A Longitudinal Look at Social Work Leadership in Hospitals: The Impact of a Changing Health Care System

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This article examines the responses of social work administrators to the changes occurring throughout their hospitals over three time periods in the 1990s; the major accomplishments of social work services in their facilities; and the failures, frustrations, and obstacles in the delivery of social work services. It compares the reports of social work director cohorts on the changes they experienced over an eight-year period with what they had expected in their settings. It also analyzes their perceptions over time of obstacles and opportunities for hospital social work administrators in response to these changes. The authors present the ways in which social work administrators understand and address the complexities they face.

KEY WORDS: *health care; hospital social work; leadership; management; organizational change; social work administration*

A growing emphasis on market-driven cost-containment strategies causes changes in the auspices, structure, and delivery of services in the health care system (Lee & Alexander, 1999; Miller, 2000). Most hospitals have restructured to achieve flatter organizational frameworks by eliminating professionally defined departments such as social work, nursing, and physical therapy. Many have moved to a more service line approach or to more integrative structures (Berger et al, 1996; Berger, Robbins, Lewis, Mizrahi, & Fleit, 2003; Edwards, Cooke, & Reid, 1996; Ginzberg & Keys, 1995; Globerman & Bogo, 1995; Globerman, White, Mullings, & Davies, 2003; Rosenberg & Weissman, 1995). Hospital management focuses as much, if not more, on fiscal accountability than on clinical indicators or quality improvement. In addition, many hospital systems have seen a significant reduction of inpatient beds, the separation of profit-making specialty centers such as renal dialysis from the overall hospital structure, and a shift to ambulatory care.

In 1994 the Society of Social Work Administrators in Health Care and the National Association of Social Workers commissioned a national study to examine the effect of changes in the health care arena on hospital social work roles, structure, and practice. It was designed to identify critical issues facing social work leaders in those systems over that decade, specifically, the mechanisms and strategies they used and anticipated using to respond to actual and anticipated changes. We reported on findings in 1996 based on responses from the first cohort of hospital social work leaders (that is, managers, administrators, and directors), who reflected on the years 1992–1994 (Berger et al., 1996; Mizrahi & Berger, 2001). This article presents longitudinal data on two additional social work administrator cohorts. It answers the following questions: How have hospital social work leaders viewed their roles over the decade? How have changes in the larger hospital environment affected their roles and functions? Are they optimistic or pessimistic about the opportunities for hospital-based social work in the future?

LITERATURE REVIEW

Leadership in the social work profession has taken on greater importance in response to social, cultural, economic, and political forces that shape social services provision (Gabel 2001; Menefee, 1997; Rank & Hutchison, 2000). Gellis (2001) explored

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clinical social workers' perceptions of the leadership behavior of their social work director or leader, by drawing the distinction between transactional and transformational leadership (Bass, 1985; Burns, 1978). *Transactional leadership* promotes exchanges between leaders and followers; *transformational leadership* facilitates organizational change toward a new vision of the future. The latter places the emphasis on inspiring and motivating followers to work toward a common organizational goal that may supersede individual interests. To the extent that transformational leadership can be attained in the current climate, social work leaders need to convey to their superiors and their subordinates a positive sense of accomplishments and opportunities.

With organizational changes (for example, mergers, downsizing), administrators find themselves balancing an internal and an external focus simultaneously. Whereas some administrators rise above the challenges and continue to provide positive leadership, others may become overwhelmed by the chaos and pressure and turn negative. Still others may attempt to survive by accommodating and adjusting to their environment, exhibiting the traits of the transactional leader (Gellis, 2001).

Kerfoot (2000) cautioned that leaders can also become overwhelmed by the day-to-day demands and lose sight of the long-range goals and objectives. She urged leaders to keep their sights on future issues and directions, while simultaneously having a pulse on daily operations (Heifetz cited in Kerfoot). This perspective enables leaders to translate patterns and trends into strategies that could positvely position their departments in the changing environment.

Edwards and colleagues (1996) asserted: "Contemporary social work managers must function in an atmosphere of increasing ambiguity and paradox" (p. 473). Social work managers often find themselves caught in a balancing act of competing demands and needs. In addition to the traditional roles of planning, organizing, and directing, social work managers must possess a high level of resilience to face the pressure created by competing expectations and instability (Berger et al., 1996; Berger et al., 2003; Ginsberg & Keys, 1995; Globerman, Davies, & Walsh, 1996; Globerman et al., 2003).

Rank and Hutchison's (2000) study found that social work leaders identified five common elements in leadership: pro-action, values and ethics, empowerment, vision, and communication. They and others (Menefee, 1997) found that social work leaders identified challenges that may not affect managers from other disciplines, such as the social work profession's values, systemic perspective, concern for others, and concern for its public image and its participatory management style and inclusiveness. That hospitals represent a host setting for social work practice creates additional challenges.

Menefee (1997) reported that executive directors in nonprofit agencies devised complex and seemingly contradictory strategies for success as a result of economic, political, social, and technological trends. These strategies include remaining true to mission; promoting the highest level of professionalism, accurately assessing and planning for the future; managing internal structures and operations in response to external demands and expectations; influencing both the internal and the external environment to promote department and organizational goals and objectives; and preserving the legitimacy of their agencies' services through boundary spanning, public relations, advocacy, interagency collaboration, networking, relationship building, and competition, when appropriate.

In a study of hospital social work leaders in restructured hospitals in Canada, Globerman and colleagues (1996) categorized the themes identified by those leaders into three areas: control over the nature of their work and decision making, social work roles, and the organizational structure. Many of their subjects' concerns appear to be similar to those expressed by hospital social work leaders in the United States: fear of loss of social work identity, uncertainty about cross-training and multiskill demands, boundary blurring, and loss of a social work department structure. Globerman and colleagues (2003) reported on the mechanisms and strategies their respondents used to preserve and enhance their roles, including negotiating, facilitation and collaboration skills, regaining power, developing new areas of expertise that recognize the importance of innovation, creativity, flexibility, specialization, and proactivity.

Our study contributes to the knowledge about social work leadership skills and managerial strategies by analyzing the challenges, pressures, accomplishments, and opportunities that hospital social work leaders identify. That we are able to report data from three different time periods increases our understanding of the changes over time.

METHOD

We used an exploratory–descriptive survey design (see Berger et al., 1996, for more detail on methodology). A standardized questionnaire developed for use in this study was mailed to a stratified random sample of 750 hospitals drawn from the American Hospital Association membership list. Hospitals were stratified according to size, geographic location, and stage of managed care development (determined at the time of the first data collection period). A total of 340 completed questionnaires were returned in the fiscal year (FY) 1994 study (46 percent response rate), 311 questionnaires for FY96 (42 percent), and 310 questionnaires for FY98 (42 percent). A difference of only 10 percent in response rates across the three data collection periods increased confidence in the comparability of the samples. More than 25 percent of the respondents said that they or someone in their department had completed the questionnaire previously, and another 50 percent said that they did not remember.

We asked social work leaders from the three cohorts the same open-ended questions about their preceding two years' experience and their expectations for the next two years. The data compiled looks back to 1992 and is projected beyond 2000. We analyzed their descriptions of the major accomplishments of social work services in their facility (in the preceding two years); the failures, frustrations, and obstacles in the delivery of social work services (in the preceding two years); the major opportunities for social work as a result of organizational changes in their hospital (in the next two years); and the major threats and challenges for social work anticipated (in the next two years) as a result of hospital organizational changes.

Most of the social work administrators responded to all six open-ended questions in all three time frames (roughly 90 percent commented in 1994 and 1996; 83 percent provided commentary in 1998). We analyzed the data from the same open-ended questions for each of the two additional times, both quantitatively, using a content analysis, and qualitatively, using the grounded theory method of a previous analysis (Mizrahi & Berger, 2001); (see Abramson & Mizrahi, 1994, and Mizrahi & Abramson, 1994 for more details on the application of this qualitative methodology). Methods established for the first data set included the use of independent coders to identify themes for each question and then code the whole data set using those themes. The frequency of responses was compared over time using chi square to determine if there were significant changes.

The longitudinal nature of the study design allowed us to look at what a cohort said had occurred and what they thought would happen in the future. We then compared what that (past) cohort anticipated would occur in the future with another (current) cohort's perceptions of what actually had happened. In Tables 1 and 2, *current* refers to responses about the two years before the respondent reported; for example, FY94 current includes answers related to accomplishments from 1992 to 1994; *future* includes anticipated responses in the subsequent few years. For example, FY94 future includes the responses predicted to occur from 1994 to 1996.

In addition to coding their responses to specific questions, we read their overall answers to all the open-ended questions. This was done to attain a global rating that we assigned to the respondents' general attitude about social work in hospital-based health care. This global rating was broken into three categories: optimistic/positive, pessimistic/negative, or mixed positive/negative perspectives. A positive rating was based on whether the accomplishments and opportunities appeared to outweigh the frustrations and anticipated struggles, and vice versa. Assigning a "mixed" attitude meant that the positive and negative experiences seemed to be balanced, if not equal.

FINDINGS

Perspectives of the Social Work Leaders

There was a decrease over time in the percentage of positive social work attitudes (from 52.6 percent in 1994 to 41.3 percent in 1998), an increase in the number of negative attitudes (from 16 percent to 21.6 percent), and mixed positive/negative social work attitudes (from 31.4 percent to 37.1 percent). Although not statistically significant, this is a continuing trend. Whereas the cohort reported fewer problems than positive opportunities in FY94 (732 versus 647), by 1998 the cohort reported a similar number of problems as accomplishments (665 versus 667).

The following reflect positive and mixed social work responses, respectively:

> Our department continues to be strong and valued. While our number of staff has decreased,

it has not been a disproportionate cut to the rest of the hospital. We have been very involved in the development of case management for our high-cost/high-risk patient populations, and the institution has embraced a RN (nurse)/SW (social worker) case management team model.

* * *

The social workers in our hospital cover all units and all age brackets. We have to have such a variety of abilities. We now have the addition of a swing bed unit and are responsible for the subsequent and discharge reviews. However, our relationships with physicians and families have changed; we've become less supportive (to patients) and more assertive in financial/utilization issues... We can play a major role in the financial bottom line, but it has really changed our department's "persona."

Leadership, Influence, and Decision Making

Several social work respondents recognized the concept of leadership in what they did or how they behaved. The words "leadership" or "leader" were mentioned more frequently over time, a statistically significant difference [$\chi^2(2, N = 882) = 10.167, p = .006$]. Not surprising, it was identified much more often by the leaders who were classified as positive. Some of them acknowledged that "increasing social work influence," that is, being at the table where strategic decisions were made, was an accomplishment in its own right. Moreover, one-third of the 1998 cohort anticipated being able to exercise such leadership in the future, up dramatically from the earlier two cohorts (see Table 1). This was consistent with the respondents' answers to a fixed-response question in the larger survey about social work's participation in hospital decision making. Sixty-seven percent of those with positive attitudes indicated that they were involved in their department's decision making compared with 42 percent of those with negative attitudes. Conversely, only 9.9 percent of those with positive attitudes said that they were not involved in hospital decisions compared with 41 percent of those with negative attitudes.

Social Work Accomplishments and Anticipated Opportunities over Time

A drop in positive outlook was reflected in the almost consistent decrease in the percentage of social workers reporting individual accomplishments.

Table 1: Social Work Accomplishments and Opportunities Over Time

Category	Current FY94 % (*N*)	Current FY96 % (*N*)	Current FY98 % (*N*)	Chi Square	Future FY94 % (*N*)	Future FY96 % (*N*)	Future FY98 % (*N*)	Chi Square
New programs (funds, grants, resources)***	38.7 (96)	19.8 (54)	21.6 (41)	$\chi^2 = 10.404$ $df = 2$ $p = .006$	4.8 (15)	12.1 (30)	8 (16)	$\chi^2 = 10.025$ $df = 2$ $p = .007$
Preservation of professional social work***	26.5 (83)	29.0 (79)	36.0 (68)	$\chi^2 = 5.141$ $df = 2$ $p = .076$	8.1 (25)	13.3 (33)	16.9 (34)	$\chi^2 = 9.366$ $df = 2$ $p = .009$
Participation in system reorganization***	25.7 (80)	31.9 (87)	31.2 (59)	NS	9.9 (31)	18.1 (45)	29.7 (60)	$\chi^2 = 32.881$ $df = 2$ $p = .000$
Expanded or reclaimed social work settings/populations***	23.6 (74)	22.0 (60)	16.4 (31)	NS	31.6 (98)	25.8 (64)	15.8 (32)	$\chi^2 = 16.018$ $df = 2$ $p = .000$
New social work roles/responsibilities***	22.7 (71)	20.5 (56)	15.9 (30)	NS	24.0 (75)	20.2 (50)	24.8 (50)	NS
Increased social work positions/coverage	22.4 (70)	20.1 (55)	23.3 (44)	NS	5.8 (18)	9.7 (24)	15.8 (32)	$\chi^2 = 14.274$ $df = 2$ $p = .001$
Increased social work influence	21.4 (67)	19.8 (54)	21.2 (40)	NS	18.6 (58)	22.2 (55)	33.7 (68)	$\chi^2 = 15.887$ $df = 2$ $p = .000$

Note: NS = not significant.
***$p < .05$ if the respondent mentioned this as either a current or a future issue.

The seven areas of accomplishment and opportunity into which all the respondents' answers were originally categorized appear in Table 1. (These categories are defined more fully in Mizrahi & Berger, 2001.) The percentage of social work administrators reporting one or more of seven areas of accomplishment declined from a range of 38.7 percent to 21.4 percent in 1994, and from a range of 36.0 percent to 15.8 percent in 1998 (Table 1). (The figures for 1996 had a slightly lower ceiling—31.9 percent, and a higher floor—19.8 percent).

The percentage of reported social work accomplishments and anticipated opportunities changed somewhat over the years (Table 1). For example, preservation of the social work department or functions, one of the most frequently identified themes previously, rose significantly to the most frequently selected accomplishment by 1998, as this social worker asserted:

> Since my arrival, social workers are organized, work effectively as a group and are viewed by other disciplines as a vital asset to the goals and mission of the hospital.

The percentage of social work leaders who participated in system reorganization also increased; this work included shifting from a discipline-specific to an integrated patient care model or reducing the length of stay. Their ability to increase social work positions and coverage, for example, moving to seven-day-a-week coverage or adding social workers to emergency room and specialized clinics, increased as well.

The most dramatic decline over time was the percentage of social work leaders who identified their ability to create new programs [$\chi^2(2, N = 837) = 6.401$, $p = .041$], new roles [$\chi^2(2, N = 837) = 8.996$, $p = .001$], and expand or reclaim social work functions [$\chi^2(2, N = 837) = 34.620$, $p = .000$]. Of particular note was the reclaiming of primary care functions. The social work leaders classified as positive mentioned primary care significantly more often as an accomplishment than those classified as negative or mixed [$\chi^2(2, N = 843) = 24.767$, $p = 000$].

Several social workers cited multiple accomplishments, typified by this leader:

> Here are my five accomplishments: (1) Staff retention, staff redesign (social work technician to social work assistant, and the addition of a 'flexi' worker; (2) collaboration with quality improvement for redesign of utilization review from nurses to clinical case managers; (3) total staff participation in hospitalwide committees for JCAHO (Joint Commission on the Accreditation of Healthcare Organizations); (4) program planning including the development of a Prenatal Bereavement Program and a new palliative care program; (5) excellent physician and administrative relationships.

Some changes occurred the cohort's predictions during the three time frames. For example, fewer social work administrators anticipated reclaiming social work settings or functions or creating new programs with grants or other resources (Table 1). Conversely, over the three time frames, the cohort predicted increasing social work influence on the system, increasing participation in system reorganization, and preserving their social work department or function, with statistically significant increases:

> Through social worker empowerment, creativity, and innovation, social workers can influence patient-centered service delivery and customer service, improve patient satisfaction, implement patient advocacy, make organizational improvements in care as well as efficiency and efficacy.
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> * * *
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> The organization has increased its awareness of the value that social workers bring to patient care and their contributions. We anticipate increases in social work staff because of their recognized value.
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> * * *
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> An atmosphere of respect exists here for social work... We are active in patient advocacy and lead in the area of diversity, cultural competence, and increasing institutional commitment to affirmative action and an appreciation for diversity.

Cohort Predictions of Social Work Accomplishments Compared with the Reality over Time

A mixed picture emerges in comparing the column FY94 future with FY96 current, and FY96 future with FY98 current (see Table 1).

Successes that Occurred More than Predicted. In 1996 more social workers than predicted in 1994 reported that they influenced decision making, preserved their department or its functions, were involved in system reorganization, and increased social work positions. These trends continued in 1998, with even more reporting increases in positions for social workers than the cohort had predicted.

Successes that Occurred Less than Predicted. Conversely, when looking backward in 1996 and 1998, these administrators did not realize their expectations of creating new programs, reclaiming or developing new social work functions, and initiating new social work roles such as case management and interdisciplinary team models.

One social work administrator reporting in 1998 reflected on accomplishments from 1996 to 1998 and looked forward to opportunities in 2000:

> These were "rebuilding years" [1996–1998], in which we increased staff, required MSW as a minimum qualification, created a new statistical reporting system, expanded service hours, expanded the Material Help Program for indigent patients, obtained improved office space for staff, greatly increased (successfully) the visibility and credibility of the department through a "public relations" campaign within the hospital, provided field placement for MSW students, and removed professional staff from nonprofessional hospital duties. And there's more that lies ahead. Continued growth and stability of our department...Money is becoming available for social work training. Our reputation among patients and professional staff should continue to [be] excellent. Our service delivery is better organized than ever.

Social Work Failures and Challenges

The negative themes that emerged in the respondents' reporting on the years from 1992 to 1994 were categorized under six themes (Table 2; more fully defined categories can be found in Mizrahi & Berger, 2001). One social worker's view of her world included the full gamut of problems:

> My problems include (1) paperwork, which takes so much time that there is not enough time to spend with patients; (2) attitudes from other social workers; nobody thinks like me, except one other social worker; (3) short hospital stays mean very rapid discharge planning; (4) nurses with two-year degrees make more money than I do, with 23 years of experience; (5) judgmental attitudes of the nurses who do not view patients in a holistic way; and they are competitive with us.

Through the late 1990s, the types and anticipated failures or frustrations stayed in remarkably similar rank order, and many reflected statistically significant changes in comparing them over time (Table 2). There were variations over time in certain categories of perceived failures or frustrations. For example, of the six types of reported failures, pressure on social work increased more in 1996 than in 1998, whereas the percentage reporting external threats and impact of department restructuring increased more in 1998. Overall, the type and number of perceived negative factors increased over the decade: in 1994, the range of the six failure categories went from a high of 33.5 percent to a low of 3.8 percent reporting them; the range by 1998 went from a high of 42 percent to a low of 6.0 percent reporting them.

Pressure on social workers from increased demands remained the top problem, with increasing percentages of respondents noting it by 1998. Some of the failures or disappointments were expressed by these two social work leaders:

> Constant downsizing has gradually chipped away at available resources...
>
> We are also being asked to extend coverage to from 6 to 7 days/week with limited resources. It is becoming increasingly difficult to meet the demands being made; there is increasing risk of burnout.
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> * * *
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> Social work morale is at its lowest. There doesn't seem to be hope for the future for the social workers at our facility. They (social work staff) complain about things, and don't seem to have the energy or ability to rise above the situation and advocate for themselves.

This was followed by a reported continued devaluation of or competition with social work by other professionals or administrators, as noted:

> It is a constant process ("struggle") to demonstrate the value of social work services to

Table 2: Social Work Failures and Challenges Over Time

Theme	Current FY94 % (*N*)	Current FY96 % (*N*)	Current FY98 % (*N*)	Chi Square	Future FY94 % (*N*)	Future FY96 % (*N*)	Future FY98 % (*N*)	Chi Square
Increasing pressure on social work***	33.5 (105)	47.7 (125)	42.5 (77)	$\chi^2 = 12.231$ $df = 2$ $p = .002$	15.3 (48)	20.2 (51)	28.4 (61)	$\chi^2 = 13.322$ $df = 2$ $p = .001$
Devaluation or non-recognition of social work	23 (72)	24.4 (64)	19.9 (36)	NS	13.1 (41)	22.9 (58)	22.0 (47)	$\chi^2 = 10.919$ $df = 2$ $p = .004$
External threats with negative con-sequences	20.1 (63)	16.8 (44)	27.6 (50)	$\chi^2 = 7.764$ $df = 2$ $p = .021$	16.0 (50)	13.8 (35)	22.8 (49)	$\chi^2 = 7.074$ $df = 2$ $p = .029$
Decreasing quality of patient care	8.9 (28)	9.9 (26)	7.2 (13)	NS	6.7 (21)	7.1 (18)	6.0 (13)	NS
Elimination or de-professionalization of social work***	8.6 (27)	10.6 (28)	6.1 (11)	$\chi^2 = 6.351$ $df = 2$ $p = .042$	28.8 (90)	23.7 (60)	25.6 (55)	NS
Problems within social work (dept. or profession)***	5.4 (17)	7.6 (20)	17.2 (31)	$\chi^2 = 20.309$ $df = 2$ $p = .000$	13.4 (42)	19.8 (50)	19.5 (42)	$\chi^2 = 5.142$ $df = 2$ $p = .076$

Note: NS = not significant.
***$p < .05$ if the respondent mentioned this as either a current or a future issue.

administration, both in financial terms (for example, timely discharges) and in human terms (for example, good patient/family satisfaction surveys, etc..).

Perceived external threats to social work, meaning factors imposed by the hospital or the outside health system or society, rose significantly. Approximately 20 percent to 28 percent of the social work administrators identified over time one or more such threats.

> Continued below-market salary scale has caused continual staff turnover; budget cuts, cost constraints keep us from being able to provide "tools" for staff to do their work.
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> * * *
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> Managed care and the insane length of time spent on the phone pre-authorizing things have made this job incredibly frustrating. Also LOS (length of stay) has dramatically decreased; I feel like we do "swat team" social work.

Also rising significantly were perceived problems within and for the social work community (that is, blaming a specific group of social workers in their own department or hospital for not adapting to change, or generally blaming the social work profession as a whole for not being able to respond to health system needs or demands); these rose in percentage and ranking over the eight years as noted here:

> Professional identity is less focused from an organizational perspective... The potential for inter-departmental social work staff competition exists.
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> * * *
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> Maintaining a social work identity and cohesiveness is a challenge; redefining social work role to be more responsive to administrative issues such as length of stay, is increasingly difficult.

With respect to predictions, although elimination of a social work department or function occurred less often over time, forecasting at each of the eight-year intervals revealed that the elimination of the department consistently loomed large on the horizon of possibilities.

> In many hospitals, RNs have taken on our role. The challenge is to stay strong as a social work department that brings in business to the

hospital, assists in lowering LOS, and builds bridges with outside agencies; otherwise, who knows if we'll be here in this climate.

Highly statistically significant over time was the frequency with which pressure on social work, already high, continued to be predicted to increase. Indeed, it was predicted with greater frequency in each time frame, as were the external factors negatively affecting social work.

The devaluation of social work by others increased as an anticipated concern in the last four years (1994–1998) of this research, as did anticipated problems within the social work community itself.

Cohort Predictions of Failures and Frustrations Compared with the Reality

There were some important findings when comparing what the social work administrators believed would happen in the future and the actual reported response by the cohort in each of the subsequent two time frames.

Failures that Occurred More than Predicted. In comparing both future FY94 and FY96, with current FY96 and FY98, respectively, the pressure on the social work departments exceeded expectations. There was also less predicted devaluation of the profession. The inability or unwillingness to accept social workers as professional peers occurred more often than anticipated in 1994 and 1996, although that pattern did not continue to 1998. Although external threats were anticipated in FY 1994, 1996, and 1998, the number of external threats occurred more than was forecast, particularly related to cutbacks and downsizing.

Failures that Occurred Less than Predicted. Elimination or deprofessionalization of social work departments or functions did not occur to the degree anticipated. There were perceived fewer problems within or for the social work community than predicted in 1994, and those problems continued to be overestimated for 1998.

DISCUSSION

Despite the continuing crisis in the U.S. health care system and its generally negative impact on hospital growth and survival, it is gratifying that hundreds of resilient, determined, and proactive hospital social work leaders in the United States and Canada act and think strategically (Globerman et al., 1996; Globerman et al., 2003; Menefee, 1997; Rank & Hutchison, 2000). Many of these leaders demonstrate a range of leadership skills and styles that could be considered transformative given their vision, values, innovativeness, and resourcefulness (Gellis, 2001). Yet, the direction in attitudes among these social work leaders is toward increasingly mixed and negative perspectives with respect to a diminution in their accomplishments and opportunities and an increase in the frustrations and challenges. Many of them could be characterized as transactional leaders whose accomplishment is professional survival, with their present and anticipated focus on participating in system reorganization and their identification of problems within social work. In reality, they probably exhibit a combination of the two types of leadership, given the nature of the challenges, conflicts, and ambiguities they face (Gabel, 2001). They are also less optimistic as a cohort than the hospital social workers Globerman and colleagues (2003) studied in Canada.

By the late 1990s, the largest percentage of social workers identified the preservation of social work as their greatest accomplishment, while anticipating the prospect of influencing the system in the future. Many of these social work leaders understand where and how to position themselves for pro-action and power (Globerman et al., 1996; Globerman et al., 2003; Rank & Hutchison, 2000).

At least two negative factors give us pause as to whether social work administrators will be able to continue to implement strategies of influence, even with a sophisticated skill set. Given that the social workers identified increasing pressures on their departments as the primary negative frustration (for example, doing more with less) and perceived external threats as also appearing to escalate, two questions arise: How long can social work leaders hold on? and, at what price, survival?

Challenge One: Maintaining Mission while Accommodating the Market

External threats to the system could lead to contradictory responses, as described by Edwards and colleagues (1996). On one hand, there could be a positive response, especially given that these findings seem to imply that the hospital system has not singled out social work for downsizing or deprofessionalizing (Berger et al., 2003); most of these social work leaders do not feel or act like victims. On the other hand, given the many macro

economic, social, and political factors negatively affecting hospitals and other social service environments (Menefee, 1997), these social workers have less control and ability, at least by themselves, to influence outcomes such as shorter lengths of stay, less revenue, more competition, and so forth. Those factors, coupled with continuing perceptions of competition with nurses, and nurses' nonrecognition of the value of social work, could lead to feelings of powerlessness and burnout (Ballard, 2001; Globerman et al., 1996; Lee & Alexander, 1999; Mladinich, 2001).

A second negative consequence of these findings relates to the question: At what price, survival? It could become increasingly necessary to sacrifice core components of the social work mission and goals to adapt and accommodate to imposed changes, a major concern described by Edwards and colleagues (1996). This issue was also raised by Canadian hospital social work colleagues in the mid-1990s (Globerman et al., 1996), although it was of less concern some years later (Globerman et al., 2003). Whereas mission and values have been found to be important to social work leaders in all settings (Menefee, 1997; Rank & Hutchison, 2000), preserving them is increasingly difficult when the service sector is being driven more by the market than by professional and patient care values (Gabel, 2001).

There is some evidence that social work survival has the potential to compromise social advocacy and commitment to social justice, and it could come at the expense of patients and their families. Over time, these social work leaders less often mentioned patient care and patient-related quality issues in either a positive or a negative context. Did the quality of patient care stabilize or did they pay less attention to that factor as they attempted to survive by performing the functions emphasized by hospital leadership? The latter may have occurred, because many social work administrators appeared to focus more on central management than on clinical operations. In doing so, however, they may have missed opportunities to connect with the line social work staff, engage patients and families as allies, document patient satisfaction and positive social work outcomes, and identify systemic patient care problems.

Challenge Two: Influencing the External while Strengthening the Internal

Most concepts of leadership note that strategic and proactive leaders focus on the internal and the external parts of their agency or system (Edwards et al., 1996; Gabel, 2001; Menefee, 1997). Yet, this appears to be increasingly difficult to do in a climate of competing demands and multiple constituencies. The social work leaders in this study appeared to focus more on systemwide rather than intradepartmental issues, and many acknowledged doing so. This reaction appears to be a necessary component of the leadership role. However, given the concomitant flattening of social work department hierarchies—that is, the reduction in middle-management positions, with an expansion in their span of control and increased responsibility (Berger et al., 1996; Berger et al., 2003)— it is no wonder that even the most proactive social work leaders feel stretched and stressed. Their ability to balance competing demands (Kerfoot, 2000; Rank & Hutchison, 2000), particularly intradepartmental activities, internal hospital operations, and external community expectations, is evident as a primary source of pressure.

It appears that sacrifices have been made, or at least some opportunities have been missed. The last cohort (FY98) reported much less often the development of community-based and primary care services. Reclaiming or creating new settings and programs, as actual or anticipated accomplishments, dropped significantly over time. There may not be as much time to devote to the development of new areas and still maintain or expand the more traditional social work roles and keep their position at the table. Because many of these social work leaders have commented that their social work line staff and supervisors are stretched to the limit, there may be no one available to do quality supervision, let alone program planning and development (Berger & Mizrahi, 2001). Yet, innovation and creativity may be essential to the survival and growth of social work's role in the hospital (Globerman et al., 2003), and in the whole social services sector (Edwards et al., 1996; Menefee, 1997).

There may be other explanations for why a decreasing percentage of social work leaders are getting involved in these service areas. The corporate hospital model, with its division into financial centers, may make it difficult or risky to be innovative. And many hospitals have consolidated, merged, or downsized.

Another way of interpreting these findings could be related to another stated accomplishment—"preserving social work (department, positions,

functions, and so forth)." If surviving means preserving, rather than adapting and reconfiguring traditional roles and responsibilities, there will be fewer opportunities to innovate and expand into other settings or work with new populations, especially in a time of resource constraint. Regardless of the reasons, by not engaging in some innovative programming, collaborative activity, and community outreach that may benefit the hospital in the long run (Edwards et al., 1996; Menefee, 1997; Rank & Hutchison, 2000), social work could take a back seat to other professions who will take the leadership role, for example, nursing or public health. Furthermore, social work's skills in these macro areas will not be recognized or used.

A final clue to the trade-offs involved in prioritizing a hospital system perspective at the expense of building the internal social work community is a problem within the social work community or profession. Issues interpreted as "internal to social work" were identified as current and future concerns by 1998. These were manifested in expressed frustration with their own staff and laments about the social work profession's inability to document effectiveness and efficiency; that is, the value-added factor. Globerman and colleagues (2003) noted the importance of setting standards and evaluating practice as paramount concerns to hospital social workers in Canada.

Social work leaders must pay attention to who is minding the social work store. Clearly, the most positive social work leaders in the study had structures and supports for staff in place. However, we did not ask what supports and resources they put in place to compensate for increased workload and feelings of devaluation among their staff. We agree with Kerfoot (2000) and Heifetz (1994), who cautioned managers not to become overwhelmed by day-to-day demands at the expense of long-range goals and future planning. However, social work leaders must not lose sight of internal operations as they fight to position social work in the larger organization.

Social work leaders need to avoid excessive professional self-blame for not being able to control key variables in their work environment. After all, physicians, nurses, and other health care professionals also voice concern about encroachment into their autonomy, income, and practice. This may be a time for coalition building with other professions (Edwards et al., 1996; Globerman et al., 1996; Menefee, 1997; Rank & Hutchison, 2000).

It is important for social work leaders to function well at three levels—the hospital/macro level, the internal (department or program) level, and the external/community level. They need to cultivate other staff leaders, redesign functions, prioritize goals, and promote internal communication to create a sense of professional pride and collective ownership. And these leaders need support from other leaders and from the professional and academic resources of major social work institutions to make their case. They must develop mutually supportive staff-driven activities, and mechanisms to share information, ideas, and resources about best practices, survival models, and methods of reorganizing roles and functions within and between hospital systems.

Finally, professional social work organizations should develop professionwide advocacy campaigns documenting the value and enhancing the image of social work in hospital and other health care settings. This effort includes mobilizing professional and patient allies who recognize the vitality and necessity of social work as part of the health care team and supporting applied research to provide the data to establish the value-added aspect of social work services.

CONCLUSION

By 2000, social work leaders in hospitals appeared to have a realistic and balanced view of opportunities and challenges. Given the social, economic, and political circumstances surrounding the health care system, it is understandable that a growing sense of vulnerability and pessimism about the future exists. It is laudatory that so many social work leaders have remained in the system as pillars of strength to the social work profession.

Despite significant barriers, a majority of social work directors are strategic and transformational leaders, using strategies that position social workers well for policy and practice roles in their institutions and in the community. Although many in this cohort successfully balance competing demands and needs, increasing numbers of health care administrators are leaving the ranks of management (Ballard, 2001).

These data point to many areas for future research. Quantitative and qualitative studies are needed to increase our understanding of leadership

and coping strategies in an environment characterized by decline rather than growth. We need to better understand how managers balance competing priorities. What skills and strategies are used to maintain the balance necessary for effective leadership in a constantly changing environment? What factors are associated with those who stay and those who leave the organization, and with those who maintain a positive rather than a negative attitude? What toll does the increasingly articulated pressure take on them and their staff? How do they manage the pressure, and what strategies are used to minimize the negative impact of the pressure on their personal and professional life? Finally, we need others' views to authenticate or present alternative views of the hospital social work leaders' world—capabilities and limitations.

Conflict and chaos are inherent in today's health care and social services environment, but with appropriate support and strategies, leaders can endure and even embrace instability rather than seek to avoid it. Kazemek (2000) said the present health environment has "courage anemia." The health care system needs leaders willing to make bold decisions, while figuring out strategically with others when to accommodate and acquiesce, when to negotiate and compromise, and when to hold on and resist destructive forces. This disequilibrium may actually promote creativity, innovation, and renewal. HSW

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