EXPLORING HEALTH SOCIAL WORK PRACTITIONERS' EXPERIENCES IN WORKING WITH HEALTH PRACTITIONERS WITHIN A MULTIDISCIPLINARYHEALTHCARE SETTING

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PREAMBLE

I embark on this study process after 21 years in the field of social work, and 19 years of practical experience in clinical social work. My primary aim was to learn more about healthcare practitioners' experiences in working with social workers within a multidisciplinary setting. However, while practicing as a social worker in a hospital setting, I understand that social workers seem to undergo self-identity hardship in the healthcare setting. Hence, there is no proper reporting structure for social workers in the setting.

My personal experiences and observations became a motivating factor and moved me to explore the unsaid, unheard part of social work practitioners' experiences, their roles, and the boundaries in working with health practitioners within a multidisciplinary setting.

I am excited about this new understanding of my profession and am determined to do well. I hope that conducting this research will be an asset and add value to the social work profession and thus improve the understanding of multidisciplinary functioning between social and healthcare practitioners for better patient outcomes.

DECLARATION OF ORIGINALITY

I hereby declare that this dissertation is my unaided work.

It is for submission to the College of Humanities, School of Applied Human Sciences, Social Work Discipline, University of KwaZulu-Natal (UKZN), Durban, in partial fulfilment of the requirement for the Degree of Master of Social work.

It has not been submitted before, for any degree or examination, at any other educational institution.

Zama Immaculate Maxhakana

DECLARATION - PLAGIARISM

I, Zama Immaculate Maxhakana, (student no: 219085972), declare that:

This dissertation does not contain other person's data, pictures, graphs, and information unless specifically acknowledged as being sourced from other persons.

Where other written sources have been quoted, their words have been rewritten and have been referenced.

Where the exact words have been used, their writing has been placed in italics, inside quotation marks, and referenced.

This thesis does not contain text, graphics, or tables copied and pasted from the internet. The sources detailed in the dissertation have thus been referenced.

DEDICATION

I dedicate this work to every single one of the social work practitioners employed by the Department of Health in the KwaZulu-Natal Province.

Thank you for dedicating yourselves to serve and improve the lives of patients and their families.

Thank you for being in a profession that helps people to identify their potential in their most vulnerable circumstances. You further help them to use their abilities to reach their full potential.

The number of challenges you experience in the workplace cannot erase the impact you have on patients and their families. Your commitment to offering high-quality services is exemplary and for that, I commend you.

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I wish to express my sincere gratitude and recognition to the following persons for their unconditional assistance and support while I completed this study:

First and foremost, to God Almighty, my Heavenly Father, for the strength, knowledge, ability, and opportunity to undertake this research study. “For I can do all things through Christ who is my strength and gives me strength” (Phil 4:13). Without His strength, this achievement would not have been possible.

My husband, Pr. S.C. Maxhakana, for proofreading my work, and for his constant encouragement and immeasurable help during my study.

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The UKZN Social Work Department for allowing me to be accepted in the prestigious Master programme.

The gatekeeper at King Cetshwayo Health District (District Director), Department of Health, KZN. Thank you for permitting me to conduct my study within your district.

My study participants in the Department of Health, King Cetshwayo Health District social workers’ forum. Thank you for taking the time to share your experiences in working with health practitioners. I appreciate your valuable contributions.

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ABSTRACT

This article explores how social work practitioners work with health practitioners within a multidisciplinary team. This was a moment for health social work practitioners to deliberate about themselves regarding their experiences in working with health practitioners. The research focused on how health professionals work, communicate, and learn together. The research is vital in attempting to comprehend social workers' encounters in working with health professionals, the understanding of their roles and the professional boundaries in the multidisciplinary team. The literature revealed that social workers are frequently identified as non-essential experts in this host setting, where professional competence, control, including respect remain centred around doctors. The qualitative research approach consisting of the combination of an exploratory and descriptive research design was adopted for this study. A purposeful sampling technique was used to select the participants from health facilities who fall under the King Cetshwayo Health District Forum. Study permission was granted by the District Manager and the ethical permission was secured from the Provincial Health Research and Ethics Committee and the Humanities and Social Sciences Research Ethics Committee, respectively. Semi-structured telephonic interviews were held with 16 participants. All the participants were full-time public health employees and were mostly females. The interview schedule was piloted with three participants who then gave feedback regarding the questions. The data was analysed using thematic analysis and three themes emerged from this process. The three main themes can be summarised as professional power dynamics, a lack of collaborative efforts, and a lack of understanding of the social work profession. The study concluded that social work practitioners perceived the overall collaboration as positive. However, concerns were raised regarding the existence of power dynamics that hindered collaboration.

Keywords: Multidisciplinary team (MDT), Social work practitioner, Health practitioner, Healthcare setting, Collaboration.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	- Acquired Immunodeficiency Syndrome
BSW	- Bachelor of Social Work
CEO	- Chief Executive Officer
DOH	- Department of Health
HIV	- Human Immunodeficiency Virus
HSW	- Health Social Worker
KZN	- KwaZulu-Natal
MDT	- Multidisciplinary Team
NASW	- National Association of Social workers
NDOH	- National Department of Health
NHI	- National Health Insurance
PCC	- Person-Centred Care
PHREC	- Provincial Health Research and Ethics Committee
RSA	- Republic of South Africa
SA	- South Africa
SACSSP	- South African Council of Social Service Professions
SDOH	- Social Determinants of Health
SWP	- Social Work Practitioner
WHO	- World Health Organisation

TABLE OF CONTENTS

Content Page

Title Page .....

Preamble i

Declaration of Originality ii

Declaration Plagiarism iii

Dedication iv

Acknowledgments v

Abstract vi

List of Abbreviations and Acronyms vii

List of Tables xiv

List of Figures xv

CHAPTER ONE: SETTING THE SCENE OF THE STUDY

1.1 Introduction 1

1.2 Background of the Problem 2

1.3 Statement of the Research Problem 3

1.4 Research Aims and Objectives 5

1.5 Research Questions 5

1.6. Research Methodology 5

1.7. Study Location 6

1.8. Data Analysis 6

1.9. Significance of the Study 6

1.10. Limitations 7

1.11. Reflexivity.....7

1.12. Pilot Study.....8

1.13. Ethical Considerations.....9

1.13.1 Action and Competence of the Research.....9

1.13.2 Avoidance of Harm.....9

1.13.3 Confidentiality.....9

1.14. Trustworthiness of the Study.....10

1.15. Definition of the Key Concepts.....10

1.16. Structure of the Dissertation.....11

1.17. Summary of the Chapter.....12

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction.....14

2.2 Fields of Social Work profession.....14

2.3. Historical Development of Social work in the Healthcare Setting.....15

2.3.1 Healthcare System in South Africa.....16

2.4 Theoretical framework of the study.....19

2.5. Social Workers Experiences in working with health care practitioners.....20

2.6. Social Worker's role within the Multidisciplinary Team.....24

2.6.1 MDT role in Chronic Disease Management.....25

2.6.2 Role as a Patient Advocate within the Multidisciplinary Team.....27

2.6.3 Role as a Discharge Planner within the Multidisciplinary Team.....28

2.7. Boundaries in Effective Multidisciplinary Collaboration.....30

2.8. Improving the Functioning of the MDT within the Healthcare Setting.....32

2.9. Guiding Framework that Informs the Constitution of the MDT.....33

2.10 Summary of the Chapter.....35

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction.....37

3.2 Methodology.....37

3.2.1 Research Paradigm.....37

3.2.2 Research Approach.....38

3.2.3. Research Design.....38

3.2.4 Sampling Procedures.....39

3.3. Data Collection.....40

3.4. Pilot study.....41

3.5 Data Analysis.....41

3.6. The Trustworthiness of the Study.....43

3.6.1 Credibility.....43

3.6.2 Transferability.....43

3.6.3 Dependability.....43

3.6.4 Conformability.....43

3.7. Ethical Considerations.....44

3.7.1. Informed consent.....45

3.7.2. Respect for individual autonomy.....45

3.7.3. Compensation.....45

3.7.4. Confidentiality.....45

3.7.5. Anonymity.....46

3.7.6. Management of information 46

3.8. Summary of the Chapter 46

CHAPTER FOUR: ANALYSIS OF DATA, INTERPRETATION AND DESCRIPTION OF RESEARCH FINDINGS

4.1 Introduction.....47

4.2 Presentation of the Demographic Profile of the Study Participants.....47

4.2.1 Gender.....49

4.2.2. Age.....49

4.2.3 Experience.....50

4.2.4 Exposure to the MDT.....51

4.3 Summary of identified Themes and Subthemes 52

4.4 Description of Themes and Subthemes.....53

4.4.1 Theme 1: Professional Power Dynamics 54

4.4.1.1 Subtheme 1.1: Professional Subordination of Social Work.....55

4.4.1.2 Subtheme 1.2: Unequal Power Relationship 55

4.4.2 Theme 2: Lack of Collaborative Efforts 57

4.4.2.1 Subtheme 2.1: Poor communication within the MDT 58

4.4.2.2 Subtheme 2.2: Underestimation of Responsibilities.....59

4.4.2.3 Subtheme 2.3: Value of the MDT.....60

4.4.3 Theme 3: Lack of Understanding of the Social Work Profession 61

4.4.3.1 Subtheme 3.1: Frustration at being Undermined 62

4.4.3.2 Subtheme 3.2: Lack of Recognition.....63

4.5 Discussion.....64

4.5.1 Professional Power Dynamics 65

4.5.2 Lack of Collaborative Efforts 66

4.5.3 Lack of Understanding of the Social Work Profession.....67

4.6 Summary of the Chapter 68

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction.....69

5.2. Summary of the study 69

5.3. Findings in relation to the research questions of the study 70

5.4. Summary of study findings 72

5.5. Study conclusion 73

5.6. Recommendations.....74

5.6.1. Recommendations for future Research 75

5.6.2. Recommendations for practice.....75

Recommendations for Provincial departments, District and Hospital Managers (CEO's) 75

i) Recommendations for Health Practitioners.....76

ii) Recommendations for Social Work Practitioners 76

iii) Recommendations for Academic Institutions 76

5.6.3. Recommendations for Academic institutions 76

5.7. Concluding remarks 77

6. REFERENCES 78

7. APPENDICES..... 98

A.1. UKZN HSSREC Full Ethical Clearance.....99

B.1 Request letter of Support from the Health District Director 100

B.2 Approval Letter from the Health District Director....102

C.1 Request for Permission to DOH....103

C.2 Permission Letter – DOH....105

D.1 Application for the Amendment of Data Collection....106

D.2 Approval of the Amendment of Data Collection....107

E. Recruitment of Participants Email....108

F. Informed Consent from the Participants....109

G. Interview Guide (Data Collection Instrument)....112

H. Editorial certificate....114

I. Turnitin Report....115

LIST OF TABLES

Table 1.1: Structure of the Dissertation 13

Table 4.1: Profile of the Participants 47

Table 4.2: Age of the Participants.....49

Table 4.3. Summary of the Identified Themes and Subthemes 51

LIST OF FIGURES

Figure 4.1: Gender 48

Figure 4.2: Years of Experience 49

Figure 4.3: Exposure to the MDT 50

CHAPTER ONE

SETTING THE SCENE FOR THE STUDY

1.1 INTRODUCTION

The multidisciplinary team (MDT) approach plays an increasingly important role in the management and quality care of patients. A multidisciplinary approach in social work is defined as a team of professionals from various backgrounds and areas of expertise who unite to tackle a common problem (Writer, 2020). MDT members share the responsibility and accountability for patients' well-being, but they each make and implement decisions independently. Treatment and intervention are individualised by each member of the MDT. Providing support to patients and their families helps them adapt to illness and treatment plans (Franek, 2013).

This study explored the health social work practitioners' experiences in working with healthcare practitioners within a multidisciplinary team in the healthcare setting. In the healthcare setting, social workers collaborate with other healthcare practitioners like doctors, nurses, psychologists, psychiatrists, dieticians, physiotherapists, audiologists, speech therapists and occupational therapists (McLaughlin, 2015). The participants in this study are the social work practitioners employed by the KwaZulu-Natal Provincial Department of Health. Undertaking this study was mainly informed by the need to contribute to the functioning of multidisciplinary teams within the healthcare facilities. Health social workers in different health facilities form part of and work within the multidisciplinary team approach.

This work highlighted the social workers' experiences in interacting with health practitioners from other disciplines. The literature reveals that the interprofessional collaboration among doctors, nurses, psychologists, social workers and other members of the healthcare team increases the collective awareness of each other's knowledge and skills (Franklin, Bernahardt & Lopez, 2015). Furthermore, interprofessional collaboration contributes to the quality of care through the continued improvement in decision-making. In a healthcare setting, every healthcare practitioner has a responsibility to improve the health conditions of patients, and this requires working together towards the same goal. A multidisciplinary approach to healthcare suggests that no single professional can unilaterally attend to the patient (Vasudevan, 2015). Accomplishing a protected worth healthcare is extremely depending on productive reporting among each of the representative of the group in the healthcare setting.

There is a realisation that the health workforce plays a critical role in advancing the health system goals, largely driven by a policy position of improving access to healthcare for all citizens (WHO, 2017). Section 27 of the Constitution of South Africa (1996) guarantees every citizen's access to health services, which is provided through both the public and private sector. The public health services are divided into primary, secondary and tertiary levels of care through health facilities that are located in and managed by the KwaZulu-Natal Provincial Department of Health (DOH-KZN, 2012). The majority of people access health services through the public sector's district health system, which is the government mechanism of health provision within a primary healthcare approach.

1.2. BACKGROUND OF THE RESEARCH

Health is influenced by many factors and the growth of these factors has endorsed a key position for social work in the healthcare environment (Gehlert & Browne, 2012). Social determinants of health are non-medical factors that can affect a person's overall health and health outcomes. These factors influence a person's opportunity to be healthy as well as his/her risk of illness and life expectancy (WHO, 2013). They can result in an onslaught of emotional, financial and social needs. Social workers are adept at helping patients meet these sorts of needs (Whitaker & Clark, 2006). Patients with health problems often experience personality and social environment difficulties while trying to manage their diseases. Health social workers remain critical towards the multidisciplinary group, because they put forward a "person-in-environment" aspect (Munday, 2013). The social work profession understands the seriousness of the existence of various life elements as they influence vulnerable health beyond the natural life.

The establishment of the World Health Organisation, which came into effect in 1948, defined health as "a state of complete physical, mental and social well-being, not a mere absence of diseases" (WHO, 2001). This definition call attention to the participation of social work practitioners to the health sector in the sense that it figures the foremost function of collective welfare for the fulfilment of physical health. It further mentions the concept of a holistic view to the healthcare framework and minimizes the medical speciality as the non- appearance of disease or infirmity. Medical disorders have far-reaching consequences that go beyond the body. Understanding professional collaboration amongst healthcare practitioners is imperative, as it is a vital part of achieving better patient outcomes, improving patient satisfaction, reducing the length of stay in hospitals, and lowering the costs in the provision of healthcare (Suter, 2009).

Hospital social work practitioners are one of the few non-medical professions working in the healthcare sector. By its very nature, social work practitioners are frequently presumed as inferior professionals therein host environment, place professional control, charge, as well as status remain located around medical practitioners (Heenan & Birrell, 2018). This may leadthe way to contradictory relationship between social work practitioners and doctors, particularly within the field concerning moral matters, policies, considerations including commitment.

Health and social services across several countries are increasingly expected to deliver integrated people-centred holistic care. However, a fundamental obstacle on the health side can be the absence of cognisance the values, purposes and organisation of social care services. Munday (2013) states that health service provision tends to be dominated by biomedical models of health, and their focus on diagnosing and responding to primarily physical symptoms of disease and disability among individuals. Social care services, by contrast, are reported, as intended, to focus on the whole person in the context of the physical, economic and social contexts in which they live and their relationships with others. In the traditional medical model, social care is viewed as predominantly adjunct to health services, enabling them to fulfil their goals (Munday, 2013). For example, social care is regarded as aiming to contribute to the increase in the number of safe and timely discharges from the hospital or to reduce avoidable admissions.

Collaboration in the healthcare can be described as the capability of every healthcare professional to effectively embrace complementary roles within a team, work co-operatively, share the responsibilities for problem-solving, and make the decisions needed to formulate and carry out plans for patient care (Franklin et.al, 2015). Furthermore, this contributes to the quality of care through the continued improvement in decision-making.

1.3. STATEMENT OF THE RESEARCH P ROBLEM

There are various factors that informed the need for this study. At the foremost, the healthcare setting is viewed as dominated by doctors and nurses. As a result, social work practitioners are seenas providing a secondary service in healthcare. A myriad from international studies on experiences of social work practitioners and interprofessional collaboration have been conducted so literature on interprofessional collaboration is extensive. The literature thus reveals that the collaboration ofmultiple disciplines often poses a challenge (Green, 2017).

Team members differ in their academic and professional backgrounds, leading to communicational,cultural or methodical challenges when working together. As such (Reeves, MacMillan & Van Soeken, 2010) expressed that the interprofessional collaboration can be affected by problems linked to imbalances of authority, limited understanding of others' roles and responsibilities, and professional boundary friction when delivering patient care. This can be described as a long-standing problem particularly in the healthcare sector. In relation to this view, (Nayes, 2021) confirmed that interprofessional healthcare groups face issues related to power and authority in the patient care process. With specific reference to social workers, a study conducted by Brooklyn and (Suter, 2016) on interprofessional collaboration and integration, social workers encountered less opportunity to work to full scope and a lack of understanding of social work ideology from other professionals. The most recent study conducted by (Hlongwa & Rispel 2021) revealed that in many African countries, including South Africa, interprofessional collaboration remains a fairly new concept. Furthermore, a research study conducted in South Africa by (Lieketseng, Cloete and Mji 2017) reported inadequacy understanding of the advocacy role that rehabilitation professionals could play in addressing social determinants of health. The study further states that rehabilitation remains poorly understood in terms of its role within the health system.

In 2018, the KwaZulu-Natal Provincial Department of Health hosted the first time ever conference for social workers, which was themed "Breaking Barriers and Building Bridges in Social Work Practice within the Health Sector". One of the key findings that the conference found was that socialwork practitioners in the healthcare setting were not receiving the recognition that they deserved (KZN Health, 2018). This conference confirmed the existence of the general view that there is an ongoing absence of recognition of the value of the social work profession within the healthcare setting. There was also a predominant view that there is limited knowledge among clinicians, in particular, about the social work profession's role and its contribution to the healthcare setting. This impacted to their day to day roles and responsibilities. As a result, the multidisciplinary team members tend to compare social work practitioners' roles with other members from different disciplines. There is also a concern about the observed skewed distribution of resources with socialwork units being considered the lowest in the pecking order. This has resulted in occupational tension among professionals. Lastly, there is an observation that social work practitioners tend to be excluded in decision-making, discharge planning and the future management of patient care resulting in poor collaboration within the team and the holistic approach being compromised.

1.4 RESEARCH AIMS AND OBJECTIVES

1.4.1 Aim of the Study

The overall aim of this study is to explore the experiences of social work practitioners in working with healthcare practitioners within a multidisciplinary healthcare setting.

1.4.2 Objectives of the Study

1.4.2.1 To explore how social work practitioners describe their experiences in working with health practitioners in multidisciplinary teams.

1.4.2.2 To explore social work practitioners' understanding of their role within the multidisciplinary healthcare setting.

1.4.2.3 To examine the social workers' understanding of their practice boundary when engaging with other disciplines within the multidisciplinary healthcare setting.

1.4.2.4 To propose recommendations for enhancing the functioning of the multidisciplinary teams.

1.5 RESEARCH QUESTIONS

1.5.1 How do social work practitioners describe their experiences in working with health practitioners within the multidisciplinary team?

1.5.2 What do social work practitioners understand as their role in the multidisciplinary healthcare setting?

1.5.3 What is the extent of social workers' understanding of their practice boundary when engaging with other disciplines within the multidisciplinary healthcare setting?

1.5.4 What are the possible recommendations for enhancing the overall functioning of multidisciplinary teams?

1.6. RESEARCH METHODOLOGY

The research methodology refers to the process that explains the logic behind the process and steps taken to answer the study questions that connect the study aim and objectives (Babbie & Mouton, 2010). As stated by (Marlow, 2011) there are two main approaches to research namely, qualitative and quantitative approach. This research study adopted a qualitative approach. This approach was chosen to explore a holistic understanding of the experiences of social work practitioners in working with healthcare practitioners in multidisciplinary settings. Qualitative

research is defined as research that reaches results through non-quantifiable processes, and is primarily interested in descriptive rather than statistical data (Marlow, 2011).

An exploratory describing goal, as proposed by Delport and Fouché (2002), was utilised for the study. The exploratory part was applied to assist the researcher to gain insight and an understanding of the experiences, focusing on answering the "what" question. The descriptive component served to provide in-depth descriptions of such experiences, answering the "how" question. The researcher desired an explanation on "how" social work practitioners describe their experiences in working with health practitioners within the multidisciplinary healthcare setting and "what" they know as their role in the MDT. The researcher set forth interview guide as a data collection instrument. Initially, the study was intended to be conducted through face-to-face interviews. However, due to the COVID-19 global pandemic (WHO, 2020), the data collection method was diverted to semi-structured telephone individual interviews. The related changes were approved by the UKZN Humanities and Social Sciences Research Ethics Committee.

1.7. STUDY LOCATION

The study was located in the King Cetshwayo Health District situated in DC28 Northern KwaZulu-Natal. The district comprises of two regional and six district hospitals, namely, Catherine Booth Hospital, Ekombe Hospital, Eshowe Hospital, Mbongolwane Hospital, Ngwelezane Hospital, Nkandla Hospital and Queen Nandi Hospital. The researcher recruited participants from the previously mentioned facilities who were the members of the district forum. As determined by the HRM 127/2008 Policy, the health social workers employed within the healthcare setting of the KwaZulu-Natal Provincial Department of Health, are organised to form district forums that operate within their health district (DOH-KZN, 2008).

1.8. DATA ANALYSIS

The facts gathered from the participators were examined using thematic qualitative data analysis. Thematic examination is an action before identifying patterns or themes within the qualitative data. This subsection is explained in detail in Chapter three.

1.9. SIGNIFICANCE OF THE STUDY

The study sought to identify various factors that hinder collaboration within health professionals working in MDT thus find possible recommendations to enhance the functioning within the

MDT. It seeks to highlight the role of social work practitioners within the MDT and its impact in the management of patient care. The researcher believes that this study will advance the knowledge and increase the understanding on the functions of social workers within the MDT in different healthcare facilities in the KwaZulu-Natal Department of Health.

Moreover, this study will provide valuable systems in interprofessional collaboration within the MDT. In addition to this, the study is intended to provide scholarly knowledge on benefits of MDT collaboration. Through this research, the findings can elucidate social work practice particularly in the public healthcare facilities. Ultimately, a better understanding is likely to improve patients' quality of care and service delivery.

1.10. LIMITATIONS

The study was a once-off study conducted in one district out of eleven districts in the province of KwaZulu-Natal. The study used a relatively small sample size, which limits the generalisation of the findings to the larger population. The sampling method used to obtain sample was biased to participants employed at the healthcare setting. Therefore, social work practitioners from other fields of social work practice were excluded. Changing from face-to-face to telephone interviews also posed some limitations in the flexibility of the data collection process, as there was no observation of non-verbal cues. Flexibility is essential because it allows the interaction of individual viewpoints (Hennik, Hutter & Bailey, 2011). The researcher observed that it was difficult to establish rapport with participants hence she was unable to respond to visual clues.

1.11. REFLEXIVITY

Gray (2009) sets out reflexivity as the "keep an eye on" by a researcher of his/her effect on the relook circumstances being scrutinized. Gray (2009) goes on to say that there are two types of reflexivity. To begin, epistemological reflexivity is used when the investigator examines their own beliefs and ideologies. This form of reflexivity is not appropriate for this research study therefore the researcher didn't think about it much. Individual reflexivity takes place when the investigator reveals on his/her point of view, standards and beliefs, and how these form the investigation. In examining personal reflexivity, I found my practical experience within the MDT to have influenced my choice of the research topic. I work at General Justice Gizenga Mpanza (GJGM) Regional Hospital, formerly known as Stanger Hospital. The hospital falls under the Ilembe Health District situated within the KwaDukuza sub-district in the Ilembe Municipality. I occupy a position of Social Work Supervisor Grade 2 in terms of Occupational

Specific Dispensation for Social Service Professions (DPSA, 2010). I have been a social work practitioner within the healthcare setting for the past 19 years. I have based my work on the skills and knowledge obtained during my training at a higher institution of learning. My intensive practical experience and exposure to the MDT were a sufficient basis to enable me to conduct this study. Furthermore, my professional involvement with the team meant bringing expertise to assess, plan and manage patients jointly to promote better quality care. Thus, coordination is critical. In reality, the multidisciplinary working is likely to operate by the position of control and participation of the different professionals involved. The standard of confidence among distinctive professionals is considered important. This research has made me to be more aware of and to explore my collaboration with health practitioners.

I consider reflexivity as one of the fundamental ethical principles. Thus, I pay careful attention to it. I have my way of reflecting on my praxis. I have learned at the initial stage of this project to differentiate and deal with my experiences by thinking reflectively throughout the entire research process. Self-awareness is the understanding of self, and I am fully aware of my standing on how I may be prone to bias. My professional training helped me to approach this study from an objective point of view.

1.12. PILOT STUDY

A pilot study is a preliminary little-scale analysis that researchers conduct towards helping them decide how best to conduct a large-scale research project (Crossman, 2019). Piloting was necessary for this study to try out the research instrument as well as adjust it prior the investigation could be administered. This subsection is further explained in detail in Chapter three.

1.13. ETHICAL CONSIDERATIONS

Few ethical issues were observed in this study. Below is the summary thereof:

1.13.1. Permission to Conduct a Study

The application for ethical clearance was made to both the Department of Health and the University of KwaZulu-Natal. The ethical approval of the study was obtained from the Humanities and Social Sciences Research Ethics Committee (HSSREC). Full written approval of the study was obtained.

Prior to that, as per the Department of Health policy guidelines on conducting a research study, it was mandatory to obtain a letter of support from the senior management. Permission to conduct the study was granted from the District Director of the King Cetshwayo Health District. Hennink, Hutter and Bailey (2011) describe gatekeepers as persons in the authority positions who are in charge for organizations. After the researcher was granted with the gatekeeper's permission, the participants were recruited who then engaged freely and elaborated on their experiences.

1.13.2. Action and Competence of the Researcher

Creswell (2013) emphasises that the analysts are morally compelled through to make sure to be capable as well as satisfactorily talented to attempt the proposed examination. The analyst accepts that she was adequately capable to conduct the investigation based on her proficient encounter within the field and her scholarly knowledge.

1.13.3. Avoidance of Harm

Physical or mental harm is referred to as harm. According to Creswell (2013), the majority harm to participants in the social sciences will be emotional. The investigator has to secure guide for participants from any bodily or emotional damage. Similarly, Creswell (2013) states that participants must be fully aware of the capacity effect before starting the research. Detailed information allows participants to opt out of the research if they so wish. After each telephone, interview debriefing was conducted with each participant in this study to ensure that they are emotionally stable. In addition, there was a system in place for those who were likely to have problems to be referred for further management.

1.13.4. Confidentiality

Polit and Beck (2008) state that a promise of confidentiality is a pledge that any information, which the participants provide will not be publicly reported in a manner that identifies them and will not be made accessible to others. The researcher ensured that breach of confidentiality did not occur by not sharing research information with people known to the participants. The information shared was treated with confidentiality.

1.14. THE TRUSTWORTHINESS OF THE STUDY

The trustworthiness of qualitative research needs to be assessed through its credibility, transferability, dependability and conformability (Babbie, 2009). These elements are discussed in detail in Chapter three.

1.15. DEFINITION OF THE KEY CONCEPTS

To provide an understanding of the multidisciplinary approach in the healthcare and social work professions, it is important to define the following key concepts:

1.15.1. Social Work

Globally, social work is defined as a practiced-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect of diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (IFSW, 2014).

1.15.2. Health/Medical Social Work

Gehlert and Browne, (2012) defines medical social work as a specific form of social case work that focuses on the relationship between the disease and social maladjustment. It provides direct treatment for patients' social and psychological problems which were among the causes of the effects of their health problems, or which acted as barriers to cooperation with the medical treatment plan. Health, medical and hospital social work are the terms used interchangeable in this study.

1.15.3. Medical Social Worker

Morrow (2014) concurs and defines a medical social worker as a social work practitioner who works within a medical setting such as hospice, outpatient clinic, hospital, community health agency or long-term care facility.

1.15.4. Multidisciplinary Team

According to Bhasin (2019), multidisciplinary team is defined as a group comprised of members that have complementary skills, qualification, and experience. Their contribution is towards a particular objectives of an organization via teamwork and they make decisions about a specific

subject in a collective manner. The terms interprofessional, interdisciplinary, and multidisciplinary, are used to describe healthcare teams. In this study, the terms, interdisciplinary, and interprofessional are used interchangeably to describe multidisciplinary team.

1.15.5. Multidisciplinary Approach in Social Work

Writer (2020) defines a multidisciplinary approach in social work as a composition of a team of professionals from various backgrounds and areas of expertise who unite to tackle a common problem or focus on a common agenda. A multidisciplinary approach involves drawing appropriately from multiple disciplines to redefine problems outside of normal boundaries to reach solutions based on a new understanding of complex situations.

1.15.6. Collaborative Practice

The World Health Organisation (2010) defines collaborative practice as "multiple health workers from different professional backgrounds working together with patients, families, carers, and communities to deliver the highest quality of care".

1.15.7. Burnout

The term burnout refers to a prolonged reaction to significant job suffering that is characterised by three factors: mental collapse, a feeling of separation from oneself and inefficacy (Maslach, Schauufeli & Leiter, 2001). Burnout can lead to negative psychological, physical and health effects.

1.16. STRUCTURE OF THE DISSERTATION

The research article is presented in five chapters as outlined in the table below:

Table 1.1. Structure of the Dissertation

Chapter	Chapter overview
Chapter One: A general overview of the study	Introduction, background of the study, problem statement, aim and objectives, method used for data collection and ethical consideration
Chapter Two: Literature Review	Introduction, fields of social work practice, historical development of social work in health, theoretical framework, experiences of social work practitioners, the three main subtopics discussed under social workers role, boundaries in rendering effective MDT, summary
Chapter Three: Research Methodology	Outline of the research methodology including approach, design, sampling processes, data collection, analysis, trustworthiness of the study and ethical consideration and summary of the chapter
Chapter Four: Presentation of findings and analysis	Presentation of results and interpretation, and discussion on findings, summary of the chapter
Chapter Five: Conclusion and recommendations	Presentation of the summary, conclusion and recommendations arising from the study and concluding remarks

Source: Author' own (2020)

1.17. SUMMARY OF THE CHAPTER

This chapter provided an overview of the research. It gave the introduction, background and rational of what the researcher intended to investigate. In this chapter, few issues were presented such as the overall aim and objectives of the study, the statement of the research problem, the significance of the study, the research methodology, ethical considerations and trustworthiness, were discussed in detail. This chapter further clarified concepts relevant to this research and the outlined structure of the dissertation.

The following chapter discusses the literature review and mainly focuses on the existing gaps in the publications regarding the encounters of social work practitioners in working with health practitioners within the MDT, the role of social work practitioners in the MDT, and the boundaries in rendering effective multidisciplinary collaboration.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review involves the critical review of existing literature and the work being undertaken. It reviews what has already been done in the context of the topic being undertaken. The literature review identifies gaps in previous research and shows how the study has filled a demonstrated need (Delport, Fouché & Schurink, 2011). The previous, existing and hereafter have crucial relationships therefore, it is imperative to review prior research and literature that is already in existence to help the researcher to understand how previous researchers approached the topic at hand.

This chapter intends to review fields of social work profession, historical development of social work in the healthcare setting. The chapter is divided into a number of sections which includes, social workers' experiences in working with healthcare professionals, social workers' role within the MDT, role in chronic disease management, role as a patient advocate within theMDT, role as a discharge planner, boundaries in rendering effective MDT, improving the functioning of MDT, guiding framework that informs the constitution of MDT and thesummary of the chapter.

2.2. SOCIAL WORK FIELDS OF PRACTICE

Social work as a profession is broad and can be classified in different ways (Blennberger, 2006). As indicated by Blennberger, social work can also be described from the viewpoint of how regulated it is by government or authorities. This means different types of social work are carried out in public and private sectors. According to Writer (2020) and several other authors like (Ajibo, Mbah & Anazonwu, 2017) and NASW (2016), social workers are found in every facet of community life, including schools, hospitals, mental health clinics, prisons, private practices, military, and in numerous public and private agencies. As such, the South African government has recently regulated and gazetted practice areas of speciality such as occupation social work, school social work, healthcare social work, clinical social work, social work supervision and forensic social work (RSA, 2020). As gazetted, occupational social work was described as focusing on the needs and problems of various client systems in the workplace, and the reciprocal relationship between them.

School social work was reported as a field that focuses on social work services as an integral part of the education context, addressing psychosocial barriers to learning as experienced by learners in education institutions. In addition, Social workers in health care setting help patients and their relatives to deal with personal and social factors affecting their health and wellness (RSA, 2020).

2.3. HISTORICAL DEVELOPMENT OF SOCIAL WORK IN THE HEALTHCARE.

Social work has its roots in the attempts of society at large to deal with the problem of poverty and inequality. In healthcare, social work originated to change the demographics of the Unites States (US) inhabitants throughout the 19^{th} and 20^{th} centuries. (Ruth & Marshall, 2017). This included the standpoint concerning how the confined ought to be managed, together with the treatment that should take place, and the viewpoints toward the position of social and psychological factors in health (Gehlert & Browne, 2012). Gehlert and Browne (2012) state that these three closely related phenomena set the stage for the emergence of the field of social work in healthcare.

Records of social work in healthcare commenced in 1905 while Richard Cabot, a doctor at Massachusetts General Hospital (MGH) in Boston, employed a person trained to care for the sick to assist deal with the social problems of his patients that he perceived as confining with their medical care and adherence. Dr. Cabot was a lead defender in the formation of the social work functions, as he presumed that there was a connection with tuberculosis and sanitary conditions. In 1914, social work was out stretched into the inpatient wards of MGH, building health social work (Gehlert & Browne, 2012). There have been various social and cultural changes since Ida Cannon (1905) planted the base of hospital social work. Ida Cannon was responsible for examining the social circumstances of patients of Dr. Cabot in the dispensary or outpatient centre as well as community services that could enhance the patient's circumstances and adherence to medical care. The foremost task of the clinical social worker was and up to this time discharge planning and the psychosocial care of the patient and his/her family (Gregory, 2005 & Beder, 2006). Dr. Cabot together with the newly created social workers redefined how health and well-being were managed. The economic, social, family, and psychological conditions that underpinned many of the conditions that patients presented with were recognised for the first time.

Social workers would work in a harmonious connection with doctors, focusing on social health, and the latter on physiological health. In addition to this, it was seen that social work could improve medicine by allowing an analytical point of view thereby operating together in a set

up structure. This process in the twinkling of an eye grew all over American hospitals. The increasing amount of health social workers gave rise to the plan of the American Association of Hospital Social Workers in 1918 to enlarge the contact along formal education and hospital practice. The establishment of the American Association of Hospital Social Workers meant to foster and coordinate the training of social workers in hospitals and to enhance the communication between schools of social work and practitioners (Gehlert & Browne, 2012). Hence, in 1929, there were ten university courses in medical social work. Around that time, psychiatry and psychology started to contest with social work as the harmonizing discussions to medicine in hospitals. The increase in social spending after World War II saw another rise in the number of social workers. In 1954, the American Association of Medical Social Workers merged with six specialty organisations to form the National Association for Social Workers. The American Association of Medical Social Workers was the largest of all the social work membership organisations (Gehlert & Browne, 2012).

In developing countries, social work is described as a relatively young profession that was influenced by colonialism in its formation (Mupedziswa, 2005). The historical and contemporary data pinpoints the importance of analysing the specific and changing form of the state in the different countries of the region to understand the social determinants of disease and the allocation of health resources. Many factors have influenced and facilitated the development of social work in Africa (Chiteleka, 2009). The key among them are extant socioeconomic and cultural challenges. It is important to consider the position of the state in the international and regional economy, its specific form, the nature of its class relations that are predictors in some sense of health and healthcare, as well as a variety of micro-level political and social decisions and mediations.

2.3.1. HEALTHCARE SYSTEM FROM GLOBAL TO SOUTH AFRICAN CONTEXT

Globally, health systems are faced with major changes and challenges as a result of various factors such as increased number of new diseases, lifestyle changes, poor teamwork, increased workloads for healthcare workers (Maree & Van Wyk, 2016). To overcome the challenges in the health system and, to enhance health outcomes for patients, collaborative practice was emphasized as a mechanism to address such challenges (WHO, 2010). As such (WHO, 2010) proposed a framework that describes healthcare systems in terms of six core components being service delivery, healthcare workforce, healthcare information system, medicine and technologies, financing and leadership or governance.

In this regard, healthcare system in Africa suffers from neglect and under funding, leading to severe challenges across the six WHO pillars of healthcare delivery (Oleribe, Momoh, Uzochukwu, Mpofana, Abediyi, Williams & Tylor-Robinson, 2019). It was further discovered that the majority of African countries were unable to meet the basic requirement for good healthcare systems. Poor governance and human resource challenges were linked to ineffective integration of services in resource-limited nations (Oleribe et al, 2019).

In South Africa prior to the first democratic elections, hospitals were assigned to particular racial groups, and mostly were located in white areas (Brand SA, 2012). The challenge of transforming the healthcare system is compounded by the profound legacy of apartheid in the aspects of life that influence health and disease. South Africa faces the task of establishing a cohesive social democracy in which its natural resources and human talent can be used to benefit its entire people (Benatar, 2013). The provision of health services is largely dependent on the sufficiency of the health workforce in terms of numbers, the quality of the skills which they possess, how and where they are deployed, and how they are managed (WHO, 2015).
A study conducted by Maphumulo & Bhengu (2019) revealed overwhelming evidence about the quality of healthcare in South Africa. The study noted various challenges that impact negatively on healthcare quality delivery includes unequal distribution of resources, management and leadership crisis and increased disease burden.

Healthcare in South Africa varies from the most basic primary healthcare, offered free by the state, to highly specialised health services available in both the public and private sector. While the state contributes to about 40 per cent of the expenditure on health, the public health sector is under pressure to deliver services to about 80 per cent of the population (Brand SA, 2012). The private sector, on the other hand, is run largely on commercial lines and caters to middle and high-income earners who tend to be members of medical schemes (Brand SA, 2012). Institutions in the public sector have suffered poor management, underfunding, and deteriorating infrastructure. The situation is compound by challenges including the burden of diseases and the shortage of key medical personnel. High levels of poverty and unemployment mean healthcare remains largely the burden of the state. The Department of Health holds the overall responsibility for healthcare, with specific responsibility for the public sector.

Provincial health departments provide and manage comprehensive health services via a district-based public healthcare model. Local hospital management has been delegated authority over operational issues, such as budget and human resources, to facilitate quick responses to local

needs. A health charter has been devised to create a platform for engagement between sectors to address issues of access, equity and quality health services. Through the National Health Insurance (NHI), the Department of Health is focused on implementing an improved health system, improving hospital infrastructure and human resources management and procuring the necessary equipment and skills (Brand SA, 2012). The NHI is intended to bring about reform that will improve service provision and healthcare delivery. It will promote equity and efficiency to ensure that all South Africans have access to affordable, quality healthcare services regardless of their employment status (Brand SA, 2012). The provision of the greater equality of access to healthcare is a potentially powerful way to foster a sense of solidarity in citizenship and community in its transition toward a more just society. The success in reforming the healthcare delivery system depends very largely on the success in reforming the shattered political and economic structure.

2.4.THEORETICAL FRAMEWORK GUIDING THE RESEARCH STUDY

A theoretical framework is defined as a group of related ideas used to guide a research project. These ideas must illuminate the theories that will be used in the study, and which are relevant to the intervention and outcome of the research (Monsen, 2017). This study was located within the systems theory. The systems theory saw its beginning in 1968 when the biologist, Ludwig von Bertalanffy, defined the general system theory (Friedman & Allen, 2011). Von Bertalanffy (1968) summoned the historical precise source and development style by specific appears at social phenomena in absolute brand new viewpoint. Von Bertalanffy (1968) instituted the idea of "wholeness" and saw existence as great worth subsystems that established a portion of the substantial approach. Von Bertalanffy (1968) further emphasised that the integration of different structures acts upon the condition of a person. The systems theory emphasises 'person-in-environment' configuration, which is developed into the psychosocial approach (Coady & Lehmann, 2008). The systems ideology force for a perspective of linked systems influencing a person, to direct possible maturity and modify unlike systems touching them (Turner, 2011). Therefore, systems theory aims to explicate dynamic relationships and interdependence between components of the system and the organization-environment relationships.

As such, systems is established based on the structure and patterns of the relationships emerging from interactions among components. As a result of these emergent patterns and relationships, each system is different from another (Sapphire & Chin, 2017). Furthermore, systems theory focuses on three levels of observations namely: the environment, the social organization as a

system, and human participation within the organization. Bridgen (2017) refers to these levels as natural, formal and societal systems. He identifies natural systems as a family, friends and neighbours. He refers to a formal system as community support and structure, and lastly societal system as the hospitals and healthcare professionals. According to systems theory, components of each system are structured in a hierarchical order, and components are interdependent with one another in the system to the extent that one component cannot function without the support of the other components (Sapphire & Chin, 2017). At the organization level, the organizations in the environment are also interdependent on one another. Underlying this interdependence are the permeable boundaries, both within and among organization.

Anderson (2016) believes that applications of this theory rest on the assumption that most individuals strive to do good work, but they are acted upon by diverse influences. Furthermore, those functional, and efficient systems not only account for, but also embrace these influences. This means, within a person there is an element of doing good but negative circumstances hinder them from achieving their goals. In relation to the functioning of the MDT, members need to strive for maintaining good working relationship for them to produce effective outcome in patient care management. Anderson further emphasise the underlying principle of systems theory that seem largely intuitive to healthcare professionals. Based on this theory, professionals in healthcare can examines their deliberations and set goals for change to ensure the functionality of team working. Importantly, this framework is found to be most relevant in this study based on its emphasis on the relationships between systems. Firstly, in this context the focus is on the relationship between the individual and systems, secondly the relationship between the individual and the organization, and thirdly relationship between professionals working within the system.

The systems theory connects the subsystems to one another and the entire healthcare system. The patient is seen in the context of his/her interactions or transactions with the members of the multidisciplinary team as a subsystem. The patient being system interconnects with subsystem of his/her family. The patient and family relationship is a structure that can impact the patient treatment outcome. Not only the family structure that brings positive treatment outcome but the working together of MDT (Franklin, et al, 2015). Therefore, the patient relies both on family structure and the involvement of MDT for better survival and compliance to treatment care plan. Remarkable connections are shaped between individuals and their surroundings and with the person and other subsystems.

In this context, the patient forms significant relationships with different members of the MDT who share a common goal of achieving a quality patient outcome. A level in relation to honesty between practices ascertains the grade of connection and amalgamation (Tamas, 2000). Treatment must be individualised, recognising the systems within which the individual exists, or which impinge on his/her existence. The intervention is either direct or indirect, or environmental treatment.

To have a complete aspect of an individual, the systems theory assists in conceptualising the unlike systems moving an individual. Within the healthcare facilities, patients are seen by the MDT who brings their expertise to ensure the needs of the patient are attended to. In a multidisciplinary team (MDT), a holistic approach is viewed as a means of providing total care to individual patients (McLaughlin, 2015). The patient's medical condition is tackled by all the disciplines within the MDT in the healthcare setting. Moreover, systems theory complements, rather than excludes, traditional science. An example, to use an analogy, if scientific inquiry is used to examine phenomena under a microscope, those employing systems theory apply a wide-angle lens to see them (Bridgen, 2017). This means systems theory looks into the person in a wide range of other substructures that contributes to the cycle of a person. Systems theory offers researchers a means to understand phenomena in a fundamentally different way than does scientific inquiry.

2.5. SOCIAL WORKERS' EXPERIENCES IN WORKING WITHIN MULTIDISCIPLINARY TEAMS

There are several international studies on experiences of social workers in working with healthcare practitioners within the multidisciplinary healthcare setting. A study conducted in Canada on experiences of healthcare social workers revealed negative workplace experience which was found to increase the subjective experience of distress (Negura & Levesque, 2021). This is supported by the study conducted by (Sierra, 2020) on attitude of the medical profession towards the professional practice of healthcare social workers. The study revealed that physicians did not recognize social workers as a group of professionals who can give scientific advice in order to improve patient's health. This can be described as the long standing problem as social workers have to dig deep for their roles to be recognised (Eaton, 2018). Globally, social workers are increasingly being placed in integrated medical and behavioural healthcare settings however, information about the roles they fill in these settings is not well understood (Fraher, Richman, Zerben &Lombardi, 2018). Furthermore, the aforementioned author mentioned that social workers have not been included in the workforce planning efforts. The lack of recognition has resulted in a paucity of information about the scope and functions of social

workers employed in healthcare settings (Fraher, Richman et al, 2018). This means that the misunderstanding of social work identity hindered the functionality of social work practitioners within the health sector.

Collaborative practice lay out a system for interprofessional, patient-centred care. However, in practice, this does not always take place. A method of disorderly workplace communication behaviours has been associated with, aggressive or superior verbalization, intentional postponement in acknowledging to MDT meetings, and hesitation to unite as a group, and the "impatience with questions" (Croker, Grotowski & Croker, 2014). Often these behaviours are associated with the inappropriate use of power within a hierarchy. In fact, to promote optimal team functioning, inter-occupational teams require a clear understanding of roles and duties (CIHC, 2010). Individual team members bring varied levels of knowledge about the skills of other professions to the table (Lynch, 2011). The role of the social worker is not as all over eagerly appreciated as the role of other professionals such as doctors, lawyers, nurses, or teachers. Consequently, it is not a surprise that in the hospital setting, nurses, like many, have traditionally held confused perceptions of social workers (Feit, 2008). At the same time, Feit (2008) further discovered that social workers have not done an enough job to simplify their profession and advertise their functions in the hospital setting, which only promotes incorrect understanding. In support of Feit, social work practitioners as part of their various roles they play, they are responsible to educate team members on their roles.

Nurses' knowledge of social workers may also be put together by the dispute disagreements, which may occur in hospitals. For example, although discharge planning is to be expected look out as a social worker's role, certain hospitals rank nurses in the roles of conduct discharge coordinators (Britta, 2012). Furthermore, the study findings of Ryan (2012) discovered that the current management model in hospitals led to substandard partnership across social workers and nurses. Social workers encounter difficulties to their departments by not having a social work manager rather having a nurse or other professional as a manager. Having said that, it was clear that when management does not respect and understand the social worker's role, how can members of the team be expected to? In support of the above, social work component in different facilities of healthcare are still supervised by the medical management services. At this stage it thus seems crucial to consider proper management of social work services in healthcare to achieve better understanding of their role in MDT. Busari, Moll, and Duits (2017) alluded, that the key competency for effective collaboration includes communication domain, maintaining and sharing of knowledge and collaborative practice based on respect. In addition, Gaboury, Bujold, Boon and Moner (2009) reports that not only is open communication

necessary but also how the information is communicated, such as in a face-to-face manner versus through the passing of affected collaboration outcomes. In the study conducted by Parker-Oliver and Peck (2006), social workers working at the hospice found that having professionals from other disciplines with whom to discuss cases and obtain different perspectives was helpful when dealing with difficult issues. On the other hand, rigidity in the use of the medical model prevented social workers from being able to work with patients outside of complaints. The systems theory emphasises the holistic view of different levels of systems for better service outcome. Therefore, this means effective interprofessional collaboration requires good understanding for each other's role so that working relationship can be established.

The study by Nkuna (2016) presented results based on social workers' experiences in working within the multidisciplinary team at Charlote Maxeke Academic Hospital. It was revealed in her study that social workers are undermined and disrespected within the MDT. Subsequently, the poor functioning of MDT's has been associated with negative outcomes in pregnancy and delivery suites for patient care and newborn mortality (Zwarenstein, Goldman & Reeves, 2009). Cassel and Howe (2002) discovered that, in comparison to other professions, it was quite likely that social workers would be able to detect interprofessional partnership, due to greater understanding of it, greater cooperation, experience along with talents, and kept above anticipation recognizing the importance of working in teams and groups. In support of the aforesaid statement, as part of social work training, communication is the first and foremost key acquired skill for social work practice. This is alluded to by Pockett (2011) who perceives social work as being a profession that is well skilled to take a leadership role in interdisciplinary care, which should be affirming to social work. The researcher endorses this viewpoint by reflecting on her professional training in social work. The Global Social Service Workforce Alliance hosted its 12th webinar to discuss MDTs in communities and local health facilities. At this webinar, McCaffery (2013) illustrates how an MDT can approach situations or problems more holistically and systematically, resulting in more effective and better-informed decisions, less duplication and a greater likelihood of sustainability than professionals acting alone.

Social workers and nurses in hospitals often work together in interdisciplinary healthcare teams. The collaboration between these two professions can be enhanced through a better understanding of each other's roles, skills and practice expectations. Hospital social workers remain the only non-medical occupations functioning in the hospital setting. Hence,

professional ethics are one of the issues in hospital social work practice. The medical model of ethical judgment differs from social work models in that medical model accords a significant amount of weight to the overall ethical domain in a hospital (Pugh, 2011).

Health social work in the hospital setting has developed concerns resulted into emotional collapse, as caseloads, paperwork and waiting lists for services grow (Whitaker, Weismiller, Clark & Wilson, 2006). A higher level of stress among social workers is conceptualised to be linked to the nature of social work and the character of human agency in delivering help in highly emotional contexts (Hussein, 2018). The causes of burnout and stress among social workers include inadequate staffing, excessive workload, poor leadership, a lack of support, a lack of opportunity for skills development and a negative public image (Bove & Pervan, 2013). It is well established that burnout has negative consequences for the mind, body, and health.

Burnout according to Peterson, Demerouti, Bergstrom, Samuelsson, Asberg and Nygren (2008) can cause symptoms of despair and anxiety, as well as sleep disturbance, memory impairment, and neck and back pain. Burnout can cause health problems such as respiratory infections, persistent headaches and digestive problems, in addition to that, psychological and physical impacts, moreover it can also affect one's overall general health (Kim, Ji & Kao, 2011). Burnout is common in the field of social work, due to the frequent intensive interactions with clients and the strong demand for services (Whitaker et al., 2006; Schaufeli, Leiter & Maslach, 2009). Similarly, according to Acker and Lawrence (2009) social workers who work with clients who have severe and persistent mental diseases feel inept which leads to increased burnout symptoms. When coping with challenging situations, ethical difficulties can develop.

In addition, the study findings by Shelley, Andrew, Michelle, Linda Gina & Jennifer (2020) confirms the literature on the stresses of social workers and provide an account of the ways in which social workers sought to reconcile their mental health needs with their role as professionals. (Miller, Grise-Owens, Owens, Shalash & Bode, 2020) emphazised that social workers have a "duty to take necessary steps to care for themselves professionally and personally in the workplace and society". However, in spite of the aforesaid challenges of self-care is an important tool to relieve workplace stress or professional burnout. Since social work profession enhance the well-being of all people, self-care is an integral component of social work practice (Newell,2017).

Limon's (2018) study findings indicated different perspectives and scopes of practice in the MDT. Each profession has a different perspective on how to approach a situation. Findings further explore the lack of understanding of the social worker's role and the scope of practice within the interdisciplinary team. From this finding, health social work explored working in a medical field as being challenging in terms of knowing medical issues such as diagnostics and

medical terminology. On the other hand a study by Beytell (2014) on the fieldwork education in a health context regarding the experiences of fourth year Bachelor of Social Work (BSW) students, who were part of a MDT, revealed that the social work practice and role is determined by the institutional context in which they work as well as the dominant discourses and policies. The students in the study further emphasised the power possessed by the doctors in health facilities, which indicated that the patient and social worker's opinions are subordinate.

2.6. SOCIAL WORKERS' ROLE WITHIN THE MULTIDISCIPLINARY TEAMS

In the MDT, it is vital to know what functions do social work practitioners play therefore it is critical to describe psychosocial factors and treatment as the main primary function of the social work intervention in the healthcare setting. Upton (2013) describes psychosocial factors as the relationship between psychological factors and the physical body that can be influenced by social factors. These effects are then mediated through psychological understanding. Examples of psychosocial factors included social support, loneliness, marriage status, social disruption, bereavement, work environment, social status and social integration.

The social work practitioner works closely with individual members of the MDT. Social workers become involved with patients at different stages of the rehabilitation process, depending on what problems the patient and his/her family may have Brannan, Manso & Brownsell, (2009). Some patients will need advice and information from the social worker early in their journey of care because of different social problems such as financial, relationship or housing issues.

Tadic, Ashcroft, Brown and Dahrouge (2020) is in support of the aforesaid that social workers assist a range of patient populations and provide services in areas including mental health conditions and addictions, chronic disease management, children and youth illnesses, geriatrics illnesses, grief, trauma, parenting issues, palliative care, dementia and other neurological issues, financial stressors, housing issues and a broad range of other general psychosocial issues. In practice, social work practitioners are required to have a wide knowledge of resources in the community so that they can advise the team and the patient about what is available for the patient upon discharge. The social worker provides the MDT with a bio-psychosocial view of the patients' strengths and needs through the use of the person-in-environment model of assessment. A study conducted by Craig, Eaton, Belitzky, Kates, Dimitropoulos and Tobin (2020) on social work model of interprofessional collaboration in hospitals, the key findings was that social workers are empowering collaboration by actively communicating

(building relationships, holding information, and filling gaps), proactively educating (training the team, advocating for patients, and teaching about systems) and Managing risk (troubleshooting discharge and avoiding liability).

When professionals work on MDT, they have different but complementary skills that contribute to the overall effort. However, they might not share the same communication skills and styles. Without good communication, confusion and misunderstanding can diminish the teams' ability to achieve its goals (Contributor, 2021). Effective communication is the skill important for any profession, however more so in social work (Farukuzzaman & Rahman, 2019). Communication in social work practice is central in building relationships with service users and carers (Tylor, Coffey & Kashner, 2016). This means communication is the key tool in social work practice. Social workers play a vital role in the helping process by exchanging information related to their patients and their needs. By actively communicating, the social worker communicates with the patient, the family members and the key people in the patient's environment (Farukuzzaman et al, 2019). As part of their roles, social workers in MDT, they ensure that care is person centered by providing information about support options.

2.6.1. MDT role in Chronic Disease Management

Collaborative care in patient management has the potential to improve health outcomes and reduce disease burden and healthcare costs for those living with chronic conditions (Tapp, Phillips, Waxman, Alexander, Brown & Hall, 2012). Since the care of patients with multiple chronic diseases such as diabetes and depression accounts for the majority of healthcare costs, effective team approaches to managing such complex care is needed since psychosocial and physical disorders coexist (Sierra, 2020). For patients, the MDT improves care by increasing service coordination, integrating healthcare fora wide range of health needs, empowering patients as active partners in care, orienting to serving patients with diverse cultural backgrounds and allowing patients and healthcare providers to spend their time more efficiently (Tapp et al., 2012). Multidisciplinary working begins in hospitals and continues to after discharge. To supplement the efforts of the primary caregiver, the team members provide support and share care tasks. Medication management, supplementing patients' knowledge with education about medication, patient follow-up, adherence support and self-management support, as well as health behaviour change are among these roles (Heart Foundation, 2010). The WHO defines cardiac rehabilitation as activities that favourably influence the underlying cause of the disease and the provision of the best possible physical, mental and social conditions, so that patients may, by their own effort, resume as normal a place as possible in the community (Hussain & Wooller, 2004).

A range of needs necessitate a multidisciplinary approach to the care of cardiac patients because of their congenital condition. Patients with congenital heart disease require special medical attention. These people are moving from paediatric to adult treatment, and their needs are often distinct from those of patients with adult-onset cardiac vascular disease. Because these patients have lifelong emotional, psychological and financial concerns in addition to heart anatomical and mechanical issues, the MDT approach is required to give optimal therapy. A comprehensive collaborative care team provides shared expertise to care for patients with heart diseases. A collaborative approach necessitates a detailed grasp of the patient's underlying cardiac disease as well as open communication among team members. The MDT would work closely to ensure quality service delivery and integration (Hussain & Wooller, 2004). Because of its ability to deliver and organize a variety of responses to persons with complex health and social care needs, the MDT is effective in mental health. The MDT manages a variety of mental health disorders by giving treatment, care, and support to mental health consumers. The MDT makes the shared decision-making easier by giving patients additional opportunities to talk about their medical and social issues.

The MDT also forms part of palliative care team. Multiple dimensions are involved in caring for palliative patients such as physical, social and psychological dimensions and those with close links to the family. Different health professionals work closely with each other sharing discussions on ward rounds and between such times, so that there is collaboration rather than disciplines working independently on what they believe to be their merit of a patient's care. Social workers have the responsibility to provide emotional support and guidance throughout the entire process. Moreover, a study by (McGill, Blonde, Chan, Khunti, Lavalle & Bailey, 2017) on global partnership for effective diabetes management recommended the implementation of an interdisciplinary team approach to type 2 diabetes management as one of ten practical steps for health care professionals to help more people achieve their glycaemic goal. Interdisciplinary approach to diabetes care provision has previously been reported to provide the greatest positive impact on glycaemic control in people with type 2 diabetes. The MDT care model for HIV has been shown to improve clinical outcomes among HIV patients (Elgalib, Sawafi, Kamble & Harth, 2018). Team members work together through care pathways to support patients as they go through the HIV care continuum from diagnosis to viral suppression. MDT has further been proven to enhance clinical outcomes among cancer patients.

The team members in this regard communicate and consult using a variety of tools including patient health records (Heather, Jasmine, Goffrey, Dunn, & Latini, 2020). The authors further indicated that oncology nurses collaborate with oncology social worker and other members of the wider interdisciplinary team to ensure patients timely access to quality care and referrals. This improves immediate and long-term treatment related outcomes.

2.6.2. Role as a Patient Advocate within the Multidisciplinary Team

Advocacy is central to the social work professions' commitment to social betterment and practice (McNutt, 2010). This means social workers represent their client's needs in various authorities of government by addressing psychosocial issues that affects their well-being. Subsequently, social workers practising in healthcare settings advocate for the needs and interests of clients and client support systems and promote system-level change to improve outcomes, the access to care and the delivery of services (NASW, 2016). Social workers play an active role in community education, speaking on behalf of their healthcare teams and institutions about disease prevention and health promotion. The health social worker plays an integral role in fostering, maintaining and strengthening collaborative partnerships on behalf of clients, families and communities (Klein, 2015). The social worker's role is to empower MDT members with the knowledge, resources and understanding of the client system (McNutt, 2010).

The position of the social worker is to promote advocacy and communication among patients, families, hospitals and the community (Researchomatic, 2010). This provides important inputs of social workers in providing effective case management. Social workers advocate for self-determination to ensure that the patient's wishes are followed (Klein, 2015). In this case, social worker provides the opportunity for the sharing of feelings. The social worker also assists the family with financial planning. Social workers further facilitate communication among the patient, his/her family and the healthcare professionals involved. Social workers coordinate with caregivers and community resources to broaden the circle of team care which ultimately provides a comprehensive and continuous care plan. As indicated by prior authors, social workers collaboratively assess the needs of the client and the clients' family. In doing so, the social worker arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific clients' complex needs (SSWLHC, 2015). Moreover, the social worker works collaboratively with other professionals to maintain a team-oriented approach to case management. This approach is proven to incorporates the patient and family in care decision making (SSWLHC, 2015).

Social workers have the ability to bring systems perspective to their work and they can contextualised the concerns that their patients and their families have, they are able to assist the team to understand the complex family dynamics. Social workers play a vital advocacy role in many different teams, including the areas of oncology, transplantation, psychiatry, addictions, complex case management and rehabilitation. Advocacy means to ensure that the needs of patients and families are not overlooked. This level of empathy is essential when working with individuals and families who are coping with acute or chronic illness, healthcare treatment plans, end-of-life care, long-term wellness planning and mental health needs (Klein, 2015).

2.6.3. Role as a Discharge Planner within the Multidisciplinary Team

Discharge planning is a series of actions designed to involve patients and their families in weighing various choices for easing a patient's transition out of the hospital and arranging for post-hospital care and services (Boland, 2006). Case managers, including nurses, and social workers provide essential services to hospitalized patients, including mandating discharge planning (Hunter, Nelson, Birmingham & Jaclie, 2013). Social workers are an integral part of the healthcare team to provide patients with a safe discharge plan, appropriate community resources, and aid in ameliorating the impact of negative social determinants (Rowlands, Shaw, Jaswal, Smith & Harpham, 2015). A study by Eaton (2018) on examination of the primary professional responsibility for discharge planning in all hospitals serving older adults in Minnesota, the quantitative analyses determined that half of the hospitals considered discharge planning as the primary responsibility of the social worker. In addition, the social worker's role in the MDT includes coordination between patients, families, community agencies and MDT members. In support of the above, it was noted that non-involvement of social workers in discharge planning contributed to readmission of patients (Hunter et al, 2013). This means patient's being are discharged without proper after-care plan which increases risks of readmission.

Discharge planning is an important part of patient care since it organizes and coordinates the patient's movement from one side to the other levels of care (Rowlands et al., 2015). Through education, collaboration and efficient communication, the ultimate goal is to prepare the patient and caregiver for post-discharge care (Coleman & Fox, 2004). Social work practitioners play an important role in discharge planning as part of the MDT. As the time of discharge approaches, the social worker will normally become more involved with patients, especially those who have complex needs.

The primary focus of discharge planning is to facilitate the promotion of independence and rehabilitation as well as to prevent readmission or further unwarranted treatment (Holliman, Dziegielewski & Datta, 2001).

The social worker will complete community care assessments for patients in consultation with the MDT, patient and his/her family. The social worker will then go on to work with the patient and the family for the period after discharge to ensure that the rehabilitation plans are meeting their needs. In this case, a level of trust between the various experts has been regarded necessary, yet there is sometimes a contradiction between nurses' 'service-led' approach and the needed attitude of social workers. It must be noted that social workers are more than just discharge planners, they provide therapeutic interventions such as counselling to enhance the discharge planning process (Costa, 2021). As such, psychosocial care and support are functions of the social worker. The management of psychosocial concerns that may arise can complicate discharge planning. As a practising social worker, in the researcher's facility of practice, the need for cooperation and interdisciplinary working is critical. In both practice and ethics, social workers find themselves compromising their autonomy in order to foster collaborative problem-solving.

An effective discharge planning requires a competent MDT to evaluate and treat patients holistically from a bio-psychosocial standpoint (Mudge, Laracy, Richter & Denaro, 2006). It has been proven that effective discharge planning can improve recovery rates and reduce hospital costs (Jenkinson, Wheeler, Wong & Pires, 2020) It is critical to include stakeholders such as the patients and their families or carers in discussion about treatment options and decisions regarding their well-being (Grimmer, May, Dawsons & Peoples, 2004). The strategy of decision-making ought to be concurred upon by all the stakeholders included. The preferred options, concerns and inputs of the patients, caregivers and MDT ought to be together included within the choices (Orchard, 2012). Social workers emphasise the importance of relationships for their work with people, perceiving it as fundamental for the best social work practice. Building a rapport and empowering relationships were thereby significant aspects, especially for working successfullywith patients and their families as well as facilitating teamwork with the MDT. Relationships within the wider health and social service networks were needed to facilitate collaboration andensure a well-ordinated healthcare system. Therefore, social workers develop extensive relationships with external stakeholders across a range of sectors including the health, disabilityand judicial/legal sectors. Further connections are maintained with cultural and spiritual-based organisations.

2.7. BOUNDARIES IN RENDERING MULTIDISCIPLINARY COLLABORATION

The medical model according to Thompson (2013) has a series of linked power dynamics with doctors being the dominating professional group. Hospital social work, like many other professions, has historically evolved in the context of medical domination and has been shaped by it. As a result, social work has historically operated within the boundaries set by this hierarchy (Perriam, 2015). According to Perriam (2015), hospitals are viewed as medical facilities controlled by medical professionals. The medical model concentrates on sickness and treatment by doctors, who are viewed as the professionals with the most competence and skill to treating ailments. The medical model elevates the medical profession's status and authority. According to the researcher's own experience the MDT does not work, roles and professional boundaries are blurred. Social workers are faced with issues of power and dilemmas around the distribution of power and status between different professions. How is this then impacting the practice and decision-making? The study conducted by Hayes and Kang (2014) revealed a lack of understanding of the importance of various professional roles and how they are allocated within the multidisciplinary care team. In multidisciplinary teamwork, professional knowledge boundaries can become blurred and professional identity can be challenged as roles and responsibilities change. Such changes can generate discomfort, anxiety and anger in team members, as they struggle to cope with the disintegration of one version of a professional identity before a new version can be built.

There are many common and distinct social and medical models of knowledge and practice within the professions (Hall, 2005). One of the fundamental failing course besides difference across professions appear throughoutthe subject of knowledge distribution and the amount put down on confidentiality and explanation thereof. The relationship between professional identity and collaborative practice remains complex. Professional identities have sometimes been depicted as a barrier to interprofessional education and working. It has been suggested that the struggle by each healthand social care professional to define its sphere of practice and role in patient care is a major factor in determining how the professions have developed in 'silos' (Hall, 2005).

The study findings of Miller (2016) emphasized the need of a collaborative culture in such a company. Leadership was highlighted as a key factor on how well collaboration occurs since formal and informal leadership reinforce collaborative ideas to the rest of the team. According to Miller (2016), collaboration begins with an understanding of one's role as a social worker. The findings highlighted the importance of social workers being competent in their roles and confident in their identities. However, the lack of clarity in the social worker's role can lead to challenges in collaboration. Decision-making processes were recognized as a barrier when discrepancies between such professions were developed. Interprofessional collaboration was also regarded as requiring excellent, whilst bad communication was described as a barrier to cooperative contributions. Whitehead (2007) used the example of interdisciplinary teams in which patient communication occurs around the doctors' timetable, strengthening the doctors' importance. The degree to which collaboration occurs is determined by the question of power.

Interdisciplinary teamwork can suffer as a result of a weak ethical environment (Rathert & Flaming, 2008). It also has the potential to increase frequency and intensity of ethical problems within the organisation (Ulrich & Soeken, 2005). When disciplinary groups are seen to have uneven status, the dominant group can set expected performance criteria and practices in ways that limits the contribution of other group members (Atwal & Caldwell, 2005). A survey conducted with Canadian social work practitioners employed within family health teams revealed that the key barriers included difficulties associated with a medical model environment, confusion about the social work role and organisational barriers (Ashcraft, Mcmillan, Ambrose, Mckee & Brown, 2018). Given that social work is performed in a hospital setting, where the primary job of the agency is medical treatment rather than social work, social workers are frequently regarded as second-class citizens. In the host context, power and prestige are concentrated in the hands of physicians who lead a hierarchy of lower-status fields (Gregorian, 2005). Physicians with this level of differential power can lead ethical practices and deliberations in the hospital and use the principles model. Tension also arises between differing explanatory models such as the social and medical models.

2.8. IMPROVING THE FUNCTIONING OF THE MDT WITHIN THE HEALTHCARE SETTING

Studies have shown that a 'systems approach' to the working of the MDT can reliably assess its quality, thus allowing for interventions that can lead to the improvement thereof. A comprehensive participation of all the MDT members is crucial for a successful collaboration. Furthermore, a full contribution includes the arrangement for and taking care of the inter-occupational gathering, which require a reasonable amount of time from all the team members. A study conducted by Jalil (2014) on improving the efficacy of the cancer MDT in urology revealed the framework of the "input and output process and outcome". This framework has been used to evaluate healthcare and teamwork quality. According to this study, these concepts have been used to build upon the "pillars and buttresses" of quality assurance and various other components, specifically affect how the MDT works.

Jalil's study (2014) further indicated that clinical decision-making by the MDT is shaped by many elements including the presence of central team members, the process of case discussion, the details at hand once acquire resolution, team leadership, preparation for meetings, facilities and equipment, and the administrative process. Sufficient patient information should be available to the team to discuss and decide upon a treatment option. The MDT is thought to improve communication and coordination by weighing up treatment options for patients. To achieve this improvement, the organisation, and the set-up of the meeting require good coordination (Jalil, 2014). There is a need for an MDT coordinator to maintain a smooth and coordinated meeting. The MDT coordinators help in the introduction and changes to the pro forma used to ensure that all the patients are discussed and considered correctly, and the conclusion are documented and re-evaluated.

The MDT coordinator ensures that a proper number of patients are discussed at the meeting. Furthermore, they play a critical role in carrying the reporting delay across the service provider and the patients to improve patient-centred care. The role of the MDT chairperson is central to the successful coordination of the gathering. The MDT chair members exercise a broad range of functions and have fundamental duties. These include ensuring the integrity of the team functioning and achieving team cohesion and goals in a timely and effective manner. These functions can only be distributed in a setting of teamwork between different professionals on the team and in contribution to decision-making. A positive working relationship between the MDT chair, MDT coordinator and other team members is critical to the successful functioning of the team (Jalil, 2014).

Jalil (2014) illustrates that training can help each member of the team to function optimally especially in bringing the relevant information to the meeting that can contribute to the decision-making process. Further, training opportunities are available to support individual roles. Learning can be achieved from gathering information about patients when studying case notes. It can be gained by attending MDT meetings for an interactive discussion. These meetings can be vital resources for doctors in training as well as nurses and other healthcare professionals.

A study conducted by Taylor, Shewbridge, Harris and Green (2013) on the benefits of the MDT work in the management of breast cancer revealed five domains required for effective teamwork in the MDT. These domains include the team, meeting infrastructure, meeting organisation and logistics, patient-centred clinical decision-making and team governance. The findings by Hellier, Tully, Forrest, Jaggard, MacRae, Habicht, Greene and Collins (2015) suggested the benefits of the communication "culture" of an MDT, which results in the increased benefits for the wider team members.

2.9. GUIDING FRAMEWORK THAT INFORMS THE CONSTITUTION OF THE MDT IN THE HEALTHCARE SETTING

According to the Ministry of Health (2012) framework that provides MDT guidance, a successful MDT has the following characteristics:

2.9.1 The Team

The team must have a meeting protocol such as written protocols describing the healthcare facility and the content of the meeting. Terms of reference must be established to govern the multidisciplinary meeting. Terms of reference must clearly describe the vision and purpose of the team. The chairperson must be chosen in accordance with the terms of reference for the MDT, and must ensure that the members adhere to the clinical protocols. The chairperson must ensure that all the affairs applicable to each patient's upcoming supervision are presented and discussed. All the members must cooperate in the meeting as appropriate to their speciality. Furthermore, the chairperson must outline the discussion and define agreed suggestions. The recommendation is documented by the MDT coordinator during the meeting.

The MDT membership includes clinicians, pathologists, radiologists, nurses, dieticians, physiotherapists, social workers, psychologists etc. The membership may vary with a core membership team attending every meeting and additional members attending when needed. Core members must be available for the consultation of all the cases where their contribution of work needed. The chairperson chooses whether there is a sufficient representation at a single meeting to make safe recommendations about any or all of the patients. The chairperson will decide on the needed action if there is insufficient representation at a single meeting. A record of who attends each meeting is kept.

2.9.2 Meeting Organisation

Referral pathways are established with clear information as to who can refer, how to refer, and the timeframes within which referrals are expected. Referral pathways should be aligned with the national agreed referral pathway. The MDT is a team with the active participation of all its team members during MDT meetings. This is a meeting where all voices are heard with no hierarchy. The MDT should have the agreed criteria for the patients and the recommendations for treatment and care planning should be discussed. No case should be discussed in the absence of the lead clinician or their delegate for that case. The standard treatment protocol used will align with the current evidence-based care or best practice. Support and palliative care needs are also discussed in this meeting.

The MDT coordinator improves and maintains communication. Coordination ensures that all the MDT meetings are ready timeously. The treatment recommendation agreed upon by the members must be documented in the patient's file during the MDT meeting. The decisions made by the MDT should be collectively agreed upon and documented.

2.9.3 Meeting Infrastructure

A regular meeting time is set, preferably in a dedicated manner of an appropriate size and layout. The meeting place should be easily accessible for all members as significant travel is a deterrent to attending a MDT meeting. Audio-visual and videoconferencing equipment must be available to help the MDT meeting to be more effective and efficient.

2.9.4 Data Collection and Monitoring

Core data should be collected before the meeting to monitor and audit patients' pathways from various healthcare facilities.

2.9.5 Patient-centred Care

Patients must be informed about the recommendations from the MDT meeting in consultation with the members of the treating team. Patients should also be routinely offered verbal or written information about all the aspects of their treatment choices, including supportive care.

2.10. SUMMARY OF THE CHAPTER

In summary of the literature review above, this chapter provided an overview of the fields of social work practice, the historical development of health social work in the hospital setting, the health system from global to South African context. The researcher found that hospital social workers engage in a remarkable diversity of roles within the MDT in a healthcare setting. The experiences of health social workers indicate gaps in the knowledge of the profession by the members of the MDT and health professionals at large. The chapter presented boundaries in rendering effective multidisciplinary collaboration and legislative framework relating to the hospital social work practice.

The next chapter includes the research design and methods. The researcher discusses methodology including paradigm adopted for the research study. The chapter further discusses sampling process, method of data collection used, pilot study, data analysis which includes six phases for thematic analysis. Furthermore, trustworthiness and ethical considerations in discussed in detail and finally the summary of the chapter.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

As highlighted in the first chapter, the study strategy describes the processes together with means embarked on in the management of the research. In this chapter, a researcher outlines the research methodology, the study paradigm, approach, research design, research instrument and data collection. The chapter also highlights the ethical considerations and the trustworthiness of the enquiry. The option on specific strategy to utilize is driven as per intent as well as goals of the research. Hence, the overall intent of the research was to explore experiences of social work practitioners in working with healthcare practitioners within a multidisciplinary healthcare setting. To attain the aim of the investigation, four goals came about, namely: (i) exploring how social work practitioners describe their experiences in working with health practitioners in a multidisciplinary team; (ii) exploring social work practitioners' understanding of their role within the multidisciplinary healthcare setting; (iii) examining the social workers' awareness of their practice boundaries when engaging with other disciplines within the multidisciplinary health care setting; and (iv) proposing recommendations for enhancing the overall functioning of the multidisciplinary teams.

3.2 METHODOLOGY

Qualitative examination looks for probe to individual's emotional state, exposure to behaviours including attitudes (Labaree, 2009). The researcher wanted to explore the social work practitioners' experiences in working with healthcare practitioners within a multidisciplinary healthcare setting, hence the qualitative approach was found to be the most suitable approach for this study. Qualitative research is a type of scientific research that consists of an investigation that seek answers to a question and collects evidence (Crossman, 2018). Qualitative methods are chosen because they are more flexible, and they allow a greater adaptation of the interaction between the researcher and the participants.

3.2.1 Paradigm

The researcher focused on the interpretivism paradigm to better understand the experiences of social work practitioners in working with health practitioners within the multidisciplinary setting.

The use of an interpretive paradigm in this research is based on the belief that the participants become actively involved in all the phases of the process (De Vos, 2011). The interpretive paradigm is concerned with understanding the world as it is from the subjective experiences of individuals. The interpretivist paradigm is rooted in the fact that the methods used to understand the knowledge related to human and social sciences cannot be the same as their usage in physical sciences because humans interpret their world differently and act based on such an interpretation while the world does not (Hammersley, 2013). Denzin and Lincoln (2003) clarify subjective exploration as including an interpretive naturalistic way to deal with the world.

3.2.2 Research Approach

The qualitative research approach studies people in their natural setting and interprets phenomena in terms of the meanings people attached to them (Crossman, 2018). The qualitative approach was the selected study method for the study. This type of approach was selected because its gives participants the opportunity to state their view points on the phenomena.

3.2.3 Research Design

The research design refers to the planned strategies of inquiry within the quantitative, qualitative and/or mixed methods approaches, which involves the interaction of the philosophy that guides the researcher in a specific direction when conducting the study (Creswell & Creswell, 2018). The authors highlighted the selection of research methods, including the data collection and analysis. Creswell and Creswell (2018) further state that the research design is a strategic framework for action that guides the research activity to ensure that sound conclusions are reached. Maxwell (2013) describes five components of a good research design, namely, the goals of the research, the conceptual framework, the research questions, the methods and the validity of the research.

In this study, an exploratory descriptive design was found to be the most suitable pattern, as the investigator desired to describe the experiences of health social work practitioners in working with health practitioners within a multidisciplinary setting. Delport and Fouché (2011) proposal to combine explorative and descriptive components made efficient use of this investigation. The explorative part was utilized because the study sought to gain insight and understanding of the experiences in working within the multidisciplinary teams.

In this context, the investigator desired to have knowledge of everything social work practitioners understood about their role in the multidisciplinary healthcare setting. The descriptive part, on the other hand, was used to seek the participants' in-depth descriptions of such experiences through the answering of questions. The investigator desired to ask for answers on the way in which social work practitioners describe their experiences in working with health practitioners within the multidisciplinary healthcare setting. As mentioned earlier, the researcher believes that a combination of an exploratory and a descriptive design was the most appropriate approach to explore the experiences of health social work practitioners in working with healthprofessionals.

3.2.4 Sampling Procedures

In this section, the researcher discusses the study population and sampling and sampling methods. Babbie and Mouton (2014) defines population as the totality of persons from which a sample is drawn in order to study a particular research problem whereas Moule and Goddman (2014) define a sample as a subset of the population selected through a sampling technique. This is when the researcher makes a choice of who needs to be interviewed. Healthsocial workers were the chosen population particularly because of their speciality in the field of healthcare. In this study, health social workers employed by the KwaZulu-Natal Department of Health who fall under King Cetshwayo health district were the populace from whom the sample was selected. Out of 216 social workers employed by the KwaZulu- Natal Department of Health, 25 social workers were employed by King Cetshwayo health district and they served as the population study (kzn-health, 2018). As stated, the selection of this population was based on the nature of the research problem and the relevancy of the population into the study phenomena.

Non-probability sampling was found to be more convenient for the researcher because the population of the study was not amenable to probability sampling, as the researcher was unable to find the entire population (Brink et al., 2012). It has assisted the researcher to select the core contributors who knew the most about the phenomenon under study. Therefore, the sample that was used in this study was purposive sampling. Mack, Woodsong, MacQueen, Guest and Wamey (2005) describes purposive sampling as applicable while the participators are selected according to preselected criteria that is relevant to a selected research question. In purposive sampling, the researcher is quite deliberately subjective in choosing those participants who will suit the reason of the research. The sampling units are selected for a particular purpose based on the institution club and experiences of the participators (Holloway

& Wheeler, 2010; Harding, 2013). The sample in a research study looks at the choice and decision of the personal representative of the study population (Babbie, 2009). Useful sampling provides a rich description of records, which improves its transferability (Babbie, 2009). The participants were chosen using the non-random method (Brink et al., 2012). The participants of this study were social work practitioners who are members of the King Cetshwayo Health District Forum. The selection was based on two main criteria for inclusion which was the exposure to a multidisciplinary team and the employment in a healthcare setting within the King Cetshwayo Health District. Social work practitioners employed in other departments were excluded in this study.

The chosen sample was the members of the King Cetshwayo Health District forum. A forum is a group of people who meet on a regular basis as prescribed in the health departmental policy to discuss the challenges, best practices and new developments associated with their work and profession. The forum applies to all full-time social workers employed by the KwaZulu-Natal Department of Health in terms of the Public Act of 1994 (DOH-KZN,2008). This structure was found to be relevant to the phenomenon and the research problem being investigated. Thus, the functions include discussing matters of a common nature that may impact upon the functioning of the health social workers within the KwaZulu-Natal Department of Health. After the letter of support was obtained from the District Director, the chairperson of the forum was contacted to request a slot during the forum meeting in order to introduce the study. There was a presentation on the proposed study followed by the recruitment of participants which was conducted via the email obtained from the chairperson of the forum. In the context of this study, a sample size of 19 participants was recruited however only 16 members participated. Out of sixteen participants, two participants were unexposed to the MDT.

3.3. DATA COLLECTION

According to Babbie (2009), a qualitative interview is an interaction between the researcher and the participant, where the researcher establishes the general direction for the conversation. At this interview, the researcher uses open-ended questions based on the key objectives in the semi-structured interview guide. Rubin and Babbie (2005) outlined that the advantage of an interview guide is that it lists an outline of the areas that the interviewer would like to cover for consistency in a conversational manner, which gives the interviewer freedom to probe into responses.

Due to COVID-19 global pandemic (WHO, 2020), the data collection method was diverted to individual telephone interviews. During the data collection process, all the interviews were conducted in English hence it is a global common spoken language. The researcher used the self-developed interview guide as a data collection instrument as well as adigital voice recorder. Voice recording was chosen as the form to record interviews, as it records the exact words of the interview and the questions asked. The recorded data was transcribed immediately into written form for closer study. Interviewing requires interviewing skills, which the researcher possessed during her professional training and fieldwork experience. The information was kept safe, with the access thereof limited to the researcher and the supervisor.

Interview guides were electronically emailed to the participants prior the actual telephone interview. This was to allow the participants to familiarise themselves with the questions. The interviews were conducted from 22 May 2020 to 29 June 2020. Each participant's telephone interview was approximately 30 to 45 minutes. Each participant was thanked for agreeing to participate in the study.

3.4. PILOT STUDY

To determine whether the data collection instrument was effective and whether the type of questions asked was applicable, relevant and appropriate, a small pilot study was completed. This was the small study of three female participants exposed to the MDT. They were selected from the participating district, however, they were not members of the forum. As mentioned in the first chapter, piloting was necessary to test the research tool and to modify it before the study could be conducted. A pilot study was conducted on three health social work practitioners who were not part of the sample that was later selected for the main study. All the pilot study participants commented that there was no particular need to change any of the questions. However, they proposed the change of the order of questions. They also reported that they liked the informal structure of the interview.

3.5. DATA ANALYSIS

An analysis of the data in qualitative studies involves an examination of the text rather than the numbers. As indicated in chapter one, a thematic qualitative data analysis was used to analyse the data collected from the participants. Thematic analysis is a method of identifying, analysing and reporting patterns (themes) within data (Braun & Clarke 2006).

It is important to examine what counts as a theme. The researcher used manual analysis, which involved a thorough review of all the recorded information that the researcher had obtained during the data collection process (Brink et al., 2012). Braun and Clarke (2006) define a theme as capturing "something important about the data concerning the research question and represents some level of patterned response or meaning within the data set". The prevalence of a theme may occur both within each data item and/or across the whole data set. However, the relevance of the theme is determined by whether it captures something important about the research question. Braun and Clarke (2006) describe six phases that are necessary when doing thematic analysis, namely:

Familiarisation and Immersion

The first phase was for the researcher to immerse herself in the written text together with recorded file noticing for a pattern and meaning. The memory bore refreshed by repeatedly reading interview notes. The data was collected through telephone interviews, which were recorded using an electronic device. However, due to the poor telephone lines and a problem with the device, some information was not clearly recorded. In those cases, the researcher used interview notes collected electronically. This was to ensure that the data collection process is not affected. In this phase, the investigator acquainted herself with the data by scrutinizing the recorded facts repeatedly.

- Generating Initial Codes

This is the second phase followed by the researcher in analysing the data. In this phase, the researcher organised a transcript and identified the data analysis. The researcher used different colours to differentiate potential codes for a potential theme. If a part of the transcript fitted in more than one code, it was repeated under the relevant coloured heading.

- Searching for Themes

In this phase, the researcher sorted different codes into different themes. This is the phase where the researcher was able to identify patterns and see the outcome prior to release along in ordinary reality. This process gave the researcher an opportunity to identify significant data to be organised into meaningful groups.

- Reviewing Themes

The researcher reviewed the themes to ensure that the data within the themes meaningfully cohered together. The researcher further refined and produced a thematic mind map showing the relationship between the codes, the subthemes, and the themes. The researcher was able to look for the words used frequently.

- Defining and Naming Themes

The analyst looked for similarities, categories, topics, and comparisons, and re-examined the first coding handle in arrange to create a more comprehensive investigation of the information. After re-examining the set of data, it was conceivable to title and characterize the subject. The researcher was able to identify and name the themes thus giving them greater meaning.

- Producing the Report

This is the phase regarding the interpretation of and checking the relevance of the data in the research questions. The themes were compiled into a report that sought to answer the research question.

3.6. THE TRUSTWORTHINESS OF THE STUDY

As mentioned in first chapter, the researcher assessed the trustworthiness of the study by using Lincoln and Guba's framework (2013). Polit and Beck (2008) as well as Lincoln and Guba (2013) suggest four criteria for developing the trustworthiness of a qualitative study, namely:

3.6.1. Credibility

Credibility checks the extensiveness to which the investigator has chased the acquired process in attending a subjective research (Kaunda, 2012). Data was collected directly by the researcher. The participants' experiences was completed by utilizing deliberate selection of 16 participants. To ensure credibility, the investigator further used and compared different data sources to verify the credibility. The investigator strongly presumed that the participants remained decisive point of supply of data, as they were qualified social work practitioners who had undergone social work training and were exposed to the MDT within a healthcare setting. Furthermore, the researcher used her skills such as listening, building rapport and interviewing to ensure accurate recording of participants' view point. According to Prior (2017) building rapport is the process of ensuring pleasant attitude creating closeness between the researcher and the participants.

The researcher experienced difficulties in establishing rapport and support vocalizations since interviews were conducted telephonically due to Covid-19 pandemic. That means the researcher was unable to respond to visual cues. In this case, the researcher used her listening technique which was acquired during her professional training. Listening is an important component to successful interviewing.

3.6.2. Transferability

Transferability necessitates the analyst's appropriate interpretation of the subject matter inside the research (Kaunda, 2012). In this study, extensive explanation of the outcome supported with verifying direct quotations from the participants were found to affect followers capacity to make judgments concerning the transferability of the outcome.

3.6.3 Dependability

The research's findings should be consistent and precise, allowing anybody who reads it to contribute to the investigation's appropriateness by following the investigator's judgement and action utilizing a check into track (Holloway & Wheeler, 2010). The investigator guarantees that the facts composed are fixed beyond a period of time. Research processes such as the details of the research design, research questions and the researcher's role are described in detail to ensure dependability. The researcher compiled an interview guide linked to the objectives of the study as a method used to collect data. Clarification of the interview process was conducted, and participation was voluntary.

3.6.4 Confirmability

The term "confirmability" refers to the notion that the facts must not be influenced by an investigator's prejudice along with intrusion. In this instance the researcher transcribed the recorded data after each telephone interview. It must thus indicate an expression of the participants (Polit & Beck, 2014). Though the data collected telephonically, verbal, and written permission was obtained before the actual telephonic interview session occurred. The participants' views were taken into consideration without discrimination and interference of the researcher's own experiences and views.

3.7.ETHICAL CONSIDERATIONS

Ethics within systematic inspection are alluded to mutual affair between investigators which is considered appropriate and inapplicable when administering a research (Babbie & Mouton, 2001). Polit & Beck (2008) describes 'ethics' as a set of moral principles and values that would apply during the research project.

3.7.1. Informed Consent

According to Creswell (2009), the participants are to be provided with sufficient information about the study, so that they can make an informed decision about whether to participate. Informed consent forms were emailed to the participants. Responding to the email was an indication of agreeing to participate. The researcher obtained a voluntary informed consent form before the commencement of the data collection.

3.7.2. Respect for Individual Autonomy

The right to self-determination is known as autonomy. The participators were free to choose whether to participate or not. This was done without fear of punishment or unfavourable critique (Polit & Beck,2008). Many participants places their signatures on the consent forms to indicate their decisions.

3.7.3. Justice

The rights to a fair selection, treatment and privacy are referred to as justice (Polit & Beck, 2008). Telephone interviews were scheduled in agreement with participants' suitable time and date.

3.7.3. Compensation

There was no compensation agreed upon between the researcher and the participants. The participants also did not face any financial charges.

3.7.4. Participants' Confidentiality

Polit and Beck (2008) state that a promise of confidentiality is a pledge that any information which the participants provide will not be publicly reported in a manner that identifies them and will not be made accessible to others. The researcher ensured that breaches of confidentiality did not occur by not sharing research information with people known to the participants. The information shared was treated with confidentiality. During the data collection, their names did not appear on any tapes or transcripts. The participants' anonymity was maintained by giving them pseudonyms. The summary of the participants'

profile is reflected in Chapter Four.

3.7.5. Anonymity

Anonymity is when the researcher hide participants' identity together with their responses. Bailey (2018) explains that anonymity is when the researcher is not able to identify the informants in the study.

3.7.6. Management of information

According to Kumar (2011) management of information is the act of organising, control, processing and delivery of information. In this research study, the collected data was coded and kept strictly confidential. Tapes and devices were stored in a locked cabinet which is only accessible to the researcher. The electronic information was also kept in the device only accessible to the researcher. Access to the information will be limited to the supervisor. Data will be stored for the period of 5 years thereafter will be destroyed.

3.8. SUMMARY OF THE CHAPTER

This chapter outlined the methodology, which shows how the investigator conducted the study. The study adopted qualitative research systems. The researcher pointed out the study outline, systems, approaches altogether strategies pursued throughout facts compilation activity and examination. The researcher also outlined how the trustworthiness of the research was ensured and how the ethical considerations were adhered to including the management of information.

The next chapter presents the data examination, description, and the interpretation of the findings. The chapter starts by introduction, presentation of demographics of participants, their experience in healthcare setting and exposure to MDT. The chapter further summarises identified themes, description, discussion and, summary of the chapter.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION OF FINDINGS

4.1. INTRODUCTION

The previous chapter focused on the research methodology used in this study. This chapter presents the data analysis in detail and the results obtained in this study. The research focuses on exploring social work practitioners' experiences in working with health practitioners within a multidisciplinary team. As mentioned in the previous chapter, to obtain the aim of the study, four objectives were formulated, namely exploring how social work practitioners describe their experiences in working with health practitioners in a multidisciplinary team; secondly, exploring social work practitioners' understanding of their role within the multidisciplinary healthcare setting; thirdly, examining the social workers' understanding of their practice boundary when engaging with other disciplines within the multidisciplinary healthcare setting; and lastly, proposing recommendations for enhancing the overall functioning of the multidisciplinary teams.

The chapter begins with the presentation of the demographic information of the interviewed participants. The themes related to the experiences of social work practitioners in the MDT are also identified. Creswell (2014) believes that data analysis is the process of bringing structure and meaning to the mass collected data. The semi-structured interviews were performed telephonically and recorded with the permission of the interviewees. In some instances, it was not possible to make a recording because of poor telephone lines, in those cases, participants preferred to respond by the use of email. Recordings, were subsequently transcribed. Therefore, the foundation of the content analysis was written notes received via the data collection method. To bring order and meaning, the data was analysed using thematic analysis.

4.2. PARTICIPANTS' DEMOGRAPHIC DATA

This study gathered qualitative data from 16 social work practitioners who are members of the King Cetshwayo Health District Social Workers Forum. All the interviews were conducted in English language, however, one participant responded to a particular question in IsiZulu. For confidentiality, the identities of the participants were concealed. Purposive, non-probability sampling methods assisted to select participants with the most knowledge about the

phenomenon under investigation (Brink et al., 2012). The participants were identified using codes - PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO and PP.

Table 4.1. Profile of the Participants

Participant	Gender	Age Category	Experience in years	Exposure to MDT
PA	F	50+	15-20	Exposed
PB	F	30-40	15-20	Unexposed
PC	F	40-50	15-20	Exposed
PD	M	40-50	15-20	Exposed
PE	F	40-50	15-20	Exposed
PF	F	40-50	20-25	Exposed
PG	F	30-40	10-15	Exposed
PH	F	30-40	10-15	Exposed
PI	F	30-40	10-15	Exposed
PJ	M	30-40	15-20	Exposed
PK	F	50+	20-25	Unexposed
PL	F	40-50	10-15	Exposed
PM	F	40-50	Below 10	Exposed
PN	F	40-50	15-20	Exposed
PO	F	30-40	Below 10	Exposed
PP	M	40-50	15-20	Exposed

4.2.1. Distribution of the Sample According to Gender

This item is related to the question of the participant's gender.

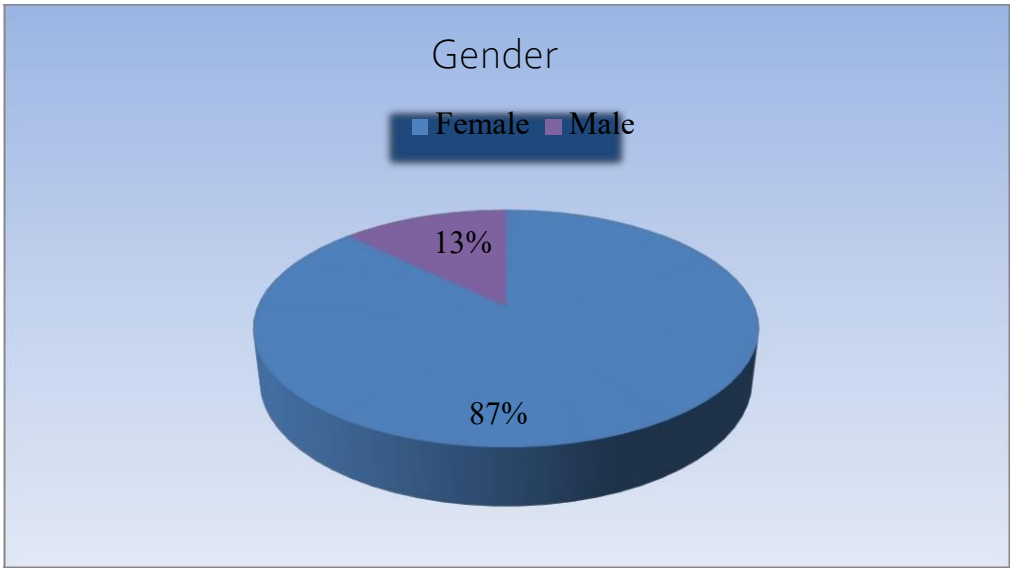

Figure 4.1. Gender

Figure 4.1. shows that the sample consisted of 13 females and 3 males. This was expected, given the fact that the field of social work is currently dominated by women.

According to Kemp, which is reiterated in Brandwein (2010), social work has been largely developed and undertaken by women and is thus construed as a feminised occupation. Cultural assumptions of women's proclivity for caring and nurturing, is based on women's position within the household, meaning that, historically, social work was seen as a natural extension of women's domestic work. Thompson (2012) described gender as a "fundamental dimension of human experience, revealing an ever-present set of differences between men and women. McPhail (2004b) argues that social work is more correctly described as a female majority, male-dominated profession. The meaning behind this is that although there are more women than men in the field, they do not necessarily dominate. This is supported by the statistics of male social work practitioners within the KwaZulu-Natal Provincial Department of Health (DOH) who occupy higher positions within the healthcare setting (KZN DOH, 2018).

4.2.2. Age Distribution of the Participants

The table below gives a general indication of the participants' ages in terms of years.

Table 4.2. Age of the Respondents

Participants' Age	Frequency	Percentage (%)
30-40	6	37.5
40-50	8	50
50+	2	12.5

Table 4.2, shows that the participants ranged in age from 30 to 50 years. Eight participants were aged between forty and fifty years, followed by six who were aged between thirty and forty years, and the last two were aged fifty and above. The age of the participants indicates that the majority of the participants are in the transition between late middle age and late adulthood. According to Berk (2007), middle adulthood refers to the period of the lifespan between young adulthood and old age.

In terms of the database of social work practitioners employed by the KZN Department of Health, there are similarities within the age range (Mdletshe, 2020).

4.2.3. Years of Experience of the Participants in the Health Setting

Figure 4.2. gives a general indication of years of experience of participants in healthcare.

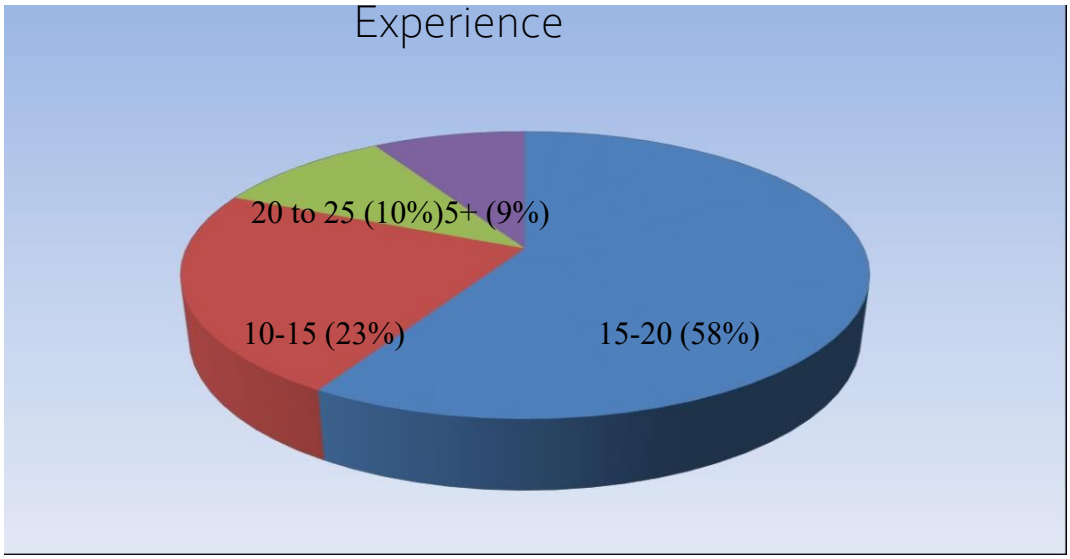

Figure 4.2. Participants' Years of Experience in the Health Setting

Figure 4.2, indicates the participants' years of experience in a broad sense ranged from 5 to 25 years. The majority of the participants possessed 15 to 20 years of experience practising in the

healthcare setting. Eight participants had the experience of between fifteen and twenty years. Four of the participants had the experience of between ten to fifteen years. Two participants had the experience between twenty to twenty-five years. Lastly, two participants have below five years of experience.

Despite the years of experience and the resolution that the practitioners with seven years of experience are eligible to become supervisors, most of these participants remained at the level of a practitioner.

4.2.4. Exposure of the Participants to the MDT

This item indicates the exposure of social work practitioners to the MDT. Social work practitioners are not stand-alone professionals in the hospital setting, as they collaborate with other health professionals.

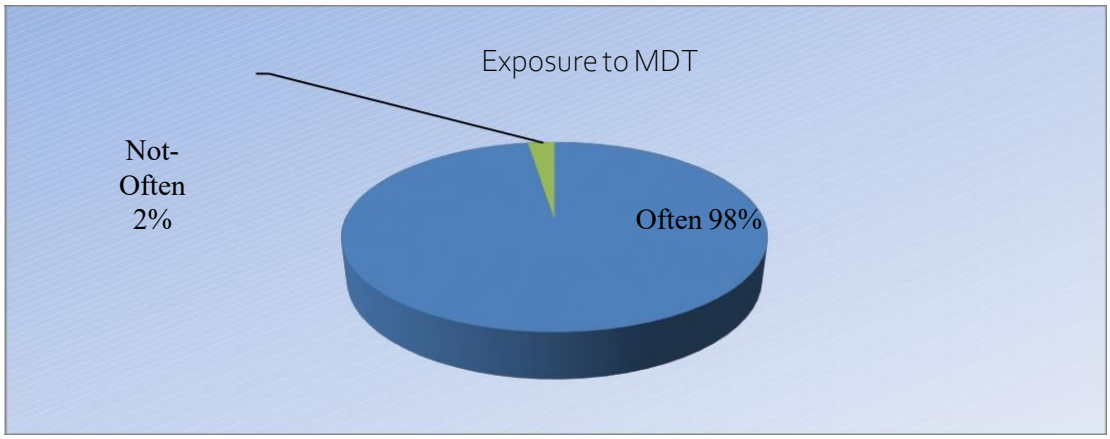

Figure 4.4. Exposure of the Participants to the MDT

Figure 4.4, shows that the majority of the participants are exposed to the MDT. Out of sixteen participants, two participants were not exposed to the MDT at the time of conducting the study.

Interprofessional teamwork is becoming more widely recognized as an important component of social workers' job. Social workers have been involved in professional teams for over a hundred years (Oliver & Peck, 2006). Teamwork and collaboration are highly valued by health social workers. According to research, MDTs performance can have a significant impact on patient outcomes. As a result, it appears likely that social workers can contribute to MDT through their procedural skills for efficient interdisciplinary teamwork, as well as their grasp of the larger social, familial, and economic context for the ongoing assessment and care of the patient (Connolly & Harms, 2009).

4.3. SUMMARY OF THE IDENTIFIED THEMES AND SUBTHEMES THAT EMERGED FROM THE DATA

Below is a table depicting the themes and subthemes that have emerged from the qualitative data. Notably, three main themes emerged from this process based on the objectives of the study.

Table 4.3. Summary of the Identified Themes and Subthemes

Objectives	Themes	Subthemes
To explore how social work practitioners describe their experiences in working with health practitioners within the MDT.	Theme1: Professional power dynamics	Subtheme 1.1. Professional subordination of social work Subtheme 1.2. Unequal power relationship
To explore social work practitioners understandingof their role within the MDT	Theme 2: Lack of collaborative efforts	Subtheme 2.1. Poor communication. Subtheme 2.2. Underestimation of responsibilities Subtheme2.3. Value of MDT
To examine social workers' understanding of their practice boundaries when engaging with other disciplines within the MDT	Theme3: Lack of understanding of the social work profession	Subtheme 3.1. frustration at being undermined Subtheme 3.2. Lack of recognition
To propose recommendations for enhancing the overall functioning of the MDT		

4.4. DESCRIPTION OF THEMES

4.4.1. Theme 1: Professional Power Dynamics

When social work practitioners were asked to describe their working relationship with other health practitioners in MDT, the majority of the participants described their engagement as more of advocating for their professional role in MDT due to the power relations that prevails. Basically, the response revolved power imbalance relationship.

They found that their professional judgments were often subjected to scrutiny. As a result, they have to continuously assert their professional identity. To their dismay, the medical team's judgment and authority are found to be accepted without question. As indicated in the findings of Miller (2016), the medical environments are frequently marked by resistance to the social worker's identity. In addition, a study conducted by Ambrose-Miller & Ashcroft (2016) revealed power dynamics as one of the barriers to collaboration.
In support of the above findings, below are some of the extracts from PA, PC and PF.

> *PA: I think the nature of the environment contributes to the fact that medical practitioners are superiors, and we have to abide by what they say. Hospitals are known to be operated by doctors, as a result, they are given more powers than any other professionals.*
>
> *PC: We are always asked to do things that are out of the scope of practice. Often indigent patients will be referred to our offices for bus fare, yet we are not given petty cash. When we refuse to do it, we will be questioned about our role.*
>
> *PF: "Only doctors have a right to discharge patients". There is nothing heart-breakingas finding your patient discharged without being informed.*
>
> On this subject, it came clear that the social work profession is not fully recognised as a profession in the hospital setting. The participants revealed the non-involvement in decision-making processes about their cases. This hindered the provision of effective psychosocialneeds of patients and lowers the morale for participating in the MDT. Focusing on power in the MDT defeats the purpose of collaboration and destroyed the relationships in the MDT.

4.4.1.1. Subtheme 1.1: Professional Subordination of Social Work

The participants were asked to state how their services are understood within the MDT. The majority of the participants revealed that their services are misunderstood within the MDT

because team members would want to instruct them on what to do. Participants further stated that the misunderstanding of their services is not only with the MDT but the entire healthcare sector. This is what PC had to say:

> *PC: Our profession is perceived wrongly. We have to report to the medical team, sometimes they instruct us. We end up not doing our assessment, intervention, and careplan.*

According to Perriam (2015), traditionally, hospitals have been thought of as medical institutions controlled by doctors. The medical model elevates the medical profession's status and authority. It must be noted that, previously hospitals were known to be facilities that treat physical illnesses hence it is dominated by medical professionals.

Response by PD, PF, PK highlights the following:

> *PD: "Kunzima ukuba usonhlalakahle esbhedlela" - meaning it is difficult to be a socialworker in a hospital setting. It is frustrating, draining, and emotionally exhausting, notbecause of the nature of our work but because of the treatment we receive from MDT.*
>
> *PF: Most of my referrals will be telling me what to do. For example, "Please find a placement, patient been discharged, no relatives", poor compliance, provide counselling, SAM case assess home circumstances. We never tell doctors what to do about their patients, why must we be told?*
>
> *PK: Sometimes to protect my role and the image of my profession, I have to demonstratemy professional value. It is very difficult to be in a work environment where I have to my prove worth.*

There is a need for social workers to understand their position within the prevailing power structures as well as understand why they feel powerless in their work (Pease, 2002). There is a clear lack of professional identity amongst social work practitioners. As a result, they do not appear as strong standing up for their profession. Their voice has faded which suits those in power.The participants revealed the issue of being told what to do. Hospitals are known as institutions run by doctors and nurses. It is normal to find doctors dominating in hospitals because hospitals are created to focus on the physical health of a person. When being told what to do means social work profession is disdain. Furthermore, this despise not only social work practitioners, but patients as well. On the other hand, participants revealed that they overcome these challenges by being continually firm on their professional roles.

4.4.1.2 Subtheme 1.2: Unequal Power Relations

The participants were asked what MDT meant to them. The response varied. To some participants MDT meant power inequities, to others it meant authority of medical professionals over non-medical professionals. Power inequities affected social workers' voices and contributions. The participants mentioned that doctors often assume greater power in the MDT and will talk over social workers and sometimes other team members.

Social workers mentioned that during wards rounds conclusions on patient care plan will be completed based on the views of the most team members excluding social work practitioners. The participants commonly reported that they work in "silos". They find it frustrating not to be informed about activities taking place within the MDT. No one would be interested in providing information. This is confirmed by PF as follows:

> *PF: We feel left behind as if we are less important. Sometimes our contributions and efforts are not recognised which lowers our morale to work within the MDT.*

In most cases, social work practitioners do not get recognition for what they do. The profession itself is disrespected compared to other health practitioners.

The above statement is endorsed by Limon (2018) who suggests that there is a high level of burnout amongst social workers due to the complexities of the negative situations which they face on an ongoing. Similarly, Gray and Van Rooyen (2000) confirm that social workers have a low prestige and are paid poorly in comparison to other professions. Most of the social workers were found to be frustrated and de-motivated. This is the quotation from PE:

> *PE: "We work to demonstrate our worth to doctors." We have to prove the value of our profession. In most cases, social workers will not be prioritised compared to other professionals in MDT.*

There is a large power and status inequality which makes it difficult to communicate across the disciplines. (Tylor, Coffey & Kashner, 2016) revealed that preparing practitioners to work collaboratively in teams requires fundamental changes in the way that health care professionals are selected and educated. The fundamental difference in a hospital-based MDT, is what is believed to be the dominant medical model and the subordinate social model. The medical model focuses on issues of health and illness, with an emphasis on the individual's physical context whereas the social model takes a wider perspective and places more emphasis on the social context in which the individual lives.

With these complexities, multiple challenges are facing social work practitioners in working with health practitioners within a multidisciplinary setting. These complexities are mainly caused by a power imbalance regarding values and work culture. This is what PC had to say:

> *PC: I feel less valued because my contribution would never be considered. There is a lot that we do. No one will recognise our work, even our extra efforts we put to make adifference.*

On this theme, the researcher discovered that the entire participants, associated with this theme. In this regard, literature indicated that disciplinary boundaries hinder interprofessional collaboration in the sense that each discipline uses different approach to patient care. As such, achieving collaboration between professionals from different disciplines may be challenging especially when a particular discipline has less institutional power (Tylor et al, 2016). Thus, effective interdisciplinary work requires bridging boundaries within the medical professional group, addressing the dynamics of resistance merging from different disciplinary backgrounds (Liberati, Gorli & Scaratti, 2015). On the other hand, the study by (Kumar, 2016) revealed the most challenge faced by social workers is that they are expected to do more with less human resources. It is thus clear that the functioning of MDT requires more than the group of professionals workingwith patient care but involvement and support from different levels authority.

4.4.2 Theme 2: Lack of Collaborative Efforts

The participants were asked to state their view on areas of the MDT where they felt that they were struggling. It was obvious that social work practitioners are poorly supported. The majority of social work practitioners interviewed in this study acknowledged MDT as beneficial for better patient outcome, however the challenge of lack of collaboration within the team demotivated them from fully functioning in the team. Over and above that, their professional experience made them feel powerless to be proactive. Social workers have been trained and supported to build trusting relationships. As also indicated in the study key findings by (Craig, Eaton, Belitzky, Kates, Dimitropoulos & Tobin, 2020) which stated that social workers are empowering collaboration by actively communicating, which is building relationships, proactively educating and systems and managing risks. Moreover, the study findings by Steihaugs, Johannessen, Adnanes Paulsen & Mannion (2016) reported recurring themes on lack of collaboration between patients and providers and between providers themselves. On the other hand, Ansa, Zecharia, Gates, Johnson, Heboyan & De-Leo(2020) emphasized the need for effective MDT as of paramount importance due to rising co-

morbidities and increasing complexity of patient care. It has been reported by a number of previous authors that interprofessional collaboration reduces the time and costs of hospitalization, decreases hospitalization and readmission rates, and improves healthcare for patients particularly those with chronic illnesses.

Many of the participants felt that there is no collaboration between health and social work practitioners. The response from PF was:

> *PF: The relationship is poor because they remember our existence when they encounter challenges that require our expertise.*

The participants felt isolated and lacked support and confidence which generated discomfort. There was further a feeling of anger as they battled to cope with the loss of a professional identity. This was articulated by PD and PF as follows:

> *PD: I always receive late referrals. Health practitioners will be working with the patient all the way and notice on discharge that the patient has social issues. I will be pushed to finalise my cases because of bed status.*
> *PF: My challenge is the medical terminology used during MDT meetings and engagement with the health practitioners. I believe medical practitioners should take responsibility for providing information and clarity on medical terms. This is a clear indication of poor collaboration.*

The lack of appropriate collaboration between professionals impedes clinical work leading to the inadequate rendering of services, the prolonging of hospital stays, and the frustration towards other team members (Steihaugs, Johannessen et al, 2016). This may be due to the fact that health professionals are used to focus on one-disciplinary approach which does not provide comprehensive care. A holistic approach to care involves understanding the inter-relationship between social, physical/biological and psychological determinants of health which allows a wider "whole—person" view (O'Connor, 2017)

The healthcare systems have to treat patients holistically to achieve better outcomes. However, the desired outcomes can never be achieved if there is poor collaboration among team members. Communication among the MDT is essential to delivering good quality healthcare services (Busari, Moll & Duits, 2017). Patients are all unique and have different needs. There is a significant amount of research to show that patient outcomes, the quality of care and the cost

of care delivery are all optimised when such disciplines work together toward a shared goal that focuses on the patient.

4.4.2.1 Subtheme 2.1: Poor Communication within the MDT

The participants were asked to describe factors beyond their control that hinder them from performing their duties within the MDT. The value of communication in the MDT was discussed extensively by the majority of the participants. The range of responses from the participants included the non-involvement of social work practitioners in discharge planning and not being invited in the MDT meetings or even sometimes receiving late invitations for MDT meetings. A research conducted by Fewster-Thuente & Velsor-Friedrich (2008) has shown that 70% of the adverse events were due to the lack of communication and collaboration between healthcare professionals. This is what PC and PI had to say:

> *PC: There is no relationship between social workers and healthcare professionals. We are sometimes informed later after the meetings about MDT. Nobody recognises our existence.*

> *PI: I have learned to do and focus on what I am paid to do. Communication is a two-way street.*

Effective communication is important in all spheres of human activity, especially in the interplay between human nature or individual agency and societal or social structure. In this regard, the formal interactions form the basis of social work, and effective communication helps coordinators relate better with subjects (Busari, Moll & Duits, 2017). Furthermore, the study identified key competency for effective collaboration which are communication domain, maintaining and sharing of information and, most importantly in this regard a collaboration practice is based on respect.

Based on the findings, it appears that the majority of the participants have difficulty in relating to healthcare practitioners in the MDT. Other negative experiences expressed are in relation to the medical terminology. When participants were asked how they dealt with those challenges. The response was that they have developed peer support system and self- care approach.

4.4.2.2 Subtheme 2.2: Underestimation of Responsibilities

The participants were asked to describe their roles in the MDT. The response was that their roles were to provide psychosocial assessments and interventions, advocacy role for patients and their families, provide counselling and emotional support to patients who experience poor

social functioning. However, social work practitioners felt that their roles were underestimated, in the sense, that they are pushed to finalise cases.

The participants revealed that cases were not referred on time which prolonged the stay of patients within hospitals and sometimes results in readmissions due to unresolved social problems. The medical practitioners decides on what must be done about social work cases even though social problems still exist. The participants further revealed that the team members felt that psychosocial support is a task that can be performed by anyone. One participant revealed that she observed a non-social work practitioner being tasked to perform social work duties. On the other hand, one participant witnessed a medical practitioner addressing psychosocial issues ofthe patient. Gibbons and Plant (2009) found that rapport building, empathy, non-judgemental attitude, practice assistance and advocacy are the important features of the social worker role.

Despite the challenges that hinder social work practitioners to render their services, social worker would receive late referral of cases resulting into increasing of the lengths of stay of patients in the hospitals (O'Connor, 2017). Due to work under pressure and pushed for discharge, social work practitioners are often being unable to engage in planned interventions with patients. In addition, the core function of MDT is to bring together a group of healthcare professionals from different fields in order to determine patient's treatment plan (Taberna, Gil-Mancoya, Jane-Salas, Antonio, Aribas, Vilajosana, Paralvez & Mesia (2020). The impairment of this function can significantly impact patient's quality of life and psychosocial status. This is confirmed by PE and PD as follows:

> *PE: I have many years of experience in the health setting. I have learned coping skillsto work under stressful conditions whereby medical practitioners tell me what to do and how to do it.*
> *PD: Looking for placement of a patient is time-consuming, requiring the activeinvolvement of stakeholders and external resources. While working on the case, team members will be continually asking about the plan of action.*

Multiple disciplines can work as a team to help improve patient outcomes. However, this can be done by effective implementation of interprofessional collaboration and learning to work together by respecting one another's perspectives.

4.4.2.3 Subtheme 2.3: Value of the MDT

> The participants were asked to describe contribution of MDT to patient care. The response was that MDT improves the quality of care to patients and reduces readmissions. The participants were of the view that an effective MDT produces

positive outcomes when teams collaborate effectively. Furthermore, effective MDT could lead to more coordinated and accurate patient care plans, better planned and coordinated patient discharges, better post-discharge arrangements, appropriate and individualised transfers to other facilities, patients' expectations of discharge dates being confirmed sooner, relevant care plans, and team members being kept up to date with patient care issues. However, in reality it was not the case. In particular, social workers being the only non- medical professionals in MDT felt that they were excluded in important decision making processes. For instance, they were often not invited to attend the MDT meetings, as a result they felt that medical practitioners viewed non-medical needs of patients as irrelevant compared to medical needs.
This is what was vocalized by PG as follows:

PG: .....of course, we have the role to play in MDT, but MDT can only be effective when there is collaboration.

In support of *PG, PC* stated that *"MDT produces better patient outcomes. Without team members working together as a team, there will be no MDT."*

This is the subtheme where the participants revealed how much the MDT can contribute to patient care for better service delivery outcomes. However, concerns have been raised about the lack of teamwork within the MDT.

4.4.3. Theme 3: Lack of Understanding of the Social Work Profession

The participants were asked about how MDT viewed their roles. The responses vary from misunderstanding, comparing, misconception, misinterpretation, confusion about the social worker role. Participants emphasized serious misinterpretation about social work profession particularly by medical professions. Few participants reported that they used to get inappropriate referrals such as social grant applications, requests for bus fare etc. Due to the lack of understanding of the social work profession, service delivery is affected in the stance that a lot of time will be spent dealing with patients that were inappropriately referred. Furthermore, social work practitioners felt that they were not fully supported as compared to other health care practitioners. This is what PG voiced:

PG: Social workers are less valued compared to other health professionals. Even the allocation and distribution of resources is based on whether the profession is

categorised as essential and critical. Social workers have never been allocated resources because the profession is less recognised.

It must be noted that social work has recognized the interconnectedness of physical, psychological, and social well-being leading to bio-psychosocial approach when dealing with patient care whereas healthcare system operates from biomedical point of view (Mann, Golden, Cronk, Gale, Hogan, & Washington, 2016). Therefore, the minimal understanding contributes to less recognition of the profession resulting in the tense relationship between social work practitioners and doctors, particularly when it comes to ethical questions, practices, discussions and resolutions. PE and PD expressed the following:

PE: I receive inadequate support because my role is not understood. Lack of support includes even the lack of appropriate resources. I would be expected to provide transport fare for indigent patients yet there would be no budget allocated for that.

PD: Due to different views and understanding, we sometimes fight over the best suitable treatment of the patient.

The participants reported minimal understanding of what social work is in the hospital setting which appeared to be the core reason for poor collaboration in the MDT. Knowledge of each other's work promotes mutual respect and recognition of each other's areas of expertise and competence. This is supported by Heenan & Birrell (2019) who note that little is known about the role and contribution of social workers in hospitals. This is further endorsed by Glaser & Suter (2016) in their study that lack of understanding of social work ideology from other professionals deprived social worker to work to full scope. In contrast to this, the researcher argues that if social workers have good understanding of their role in MDT, misconceptions could have been addressed simultaneously while providing services.

4.4.3.1 Subtheme 3.1: Frustration at being undermined

On this subject, the participants were asked how satisfied they are with MDT understanding of their role. The participants revealed that they while providing psychosocial interventions, patients would be discharged without them knowing.

The response was the following:

PD: In the true sense, MDT meeting is supposed to be the platform where all membersgather and share their involvement in inpatient care. The lack of coordinator for MDTresults in poor information sharing. Doctors and nurses care for the patients' physical

needs but are not trained to deal with other issues. There is much focus on authorityand less focus on clarity of roles in MDT.

A study conducted by Ryan (2012) confirms that health practitioners tend to focus solely on the patient whereas social workers concentrate on the patient and their social issues. In addition,social workers centralize their services to various levels of intervention ranges from individual patient to societal level.

The following is said by PF:

PF: It is quite overwhelming not to be involved at the beginning of the process or planning. When they feel they cannot solve it they call me to intervene.

Social workers felt that they understand their role of being proactive in MDT, but based on their professional experience, they felt powerless to fight for their recognition. The feeling of powerlessness was based on the fact that even if they would fight for their recognition within the MDT, there would be no support from themanagement so they did not was to fight a losing battle. Furthermore, based on the fact that the social work discipline is the only non-medical profession as well as the nature thereof, there is a tendency to disvalue their contribution to patient care.

Hospitals tend to focus on the physical state of a person, believing that the absence of disease is health whereas social work promotes social change, social cohesion and theempowerment and liberation of people. The environment and circumstances in which people live contribute to their health conditions. Thus, non-medical factors can influence health outcomes (Green, 2017).

4.4.3.2 Subtheme 3.2: Lack of Recognition

This subtheme emerged from the question on how does MDT value your contributions. The response was that participants believed that lack of recognition is one of the biggest challenges in the MDT. The only category that is mostly given respect and recognised is the medical team. The participants further reflected on their inputs being less seriously considered as of doctors. This was supported by PC, PE and PH as follows:

PC: I have experienced a circle of exclusion in knowledge exchange and development.I was notified late about one MDT meeting and I was expected to report on my intervention and care plans on my cases. My care plan was not recognised. Instead, I was informed that the hospital is for a sick patient.

PE: One doctor said social workers render services that can be rendered by anyone. We sometimes have to drop everything we had to attend MDT meetings that were planned without us being involved.

PH: I believe that the reason we are not supported relates to being supervised by themedical manager who has no idea of what social work is.

In most instances of multidisciplinary working, social workers are in the minority (Reese 2011). In a hospital setting, for instance, there might be a small team of social work professionals, sometimes just one person, compared with a sizable workforce of medical staff. The challenge of social work practitioners lies in providing their worth, gaining equal esteem and emphasising their distinctive contribution. Social workers need to recognize the importance of team-based care while emphasizing their distinctive training and skills. Without distinguishing its unique capabilities, the social work profession may be relegated to a subordinate status within health care facilities (Collins, 2013). Furthermore, (NASW, 2011) emphasises that social workers should be part of the interdisciplinary effort for the comprehensive delivery of long term care services and should strive to enhance inter-organizational cooperation.

4.5. DISCUSSION

In this section, the discussion is presented in line with the three thematic areas, namely, professional power dynamics, a lack of collaborative efforts and a lack of understanding of the social work profession.

4.5.1. Professional Power Dynamics

It is important to understand how social work practitioners function within the MDT. In this regard, a study conducted by (Haines, Perkins, Evans & McCabe, 2018) revealed that decisions taken within MDT meetings are unequally shaped by the professional and personal values. Therefore, the researcher can conclude that power dynamics exists in MDT. On the other hand, a study by Reese (2011) found that the conflict between social workers and doctors in a hospital mostly concentrated on the doctors' expectations of the social workers' role and the social workers' perceptions of the doctors. In a hospital setting where the life and death of a patient are crucial factors, doctors have a more dominating authority. For instance, when the doctor is done with the patient, they are the ones with the authority to discharge the patient even without the social workers' knowledge and/or before the social work intervention has fully concluded and terminated the case.

Several factors hinder collaboration among the MDT includes, the organisational characteristics such as the power-dependence and actions of individuals such as the status that they have about their profession which falls under certain role perceptions (Steihaug, et al, 2016). This study informs the reader about the contributing factors on differences in professional power and how it impacts collaboration in MDT. This is supported by (Nkuna 2016) on her study that revealed that even though the social workers play an important role in the MDT, they are still not fully recognised as important practitioners.
Social workers reported being lost in the MDT due to role confusion, being undermined by being told what to do by other team members, patients being referred when close to discharge, social workers being pressured to finalise cases, and a lack of interest in knowing the social worker role. The study further revealed exposure of social work practitioners to different kinds of challenges such as psychological, social and emotional difficulties in their field when working with other health practitioners.

Differences in power have to be considered and a new procedures must be introduced to improve communication, which can foster effective conduct for social work in the hospital setting. It was clear that, following the participants' experiences, the social work profession is perceived to be on a lower level category than other health professionals. The fight for the recognition of social work professional status has been influenced by multiple factors including negative public perceptions of the occupation. The results identify a need to redirect identities and MDT goals. The analysis further revealed a consistent pattern of inappropriate use of power by doctors in the MDT, the dictatorship of the social work role, stereotypes among health professionals, and doctors being given more recognition and acting as the sole decision-makers regarding patient care. An effective leadership is essential to address collaboration between professions. However, according to (Folkman, Tveit & Sverdrup, 2019) leaders may lack understanding of the specific professional roles and responsibilities of the different occupational groups. In this regard, there is a need to develop knowledge on how CEO's or hospital management facilitate the development of collaboration, daily challenges they face in practice within the MDT. Uncertainty in professional roles can hinder collaboration. On the other hand, a strong leadership support could contribute to the improvement of collaboration and foster a better understanding of communality in a professional setting, develop new relationships and ways of working together (Folkman et al, 2019)

There is a need to acknowledge the importance of communication and teamwork within MDT. The lack of effective MDT functioning, perception of others, attitudes and decision-making

processes, including the hierarchal order of professional responsibilities, may contribute to the pattern of conflict and reluctance regarding participation in the MDT (Tadic et al,2020). There is evidence that the MDT can improve outcomes in a range of patient groups as well as reduce hospital readmissions.

4.5.2 Lack of Collaborative Efforts

Generally, the relationship between medical practitioners and social workers are poor. As such, a study report by (Holder, Kumpunen & Castle-Clarke, 2018) emphasized that health and social care are dependent on one another to succeed. This means for effective collaboration to happen healthcare and social work practitioners need to remove boundaries and barriers to impact quality patient care. It has been observed that collaboration have many benefits such as reducing length of stay of patients to hospitals and avoiding readmissions of patients. According Clwyd & Wood (2013), the following are some of the difficulties that social workers face when working in a multidisciplinary team; to be heard by medical colleagues, social workers frequently have to pound on the door; managers of social work organizations are frequently excluded from key decision-making processes. Because social workers' occupation is regarded as low-status profession, they are therefore unable to reach their full potential. There is also a lack of professional respect among medical colleagues for social workers. Webber (2012) feels that social workers are underutilized and marginalized as a result of their challenges and how patients should be treated by other health professionals.

The study by (Abramson & Bronstein, 2013) demonstrated that teamwork is not only a key element in cost containment, effective care coordination and accountable care organisation, but it is also a central component of quality social work practice and delivery. Failures of the patient and quality care within the multidisciplinary system have, to some extent, attributed to the inabilities of health practitioners to communicate or work effectively (Laming, 2009; Francis, 2013). Such findings highlight a need for a continual focus on improving the understanding of the multidisciplinary approach and for further discussion of the relationship between professional identities, roles, boundaries and a collaborative practice. This is confirmed by the aforementioned researchers that social workers are constantly needed to prove their competence through their work and their communication with other team members and their patients because they are undermined and their judgments are not trusted.

The subthemes under discussion provide insight into the difficulties social work practitioners experience in working with health practitioners within the MDT setting. The content elicited by the participants reflected how their role is underestimated as well as the difficulties in functioning and collaborating with different disciplines. Based on this research, the participants viewed their experiences in the MDT as negative and developed a reluctance to be part of the team. A lack of dedication towards collaboration has impacted negatively on the working relations within the team. However, despite the challenges faced by social work practitioners, it is of equal importance for social workers to continue to advocate for the profession to be recognized as a clinical profession that form integral part of MDT.

4.5.3 Lack of Understanding of the Social Work Profession

Albrithen & Yalli (2016) found that there is a lack of awareness of professional roles among various members of the healthcare team as described by the rest of the team during their interviews regarding social worker' job. The lack of awareness about the social workers' role impacted upon the effectiveness of their social work intervention outcome. Subsequently, according to (Macdonald, Bally, Ferguson,Murry Fowler-keryy & Anonson, 2010) knowledge of professional role of others is one of the key competency of interprofessional collaborative practice for patient-centred care. Furthermore, knowledge of professional roles of others is associated with behavioural indication of interprofessional practice. The study findings of Beddoe (2013) on the professional identity and knowledge of health social workers revealed a weak social work knowledge, which impacted upon their professional identity and status in the multidisciplinary institutional setting. However, besides poor social work knowledge, a survey that was conducted with Canadian social work practitioners revealed key barriers to social work integration (Ashcroft, McMillan, et al, 2018). Therefore, regardless of how skilled social work practitioners may be in building relationships, maintaining collaboration in an interprofessional environment will still be a challenge.

The elements required for effective and integrated models for multidisciplinary care includes flexibility and cooperative teamwork with an identified coordinator supported by an effective communication process. Integrated care goes beyond the sharing of the information provided through shared health records. It needs to be complemented by formal and informal relationships among various disciplines to support communication (Shelley, Andrew, Michelle, Linda, Gina & Jennifer, 2020). The MDT conveys many benefits to both the patient and the health professionals working in the team.

The benefits include improved health outcomes, enhanced client satisfaction, the better use of resources and enhanced job satisfaction for the team members. However, to ensure optimum functioning of the team and effective patient outcomes, the role of the MDT members in care planning and delivery must be negotiated and defined. This requires respect and trust between team members. Social work practitioners have skills to build rapport and maintain an effective working relationship with health professionals. Therefore, social workers are experts in facilitating teamwork within the MDT. Social workers develop extensive relationships with external stakeholders across a range of sectors including health, disability, government, community, housing, education and justice. This was further elaborated by Rosanne, Leipzig, Hyer, Ek, Wallenstein, Maria, Vezina Fairchil, Christine, Cassel & Howe, (2002) who discovered that, compared to other disciplines, social workers were more likely to have been trained to value interprofessional collaboration, had more knowledge of it, experience and the essential collaboration skills. Having members of the social work team participating more actively in the organisation of the MDT meetings may improve multidisciplinary communication and functioning.

The above-mentioned input of participants validates the standpoint of the literature on the experiences of social work practitioners in working with health practitioners within a multidisciplinary care setting.

4.6. SUMMARY OF THE CHAPTER

This chapter provided the results of the qualitative thematic analysis of the data. An overview of the participants' demographic characteristics was presented in the form of figures. The researcher presented a summary table on the age of participants and a figure on the years of experience in healthcare setting was presented and exposure to MDT. The three themes and subthemes emerged from the data collected were presented in the form of a table and was further discussed.

The next chapter is the final chapter of the research study. The final chapter includes the summary of the research study, findings in relation to the research questions, summary of findings, study conclusion and recommendations. There are different levels of recommendations presented in this chapter and finally the closing remarks.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter presented the findings that emerged from the process of data collection. Findings were presented in the form of themes, and the discussions thereof. This is the last chapter of the study. It summarizes the study in the form of chapters, findings in relation to the research question, summary of findings, study conclusion, different levels of recommendations and closing remarks.

5.2 SUMMARY OF THE STUDY

A qualitative study design technique was used to explore the experiences of social work practitioners in working with health practitioners within a multidisciplinary healthcare setting. A semi-structured telephonic dialog was administered utilizing preselected questioning out of examination lead. The data was examined in a strenuous manner using the thematic scanning technique. All the applicable moral standards were obeyed. The genuineness of the data was examined using Lincoln along with Guba's (2013) framework criteria of credibility, transferability, dependability and conformability.

Chapter one began with the introduction to the study which included the background and rational of the study, the problem statement, aim and objectives of the research paper which were discussed in detail, terms relevant to the study were defined and clarified along with the methodology of the study and the ethical considerations.

Chapter Two elaborated on the historical development of health social work from a global and African context, fields of social work practice and, healthcare system from global to south African context. The theoretical framework the study undertook was discussed in this chapter. The discussion on experiences of social workers was based on the findings from previous studies, their role per healthcare setting and boundaries in rendering an effective MDT. The guiding framework that informs the constitution of MDT was also discussed.

Chapter Three discussed a detailed research process, design and methodology. The study undertook a qualitative research design that involved a combination of exploratory and descriptive research. Under the research methodology, the researcher explained sampling procedures which involved the sampling technique, sample data analysis and the data

collection approach and method. Trustworthiness and ethical considerations were also included in this chapter.

Chapter Four focused on the presentation of the demographic characteristics of the participants the interpretation and description of the research findings. The three identified themes that emerged included professional power dynamics, a lack of collaborative efforts and a lack of understanding of the social work profession.

Chapter Five includes a summing-up of the investigation, closure with regard to discoveries of the research as well as the different levels of recommendations. The study conclusion focused on the importance of interprofessional relationships with the social work profession as valuing social justice and expertise in behavioural services. The researcher proposed recommendations for the National Department of Health, Provincial Department of Health, healthcare professionals, health social work practitioners and academic institutions. There was a strong recommendation for future research on the experiences of social work practitioners in working with healthcare practitioners within the MDT.

5.3FINDINGS IN RELATION TO THE RESEARCH QUESTIONS OF THE STUDY

The study was conducted to explore the experiences of social work practitioners in working with healthcare practitioners within a multidisciplinary healthcare setting. The study aim was achieved through the themes which emerged from the participants. The themes were achieved based on the research questions which were the following:

5.3.1 Research Question 1

How do social work practitioners describe their experiences in working with health practitioners within the multidisciplinary healthcare setting? This question intended to address the experiences of social work practitioners in working with health practitioners within the multidisciplinary team. Social work practitioners were expected to describe their experiences in working with the healthcare team within the MDT. The study found that it was difficult to work within the MDT because team members would want to instruct them on what to do. Furthermore, social work practitioners felt frustrated, drained and emotionally exhausted due to the treatment that they received from the MDT. Being told what to do made them feel less important within the MDT. They also revealed that their engagement was about advocating for their professional identity due to the power relations that prevailed in MDT.

5.3.2 Research Question 2

What do social work practitioners understand as their role in the multidisciplinary healthcare setting? This question intended to grasp the social work practitioners' role in the MDT. The findings obtained in the study indicated that their role includes; providing psychosocial assessments, providing counselling and emotional support, and advocacy for patients and their families however, due to poor working relationships within the MDT,they felt that their roles were undermined.

The study found that the participants felt isolated and lacked support which generated discomfort. There was an emphasis on role confusion which led them to lack confidence in their professional roles. It was discovered that the knowledge of each other's work promotes mutual respect and recognition of each other's areas of expertise and competence.

5.3.3 Research Question 3

What do social workers understand as their practice boundary when engaging with other disciplines within the multidisciplinary healthcare setting? This question intended to address the extent of the boundaries when working with health practitioners within a multidisciplinary healthcare setting. The study learned that social work practitioners struggled with medical terminology. Poor communication was identified as the contributing factor to many challenges faced in the MDT.

5.3.4 Research Question 4

What are the possible recommendations for enhancing the overall functioning of multidisciplinary healthcare? This question intended to address the possible recommendations to improve the overall functioning of the MDT within the healthcare setting. Although the feedback on this question did not develop a theme, however various views on the recommendations for an effective MDT, to improve the MDT functioning and patient outcomes. At the foremost, it was discovered that social work practitioners play a vital role in improving the functioning of MDT. Social work practitioners are change agents when it comes to behaviour modification. Furthermore, social work practitioners are key role players in building interprofessionalcollaboration. There was a great need for improvement of relationship between health professionals and socialworkers and social workers being at the forefront.

5.4. SUMMARY OF RESEARCH FINDINGS

This section summarizes the main research findings of the study. The current research study collected informative findings on experiences of social work practitioners in working with healthcare practitioners within the MDT setting. The study reinforced some emerging themes from previous literature such as professional power dynamics, lack of collaborative efforts and lack of understanding of the social work profession. Despite participants' demonstration of their feelings about their working relationship with health professionals, results highlighted crucial role of social work practitioners in both MDT and healthcare system. Four objectives were formulated, namely exploring how social work practitioners describe their experiences in working with health practitioners in a multidisciplinary team; secondly, exploring social work practitioners' understanding of their role within the multidisciplinary healthcare setting; thirdly, examining the social workers' understanding of their practice boundary when engagingwith other disciplines within the multidisciplinary healthcare setting; and lastly, proposing recommendations for enhancing the overall functioning of the multidisciplinary teams. The objective to propose recommendations for enhancing the functioning of the MDT emerged as the key findings for social work practitioners to act on improving collaboration in MDT.

The findings that formulated theme one on professional power dynamics is supported by the study conducted by (Haines, Perkins, Evans & McCabe, 2018) which revealed decision in MDT being shaped by the professional values and power dynamics. Similarly, (Steihaug, et,al,2006) described MDT as influenced by differences in professional power, knowledge bases, and professional culture. The researcher shares the same sentiments with literature and the research findings regarding the existence of power dynamics within the MDT. Unequal power relationship has been found to have impacted negatively on the interprofessional collaboration.

The findings that formulated the second theme on lack of collaborative efforts is supported by (Steihaug, Johannessen,et al, 2006) who found that lack of appropriate collaboration amongst team caused division to members. In attempts to overcome the challenge, findings reported that social work practitioners exercised advocacy role to members.
In other words, social work practitioners need to firmly demonstrate their professional skills and be consistence on building relationships within the MDT.

Macdonald, Bally, Ferguson, Murray, Fowler-Kerry & Anonson (2010) presented that knowledge of professional roles of self and others as one of the key competencies of interprofessional collaborative practice. It was discovered that when professional join interprofessional team, roles of each team members are not clearly defined as results members would be working as a team without knowing exactly their roles. The last key study findings indicated that social work practitioners enable collaboration by actively communicating with the intention to strengthen connection amongst the group (Craig, et al, 2020). Thus communication is considered as an essential expertise in social work practice (Kennedy, 2019). In addition, as social work practitioners are advocating for patients, it was discovered that they raise awareness to the team about the availability of systems for better patient outcome. This automatically fills the gaps of better understanding of practice. Over and above, social work practitioners have specialized knowledge of influencing positive interprofessional collaboration however limited exposure hindered them to fully connect to the team. Therefore, according to (Zerben, Lombardi, Fraser, Jones & Rico, 2018) there is a need to integrate social workers into professional teams. This requires educating all members of the healthcare team on the roles and functions of social workers and it can be done by allowing social workers to demonstrate and participate in interprofessional collaboration. Importantly, a study by Bronstein, Gould, Berkowwitz, James & Marks (2015) revealed how a social work-led care coordination intervention would reduce readmission rate.

5.5. STUDY CONCLUSION

Exploring health social work practitioners' experiences in working with health practitioners within a multidisciplinary healthcare setting has brought about enlightenment regarding how health professionals viewed the social work profession and its involvement in the MDT. It must be noted that like all other health professionals, social workers are tertiary qualified. The profession of social work education is undertaken as a four-year undergraduate degree and includes supervised practicum block placements. While this may be the case, practice has revealed that social work in the healthcare setting is unique and requires specialised training in order to prepare social workers. Furthermore, the study can be concluded by reflecting on the research problem statement which stated that the social work profession within the healthcare setting does not receive the recognition it deserves.

Little is known about the role and its contribution to the healthcare setting. This has subsequently led to the profession being considered as a non-critical and non-essential service. This lack of recognition impacted the collaboration within the MDT.

As indicated in Chapter two, previous research studies revealed the power of doctors and social workers being viewed as subordinates. It was further discovered that a poorly functioning MDT has been linked along with adverse results on patient care, readmission of patients and an increased mortality rate.

This study revealed that social work practitioners are exposed to professional power dynamics which resulted in unequal power relationships and the subordination of the social work practice. The participants felt that their views were poorly supported which resulted in poor communication within the MDT and an underestimation of responsibilities. The study further revealed a misunderstanding of the social work profession which resulted in the lack of recognition of the contributions of social workers. Social work practitioners perceived the overall collaboration as positive however, functioning of MDT depends on improving the relationship between social work practitioners and healthcare practitioners. Therefore, it is imperative that improvements are made in the relationships between health professionals and social workers. The researcher concludes that although social work practitioners encountered unequal power dynamics in MDT, their role remains crucial in team collaboration therefore, they should play a leading role in the process of joining the team together.

5.6 RECOMMENDATIONS

Regard highly on the study findings, the following different levels of suggestions was formed to improve the MDT functioning within the healthcare setting.

5.6.1 Recommendations for Future Research

This study highlighted valuable lessons on the MDT functioning and would therefore recommend further research to truly understand and explore health social workers' experiences in working in the MDT. The researcher suggests a larger sample to include an interprovincial or even national study to acquire an overview about encounters of social workers within MDT in the healthcare setting. There were many gaps around the issue of multidisciplinary functioning. Therefore, the researcher recommends that a broader view be taken to strengthen and improve the MDT relationship and practice. The researcher recommends further studies that specifically include a quantitative research study on measuring the effectiveness of the MDT approach in healthcare.

5.6.2 Recommendations for Practice

(i) Provincial Departments of Health, Health Districts and Hospital Managers (CEOs)

The advancement of inter-occupational functioning in the distribution of health services and social care can be considered by policymakers as proposal to follow for the delivery of quality health services. In doing so, there must be an acknowledgement of the MDT as a key driver of the improved quality of care for patients. This can be achieved by formulating a standard operational guideline on the MDT and its collaboration.

There is a need for the implementation of transformation from the traditional medical model of care to a more collaborative patient-centred model in healthcare facilities and the MDT.

It is evident through this study that there is a need to review the MDT structures and the involvements and roles of all disciplines. Healthcare facilities need to be redesigned to better nurture collaborative relationships, information sharing and support integrated working between healthcare professionals and social workers.

The study found challenges regarding discharge planning. In order to create a good working relationship amongst the MDT, it is highly recommended to make discharge planning be a key function of all the involved disciplines in the MDT.

The majority of the participants revealed greatly unequal power relationships amongst the MDT. It is recommended to acknowledge the key roles played by social work practitioners in the MDT, as it impacts on patient care and the recurring readmission of patients. Furthermore, there is a need to clarify the different roles and responsibilities of the MDT.

A lack of coordination amongst the MDT emerged when analysing the transcripts. It is therefore recommended that the DOH appoint a credible professional to coordinate the MDT functioning.

Training and preparation for working in the MDT for healthcare practitioners are of paramount importance to ensure effective collaboration within the MDT. This can be done through the creation of interprofessional education opportunities.

A proposal for a significant determinant of MDT functioning may be the presence of team members who have a personal commitment to the MDT approach and to identify key barriers to the MDT.

(ii) Recommendations for Healthcare Practitioners

There is a need to develop ways of working together through team building activities or joint practices, which address tension creatively through respectful engagement with diversity while developing common team values. Capacity building is thus important to strengthen the relationship between healthcare and social work professionals.

To develop a clear, frequent and multifaceted strategies for communication within the MDT, the focus should be on identifying and addressing obstacles to good patient care and taking accountability for the agreed actions.

It is recommended that health practitioners integrate their services, including discharge planning. Social work practitioners should thus be present and play a meaningful role in discharge planning.

(iii) Recommendations for Social Work Practitioners

Social workers need to educate and provide in-service education to health professionals on their roles and how they contribute to patient care.

Social workers need to establish methods of communication and building relationships within the MDT.

Social workers, as part of their roles, need to link appropriate organisation and support for the working of the MDT. The researcher recommends the strengthening of peer support programmes for social work practitioners.

5.6.3 Recommendations for Academic Institutions

It is recommended that training for all health professionals with a focus on teamwork in a multidisciplinary context be strengthen. This is essential for undergraduate training.

The social work curriculum should place emphasis on an integrated and multidisciplinary approach so that students can develop consciousness about the collaborative nature of the workplace, especially the healthcare setting.

Health social work is a specialised practice. As a result, it is suggested that this is emphasised as a speciality as part of the university education programme.

5.7. CLOSING REMARKS

When thinking of the professionals employed in the healthcare setting, social workers may not be the first people that comes to mind, yet they are a critical piece of the service delivery puzzle in healthcare setting. Their contribution can be very influential in helping to prevent the reinvention of the wheel in both healthcare and disease prevention. Social workers are indeed making significant contributions to the MDT and patient outcomes. It is time that their contributions are fully recognised.

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7. APPENDICES

Appendix A. UKZN HSSREC Full Ethical Clearance

Appendix B.1. Request letter of Support from the Health District Director

Appendix B.2. Approval Letter from the Health District Director

Appendix C.1. Request for Permission to the DOH

Appendix C.2. Permission Letter - DOH

Appendix D.1. Application for the Amendment of the Data Collection

Appendix D.2. Approval of the Amendment of the Data Collection

Appendix E. Recruitment of Participants - Email

Appendix F. Informed Consent for the Participant

Appendix G. Interview Guide (Data Collection Instrument)

Appendix H. Editorial certificate

Appendix I. Turnitin report

Appendix A: UKZN HSSREC Full Ethical Clearance

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

04 March 2020

Mrs Zama Immaculate Maxhakana (219085972)
School of Applied Human Sciences
Howard College Campus

Dear Mrs Maxhakana,

Protocol reference number: HSSREC/00000603/2019
Project title: Exploring health social work practitioners experiences in working with health practitioners within a multi-disciplinary health care setting
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your response received on 02 March 2020 to our letter of 21 October 2019 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 04 March 2021.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

Professor Urmilla Bob
University Dean of Research

/ms

Appendix B.1: Request letter of support from the Health District Director

UNIVERSITY OF
KWAZULU-NATAL

15 August 2019

Mrs. NE Hlophe

District Director

King Cetshwayo Health District

Empangeni

Dear Mrs Hlophe,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH SOCIAL WORKERS WITHIN THE KING CETSHWAYO HEALTH DISTRICT

I am Zama Maxhakana a Masters (Research) candidate at UKZN, Howard College. I am conducting a study on hospital social work practitioners' experiences in working with health practitioners within a multidisciplinary health care setting.

The overall aim is to explore the experiences of social work practitioners in working with health care practitioners within a multi-disciplinary health care setting.

The objectives of the study are:
To explore social work practitioners' understanding of their role within the multidisciplinary health care setting.
To determine social work practitioners' experiences of working with health practitioners in multi- disciplinary team.
To examine the extent of boundaries in relation to social work practice within the multi-disciplinary health care setting and
To propose recommendations for enhancing the overall functioning of the multi-disciplinary teams.

The study has a potential benefit to contribute in building knowledge and support needed in multi disciplinary approach health care facilities.

The study will further contribute in improving health service delivery to patients and their families and community at large, less burden of diseases and increased life expectancy span.

I hereby seek for permission to conduct in depth interviews with the hospital social workers working with health practitioners within King Cetshwayo health district. The participating facilities are Ekombe hospital, Eshowe hospital, Kwamagwaza hospital, Mbongolwane hospital, Ngwelezane hospital, Nkandla hospital and Queen Nandi hospital. The planned sample size is 15 participants.

The proposed visit dates will be between September to October 2019. Interviews will be done after the scheduled district social workers' forum meeting.

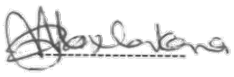
Interviews will take about 45min to an hour. There will be a report back of study findings. This research will only commence once the Provincial health Research committee (PHRC) has granted approval.

As per SOP circular no: 08/01/2019 a gate keeper permission cannot be obtained without prior letter of support from the office of District Director.

If you require any further information, please do not hesitate to contact me telephonically on 083 542 5723 or via email address zmaxhakana@gmail.com or my supervisor, Mr Sithole on sitholes3@ukzn.ac.za.

Thank you for your time and consideration in this matter.

Yours sincerely,



Zama Maxhakana(Mrs)

Masters Student at UKZN(Howard college)

Email: zmaxhakana@gmail.com

Cell: 083 542 5723

Appendix B. 2: Approval letter from the Health District Director

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE

Physical Address: No2 Lood Avenue Corner of Chrome & Crescent Empangeni
Postal Address: P/Bag x20034, Empangeni Rail 3910
Tel. 035-787 6201 Fax: 035-7870644 Email: khanyo.hlophe@kznhealth.gov.za
www.kznhealth.gov.za

Reference: Research Study

Date: 31 October 2019

To: Principal Investigator: Zama Maxhakana
Student Number: 2190 85972
School of Applied Human Sciences (Social Work)
College of Humanities
University of KwaZulu-Natal
zmaxhakana@gmail.com

Supervisor: Sithole M.S
Tel. No.: 031 2603 802
Email: Sitholem3@ukn.ac.za

CC: Dr. E Lugte: Manager Research Unit ZN DOH

RE: PERMISSION TO CONDUCT RESEARCH "EXPLORING HEALTH SOCIAL WORK PRACTITIONERS' EXPERIENCES IN WORKING WITH HEALTH PRACTITIONERS WITHIN A MULTIDISCIPLINARY HEALTH CARE SETTING, KING CETSHWAYO DISTRICT"

I have pleasure in informing you that permission has been granted to you by the King Cetshwayo District Director to conduct research on "Exploring Health Social Work Practitioners' Experiences in Working with Health Practitioners within a Multidisciplinary Health Care Setting, King Cetshwayo District.

Please note the following:-

1) Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2) This research will only commence once this office has received approval of your study from the Provincial Health Research and Ethics Committee (PHREC) in the KZN Department of Health.
3) Please ensure this office is informed before you commence your research.
4) The District office/facility will not provide any resources for this research.
5) You will be expected to provide feedback on your findings to the District Office/Facility.
6) You are required to contact this office regarding dates for providing feedback when the research has been completed.

Sincerely,

Mrs. NE Hlophe
District Director:
King Cetshwayo District

Fighting Disease, Fighting Poverty, Giving Hope

Appendix C.1: Request for permission to the Department of Health

UNIVERSITY OF
KWAZULU-NATAL

13 November 2019

Chairperson

Health Research Committee

Health Research and knowledge Management

Department of Health -KZN

Private Bag X90951

Pietermatizburg

3201

Dear Dr. E. Lutge,

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY WITH SOCIAL WORKERS WITHIN THE KING CETSHWAYO HEALTH DISTRICT

I am Zama Maxhakana, a Masters (Research) candidate at UKZN, Howard College. I am conducting a study on hospital social work practitioners' experiences in working with health practitioners within a multidisciplinary health care setting.

The overall aim is to explore the experiences of social work practitioners in working with health care practitioners within a multi-disciplinary health care setting. The objectives of the study are:

- To explore social work practitioners' understanding of their role within the multidisciplinary health care setting.
- To determine social work practitioners' experiences of working with health practitioners in multi- disciplinary team.
- To examine the extent of boundaries in relation to social work practice within the multi-disciplinary health care setting and
- To propose recommendations for enhancing the overall functioning of the multi-disciplinary teams.

The study has a potential benefit to contribute in improving and building knowledge and support needed in multi disciplinary approach health care facilities. It will further contribute in

improving health service delivery to patients and their families and community at large, less burden of diseases and increased life expectancy span.

I hereby seek permission to conduct interviews with the hospital social workers working with health practitioners within King Cetshwayo Health District. The proposed participating facilities will be Ekombe Hospital, Eshowe Hospital, Kwamagwaza Hospital, Mbongolwane Hospital, Ngwelezane Hospital, Nkandla Hospital and Queen Nandi Hospital. The planned sample size is 15 participants.

Interviews will take about 45min to an hour. There will be a report back on study findings. I am aware that this study will only commence once the Provincial Health Research committee (PHRC) has granted approval. As per SOP circular no: 08/01/2019

A letter of support from the office of District Director King Cetshwayo has been obtained.(Attached)

Thank you for your time and consideration in this matter.

Yours sincerely,

Zama Maxhakana(Mrs)

Masters Student at UKZN(Howard college)

Email: zmaxhakana@gmail.com

Cell: 083 542 5723

Appendix C.2: Permission letter- Department of Health

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_202001_009

Dear Mrs Z. MAxhakana
UKZN

Approval of research

1. The research proposal titled **'Exploring health social work practitioners' experiences in working with health practitioners within a multidisciplinary health care setting'** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at the King Cetshwayo District.

2. You are requested to take note of the following:
   a. Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.
   b. Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.
   c. Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za
   d. Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Provincial Health Research Committee
Date: 18/04/2020.

Fighting Disease, Fighting Poverty, Giving Hope

Appendix D.1: Application for the Amendment of Data collection instrument

UNIVERSITY OF
KWAZULU-NATAL

20 April 2020

Dear Mr. Sithole,

RE: AMENDMENTS OF DATA COLLECTION INSTRUMENT DUE TO COVID-19 PANDEMIC

The approved (both full and provisional HSSREC-00000603/2019) ethics application indicated in depth interviews as a method of data collection to be used.
However due to covid-19 pandemic and as part of preventive measures to reduce the spread of the transmission, I would like to devise and consider telephone interviews as a data collection strategy. Informed consent forms will be attained in writing.

Your consideration is highly appreciated.

Yours faithfully,

ZI Maxhakana

Principal researcher

MS Sithole

Supervisor

Appendix D.2: Approval- Amendment of Data Collection Tool

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

04 May 2020

Mrs Zama Immaculate Maxhakana (219085972)
School of Applied Human Sciences
Howard College Campus

Dear Mrs Maxhakana,

Protocol reference number: HSSREC/00000603/2019
Project title: Exploring health social work practitioners experiences in working with health practitioners within a multi-disciplinary health care setting
Degree: Masters

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 22 April 2020 has now been approved as follows:

- Change in data collection tool

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

Best wishes for the successful completion of your research protocol.

Yours faithfully

.....
Professor Dipane Hlalele (Chair)

/dd

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

Appendix E. Recruitment of Participants

RECRUITMENT EMAIL

Dear Colleague,

I hope this email finds you well.
The purpose of this email is to formally solicit your participation in my qualitative study on "Exploring health social work practitioners' experiences in working with health practitioners within a multi-disciplinary health care setting'. I will have a time slot to conduct the interview which will take about 15-30 minutes of your time.
Your participation and perspective will be greatly appreciated as I conduct my research.
Should you have any questions or queries regarding this research, please do not hesitate to contact me.

Warmest regards,
ZI Maxhakana
Cell no 083 542 5723

Appendix F: Informed Consent for the participants

community at large, less burden of diseases and increased life span. There will also be no foreseeable risks or harm that can be imposed by the research study to you. Participation involves an interview where you will be asked to relate your professional experiences, and no names of people or sensitive information will be required of you.

You are hereby being asked to take part in this research study. Before you decide to participate, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

The study procedure is as follows:

In order to participate in this study: you need to be employed by department of health as a social worker and be part of the MDT. You will be required to sign a consent form should you agree to participate.
Participants will be asked to participate in-depth interviews reflecting on their perceptions and experiences of working with health practitioners within the multi -disciplinary health ca re setting.
Interviews will be conducted after the scheduled district forum meeting.
Interviews will take about 45min to an hour and the time of involvement will be a minimum of 2 occasions.
Interviews will be audio recorded. Participants are welcomed to object audio recording.
Participation is voluntary. You can withdraw anytime should you wish to do so.

BEFORE YOU TAKE PART IN THIS STUDY: PLEASE NOTE THE FOLLOWING

Your anonymity and confidentiality will be ensured.
Your personal identifying details is not required in this study.
You are not forced to answer if you don't want to.
You do not pay anything to participate in the study.
Responses will be treated in a confidential manner.
You are free to withdraw at any given time.
Interview transcriptions will be kept in the personal possession of the researcher and with the supervisor of the study for the period of 5 years. Necessary procedure for disposal will be adhered to.

CONTACT INFORMATION:

Should you have queries, questions or you experience adverse effects as a result of participating in this study, you may contact directly the research office:

Name : Ms P. Ximba (HSSREC)

Contact no : 031- 260 3587

Email : ximbaP@ukzn.ac.za

or

Name : MS Sithole (Research Supervisor)

Contact no : 031 2603 802

Email : SitholeM3@ukzn.ac.za

Or

Name : Zama Maxhakana

Contact no : 084 542 5723

Email : zmaxhakana@gmail.com

CONSENT TO PARTICIPATE:

I hereby confirm that I have been informed by the researcher, Mrs Z Maxhakana about the nature, conduct, benefit and the objectives of the study.

I have also received, read and understood the above written information regarding the study.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost.

I understand that I will be given a copy of this consent form on request.

In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.

Surname and Initials

Participant's signature _____ Date _____

Surname and Initials

Researcher's signature _____ Date _____

Appendix G: Interview Guide

INTERVIEW GUIDE

EXPLORING HEALTH SOCIAL WORK PRACTITIONERS' EXPERIENCES IN WORKING WITH HEALTH PRACTITIONERS

Date of data collection:

1. DEMOGRAPHIC INFORMATION

Please tick the appropriate box

Age : | 20-30 | 30-40 | 40-50 | 50+ |

Gender : | F / | N / A |

Years of experience in healthcare setting: | 5 | 10-15 | 15-20 | 20-25 | 25+ |

Exposure to the MDT: PLEASE TICK | Often | Not often |

1. UNDERSTANDING THE ROLE OF THE SOCIAL WORK PRACTITIONER IN THE MULTIDISCIPLINARY TEAM

1.1. How would you describe the understanding of your role in the MDT?

1.2. What services do you provide in the MDT?

1.3. Do you think your role is vital as part of the MDT? If yes, explain.

1.4. Can you describe contribution of MDT to patient care?

1.5. What factors beyond your control hinder you from performing your duties within the MDT?

2. EXPERIENCES IN WORKING WITH HEALTH PRACTITIONERS WITHIN THE MDT

2.1. How do health professionals view your role within the team?

2.2. What does the MDT mean to you?

2.3. Can you describe your working relationship with health practitioners in the MDT?

2.4. What are your views on areas of the MDT do you feel you are struggling?

2.5 How do health professionals value your contribution within the team?

3. BOUNDARIES IN WORKING WITH HEALTH PRACTITIONERS IN THE MDT

3.1. What boundaries do you know about working with other health practitioners?

3.2. What have you noticed in your experience as the most challenging boundaries in the MDT?

3.3. What are you currently doing to manage or cope?

3.4. What impact does it have on you?

4. POSSIBLE RECOMMENDATIONS IN ENHANCING THE FUNCTIONING OF THE MDT

4.1. What recommendations can you suggest?

4.2. What can be done to improve the MDT functioning?

4.3. What are your expectations in working with health practitioners within the MDT?

4.4. What is your biggest challenge in the MDT? How can it be resolved?

THANK YOU FOR YOUR PARTICIPATION

Celine Lourens

57 Somerset Country Estate
450 Queen Elizabeth Avenue Westridge,
Berea Durban
4091

078 905 8517

Lourens.r.celine@gmail.com

20 July 2021

Letter of Editing

This report serves to state that the dissertation submitted by ***Zama Immaculate Maxhakana*** has been edited.

The dissertation was edited for errors in syntax, grammar, and punctuation. The in-text referencing system used has also been edited along with the bibliography.

The edit will be regarded as complete once the necessary changes have been made and all the comments have been addressed.

Thank you for your business.

Yours sincerely,

Celine Lourens

Exploring Experiences of health social workers in working with health practitioners

ORIGINALITY REPORT

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