they possess and organizationally lead demands. Further tensions surface as well between the interplay of the clinical pathway as a text dominated "virtual reality" (Rankin and Campbell, 2006, p.66), and the actual reality expressed by patients and staff. Overall the authors see the use of clinical pathways as governing "practitioners knowing and acting. They systematically and quietly insert the relevance of counting and benchmark targets," (Rankin and Campbell, 2006, p. 75) into nurses' everyday practice, modifying the manner by which it unfolds.

A second example of restructuring technologies offered by the authors refers to the practices involved in alternate level of care processes. The authors envision ALC as a case-typing activity dominated by textual procedures. Rankin and Campbell suggest that ALC provides yet another example reflective of the virtual reality used to adjust nurse's mindsets. As a process ALC is directed toward

the appropriate use of labour resources ... used to make the difficult decisions of hospital restructuring ... ALC foregrounds the hospital's business oriented practice ... and it backgrounds other issues, (Rankin and Campbell, 2006, p. 85).

This in turn is taken up and internalized by nursing staff in a manner that often reduces the services made available to certain types of patients. ALC exacerbates professional tensions, pitting professional training against standardized procedures, nursing codes of ethics versus institutional expectations and patient interest against organizational desire. ALC elevates administrative decisions to a level that results in the negation of the skills of hospital staff. "Methodically inserted into the local sites of nursing practice ... the ALC designation process requires nurses to think of people in its terms," (Rankin and Campbell, 2006, p. 86).

In attempting to account for the transitions related to ALC, the authors suggest that a "carrot and stick" (Rankin and Campbell, 2006, p. 32) approach is taken. The carrot is described as the assurances made by management that appropriate data collection and workload measurement will result in a rebalancing of staff ratios as efficient application of ALC processes ensue. The stick reflects the implied continuance of further human resource reductions should compliance flag. In this manner the organization corrals hospital staff in its quest for the continued effective and efficient use of hospital resources.

The second account of the effects of organizational restructuring on professional practice comes from a study by Martin, Phelps and Kathbamna (2004). The authors use as a point of reflection, work previously presented by J. LeGrand, (for a complete explanation see J. LeGrand 1997, 2000, 2002). LeGrand describes two distinct time periods which characterize social service delivery. In the first, the administration of services flows from an overarching sense of altruistic motivation on behalf of both the people who provide services and those that pay for them. Le Grand refers to these peoples as "knights." In the contemporary portrayal, services delivery is marked by more self interested activities and participants are seen as acting as "knaves." In essence LeGrand argues that contemporary policy directives were enacted to acknowledge the usefulness of knavish behaviour in an attempt to increase service user participation while simultaneously encouraging greater compliance with organizational priorities. Martin, Phelps, and Kathbamna (2004), build on LeGrands' work taking as their point of reference changes enacted through the 1990 National Health Service and Community Care Act with a specific focus directed toward care management. The authors suggest that at one level the changes enacted allowed workers greater latitude in advocating on the client's behalf by allowing them to tailor care packages to the needs of the individuals they encountered. They contend as well that alongside of this goal care management was used to address systemic cost and efficiency concerns within the organizational sector. Essentially the authors suggest that "care management had two objectives; to make professional more responsive to the requirements of service users, and to make them more responsive to organizational concerns," (Martin, Phelps and Kathbamna, 2004, p. 476).

The changes enacted resulted in, amongst other things, the separation of the purchasers (social workers and case managers) from the suppliers of services (private or voluntary sectors) and in increased eligibility requirements for services rendered and provided. What the authors found is that a number of tensions were created that resulted in a shift in practice. For example, where social workers acted as both the assessors and providers in the past, under the new regime the provision of services now fell to private and voluntary concerns. Professionals assessing for need did so with looming fiscal constraints in place and in the process the worker's ability to advocate on behalf of a client was reduced. Specifically when it came to issues of placement it was noted that

“financial concerns had to take priority over clients’ needs,” (Martin et al, 2004, p. 476). Similar concerns were noted with respect to eligibility criteria. The authors state clearly that eligible services were often tied to spending caps that dictated the amount of services that would be supplied. As well, eligibility criteria were focused on addressing the concerns of those most in need resulting in a denial of services for those with less serious concerns. Preventative work was reduced, leaving large segments of the population to fend for themselves. The authors suggest that in this scenario the most pressing issue for the worker, “the knave,” is to meet the needs of the organization over those of the client. They continue that in the current domain the present-day focus revolves around the effective and efficient use of resources. Managerial practices that resulted in a division of labour and the segmentation and standardization of work processes further restricted service provider options available to clients. The authors conclude that “in considering the self-proclaimed attitudes of some of the professionals we interviewed, then, the primacy of the organizational context is evident,” (Martin, et al, 2004, p. 482). They suggest that far from meeting the objective of using workers’ knavish instincts for the greater good, care management policies and practice as they stand, do nothing more than make service providers pawns of the organization.

In the final study to be reviewed Debra Leahy and Penny Lording (2005), examine social work interventions designed to address the effects of an aging population and increased service demands on the hospital system in Australia. Specifically the authors address organizational concerns surrounding elderly patients waiting for nursing home placement in acute and sub-acute sectors within the institution, resulting in an increase length of stay. The authors indicate that earlier attempts to solve this issue resulted in the creation of the Social Work Aged Care Senior Clinician in 2000. Duties related to this position were specific to meeting the institutional need for expedited discharge and reducing the length of stay of these patients. The authors note that while improvements in these areas were noted, the problems of long stay patients continued and were experienced as a threat to the social work role and staffing allocations. As a result, social workers petitioned for and were successful in creating the residential care team (RCT), in 2002. The team was comprised of three full-time social workers and one allied health assistant. The team would provide “a holistic approach to patient care and the services included; assessment, counseling, discharge planning and post discharge evaluation,” (Leahy and Lording, 2005, p.288). The need to “meet organizational needs which include increasing the rate of discharge and decreasing the LOS (length of stay) for inpatients,” (Leahy and Lording, 2005, p. 287), remained a constant for the team.

The team developed data collection techniques to allow for benchmarking between hospitals and to measure the effectiveness of the services provided. The authors identify a reduction in the number of patients awaiting residential care, an increase in the number of discharges and a decrease in the overall length of stay as the positives attached to their service. They indicate that their duties were performed in a

fiscally responsible manner under the umbrella of cost containment. The authors highlight the importance of communication within the organization by highlighting the need to “statistically and deliberately... disseminate information ... intended to demonstrate the benefits of the Residential Care Team (RCT) staffed by experience social workers in meeting organizational needs” (Leahy and Lording, 2005, p. 287).

The authors concluded that as a department social work realized an increase in the credibility and legitimacy of the tasks they performed. Social work staffing allocations were increased and “it was felt to be more cost effective in the long term to employ three full-time social workers who understood the organizational and financial pressures” (Leahy and Lording, 2005, p. 287) facing the hospital. This was felt by the authors to be all the more important when it is considered that,

Employs who create no revenue; whose efficiency is questionable or not readily demonstrated; whose cost saving value is unmeasured; and whose role is misunderstood, challenged, or under-rated are valued least in the current hospital environment, (Ross, 1993, p. 243 in Leahy and Lording, 2005).

The literature suggests that social work as a profession has wrestled with attempting to clarify its professional role for some time now. It details the changes encountered in the provision of social services as they unfold in an era focused on the efficient use of resources and the need for organizational restructuring. Efficiency imperatives are perhaps especially evident in health care, yet few studies have asked medical social workers themselves how the current climate has affected their practice and social work more broadly. This thesis attempts to better understand social workers' responses to restructuring, and to explore the new direction social work seems to be pursuing.

METHODS

The process of inquiry undertaken in this study is guided by principles typically associated with a qualitative approach and are operationalized through the use of focus group data. As well elements of historical-comparative procedures have been incorporated to highlight changes described by the focus group members (Kreuger & Neuman, 2006, p. 38). The study develops from a hermeneutical platform to assist in making obvious that which may be taken for granted in the day to day activities of the participants (Kreuger & Neuman. 2006, p. 77). At a practical level a primary mandate of the study was to better understand what the participants did as part of their regular duties, what they experienced in their interactions with others and how they attempted to resolve any of the conflicts that they may encounter. It was felt that in adopting this approach the complexities of the situation would be simplified, providing a wealth of detail for further examination. Use of the above methods is congruent with the literature which describes studies defined as being "exploratory," in nature (Kreuger & Neuman, 2006, Peek & Fothergill, 2009). Overall interactions with participants unfolded in an informal manner, with an interview guide used to direct the conversation.

The use of a focus group as a research method played a significant role in the development of this study and was initiated after thorough consideration of the strengths and weakness inherent in the format. "A focus group is a carefully planned discussion designed to obtain perceptions on a defined area of interest," (Kreuger, in Peek & Fothergill, 2009, p. 31). As a process focus groups present many challenges. These include the logistical questions created in attempting to co-ordinate a time and place to meet with multiple individuals. Depending on the group size it may, at times, be difficult to provide all members with enough time to fully discuss issues as they see fit. Care is required to ensure no one member dominates the conversation. Researchers need to be aware of and try to address issues of censorship (e.g. not disclosing for fear of embarrassment) that may occur during interaction with group members. Finally, analysis of focus group data may for some pose a unique concern. Focus group data analysis requires a flexible approach and methodologically little literature is available to guide the process (Peek & Fothergill, 2009, pgs. 46 - 53).

That being said focus groups contain many positives. As a process they allow for the quick, efficient and effective collection of data. Peek and Fothergill suggest that

A small number of individuals brought together as a discussion or research group, is more valuable many times over than any

representative sample. Conducting interviews in a group setting allows us to speak with several participants at once, more efficiently using our limited time and resources to gather data, (p. 33).

Focus groups bring to the table multiple points of view and in doing so allow for a wide breadth of information to be obtained. Similarly "the hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group," (Peek and Fothergill, 2009, p. 47). A focus group format encourages a multi-pronged examination of the topic at hand with the moderator and participants "playing off each other" to identify and establish the direction of the conversation. As well focus groups may be of assistance to the participants by reducing elements of isolation.

RECRUITMENT

Recruitment for the focus groups was guided by the nature and goals of the research being undertaken and by accessibility to the sample population. Procedurally, recruitment developed as a "researcher driven; key informant," (Peek & Fothergill, 2009, p. 35), process. In this instance the researcher is held as being most accountable for contacting participants, scheduling a meeting time and arranging for a suitable location. Key informants are identified by the researcher based on his/her evaluation of their investment "in seeing the focus group carried out, or individuals with strong connections to the community of interest," (Peek and Fothergill, 2009, p. 35).

Specific to this study, recruitment procedures entailed the following. First an e-mail was composed and sent to the Social Work Professional Practice Leaders of two local healthcare facilities. I asked them to forward an invitation to their staff requesting their participation in the research project. The potential participant pool, available in all healthcare campuses approached approximated 100 possible participants. The Professional Practice Leaders were supplied with an overview of the research project, a copy of the confidentiality agreement and the appropriate Research Ethics Board approvals. Included in the package was a return e-mail address that potential participants could use to contact the researcher as appropriate. Individuals who responded to the invitation were then contacted by the researcher. Potential candidates were provided with a short overview of the research project and a copy of the confidentiality agreement. They were made aware at this point that their participation in the process was voluntary and that they could choose to withdraw at any time. They were asked to review the documents provided and to contact the researcher once they had done so, should they choose to proceed. For those individuals that did not respond no further contact was pursued.

Efforts were made throughout the recruitment process to create a purposive or segmented group framework. Peek and Fothergill define segmentation as “controlling the group composition to match carefully chosen categories of participants,” (p. 39). The authors point out that the “goal is homogeneity in background or personal characteristics, not in attitudes and opinions,” (Peek & Fothergill, p. 39). For the purposes of this study participants were required to have at least three years experience in healthcare, to be certified social workers and to have intimate employment experience with ALC policies and procedures.

A total of 7 responses were received from the invitation to participate, sent out by the Professional Practice Leaders. Of these, 2 respondents discontinued communication after initial contact with the researcher was made. Of the remaining 5 potential participants all agreed to participate as group members and arrangements were made to find an appropriate location and time to meet. Just prior to the focus group one participant informed the researcher of her intent to withdraw from the proceedings due to a conflict in scheduling.

A total of 4 participants provided the data obtained. All participants were female and had on average 6 years of direct healthcare practice, with a range of 3 to 15 years of experience. All members had worked in other segments of the profession including child welfare and elder care. All the participants met or exceeded the requested group membership expectations. Two of the group members described their roles as encompassing specific ALC duties and the remaining two members described themselves as front line social workers.

DATA COLLECTION

The focus group was held in one of the boardrooms of the healthcare facility employing the focus group members. All the participants agreed to meet on their own time after completing their work day. Each indicated that they felt comfortable in the surroundings and appreciated the accessibility of the site chosen. They believed the location to be secure, private enough to speak openly and appropriately appointed with the required amenities.

As an indication of gratitude for participating in the research group members were provided with a meal prior to the actual interview occurring. This allowed time for group members to disengage from their work day, to get to know each other better and to interact with the researcher in an informal manner.

Before the focus group formally began the letter of information/confidentiality was reviewed (see Appendix A). Specific attention was paid to the voluntary nature of the group member's participation. Group members were informed of their right to withdraw from the process at any time or to refrain from answering any of the questions asked. The issue and limits of confidentiality were reviewed in detail. Participants were made aware that the proceedings would be recorded so they could be transcribed at a later date. Finally participants were made aware of the process of obtaining research results once the study was complete. Participant signatures were obtained and witnessed and the interview proceeded.

Discussion related to the topic of examination lasted approximately 2 hours. Generally participants were invited to share information about the workplace changes they had noted in the preceding 3 or 4 years. Participants were asked about their involvement with ALC process and to highlight any correlations between the two. For the interview guide see Appendix B.

ANALYSIS

Data analysis paralleled the coding process as described by Kreuger and Neuman (2006) and involved repeated examination of the prepared transcript of the focus group proceedings. Initially the raw data was reviewed at a general level to begin to develop and define general themes and to condense the voluminous information provided by group members. Kreuger & Neuman refer to this process as "open coding," (p.438). Proceeding through the stages as described by the authors the data continued to be reviewed with a shift or narrowing in focus. During the second stage or "axial coding," (Kreuger & Neuman, 2006, p. 439) the general themes that were initially developed were reviewed against the data to synthesize the themes and establish a flow to the information. This created deeper associations between concepts that were then used to develop the presentation. In the final stage of analysis specific examples were pulled from the data set to provide illustrations of the concepts being discussed.

FINDINGS

Discussion with the participants revealed a number of features salient to the present review. Participant comments were reviewed under the general rubric of social work role which was further sub-divided into the categories; Alternate Level of Care (ALC), function, identity, accountability, and role tensions. The findings will be presented below.

ALTERNATE LEVEL OF CARE: LOCATING THE PROBLEM

Each of the participants was asked to discuss the role of social work using Alternate Level of Care as a backdrop and to provide a definition of the concept. In defining and explaining ALC, two tangents began to develop: one where the primary focus seems directed toward the organization and another that tended to centre more on the patient. The first comment came from a group member who identified herself as being "the ALC co-ordinator" in the hospital. She stated that

alternate level of care was a phrase or concept that was developed by the Canadian Institute for Health Information... almost 30 years ago in the late 70's ... meaning a patient no longer requires an acute care bed or service. They are medically stable. They are being held or housed, or occupy a bed that they no longer require.

Further information was provided when she added to this definition in a latter passage that,

it represents a systems failure, basically that's what ALC represents and I think it's very important to appreciate, and some of the physicians and some of the staff, don't get that it's not patient failure, it's a systems failure and that's why the individual or that patient can't move out of one place and get to where they need to be.

The other participants tended to be a bit more succinct in their responses. For example, a second opinion suggested that "ALC means that I need to work with people to get that person out of the hospital to the right place." Another focus group member felt that "ALC is someone that I need to work on. I need to get this person a plan. I need to do it as soon as possible and as far as possible". A final suggestion indicated, "That they

have been deemed as not needing the type of bed that they're in, they no longer require an acute care bed".

In attempting to understand ALC Crystal cautions,

I think it's very important to understand that acute medical services are very focused on treating what you are specifically admitted for, recognizing that you have co-morbidities and other issues but you came in with those and you can go back home with those and get them treated in the community. That's not your intended purpose in this bed.

Bobby added at later, that at this point the patient is considered "medically stable, the acute issue is done with, that's when they're ALC."

The complexity of the issue is highlighted by the divergence of the comments highlighted above. At one end of the spectrum it appears that ALC comprises an amorphous mass of policies and practices that have for some yet to be determined reasons failed, thereby creating the current crisis - the system failure view. From another perspective, the present situation seems to be directly attributable to patients who use what is available within the system, in a manner that is inappropriate, and in a way that taxes an already over burden system - the patient failure approach. In the middle is a mix of both perspectives.

Feedback from the focus group indicated that they may take up each of these perspectives to varying degrees. From the "systems failure" perspective, Crystal suggested that

We are shifting our philosophy. Before it was almost an accepted norm to be hospitalized and to live in institutions and healthcare systems, long-term care, hospitals, hospital beds ... there's no social stigma on being in a hospital bed for years ... that's no longer acceptable and probably no longer acceptable from a government systems perspective.

Here the focus of blame appears to reside outside the person, the patient. A combination of social stigma and government desire seems to have resulted in the creation of a process primarily directed toward addressing deficits in service delivery versus patient care. The focus groups comments along these lines direct our attention to the fact that the ALC designation was created outside of the confines of the hospital. It is an externally generated concept, one they describe as a "label". A delineation of ALC that appears to fall within systemic parameters is provided by Crystal, who suggests that,

It's really important to distinguish the difference between the issues in long term care and the issues of ALC. I don't associate ALC equals long-term care and long-term care equals ALC. I see long-term care as one part, maybe a large part, but one part of ALC. [ALC is] a designation.

Celeste indicated that for her ALC meant that she needs to "work with people to get that person out of hospital to the right place." Here again the focus becomes the system.

The implication is that the people being worked with include the doctors, occupational therapists, the Community Care Access Team, the "system participants". The people being worked on are patients. Another participant identified this process as containing pressures to complete her tasks "as soon as possible ... and ... as far as possible." Inherent in this comment is an indication that these concerns are primarily driven by the need to satisfy system concerns (time constraints and service gaps) versus patient concerns (care and cure). Fractures within the specific work site, the internal system, are observable in comments which highlight the system/patient dichotomy as evidence by the following observations made by Crystal.

It represents system failures, basically that's what ALC represents and I think that's very important for people to appreciate and some of the physicians and some of the staff don't get that it's not patient failure it's a system failure.

Remnants of the patient failure viewpoint are also evident in the focus groups comments which seem at times to influence their views and dealings with patients designated as ALC. The focus group suggested that they labour under and implicitly accept the definition of ALC of patients inappropriately "occupying" a bed within the hospital. It would seem that the act of occupation implicates the patient in the ALC process in a manner that contradicts earlier comments about ALC being a just a system problem. In these instances the workers' focus becomes the individual and the job entails emptying the bed so that services can be made available to another individual. One participant indicated that "this is someone I need to work on; I need to get this person a plan".

Lola suggested that amongst different disciplines patients continue to be thought of as "bed-blockers." She continues, that at times the feeling on the floor suggests that, "If it weren't for these people, my so and so could get into hospital." Celeste indicates that ALC policies are "constantly being revised too because of how many people we have waiting for long-term care." Here it appears that the problem lies with "the people waiting" not the policies being revised.

In the final scenario, focus group comments suggest that some combination of both systems and patient failure are at play. The focus group indicated that concerns related to ALC may be attributed to a number of competing elements drawn from both a systems and patient perspective. Bobby suggested that "this is directly linked to demographics. It's statistical. It's everything combining and we have more people with more needs and less resources." On the patient side of the equation the focus group noted that "the numbers of old people are increasing" and they worry that "it's not going to get any better." Implied here is the idea that increasing numbers, more people, more bodies will strain an already over extended system. The locus of attention seems to be directed toward the numbers of people versus their needs. Yet at the same time the

focus group acknowledges that systems issues are at play. One group member commented that patients do not have the “all the services they need in the community.” Another suggested that “the economy” plays a role in the current situation and concluded “ALC has always been an issue but I think it’s magnified by all those things right? Lack of resources, more elderly people.” As may be expected, the professions interactions with the ALC process, influences the type of work social workers do. Some of the implications inherent to the situation will be examined below.

SOCIAL WORK’S FUNCTION: CHANGES IN FOCUS, PURPOSE AND APPLICATION.

Important in understanding the role of social work is appreciating the functions the profession assumes. Here function is used in the context of task performance and is reflective of a healthcare setting. Specifically, this section will highlight the transformation of tasks experienced by social workers as a result of their involvement in the ALC process. The focus group comments were analysed to uncover repeated themes after having first obtained from each member their unique perceptions of what they do. Results include an expansion of advocacy duties directed toward the increased care taking of the organization, morphing of communication styles for the distillation of institutional messages, enhanced ALC administrative duties and by extension a greater focus on organizational data gathering and funding requirements.

Individually group members provided information that indicated both similarities and differences in what they do. All are registered social workers in the province of Ontario. Three of the members identified tasks associated with the discharge of patients as their “primary” responsibility. Two of these participants combined discharge and the assessment of patients. For these two participants assessment and discharge were the only tasks they identified as performing. One member of the focus group indicated that her job fell under the title of “Discharge Specialist.” She added that she also assumed the role of “co-ordinator of the transitional unit for people who are awaiting long-term care,” one component of the ALC process. She explained further that one of her tasks was to “work with social workers to help with discharge planning.” The last member of the focus group provided a job title that seemed unique to the setting. She indicated that she was the “ALC Co-ordinator... for the hospital” ... and that she was a “social worker by background and training.” She informed me that her ALC duties were carried out on a part-time basis and that “my job is also clinical social work.” Collectively the members of the focus group listed their job sites within the hospital as including mental health, general medicine and surgical departments.

The challenge faced by the focus group members, in context of the above descriptions and with ALC as a backdrop, is offered in the comments of one of the participants who indicated that

I think it has changed over the years because there are a lot more pressures on social workers to move things quickly through the organization where we had a little bit more time in the past. I think the bed pressures are really strong now. It's almost run like a business in mind. Things have to be corporate in fact: even the changing of some of the language to the corporation, all those things I think are changing.

This may account for the types of duties the focus group described as currently performing and for some of the new tasks undertaken by social workers within the institution. For example the focus group described acting as an advocate on behalf of the individuals and families they encountered, as one of the major components of their job. They strive to provide patients with "a full basket of services," and they meet with families to explain policies and procedures while trying to assist in meeting their needs. They identify services that patients need yet may not be entitled to and argue for their inclusion in the treatment plan. These are all, of course, traditional social work roles.

Interestingly in the current climate it appears that the advocate role has expanded. Social workers continue to work on a daily basis with individuals and families yet the focus and purpose of their interactions now includes the need to champion the causes of the organization as well. At an institutional level the focus group indicated that there are times when organizational want trumps patient need and the organization expects the social worker to ensure its needs are met. Crystal explained,

When a patient or family feels that they should remain in hospital or that they should remain to wait for X, Y or Z and the message of the organization ... is ... I'm sorry, you can't. I have to be the person delivering that message ... It's almost like you play both sides of the fence.

The focus group identified another of their functions as being communicators. They suggested that communication as an attribute belonged to social work and was an identifiable ability inherent to the profession. As part of their role, the focus group indicated that their communication skills provided an important link between the patients they work with and the hospital. Social workers use communication skills in combination with many of their other abilities in a wide variety of manner including speaking, listening and writing. Yet here too the function has expanded to include the organization. This change requires that social workers modify their jobs in a manner that prioritizes organizational needs. As detailed above now social workers are expected to be the messengers of the organization. When the message conflicts with traditional social work values the focus group suggests that the organization's values tend to triumph.

Acceptance of the new function may be signified by social workers now identifying themselves as “agents and or ambassadors” of the organization.

In a rather dramatic departure from the traditional, the focus group indicate that dealing with the administrative issues related to ALC has become a primary function of their day to day interactions. One group member suggested that,
as numbers go up, it becomes more of an issue for us...We could go through these periods where, as social workers we have to be very aware of how many alternate level of care patients we have and what were doing about it.

Another group member echoes these sentiments adding

You have to spend time at your computer looking at ALC reports because it's necessary. It's become part of your job ... it's an integrated part of what I do right now so that for me is a change.

This transformation may in part, be operationalized by directing the social worker's focus toward numbers, yet another change in function. One group member indicated that “When I started here I rarely looked at numbers and now it's part of what I do every week, you know, I go to my ALC reports.” This observation is echoed in another group members comment that “we're also now responsible for the numbers and the actual data and quantifying that information.” The intended purpose of the task seems to be directed toward enhanced managerial functioning and implicates social work in the process. She continues,

Across our entire organization social workers are primarily responsible for facilitating the patient information and the ALC information so that we can produce the data and allow our administrators to make decisions.

The focus on numbers leads by extension to another facet of the modified social work function, one raised by the focus group participants throughout our discussion with seemingly great importance attached to it. Here the focus group examined the profession's role in the attainment of funding. At a basic level they suggest that “It's sad to say but the numbers get us money and numbers produce dollars and cents.” At a deeper level the importance of funding is associated with the ALC functions that social workers perform and its impact on the large organization. One of the participants suggests that failure to adequately perform this role could result in producing data that

screws up the ALC reports ... which has a bigger impact on funding and that has a bigger impact on our whole system. I mean numbers count and that's important to understand as well. Funding is based on numbers and we right now have a role in that.

For this social worker this all became part of understanding the “big picture.”

In the near future social work functions within the hospital will once again be altered to allow for the incorporation of additional duties related to ALC. One of the participants pointed out that as of July, in her organization, non-acute bed social workers will be the individuals designating a patient as ALC or RLC, alternate level of care or right level of care. This will be further extended, and on October first, "acute care social workers will be the ones in the entire organization that will be responsible for that designation process ... It will be held with social workers to follow through on that process and facilitate that discussion."

The focus group identified a number of benefits resulting from the array of new functions they perform. For the people that social workers interact with the focus group felt that "in a way you're doing something for the patients because your allowing programming to be developed and you're allowing money and dollars to flow into that." It was also suggested that,

ALC information is used for program development and for system development, for opening and closing beds, a whole host of things that we devote our time budget and our energies to both internal to our organization, in our local health integration network and also in the province.

When considering issues of role function in relation to the profession more broadly, Bobby suggested that

It's not so prescriptive. You have to be a lot more creative, and I think, in a way, that it's good for social workers because it gives us a chance to be pivotal in discharge.

Crystal indicated that through their efforts workers recognize a direct pay back,

We get .4 FTE's (full time equivalents) and more energy or resources in our department because we submitted a proposal and part of that proposal was using ALC numbers that they provide.

One of the focus group members seems to have captured the current view with her statement that indicates that,

I think it's a natural evolution of our role perhaps as we sit back and talk more and more about it, because certainly the buy in for me was we can effect change if we put in the right data and I think the more workers are introduced to this whole concept, that's our buy in, that's how we get workers to look at wow, like I didn't know the numbers could give us more beds or more jobs.

On the negative side of the equation the focus group identified a number of concerns that arise in pursuing some of these avenues. One member suggested that

doing so resulted in taking a “bit of time away from that direct patient care,” and continued that the

The downside is that you can get distracted by the glam of the numbers and the push, and the patient flow and the moving people through the system and you lose track of the fact that those numbers are patients and people.

Other considerations will be examined in detail, later in the thesis under the tensions section.

SHIFTING IDENTITIES IN A RESTRUCTURED ENVIRONMENT

An equally important concept to understand in appreciating a social worker’s role is that of identity. Identity is thought to differ from function in that function tends to be more of an observable construct versus identity which may often be less visible. Identity speaks to the unique attributes of a given entity. Of interest is the identification of the specific construct claimed by the focus group in the formation of a professional identity, in the face of a shifting landscape. I was most interested in discovering any incongruencies that existed and how the focus group dealt with these.

While getting to know each of the participants and learning more about them I was struck by the fact that each used the title social worker to identify themselves. Each of the participants seemed to be attempting to establish a connection to the profession as a manner of providing legitimacy to their presence in the group. They tended to provide specific information about the organisations that they had been employed with and highlighted the departments or positions that they currently worked in. Each provided a demarcation of when they “became” a social worker. The focus group participants often spoke in terms of group identity using terms like “we” and “as social workers,” inferring a taken for granted level of group cohesiveness. Conversely there were times when the focus group members claimed some level of unique status indicating that “we’re not cookie cutters here.”

As indicated earlier, communication was one of the functions performed by social as part of their day to day duties. It appears that communication as a function also transcends into an attribute of identify for this group. One group member suggested

One of the strengths of social work is communication. I mean that’s what we’re taught, effective communication, effective listening, so we have those skills sets to be able to do that versus ... doctors - and not to diminish any of the other roles, physio and OT’s - but we’re communicators.

The focus group members seemed to set themselves apart from the other professions that they work with based on this skill, claiming a degree of mastery not attributable to their counterparts. They indicated that as part of their job they often had to deliver bad news and informed me they did so "better, faster and with more compassion," than others in the hospital. Overall they seemed to feel that they were "the right people to deliver some of the messages." The focus group participants added a new dimension to the communication spectrum in identifying themselves as ambassadors and or agents of the organisation, a term that ties them in a direct manner to the organization and simultaneously implies a level of status, accountability and responsibility new to the profession. To ensure that patients and families accept systemic limitations the hospital is reliant on the ability of social workers to effectively communicate current service parameters. In this case, it appears that because of their enhanced communication skills social workers fill this void resulting in an increased prominence within the organization.

Problem solving was another area that the focus group seemed to include as part of their identity. Another marker reflective of function, problem solving seems to be an identity indicator for the focus group due in part to their perception of how others see them. The participants informed me that in their day to day duties they assisted individuals and families in obtaining resources, services and information that supported recovery. "Families still look to us to help them with any problem solving; they know that's what social work does." In an interesting twist one of the focus group members' explanation of family interactions mirrored directly organizational expectations. Families expect the social worker to "*move things along*, (emphasis added) so they look for guidance. What's next? What's our next plan? Who do we talk to?" Social workers provide aid to their teams by collecting collateral information (e.g. patient health and social histories) and assessing need. They support the organization in meeting its needs and the focus group seemed again to feel that they were uniquely equipped to do so. "I think that historically, my understanding is that we have a very good grasp and a very good picture on the systems issues and where the gaps are." As a final example, group members suggested that their problem solving skills are also used in data collection to allow their administrators to make decisions for the organization.

In an illustration of social work's changing character, the focus group seems to claim their participation in the ALC process as part of their identity. As has been detailed in the proceeding section, ALC functions within the institution appear to have fallen to social work and they have accepted this challenge. As a group, they appear to have created language that is specific to social work and the ALC process (To Be Determined; TBD's, tracking forms, and Right Level of Care; RLC as examples), which sets them apart from their contemporaries. As well, they will soon have their ALC responsibilities expanded through their participation in RLC.

Interestingly, despite the changes perceived in the social work identity as described by focus group participants they indicated that for them their identity had changed very little. Lola felt that "there have been minimal changes clinically for front line social workers." She continues in a latter passage,

I don't think the social work role has necessarily changed because we put into it what we want. We still at the end of the day have to answer to ourselves and why we went to school and why we're doing social work.

Another focus group member suggests that "I don't think for me fundamentally - I'm still going by the work ethics and that still guides me and still guides my practice."

That being said conflicts appear to exist, one group member indicated that,

Overall the style of management has changed over the years. We've gone from a kind of very tradition social work management ... to how we are managed in a business style, which ultimately affects our role.

In wrestling with this idea one worker offered the following,

Am I a good employee or a good social worker? If I'm a good employee my stats are good, my ALC numbers are good, my documentation is good, I've got great tracking forms, I've got all of that stuff that is kind of in the ALC and I'm a good employee. Am I a good social worker? I don't know I'm not sure how families feel about it because I don't have time to talk to them about it because I'm a good employee.

This same worker concludes later in the conversation,

The organization asks us to collect ALC data and as good social workers we decide, we will participate in this but we will also advocate having the data used in the development of programming and advocate for our patients, ultimately by doing that, that's where, I think, the good employee and social worker combines.

Here the multiple identities the profession inhabits become apparent and a partial resolution to the problem is provided. That being said, social workers are left feeling that

For social workers it's hard to balance all the advocacy and things we want to do for our patients, but also fit into the organization and be able to work within it.

In attempting to achieve this balance, focus group feedback suggests that the changes in role structure afforded social workers an increase in control; including the control of numbers, people, programs and funding. They felt that they enhanced "the voice" of social work within the organization. They believed that they were seen within the organization as being more "credible."

MANAGING MULTIPLE ACCOUNTABILITIES

Accountability as a construct of role is important in that it allows for the delineation of duties, assignment of tasks, creation of responsibility and the establishment of boundaries within a setting. Social work as profession has historically struggled with this issue, often asking if the profession's efforts are best directed toward the individual or the greater good. It is an argument that continues to this day and as an issue in health care has a direct impact on the current discussion.

At one level there seems to be an implied accountability connected to the job titles that the focus group members described themselves as occupying. For example, in describing herself as the ALC co-ordinator one of the focus group implies that the locus of her attention is divided amongst the needs of organization, the staff, the patients, the policies and the procedures. Likewise with the focus group member who identified herself as the "discharge specialist," multiple roles and accountabilities seem to exist yet she indicated that a primary concern was to "work with social workers to help with discharge." Here the focus seems to be directed toward a staff/organizational interplay to a greater degree. The remaining two focus group members seemed clearer and indicated that their accountabilities revolved around the tasks of assessment and discharge planning, a predominantly patient focused activity. This is of course an over simplified discussion of a complex situation. In the following section I will attempt to tease out some of the issues that fall under this topic.

Through out the focus group discussion the participants provided information both explicit and implied that speaks to the issue of accountability. At a basic level they spoke quite cogently about the accountabilities to the self. One of the group members indicated that it was important in carrying out her job that she be guided by the thought that "We still at the end of the day have to answer to ourselves and why we went to school and why were doing social work." Another group member in discussing social work's participation in the ALC process indicated that "for me it's an easy link," implying some level of agreement at a personal level that allowed her to fulfil her responsibilities. A similar comment made by another group member indicates that social workers think

about and are able to come to some consensus within themselves about the competing accountabilities they face. She suggests that "I still need to get up in the morning, be able to sleep at night and be able to make the best of collecting that data each day."

Interestingly focus group members neither implied nor were explicit about their accountability to the teams they work with. While they function in a multi team environment few if any of these interactions were discussed during our conversation.

The focus group did although, talk about the responsibilities they felt in dealing with the social work department. As detailed previously the focus group noted a change in management style. They suggested that because of this change, their accountabilities to the department have changed as well. Currently, they suggest, the department is less concerned with psycho-social and family concerns and now tends to focus on more of a business protocol. Social workers are expected to focus on "balanced score cards, budget, and how many people we see a day". The focus group informed me that with respect to numbers and data management it was important to get the "right information." Failure to do so would result in a phone call from the social work department to correct the situation. It was implied that these were not pleasant messages to receive.

The workers spoke at length about their accountability to the organization. As has been detailed above, the focus group spoke of being responsible for and accountable to the organization for a multitude of issues. These included the assessment and discharge of patients, "moving them through the system," and doing so as quickly as possible. Gathering, co-ordinating, deciphering, and presenting ALC data on a daily basis. They are at some level accountable for resource allocation and bed management. They perceive themselves as playing a pivotal role in the acquisition of funding and are required to operate with budgetary constraints in mind. They are the conduit through which the organization delivers its communications, specifically related to service delivery or the lack thereof. They are the organizational problem solvers and in their acceptance of ALC duties, become by default, accountable for the movement out of the hospital, for those patients deemed to "no longer require an acute care bed." One of the focus group members captured the sentiments of organizational accountability beautifully indicating "it was hospital time not patient time."

The focus group members also acknowledged accountabilities to the profession of social work. This was perhaps most clearly exemplified in the "good social worker/good employee," discussion and resolution of same. One of the members suggested a link between the functions she performs and her perceived co-ordination with the social work code of ethics. Throughout the conversation group members spoke of equal rights to access of services, advocacy, and social justice, terms I would suggest that are identified with the profession of social work.

Finally the focus group provide multiple examples of the accountability they feel towards the individuals and families they encounter.

I think on a team we are good people questioning so what does the family think? We're trying to bring it back to that level even though some of the messaging is difficult. I think we're trying to alert the doctors, administrators to that when they're not thinking of the person, I do think we try to do that.

The focus group members indicated that they often go to the team to argue for a resolution to a patient's condition that is larger than just the acute issue that brought them to the hospital; something they indicated is a hallmark of the current environment. They informed me that they frequently take their colleagues to task to address the stigmas experienced by patients, especially the elderly. In a direct reference to ALC that connects this process to patient interactions they indicate that "I think continuing to designate ALC and to manage it gives us the ability to have our pulse on it and say these people are individuals and not just numbers. It feels like we have a hand in the pot."

As was mentioned above by October of 2009 social workers within the organization will be expected to participate in the "Right Level of Care," process as an extension of their current ALC duties. As social workers move toward and eventually incorporate these tasks into their role an expected shift in accountabilities may be expected. Further consideration of what this might mean for the profession will be examined in the discussion section.

TENSIONS AND DIFFERENT TAKES ON NEW FUNCTIONS AND ROLES

During the focus group conversation the participants made reference both implied and direct about the tensions they experienced in attempting to fulfil their duties. These touch points appear to correspond with the difficulties they encountered in their roles as social workers within a healthcare field and more specifically, while attempting to operate under ALC processes. Examples of the tensions social workers encounter include the following. One group member felt a need to create "quick discharges." Another spoke of the current downturn in the economy. This in turn lead to a discussion of funding concerns and the need to be mindful of budget constraints, cost savings and revenue generation opportunities. The focus group also emphasized that an ongoing lack of resources was one of the difficulties they faced each day. A central theme began to appear and is highlighted in the comments made by Bobby who suggests that

workers are stuck in wanting to do what's best for the patients but also knowing that there's pressure to move things along, there's a double message that workers have to deal with.

Another group member agrees suggesting that,

The only time I feel conflicted was when I was working with families, that they truly expect me to support them and I may not be able to do that because I feel like I have to support the organization.

In essence it appears that one of the biggest tensions currently experienced by social work is the triangulation of social worker, patient/ family and the organization. Each has their own concerns. Each has their own agenda and often these enter into conflict.

The focus group provided numerous examples of feeling caught in the middle, between the patient and the organization that seem to combine the tensions of triangulation with elements of the concerns of restructuring,

There are limits. There is only so much that I can push for, or advocate, so you know if the family is feeling that the patient still needs a whole bunch of tests ... and the doctor is saying absolutely not most times it's the social workers who have to go back and say that's not happening.

The designation of ALC seems to carry with it a number of concerns as well. The focus group indicated that in general ALC was nothing more than a label yet the designation appears to operate in such a manner as to conceal the root of the problem and increase the tension social workers experience on the job. The focus group suggested that as the system operates now "the patients are so not going to be in the right level of care. The reality is the system is failing and it's not working." For one of the focus group members this left a bitter taste in her mouth. She speaks specifically about the movement of patients from ALC to long term care.

ALC to long-term care is such a horrible thing, cause for me, I mean they need to be here, but all of a sudden they don't have access to services like we have. That's a real sore spot for me.

This group member worried that the ALC designation would result in the withholding of services over and above those directed toward the patient's acute care. While the patient may need or may benefit from further physiotherapy, respiratory or other services, these are often not available due to the patient's ALC status. Another focus group participant offers a similar sentiment stating that

Somehow they are less worthy of the medical bed, yes? Or the psychiatric bed or what ever and I would challenge, less attention from the medical team, the treating team. I don't need to see them every day, they're ALC. Because they're old.

In later discussion, Crystal provides some indication of the organizational philosophy that accounts for ALC processes and by extension the tensions experienced by social work staff in carrying out their duties,

One of the questions that ALC always brings up is the whole notion of social justice and is it really for the individual good or the greater good and when you look at ALC that is really what it comes down to. I think as social workers we are looking for individual and the greater good at the same time. ... However I think our organization uses it and they way they slant it and do this messaging you're talking about is the greater good notion of social justice which is, if you get the individual out of that bed and force them to go to X, Y, Z where they don't want to be you're serving the greater good by having someone be admitted into the beds in Emergency and not dying.

Interestingly the question of ALC existing for the greater or individual good remains unanswered. Crystal details an organizational perspective that appears to be dominated by processes reflective of an overall business approach. Limited resources create organizational tensions that need to be addressed by those occupying the system; patients and staff alike. Here the tensions experienced by social workers surface. As professionals, social workers attempt to straddle the organizational/patient divide and in attempting to incorporate these two divergent positions they become caught in a bind that heightens the tensions they encounter.

As is indicated above the focus group also spoke at length about the issue of messaging. What became apparent was a difference in opinion amongst the focus group members with respect to messaging in general and specifically related to ALC. The participants provided feedback related to their involvement with a previous ALC policy that highlights this point. In this instance patients were required to provide the social worker with three long-term care placement choices from a Community Care Access Centre, generated list. Patients would be moved at the discretion of the hospital to any available bed in the community whether it was on their list or not. They would be informed that they would wait at this site until one of their first three choices became available at which time they could move once again. Bobby suggested that delivering this message contained multiple tensions.

As an agent of the corporation social workers message that and we were the ones that had to say to families you got a bed offer but not your choice and that goes against everything that we as social workers advocate right? For me it was hard. It's almost like, what's the saying; you can't bite the hand that feeds you.

In this case the social worker seems stuck between meeting the needs of the patient and the demands of the institution and in this instance professional autonomy is mitigated by organizational affinity. Bobby's comments seem to highlight at a very personal level the struggle that social workers wrestle with and for her this is a bitter pill to swallow.

At the other end of the spectrum Celeste provided a different perspective on the same issue. "Sometimes it is easier to message one thing. When it was a policy that this is what the hospital does; you have to go to the first available bed because we have to have patient flow through." Here the struggle seems less intense. For this worker organizational policies determine service provision in a manner that locates the onus of the concern within the system. Avenues of assistance are acknowledged as being restricted because of organizational policy and as a by-product social workers involvement in the process is deflected back toward the organization.

The focus group also identified the issue of numbers as a prominent tension in their daily working lives yet they imply that focusing on data and numbers has become a necessary evil. At one level social workers try to attend to the rival demands of "hospital time and patient time." The focus group informed me that clinical requirements compete with administrative duties for their attention and that paperwork often negates the ability to simply return phone calls. They suggest "the more time that we focus on the data and the numbers the less time we actually focus on patient care and our social work."

That being said the focus group also indicated that to them, the acquisition, manipulation and presentation of data played an important function in their jobs. Data gathering was seen as the way of obtaining the funding that allowed programming to be enhanced, services to be expanded and gaps in services to be addressed. Without the numbers funds would not flow and without the money service delivery and service gaps would grow. Workers appear to be stuck between a rock and a hard place.

In general it seems appropriate to conclude by returning to and reiterating the comments made by one of the focus group members, "I think it's hard for social workers, it's hard to balance all the advocacy and the things we want to do for our patients but also fit into the organization and be able to work within it."

DISCUSSION

This study originated as a way of better understanding the impact of organizational influences on the practice, role and identities of social workers in health care. Although previous research has examined this concern from a more theoretical approach, little attention has been paid to the day to day experiences of front line workers. It is my contention based on this study that contemporary organizational influences fundamentally change the manner in which the profession operates. The profession appears to be integrating current organization practices in a way that modifies the profession's focus, practice and purpose. If left unchallenged social workers risk losing the ability to serve either or the individual and greater good making moot the debate surrounding our most appropriate role.

WHAT THE PARTICIPANTS HAD TO SAY

Social workers who participated in this research provided feedback on a variety of topics and discussed a range of influences affecting the manner in which they practice. They made reference to the economic and political context in which their practice unfolds. Here it was not uncommon for participants to discuss the effects of restructuring on their day to day duties. They indicated that many of their actions were influenced by outside agencies including Local Health Integration Networks. The participants situated themselves as occupying one small part of a larger system and in the process implied that they had some responsibility in ensuring its continued and smooth operation.

Focus group members drew on the longstanding debate in social work about the purpose of the profession. In reviewing the role of social work within the health care field focus group members identified a number of attributes which seemed to reflect a traditional social work presentation. For example the defined the primary focus of their interventions as being directed toward the assessment and discharge of patients within the hospital. Focus group members carried out their duties on surgical, medical and psychiatric wards. They identified themselves as the problem solvers, and patient advocates of the institution. They spoke of the importance of their education and training in developing ethically sound practices. One of the members expressed the importance of reflective practice.

Group members also referred more narrowly to the expectations of their specific organizations. They indicated that currently they often operate as data collectors and information disseminators to ensure organizational needs are met. Today's social worker continues to be a consummate communicator but is now, it seems, required to champion the policies and procedures of the institution as a priority. Focus group participants indicated that they spent increasing amounts of time in front of a computer and less time in face to face meetings with patients to meet organizational demands. Patient care seemed to compete with patient flow.

The changes in social work practice were understood in a range of ways by the focus group participants. In the most positive framing, any changes that were acknowledged were seen to be "instrumental," and here the focus group saw these as being to the advantage of the patients they encountered. Group participants suggested that modifications to practice methods, for example the daily and/or weekly review of ALC reports, allowed for the improved identification of patient needs and of service gaps. This in turn provided an entry point for the development creative solutions which were then introduced within the organization. The participants suggested that often these were initiated by the profession.

At the same time, group participants identified many potentially problematic changes in the actual practice of social work associated with ALC. For example, the gathering of and supplying data to management became a primary goal for these participants. The focus of the workers attention entailed filling out forms and doing so in a timely manner to allow for the smooth running and operation of the process. Focus group members were aware that as a by-product, participation in this practice afforded management a level of worker surveillance. They indicated that while this was not an enjoyable part of their practice they seemed to imply it was also necessary. Various group members indicated that failure to complete this task resulted in inaccurate information being produced which ultimately impacted negatively on funding levels. Reduced funding would of course have many adverse effects, but those identified by the group members seemed to focus on the organizations goals of increasing patient flow and decreasing lengths of stay. Getting people out of hospital and back to the community above all else has clearly become a primary organizational mandate one which the profession currently supports.

Focus group members provided some insights as to how organization influences impacted on social work's apparent change in focus and practice. Of the many workplace changes the participants detailed, modifications in management style seem to play a prominent role. One of the focus group members indicated that in the current environment the management of social work staff and issues reflects to an increasing degree business practices and less so a social services orientation. It was noted that the language used in communication with social workers reflected contemporary

business pursuits directed toward organizational efficiency and effectiveness. Interestingly the social workers that were interviewed continued to operate under a departmental umbrella, once thought to be an arrangement that afforded workers some level of professional autonomy. It now appears that changes in management style have resulted in exactly the opposite. Adoption of organizational business practices at the management level appears to legitimize institutional desires in a way that becomes palatable to the profession. In the process, the need for quick discharges, bed management techniques and the use of evidence based practice become the norm.

Under this new management approach, social workers become data management experts supplying the organization with the information designed to meet its needs and they do so willingly. Documents (assessment forms, reports and or tracking forms) prepared by social workers and related to ALC reflect this theme. Traditional social work practices are changed in the process due to the competing demands of the hospital, profession and patient needs. Where once social workers were expected to address a wide range of personal and social issues the current organizational focus, on decreased length of stay and appropriate resource use, has constricted their practice to dealing with issues identified as being acute. Social workers become fixated on patient flow, worry about not providing all the services they feel patients require and are left feeling caught between the organizations demands and individual and family needs. Focus group members suggested that as a result currently social workers find it difficult to balance the competing requests that are made of them daily.

Focus group members spoke of ALC and the importance of social work's contribution to its efficient running. As detailed by the group, ALC appears to operate more as a health care and less as a patient care process. Here organizational expectations take precedence. ALC defines service levels and anything falling outside of an "acute" issue may not be addressed while the patient is in hospital. ALC segments and compartmentalizes care.

Time spent on ALC concerns also results in a direct reduction of face to face, patient to social worker interaction. While focus group members suggested that ALC assists in identifying service gaps, they implied that most of the service gaps could best be located outside of the confines of the hospital. Negative impacts of the ALC process including the reduction in direct patient care, was not identified as a service gap.

The focus group members spoke at length about the tensions they experienced in the current environment yet interestingly their feedback seems to identify a shift in the location of the tensions. In the past social workers may have wrestled with patient dominated tensions. Time and effort would be used to address both, acute issues and to develop a plan that would assist in enhancing quality of life concerns. In the current

environment organizational influences define the tensions that are created. For example one of the focus group members indicated that because she must meet the needs of the organization she had less time to meet with patients. The assessments that she completes address acute issues and little else. She does not have the time or the mandate to better understand the roots of any particular concern as her focus is directed toward the institution requirement to increase patient flow. Having the time to return a phone call becomes a source of concern for her.

This suggests that intervention practices have changed. Members of the focus group clearly indicated that face to face interactions have declined. Efforts directed toward patient education, community advocacy and relationship building, typical social work interventions, become more difficult to supply. This is not to say that social workers do not act on their patients behalf, clearly they do. One of the group members suggested that one method she may use to support a continuation of services and reduce possible stigmatization is to delay the date that she begins her ALC paperwork. While this is commendable it also crystallizes what I would suggest is the new social work intervention, the textual intervention – interventions based on the documents the profession uses to manage, initiate or terminate services. Whereas in the past social workers interacted directly with their colleagues to obtain the services patients needed, in today's environment paperwork dictates what will and will not be done. The concerns of the patient may not appear on the check lists used to determine service levels and as a result interventions are not offered. While the quality of this intervention is dubious the quantity of services provided is etched in paper

FOCUS GROUP FINDINGS IN RELATION TO THE LITERATURE

Little has been written about the influences of organizational practices on the profession of social work. What does exist seems to approach the topic from a theoretical perspective. Information related the day to day experiences of front line workers seem to be less common. That being said it appears that a number of correlates exist between what the literature offers and what the focus group members reported about organizational influences. Below two examples of the more theoretical approach related to the topic will be followed by an examination of the correlation between ALC literature and current practices.

Carol Smith's 2004 article examines the issues of trust and confidence as they affect organizational practices. Smith suggests that "the 'modernization' agenda in social care privileges confidence in systems over trust in moral agents" (p.5). In this case I would argue that the hospital represents the system and social workers the moral agent. Smith continues that changes in the delivery of social services has resulted in the,

Development of systems for providing safe, reliable, standardized services and predictable outcomes. This approach to service provision neglects issues associated with moral motivation and moral consequences which are central to service users' experiences of intervention and expression of care (2004, p. 6).

Although Smith appears to focus on outcomes specific to service users I would argue that through participation social workers are impacted in the process. Smith suggests that this change is made possible through the segmentation of work processes which allows for a re-definition of processes, action objects, outcomes and goals. Confidence is enshrined in practices dominated by a focus on efficiency and as a result organization expectations dominate. As a result the author contends

Arrangements for accounting, audit and ensuring compliance reduces uncertainty and increases predictability. System effectiveness makes trust at best invisible and at worst redundant, (2004. p. 8).

Arguably social work practice is guided by ethical considerations that establish relationships of trust. If, as the author contends, the current situation negates the concept of trust the implications for the profession are huge. Trust speaks to interpersonal relationships of an intimate nature that expose the vulnerabilities of one to another. Implied is an expectation that any outcomes achieved will do no harm to any of the participants. Focus group feedback suggests that with respect to social work and ALC procedures this is not always the case. Due to their nature, ALC processes become prohibitive to traditional social work practices. Components of ALC policies have restrictive components to them designed to enhance patient flow through. Examples include instituting co-payment policies or forcing patients to accept a first available bed offer. Social work's acceptance of these procedures appears to confirm Smith's contentions and implicate the profession in the organization's desire to obtain predictable outcomes. In the process social workers risk losing the trust of the individuals they encounter. If this trust is lost, the patients the profession provides assistance to will be further marginalized, and the social worker/organizational bond will be strengthened.

The next observations come from Gitterman and Miller who suggest that "Almost all, if not all clinical decisions represent agency policy and organizational imperatives in action," (1989, p. 151). At the time of writing the authors indicated that little information existed with respect to the influence of the organization. Gitterman and Miller highlight a growing business orientation in the social services sector and account for this in the organizations developing fixation on increased accountability. They continue that as a result, institutions create new "technologies" designed to meet the organizational bottom line. As this unfolds organizations refocus their gaze toward issues of organizational maintenance at the expense of their service mission. The authors use as an example the need for timely discharges. Gitterman and Miller suggest that the process of change is

operationalized in the management structures inherent to the organization that result in the creation of power differentials and skewed communication pathways. Put more simply what management knows and what workers know are two different things.

Gitterman and Miller's examination of the topic while highly informative does little to demonstrate what this means for front line workers on a day to day basis. That being said, their observations appear highly reflective of the current situation as described by focus group members. To better understand we need to return to the feedback provided by the focus group. As has been detailed previously group members spoke at length about the introduction of an emerging business mentality and work practices in the current environment. Data reporting strategies, service volumes and resource allocation have all become part of social workers' daily routine. ALC procedures have become a primary focus for workers used to improve efficiency through increased patient turnover and accountability through worker surveillance. Perhaps most importantly focus group feedback supports the author's contention that changes in management practices assist in the process of invoking change. Members of the focus group noted that while previously, managers were seen as mentors who interacted on a much more interpersonal level, today things have changed. In the current environment focus group feedback suggests that managers operate as process overseers, charged with the disciplinary authority designed to ensure workers meet organizational expectations. Conversations tend more often than not to be directed toward meeting benchmarks and resource allocation. In the process avenues for collective resistance fade away as organizational expectations are communicated as being the new norm. This will of course have a direct impact on practice and ALC procedures provide one example of this.

Although concerns related to ALC have been documented for a significant period of time, little more seems to have changed than the markers used to describe the concern. The literature and the focus group agree that ALC is a health systems problem, typically located in hospital settings, related to the timely and efficient discharge of long stay patients, commonly elderly people and people with psychiatric diagnoses.

Perhaps the most interesting information available with respect to ALC can be found in the 1981 writings of Shapiro and Roos. At that time the authors provided a comprehensive overview of the concerns related to individuals referred to as "long stay patients," (Shapiro and Roos, 1981, p. 49). The authors forecast dire consequences possible for both families and health care organizations should the problem not be adequately addressed and detail the solutions that had been enacted to date. These included adding to the already existing complement of nursing home beds and/or forcing patients to accept open nursing home beds in the community, to await availability in a setting of their own choosing. The authors argued for the creation of a central screening

agency to assist in monitoring patient movement increasing hospital discharges. Finally Shapiro and Roos suggested reallocating a portion of hospital beds making them available to patients awaiting transfer to an alternate site. The authors conclude through their study that none of the above suggestions had any measurable impact on the concern.

Feedback from focus group members indicated that all of the above strategies for increasing patient flow have been instituted in current environment within the last five years. In fact they informed me that currently, changes are being put in place to reallocate hospital beds for ALC use, the last suggestion detailed in the Shapiro and Roos paper. Given that previous experience suggests that this is a mugs game, it is doubtful that any appreciable benefit will be realized through this initiative.

It is deeply problematic that social work as a profession has not adequately engaged the history and politics of ALC. In doing so the profession could truly demonstrate its appreciation of a very complex issue. The organization, the families and the individuals caught in ALC process could be spared the futility of applying old solutions to the current crisis and opportunities to address systems issues could be intensified. The profession could forward an agenda of change that supports more positive practices while re-establishing its advocate role. Failing to do so allows for the maintenance of the status quo and a continuation of the problems that plague the all the parties involved in the process.

THAT WAS THEN AND THIS IS NOW

The findings of this study although modest are important. As much of the literature details, social workers in health care settings are under constant pressure to provide proof of their value to the organization (See Sulman, Savage & Way, 2001; Davis et al., 2005) As a professional group social workers are often feel misunderstood, (Davis et al., 200). This study extends our understanding of the impact of organizational influences on the role social workers occupy within health care organizations. It provides information specific to the profession of social work, something that was previously lacking.

Reflective of the exemplary work of Janet Rankin and Marie Campbell (2006) this study initiated a discussion particular to social work from a front line perspective. Of specific interest to the topic at hand is the triangulation created between the workers, service recipients and the organization. Through the information provided it became apparent that social work's traditional roles are being made moot in the current

environment. No longer can the profession focus only on its interactions with service recipients. The focus group participants self identification as agents of the organization indicates that a shift in the social work role is currently being experienced. Practice methods that view data entry as a necessary part of the job suggests that what we do as a group is changing and that the change is being initiated from "outside" the profession. In the contemporary environment the power, influence and mandate of the organization must be considered. The purpose of our tasks currently seems overwhelmingly directed toward meeting institutional directives and our focus appears to have shifted in the direction of addressing organizationally defined goals. If left unabated the viability of the profession remains in question

These same concerns become the challenges that the profession must wrestle with. This study suggests that the dialogue surrounding the role of social work must continue and be expanded to include organizational influences. Understanding the genesis, impact and repercussions of continuing as we currently operate is important in creating viable solutions to the negative effects of organizational influences. Enhancing traditional methods of practice and developing new resources that are of the profession's own making are imperative in maintaining the status of the profession. Resisting the ongoing segmentation of labour and patient care processes is essential in addressing the divide and conquer strategies that seem to be in place in the current environment. To do so social work needs to expand the research and practice activities it currently engages in.

POSSIBILITIES IN PRACTICE AND RESEARCH

The information provided by the focus group participants was important both in what was said and what was not said. Each provides a point of entry to pursue practice activities and research opportunities that may be of further assistance in better understanding and addressing the concerns reviewed in this study.

From a research perspective a number of avenues become available. For example, information provided by focus group members indicated that for them, the impact of organizational influences on the role of the profession remains unclear. At times the group members were unambiguous and provided numerous illustrations of the changes experienced that impact on the social work role. They note for instance differences in management styles as having a harmful affect on the current situation. On the other hand a couple of the members suggested that in their view there have been no fundamental changes to the role as they see it. Here the first entry point becomes apparent. This contradiction suggests that further research specific to this topic is

warranted. Enlarging the sample size would go a long way in further teasing out information relevant to the topic. Focus group composition could be expanded to include social workers employed in other fields or social workers operating in management positions. Adopting an ethnographic approach would assist in developing an environment better suited to review the task at hand.

A second tangent that could provide fruitful results may reside in research directed toward an increased understanding of the resistance offered to the changes currently being encountered. Although this was not a major part of this review, there was some indication that resistive measures were being utilized in the work site. Delaying ALC paperwork to reduce stigmatization springs to mind. In this light I would suggest that other alternatives could and are being used, but are not recognized as such because of a lack of discussion.

Much of the discussion occurring in the focus groups centered on the reduction of resources related to the process of restructuring. The members of the focus group suggested that a major factor increasing their motivation to participate in ALC processes was attached to the promise of increased resources, specifically funding. As such it is imperative that as a group social workers better understand organizational financial matters. This is not to imply that the profession adopts the stance offered by Karen Nelson (2007) when she suggests that the profession may be best served by "owning the financial imperatives in healthcare management." In this I strongly disagree. Rather the profession may best profit by pursuing cost analysis, prefaced on the work of Henry Mintzberg and Sholom Globerman (2001), who suggest that,

Cost are more easily specified than benefits. So analysts race around cutting the costs with no measurable effect on the benefits. Efficiency thus becomes confused with economy, and performance deteriorates, (p. 74).

It is this premise that is most intriguing and one that appears to provide the best options specific to the profession if our role is to be enhanced. Social workers could take the lead in providing research that examines the impact of increasing social supports to enhance community care, reduce the need for hospital visits and decrease length of stay.

A final suggestion for further research would be to include family feedback specific to ALC processes. While researching this topic only one article, (not written by a social worker), was obtained related to this subject. While the impact of ALC processes may be difficult for social work I believe them to be devastating for the individuals and families they ensnare. Social work driven research in this area could assist in mobilizing the support of affected individuals directed toward the common goal of improving care. Doing so would signify a return to practices traditionally associated with the profession while assisting in establishing healthy organizational boundaries. Social work could

reframe professional practices in a manner more appropriate to its long established mandate. In the meantime social workers can, on a day to day basis, make alterations in their practices that could result in addressing the concerns being discussed.

Options for initiating workplace changes can be found on a number of fronts. One example, taken from the literature, comes from the work of Donna Baines (2007) who provides a number of salient suggestions. Paraphrasing just one of the six principles Baines describes I would suggest it is important to break down the silos of healthcare. In other words reach out to and speak with others of like mind. Collect advocates, join associations relevant to the cause and or participate on committees within the work place that address issues of concern. As the number of interested participants grows it will become increasingly difficult for the organization to ignore the questions they raise. Silence and poor communication serve the status quo and minimize the opportunity to invoke positive changes.

As well it is important that social workers approach the individuals and family members they encounter in a manner that engages them fully in the process of health care. As discussed in the focus group, social workers at one time participated in the organizationally initiated practice of forcing families to accept the first available long-term care community bed offered. As one of the group members pointed out this went against everything she was taught yet it became part of her practice. This is not to suggest that workers operate as nothing more than organizational automatons. I simply suggest that in light of the above there may be room to re-evaluate how and why we are operating the way we do. Engaging families increases the numbers of allies the profession has and in the process reduces the risks social workers take.

As a last suggestion, I implore the social workers to ask to the "simple questions" and to join with others in obtaining answers. For example, why do we do this, this way, who does this process benefit, how can we change this to make it work better? As the questions arise I would hope the irrationality of the current system would become more clear. For those things that work well little needs to be done, but for that which is deficient, in the asking comes the change.

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APPENDIX A



October 27, 2008,

**Letter of Information /Consent
With Respect to Social Work
And Alternate Level of Care
A Study of the Intersection of
Organization and Social Work Practices**

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Purpose of the Study

You are being invited to participate in a research study conducted by Todd Sholtz because you have experience as a social worker in the medical field who interacts with patients designated as requiring an Alternate Level of Care. This is a student research project conducted under the supervision of Dr Christina Sinding. The study will help the student learn more about the topic area and develop skills in research design, collection and analysis of data, and writing a research paper.

My name is Todd Sholtz and I am a Masters of Social Work candidate presently enrolled at McMaster University. I am in the process of completing the thesis requirement of the program and would like to speak to you about participating in a study I am undertaking. Much of the social work professional literature looks at the changing role of social work in the health care field. It is argued that healthcare is in a state of being reformed, restructured, and re-engineered. In this

environment workers express concern that their roles within the hospital are misunderstood, that their positions are threatened, and that they are left competing for roles. Studies to date point toward policy and/or political implications to account for these changes. **I hope to better understand the changes that the social work role encounters as organization and social work practices intersect.** I hope to learn more about how organization practices and expectations influence profession behaviour. Specifically I want to look at the unfolding dynamics that develop as social workers implement Alternate Level of Care practices. In doing so we may become better positioned to advocate on behalf of the profession, the clients, and the organizations that we work for.

Procedures involved in the Research I am taking a qualitative approach in this study. In other words I want to understand the social and cultural landscape from an 'insiders' point of view. If you are interested, I would ask that you meet with me in a focus group setting, over dinner. I am hoping to meet with 5 to 6 people at a time and would expect that we will meet for two hours in the early evening. My goal would be to better understand what is "typical" for you. I am most interested in how organization expectations impact on the structuring of your duties. I would like to talk with you about the role of social work in your work site as well the policies, forms, reporting requirements, and expectations you encounter with Alternate Level of Care practices. I want to be clear that this is in no way a performance review. I will ask you to tell me about the area in which you work, the number of years you have worked as a social worker, and your role in relation to Alternate Level of Care. My interest is in better understanding the impact of organization procedures on the profession as a whole. While meeting with you I will take notes and make an audio recording of what unfolds for later review. I would ask as well that I be able to contact you via e-mail after our meeting, to ask follow up questions that may arise during the data analysis stage of the project.

Potential Harms, Risks or Discomforts:

It is anticipated that there will be little if any harm or discomfort associated with participation in this study. It is possible that during the course of our interaction situations may arise or topics will be discussed that may cause some level of concern for you. You might worry that your responses reflect poorly on your work site or that specific statements you make may be traced back to you. You may worry that punitive actions may result from your participation in the study

I will take every precaution to ensure the confidentiality of any and all information that you provide. That being said, I need to make you aware that because the study uses a focus group method I cannot provide you a guarantee in this matter, and you should keep this in mind in your comments. You do not need to answer any questions that make you uncomfortable or that you do not want to answer.

In terms of reporting the findings, every effort will be made to preserve your anonymity. The information I collect about you (for instance, years of practice, and the area that you work) will be used only to describe the sample, and not linked to any quotes I may use.

As we will be enjoying a meal during the focus group I would ask that you inform me of any dietary needs prior to the focus group.

This study has been reviewed and approved by the Hamilton Health Sciences/ Faculty of Health Sciences. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

**Office of the Chair of the Hamilton Health
Sciences/Faculty of Health Sciences Research Ethics Board at 905-521-
2100, ext. 42013.**

CONSENT STATEMENT

**SIGNATURE OF RESEARCH PARTICIPANT/LEGALLY-AUTHORIZED
REPRESENTATIVE***

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form

Consent Form Date: September 2, 2008
October 27, 2008, 2008

Page 3 of 4 Protocol # and Version Date: sw0058
Subject Initials: T.S.

Name of Participant

Signature of Participant

Date _____

Consent form administered and explained in person by:

Name and title

Signature _____

Date _____

SIGNATURE OF INVESTIGATOR:

In my judgement, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

Signature of Investigator

Date

Consent Form Date: September 2, 2008
October 27, 2008

Page 4 of 4 Protocol # and Version Date: sw0058
Subject Initials: T.S

APPENDIX B

INTERVIEW GUIDE

1). I would like to start by getting your impressions about how you see hospital social work having changed in the past 3 or 4 years? What's different about being a social worker now, than in 2005?

I would next probe for positives, negatives.

Ask about changes in duties including documentation, community involvement, reporting requirements.

I would ask about changes in expectations from with families, co-workers, and managers.

2). Alternate Level of Care (ALC), patients have become a topic of concern in medical settings in the recent past. I would like to have a general discussion about ALC; when did you first encounter this term, what does it mean to you and within your setting, who does it apply to (how does someone get designated as requiring ALC), tell me about documentation requirements.

3). What is the social work role with respect to ALC? What are your thoughts on this?

4). Has the current ALC situation changed the way you work or expected to work? If so how? What are your thoughts on this?