Beddoe, L. (2017). Field, capital and professional identity: Social work in health care. In S. Webb (Ed.), Professional identity in social work (pp. 122-135). Oxon UK: Routledge. Chapter Nine

Field, Capital and Professional Identity: Social Work in Health Care

Liz Beddoe

This chapter will explore social work identity in health settings, a significant field of practice in many parts of the world, including North America and Australasia. The influence of the French sociologist Pierre Bourdieu's philosophical framework is explored in a consideration of professional identity. His concepts, 'field' and 'capital' are used to analyse the influence of power relations, utilising an additional concept of 'professional capital'. Social work may be perceived as successful in health contexts as it is not as subject to media and critical public scrutiny as children's social work is, but health social workers still often express feelings of marginalisation (Beddoe, 2013a). In Bourdieu's terms, social work may be viewed as a collective of 'agents' occupying a field, playing out their roles in a "structured social space, a field of forces" (Bourdieu, 1998, p. 40). In such fields there may be palpable competition between actors for the accumulation of different kinds of capital and it is here perhaps that social work identity is less secure.

Introduction

Historical accounts of social work in health care place the earliest developments in the USA with the work of Ida Cannon in the first decades of the 20th century (Bartlett, 1975). Cannon is reputed to have described social work in hospitals as being practice in a 'host setting' and

this notion of social work being a 'guest' is highly significant in an analysis of the development and nature of social work identity in health. Richard Cabot, a doctor and early supporter of social work, and with whom Cannon worked, published a series of essays on the relationship between an emerging social work occupation and the medical profession (Cabot, 1919). These early conceptions of social work in health implied a social practice dependent upon the sponsorship of doctors and, to a lesser extent, the willingness of nurses to allow social workers access. Bartlett (1975, p. 214) writes:

> Her [Cannon's] approach was to proceed quietly, using gentle pressure and watching for opportunities to move the idea ahead. She always kept the central focus on the patient's needs and the doctor's concern for giving good care. She was careful not to go too fast and showed extraordinary patience in waiting over the years for the readiness of the physicians on the various services to come to her and request the assignment of a social worker.

In a similar vein, the story is told of the career of Anne Cummins (Bell, 1961, cited in Bywaters, 1986, p. 663): "at first sight so self-effacing and submissive" and yet it is noted that,

> far from restricting her role to the support of doctors in their individual treatment of patients she instituted a preventive ante-natal care system in the district, with what we would now call self-help groups, was responsible for establishing the first maternity ward in a general hospital, and organized a widespread 'community care' scheme for tuberculosis patients.

Despite the sense of heroism invoked, these early texts are nonetheless imbued with notions of patronage and of women pioneers playing a highly gendered role in order to insert social work into the hallowed spaces of medicine. And, much later, Bywaters (1986) wrote of health social workers: "they are exhorted in the literature of social work to act as partners, when many experience their position as being barely tolerated visitors" (p. 665).

In New Zealand, where health social work emerged in the 1930s, the profession lacked a clear demarcation between social workers and nurses or midwives. Nurses learned "the tenets of social service" within their nursing practice (Beddoe & Deeney, 2012, p. 44). Nonetheless, social work in health care in New Zealand, from its inception, added a holistic dimension to health care, as indicated in Spensley's simple description:

> It is difficult to enumerate a daily routine of her duties as they vary from day to day, but *by uniting the medical and social needs of the individual she seeks to help the person as a whole.* (Spensley, 1953, p. 177, emphasis added)

Regardless of the challenges faced, social work developed rapidly in the early decades of last century, with educational opportunities in the social sciences leading to qualified social workers appearing in greater numbers. In the same year that Cabot's book was published (1919), Todd, a sociologist, advised social workers to adopt a scientific approach in their practice, arguing: "the scientific spirit is necessary to social work whether it is a *real profession* or only a *go-between craft"* (Todd, 1919, p. 66, emphasis added). Todd's sociological viewpoint and appeal to science suggests the potential for social work to carve a more discrete role in the health field, with less focus on the body and illness and more on social factors. This laid the groundwork for social work in contemporary healthcare to be

underpinned by an understanding of the profound impact of socio-cultural inequalities evident in health disparities. Both Todd and Cabot recognise social work as intrinsically preoccupied with the alleviation of suffering at individual, family and community levels, while acknowledging that social change is needed to reduce health inequalities. Where Todd and Cabot "differ significantly is in their understanding of social work's striving for a distinctive space and a knowledge-base so as to develop into more than a 'go-between craft'" (Beddoe, 2013a, p. 25, also see Abbott, 1995 on social work as working across boundaries. Here social work is a complex defended turf in a complex system of professions.).

The history of social work in health care is one of growth and adaptation and yet the literature also articulates a struggle to be defined within a complex health system inhabited by many powerful players in the 'field of forces' alluded to earlier (Bourdieu, 1998). Bywaters (1986, p. 663) describes another history, "viable but less articulated, a history of interprofessional conflict, of the widespread emasculation of social work in hospitals". The unequal power relationships and differential statuses of health professionals reflect very old but still powerful dynamics. Power, gender and managerialism exert an influence in the contemporary environment, defining and restricting social work identity. Bourdieu's (1984) concept of 'distinctive space' proves useful in exploring the enduring struggle for recognition and respect for social work in health care to be discussed further below (Beddoe, 2010, 2013a).

Social work in health care: An overview

As social work has been introduced into health care provision at primary, secondary and tertiary levels it has tended to define itself by its focus on the relationship (at the macro level)

between the social, cultural, and economic determinants of health and the impact of illness on personal and family coping. In addition, social work has advocated for social and emotional support for those with health needs and stressed the importance of multi-professional collaboration to address individual and community health problems. In its eleven decades of social work in health care the profession has clearly nailed its colours to the mast of a holistic concept of health, often referred to as the biopsychosocial model. Auslander's Delphi study identified that social work's greatest contribution to health has been its "influence on mainstream health care to adopt a broader conception of health and illness" (Auslander, 2001, p. 210).

In the United Kingdom in the 1980s a social model of health was proposed by Bywaters (1986, pp. 670-674). Such a model would incorporate clear principles: health was conceptualised as a human right with an understanding that social and environmental factors created direct impacts on health and illness; 'patients' were to be recast as citizens and consumers rather than merely the subjects of an expert-dominated system. The mandate for social work was to value social care as well as treatment, to advocate for support as a right, and for social work activity to be unrestricted by gate-keepers; to develop and support self-help groups and assistance for health services users and carers to find and disseminate alternative sources of information (Bywaters, 1986). This aspirational view suggests a more confident profession. It envisaged social work standing its ground in its fight 'on two fronts', between those they wanted to help (who may be deeply demoralised) and the "administrations and bureaucrats divided and enclosed in separate universes" (Bourdieu, 1999, p. 190).

There is a significant body of literature exploring the development of social work in health care through a lens of power and influence and, in particular, its status within the professions. From a US perspective, McCoyd et al. (2016) describe social work in health care as going through a pre-professional phase in the face of a struggle to establish its foothold in health. They comment, "while social workers lived their values and did not assert professional privilege" (p. 33), the habits of deferring to others and being associated with people 'of low status' paradoxically interfered with progress towards recognition of social work as a health profession. They note that this resulted in social workers being seen "as helpers rather than professionals in their own right. This paradox continues to influence health social work today" (p. 33) and whether social work is a profession or a 'semi-profession' is still debated.

Etzioni (1969) coined the term 'semi-profession' to describe teaching, nursing and social work, inferring they had not developed the degree of monopoly power and public esteem associated with medicine and law. The semi-professions drew on theory and knowledge, promoted membership and participation, and adopted codes of ethics, but they did not seek to position themselves above the communities they worked in and for. Freidson (2001, p. 29) has suggested that the professions represent the organisation of particular kinds of (codified) knowledge and skill into 'disciplines' in the Foucauldian sense, the constructed notion of:

> Institutions *set apart from everyday life.* Special groups of intellectual workers embody the authority of those disciplines, their work being to create, preserve, transmit, debate and revise disciplinary content. The formal knowledge of particular disciplines is taught to those aspiring to enter specialized occupations with professional standing (emphasis added).

Instead nurses, teachers and social workers preferred to keep close to the pupils, patients, service users, the people they worked alongside. Another defining feature for Etzioni (1969) was that these 'semi'-professionals were employed within large bureaucratic institutions, and this is significant for social work in health care, given the prevailing depiction of social workers as guests in a host setting.

One additional salient aspect is gender. Bywaters (1986, p. 665) talks about medical social work being perceived as 'a soft option' in the 1970s and 1980s as the influence and prominence of statutory social work grew. Statutory social work may have been seen as more attractive to men, given Bywaters' comment that health social work was "caricatured by sexist and ageist stereotypes" (p. 665). In health the association of social work with nursing led to its positioning as an occupation *invited into* hospitals and clinics and thus under the patronage of men. The gendered nature of social work has always been a salient issue in considering the journey to professional status. The seminal work of Ann Witz is useful here. In *Professions and Patriarchy* Witz examines the gendering of professionalisation projects: "indeed, gender was integral to the very definition of a 'semi-profession' which, according to Etzioni (1969), has a second defining feature. It is one in which women pre-dominate" (Witz, 1992, p. 57).

The somewhat presumptuous, patriarchal interpretation of this predominance was that women preferred to work in close proximity to the families and caregivers who may also have an interest in a service user's welfare. Witz, however (1992, pp. 88-93), challenged this suggestion of 'preference' in relation to nursing and midwifery, suggesting that the history of medicine included deliberate attempts to exclude women from medical school. As evidence of a continuing androcentric approach to the study of professions, she cites Rueschemeyer's

remark (1986, p. 137) that the "high devotion/low power syndrome" of the social service professions "articulates well with women's traditional roles" (Witz, 1992, p. 58). This notion of devotion echoes Bourdieu's idea of social work as 'a profession of faith' emerging (like teaching and nursing) during a period where the middle classes sought new occupations. Jenkins (1992, pp. 144-145) noted that Bourdieu included such employment as a solution for those whose access to higher education in the 1960s had "created a disjuncture between their subjective expectations and their objective probabilities".

In Witz's feminist analysis, professions are constructed as integral features of patriarchal societies. The gendered activities of caring and support, originally intra-familial roles which developed last century into paid occupations in health and social care, still underpin the nature of the helping professions. Witz's case study of midwifery (1992, p. 104), for example, demonstrates the processes by which midwives battled with the new medical specialisation of obstetrics for autonomy within the highly contestable territory of childbirth. The struggle over midwives' roles and professional autonomy remains a potent example of 'turf-conflict' many years later (Abbott & Meerabeau, 1998).

Despite the contested nature of its status, social work persists as a player in health care and it remains a substantial field of practice especially in North America and Australasia. The field makes well-established contributions to patient care in both physical and mental health. In many countries, health social workers are highly educated and increasingly participate in health research and service development. Joubert (2006) writes of the establishment of academic–practice partnerships leading to active collaboration between universities and major hospitals in Melbourne, Australia. Health social work has a strong literature base with journals focussing on many aspects of social work including mental health, primary and

public health. It is assertive in the development of practitioner research and the development of leadership in a highly articulate professional sub-sector, not simply utilising research in practice but producing it. An excellent example of this development is found in New York's Mt Sinai Medical Centre exchange program promoting visits of practitioners and academics to Victoria and New South Wales in Australia and, more recently, other countries (Fouché, 2015; Rehr & Rosenberg, 2006).

So what are the contemporary challenges and opportunities for social work in health care? What is reported in the contemporary literature? The growth of a health research culture as an indication of professional confidence suggests gains have been made (Joubert, 2006), however, calls continue for further development of social work contributions to research (Brough, Wagner, & Farrell, 2013; McNeill & Nicholas, 2012). Despite these gains, social workers arguably remain in positions of low visibility (Morriss, 2016) and potential disempowerment in host settings, despite decades of significant contribution to health care. Whether this is a consequence of medical dominance in health care organisations or a feature of the natural ecosystem of health organisations may be contested as a matter of perspective. What is clear is the impact of wider social change on the political economy and management of health services.

Contemporary perspectives

Recent literature about social work in health care addresses several recurring themes: firstly, the role of social workers in changing health system contexts and secondly (and connected to the former), the reconciliation of social work's espoused commitment to social justice and human rights with the kinds of practice occurring in systems often dominated by

managerialist and even commercial concerns. In the US, Spitzer, Silverman, and Allen (2015) recognise the long-standing challenges for social work in health contexts but see great potential for social work under the Patient Protection and Affordable Care Act 2010 which positions social work as integral to integrated care. They extol a highly pragmatic position, urging social work to "reconcile the gap between professional competence and ideology" (Spitzer et al., 2015, p. 197). Health social workers, in their view, "reside in an ecosystem that does not naturally support social work life" (p. 198).

Advocating for an organisational competency approach, Spitzer et al. assert that the profession should "lead with social work competency rather than ideology" (2015, p. 199). Success and the prospect of an 'expanded marketplace' for social work services will come to those who are strategic and can "adeptly align their competencies with organisational goals" (p. 199). Essentially this position urges social workers to resist the urge to challenge managerial systems head-on but rather, to adopt the patient and tactful strategies of Ida Cannon. The health social work virtues of patience, tact and non-confrontation have a long shelf-life.

So what about the experiences of social workers themselves in contemporary health care? Haultain (2015, p. 40) in New Zealand writes about the range of challenges impacting on health social work:

> These challenges include the ever-increasing global prominence of market-driven, cost-containment strategies … reduced length of hospital stay and pressure for rapid discharge … demographic changes such as the aging population… growing numbers of patients with multiple, chronic health

> problems…health inequalities … and the impact on the profession of a constantly changing health environment.

These features are not isolated (see for example, Cleak & Turczynski, 2014; Judd & Sheffield, 2010; Mizrahi & Berger, 2005). Several texts are useful here in illuminating the lived experience of social workers practising in these constrained and stressful environments. Wilder Craig (2007), writing about the nature of the social work role in the restructured health care environment, underscores the importance of the profession telling its own 'stories' of practice. She cites Weick (2000) who wrote of the submerged 'first voice' of social work which, in the midst of the neoliberal regime of market-driven health care, is a voice "framed by logic, rationality and rules, where right and might are more important than care and comfort and where winning eclipses warmth and worry" (Weick, 2000, p. 398). The domination of this 'second voice' has rendered "mute the profession's collective wisdom and power" (Weick, 2000, p. 396). Wilder Craig (2007, p. 436) writes:

> Most of us have become experts in using this voice as it is the voice of the larger corporate culture that is so much part of our world. However, it is a voice that is not up to the task of either describing adequately what we do or of differentiating social work from the work of other helping professions. Weick suggests that the voice that is capable of doing this is what she calls our 'first voice'—the voice of storytelling.

Thus research that captures the lived experiences of social workers can help us to understand contemporary roles. Craig and Muskat (2013) interviewed 65 health social workers in a large Canadian city. Their study focused on the self-described roles, contribution and professional functioning of social workers. Their thematic analysis identified seven roles: "bouncer,

janitor, glue, broker, firefighter, juggler and challenger" (p. 10). These data produce a picture of a complex set of functions and roles with a central unifying focus on using highly developed relationship skills to sort out 'mess' and to meet immediate needs whether these are providing pants for a person being discharged from an emergency department or providing emotional support for colleagues in the multidisciplinary team. This suggests a professional tendency to being indispensable in messy, complex situations, echoing Wilder Craig's description of a day in her life as she responds to a mix of the practical, emotional, the crisis, the long-haul planning and the sometimes bizarre 'referrals' that typify a health social worker's daily experience (Wilder Craig, 2007). This breadth of focus can be critiqued as being a weakness; one of the authors' own research participants commented, "social work is such a broad kind of profession that you kind of come out like a jack of all trades but master of none" (Beddoe, 2013a, p. 35). But it could also be seen as where our strength lies—having strong values which mean social workers meet need with skill rather than insisting on rigid roles. Morriss (2016) interviewed social workers who were isolated in mental health services in England and describes their depiction of social work visibility/invisibility; she cites participants reporting that social workers had freedom but that "this freedom comes partially from being 'the people who mop up the stuff [others] don't want to do'. Thus, social work's 'space' is again depicted as liminal; operating in the gaps left by other professions" (p. 5). Social work identity can be forged in in-between spaces, performing actions that may be unappealing to others, or which may fall between their understood roles.

Such research hints at a world of practice where social workers, in part at least, construct their identities in interaction with others. Their relationships with other professionals, in multidisciplinary teams for example, may lead to perceived weakening of professional identity, as noted by students (Wiles, 2013 and Chapter 3 in this book) and among members

of mental health teams (Barnes, Carpenter, & Dickinson, 2000). As Leigh (2014, p. 642) has observed in her study of child protection social workers, a "different meaning of profession" may emerge when researchers talk directly with professionals who deal with "certain cultural scripts". If identity develops as a result of "interactions with others", then Leigh argues, "narratives show how these social workers have constructed their own, in part, through the discourses that have been made available" (p. 642). While Leigh's participants were constructing identity in the face of unrelentingly negative narratives about social work, Craig and Muskat's participants were building theirs through interactions with other professionals in the spaces created in health settings for their 'useful' work.

Health social work: Professional capital in health settings—the utility of Bourdieu's concepts

What emerges from these narratives is a need to focus our attention briefly on the power relations between professions and how these might position social work. In health, I argue, the system of power is expressed in symbolic acts and material practices. Clothing and equipment may, for example, signify hierarchies and differential positioning. Social work may have a significant role in the hospital but lacks the accoutrements indicating special (or specialised) contributions—no stethoscope around the neck, no uniform (Beddoe, 2010; Scholar, 2016) and limited control of the spaces in which health care happens. It is rarely enacted *on* the body but the body is central to health care for almost all other health professionals (Cameron & McDermott, 2007). Social workers feel that their work is often a site of struggle, over patients and their rights, acting as active agents in the broad and expansive field of health and welfare (Beddoe, 2013a).

Gartman (2007, p. 391) writes: “Bourdieu conceives of society not as one big unified struggle for a few common resources, but as a conglomeration of relatively independent struggles for a variety of resources”. Modern societies include ‘fields’ such as economics, religion, science, academic institutions, health and justice systems and large ‘welfare’ bureaucracies within the state apparatus, where professionals perform distinct roles often in situations demanding clear demarcation. This demarcation (and the status and expertise which accompanies it) can be a site of struggle. Bourdieu rejected a conceptualisation of the state as one large body manipulated by the ruling class and Garrett (2009, p. 345) argues that the neoliberal state comprises “multiple identities and multiple boundaries”. Furthermore, Garrett suggests “the state may be less a ‘battlefield’ site and more an expansive terrain on which occurs a series of seemingly discrete and unconnected skirmishes” (p. 345). While undeniably the immediacy of patient needs may often place clinical leadership in physicians’ hands, this does not explain the extension of medical dominance over all aspects of health care. Bywaters (1986) warned of the risks of “unconditional collaboration” urging the adoption of a set of principles for social work in health, noting that “power will not be relinquished lightly by the medical profession and its allies, either to other workers or to lay people” (1986, p. 674). But Bywaters could not have foreseen the huge changes to power and control that would later be visited upon the health sector by managerialism.

More recently it has been asserted that medical dominance has waned and, in large part, this is held to be a consequence of new forms of management and governance in health care. Willis (2006) and Coburn (2006) have argued that, with the advent of new models of public management, technologies of control such as evidence-based practice and clinical governance (Webb, 2001), bureaucracies assert greater control of professions—and with these changes even the dominance of medicine has been weakened. Professions had been criticised over the

last four decades for their use of power, based on their disciplinary control of knowledge and expertise (Evetts, 2006) and Coburn suggests that the growth of 'managed' environments means that the claim of specialist knowledge is no longer sufficient to guarantee autonomy. Epistemological changes, the influence of mass media and the vast access to information offered by the internet have altered some aspects of the previously "unbreakable tie between knowledge/expertise and power" (Coburn, 2006, p. 438).

Neoliberalism also brought into play the idea of evidence-based practice (EBP) as a solution to burgeoning health budgets. EBP challenges the potency of an exclusive knowledge claim for any profession, and this is one of the essential components of professional status (see Webb, 2001). Accordingly, while EBP might symbolise the power of medical expertise, some deconstruction of this idea suggests it represents a *weakening* of power. EBP aims to evaluate practices against other practices, using the so-called gold-standard method of random controlled trials. The results of these projects create codified knowledge packaged as 'best practice'. Coburn (2006, p. 439) points out that, while medical scientists contribute to the production of this knowledge, the codification process is under bureaucratic control which shifts the intellectual activity further away from clinicians. In the neoliberal regime, of course, EBP does what it is intended to do: empower bureaucratic agents to apply 'science' to rationing. Thus, social work is exhorted to ensure its survival in this climate by contributing to the production of knowledge and to defend its contribution with evidence of its effectiveness (see, for example, Sheldon & Macdonald, 1999). Health social workers participating in a study of continuing education were notably concerned to keep up with other professionals in research in the 'battlefield' of the multidisciplinary field (Beddoe, 2013a). Research became a highly desirable social work practice (Fouché, 2015; Joubert, 2006) and is often linked to status and power differentials with other professions: see for example

Björkenheim (2007, p. 273) whose participants in focus group interviews "felt it would be good to do some research themselves, because it would give them a higher status in the university hospital, where research is highly valued. They wanted to do research in order to get 'hard facts' that they could present to their colleagues of other professions"; however, they also identified a problem in health care: "doing social work research in a multiprofessional setting [makes it] hard to distinguish the social work part from the work of other professionals. When doing research within a multiprofessional team, there is also a risk that other professions take the lead". While the uncritical adoption of EBP has been challenged by many scholars (Webb, 2001; van Luitgaarden, 2009) this imperative has put research on the agenda and the adoption of research-mindedness and skill is a well-embedded and important aspect of social work education and professional development (Fouché, 2015).

It is clear that knowledge is a major facet of professional identity for social workers and, in health care in particular, this is linked to codified knowledge and the power that accompanies it. Elsewhere I have conceptualised this as 'professional capital' (Beddoe, 2010, 2013b). The professional capital construct is an extension of cultural and social capital (Bourdieu, 1986; Bourdieu & Passeron, 1977), and is a form of symbolic capital, "where prestige, status and influence in institutional life… are significant to social workers, because they perceive themselves as lacking" (Beddoe, 2013b, pp. 53-54). Professional capital is relatively undeveloped conceptually, although there is considerable literature concerned with Bourdieusian constructs of social and cultural capital as applied to professional *practices* and social work identity (Garrett, 2007a, 2007b; Houston, 2002), and education (Bourdieu & Passeron, 1977). References to professional capital are found mainly in discussion of the challenges faced by contemporary professions, including those of multidisciplinary teams. Chau (2005, p. 671) similarly uses the term 'professional capital' in a summary of an

unpublished conference paper on knowledge in nursing, stating that she uses it "to inscribe a profession's value, as being recognised and appreciated, by other professions". Chau offers "a preliminary definition of 'professional capital' as the value of recognition and understanding of the contributions of a profession to include trust, appreciation, reciprocation, and the allowance of growth through change within the context of related professions" (p. 671). Developed via a qualitative study of social workers' engagement in continuing education (Beddoe, 2010), professional capital can be defined as the aggregated value of several attributes: the holding of mandated educational qualifications; the occupation of social 'distinction' based in the territory we call health and social care/services; and finally, the achievement of the economic value of occupational closure, a key artefact of professional status (Witz, 1992, also see Abbott, 1988).

Concluding discussion

Social work practice in health care has many strengths. Craig and Muscat (2013) and Wilder Craig (2007) evoke imagery of a professional role rich with multiple identities. Paradoxically, this diversity and multiplicity can be framed as a strength, expressed in the pervasive idea that carrying out psychosocial support tasks that other professions prefer not to do is still a territory of sorts. More than a century after its inception, health social work can be usefully conceived as positioned within a field of forces (Bourdieu, 1998) holding ground in spite of medical dominance, evidence-based practice and managerialist institutional regimes. The field of health and social care is populated by active agents taking ideological standpoints on many aspects of care or health—social justice, challenges to privilege, seeing humans as productive or unproductive, deserving or undeserving, favouring universalism or targeting in meeting health and social needs, and so forth. This field of is a site of competing discourses about inequalities and how to address them and remains a place of struggle and contestation over power and resources. This complex, contested space is a valid place for social work to

stand. Social workers employed in the health sector remain deeply engaged in the enduring goal of holistic, socially focused health care, while seeking simultaneously to improve their own status and influence. That social workers articulate their concerns using the language of competition, even the military metaphors of the battlefield (Beckett, 2003; Beddoe, 2013a) suggests an enduring struggle to achieve professional capital. They remain optimistic and future focused. They are up for the fight.

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