

I Could Never Do What You Do

Contributed by Gary Weinstein

Social workers often hear this: "They couldn't pay me enough to do what you do!" Or, more flattering, "Thank goodness you're here!" Or, "I don't know how you do what you do." And even, "I thought about social work, but I could never do what you do." {mosgoogle right}

Our colleagues in nursing and throughout the medical community have some idea what social workers do—enough of an idea to know it is difficult, mysterious, taxing and sometimes risky work. Some have no concept of what it is we do and are only further mystified when we try explaining.

Oddly, social workers know well what nurses and physicians do. We feel similarly: we could never do what they do! We've often called social work the invisible profession. We do little, if any, self-promotion. Our greatest skills, our greatest assets, are unseen. The ability to occupy a room with grieving or enraged clients and remain clear-minded and helpful, strategic, and professional—this is a lifelong skill developed over years of training and experience. The management of complex family, community, and professional systems is an acquired expertise. The management and counseling of difficult emotions, mental health crises, and social catastrophe is a fine art, honed in the heat of countless client encounters. Skilled listening, systems thinking, advocacy, alignment, and decisive interventions are all designed to unlock obstacles and resolve patient difficulties.

They are non-transferable, and they are invisible to colleagues, cohorts, and clients. Yet we use them all day long, hone them, and offer them—in how we enter a room, the precise words we choose, the manner in which we carry ourselves, the thinking and sensitivity we bring to bear when most other professionals may be at a loss.

As an Emergency Department and Intensive Care Unit social worker at University Hospital in Syracuse, New York, I rotate hats and work many roles. Upstate Medical University's 360-bed hospital is a Level One Trauma Center. It is a crossroads for treatment, trauma, research, and teaching for a vast swath of upstate New York. Here, these skills are brought to bear daily by our staff.

Diplomat

Ralph wants to leave against medical advice, because he is terrified about the expense of his hospital stay. He needs to get home to his pets, and he's angry. Nursing has called social work to speak with him. Ralph's physicians want him to stay through the weekend, but he refuses. I ask him whether our patient financial office has had a chance to meet with him, given he has no health insurance.

"No! And I don't care, and you can't make me stay!" He'd been in surgery and unable on other occasions to receive counsel on his financial options.

"Ralph, I understand; it's Sunday, and no one is here. But first thing tomorrow, I promise to have someone here to review your options. You have several. Leaving against medical advice is your worst option. You haven't gotten to hear all your options, because you were in treatment. You might well be Medicaid eligible. There is hospital financial assistance. There may be worker's comp or Federal disability. But if you leave without working it out, you'll actually be in far worse shape."

We problem-solve who will feed his animals. I make some calls and locate a trusted neighbor. After napping and his pain subsides, he decides to stay.

Family Therapist

"Don's wife has received a definitive diagnosis of terminal liver cancer. I can't tell my daughters. I've always tried to shelter them."

"So, Don, your strong wish is to protect them from this and not tell them. They are how old?"

"19 and 21. The older one, she may already know, or sense something."

"So, they're both young adults. Given Gwen's limited time, how do you think this will go—if you told them both, and, alternatively, if you did not?"

"Well, I could tell my oldest, but my younger one, she could never take it."

"Her mom's news is coming one way or another, no? Can I help you find a way, or find the words, or some way through this?"

"That would be good...."

"How might you start, Don? Can you picture it? What words would work?"

Don begins to tremble and cry again. We spend an hour together, down the hall from his critically ill wife, examining his family's crisis. We carefully select words, and imagine his daughters' grief. I help him reason through his options. He'd been stuck; he feels he's reached new ground.

Psychotherapist

"How do you deal with the guilt?" Drew asks, standing beside me in the Emergency Department by his 92-year-old mother's room. He's decided to place her in long term care, ending her life of independence.

"She always said, 'Don't ever put me in one of those homes!'" Tears fill his eyes, this grown man of seventy years, as deep regret and guilt grip him for fear he's betraying her. The ED swirls around

us as we have about fifteen intense minutes to process his anguish.

I offer, "Imagine, Drew, if you did not place your mom at this time, and she fell while alone at home and possibly died alone. Or if she accidentally set fire to her house. How horrible that would be."

He brightens with this reframe. It dawns on him he is protecting her by considering placement, "Well, that would be so much worse. You're right. I need to think of it like that. Still, it's hard to look her in the eye and tell her. She's not demented. She knows what's going on."

"Keep repeating to her your promise to keep her safe, and your promise not to abandon her or forget her."

Drew seems visibly lighter when we are done. His work has only just begun. But he has been helped to know in what direction to head.

Death Notification

Ambrose arrives to the Emergency Department with only a scrap of paper recovered from his pants pocket by EMS. It has two phone numbers. One is a home phone, though before losing consciousness with massive heart failure, he told EMS he lives alone. Moments after arriving, he dies. I have nothing but this scrap of paper, so I call the first number on an off chance, and...his brother answers. Before I can fully explain anything, he tells me he's unable to drive and cannot get to the hospital. He'll call a sister.

Moments later, Ambrose's sister Helene calls. In an instant, I must assess: Do I tell her of her brother's death, or not? Or do I mask the fact and say he's "critical"---even as this is not true---to prevent her learning the bad news while unaccompanied and risking that she drives here while distraught? How do we know she'll be distraught? Do I tell her, simply, she "must" come to the hospital? What if she, perhaps angrily, presses me about his condition? Do I maintain the deceit? Do I hand the phone off to an attending physician, risking they may or may not maintain the fiction I have offered?

Who am I to tell her she must come to the hospital? I have no idea of the quality of their relationship. She may not be the appropriate person to come. Do I tell her "someone must come"? Wouldn't that be suspicious? Why must someone come? Do I conceal the fact of his death, risking she may later find out that at the time I called, he was, in fact, already deceased and that the truth had been withheld?

All these questions spin through my thought. In the end, on wisdom and instinct, I tell her, as compassionately as I can, "I'm so sorry, Helene, he did not make it. He collapsed at work. Everything possible was done to save him while in the ambulance and once he arrived. Is there someone who can come to the hospital?"

I can tell she is tearful, but calm. She thanks me. She says she will inform family and come as soon as she's able, with their accompaniment.

Advocate

Muriel is a 54-year-old woman suffering crippling major depression. She is suicidal, helpless, hopeless, barely responsive to staff, and reports auditory command hallucinations. Our own inpatient psychiatry unit is full. ED staff ask me, "When can we get her out of here?" and, "Have you found a bed for the psych case?" and "When is our nutcase going?"

Muriel has seen three psychiatrists in 36 hours, but has not been prescribed medication. Had she broken her arm, or reported chest pain, fainting, or vision loss, or any of countless other symptoms, she would be 30 hours into treatment. Not so with psychotic depression. Muriel languishes, awaiting transfer to a different hospital, yet to be located. Staff are annoyed, frustrated, angry with a system that fails the mentally ill. Stigma and discrimination unfortunately bubble up as a result.

Until I suggest to staff, "Few see it this way, but her condition is, in fact, life-threatening. People with her illness deserve and need better. Her pain and suffering is equivalent to other emergency presentations, but our response is not. We're the problem, not her."

To her sister and daughter, I try diplomatically and compassionately to explain the scarcity of treatment beds and the discrepancies in care. I explain our plan to keep Muriel safe and locate treatment. Surprisingly, they understand and accept. The deficiency in our local mental health system is not new to them.

Life Investigator

Sam arrives on the ICU with only his sliced and bloodied clothes. He has no wallet, no ID, no cell phone. He is near death, having been shot point blank in the chest by someone reported to be his lover's boyfriend. By happenstance, I know the patient from the county correctional facility where I once worked. I contact a local mental health case management agency to begin searching facts of his existence. His old case manager says they have not worked with Sam in years. I call the area psychiatric emergency program, where they tell me Sam has made over 100 presentations. I learn his psychiatric med regime.

They inform me of a "sister," who is in fact a woman with whom the patient grew up in foster care. She is not next of kin, nor Sam's health care proxy. She tells of various possible siblings and an aged, out-of-state mother. I follow every lead in search of them, but none materialize. She tells me of Sam's estranged legal spouse. I search her phone number regionally and call her. She is psychiatrically disabled and unwilling to be any part of Sam's care. The two had met at the psychiatric emergency program. Sam violently assaulted her numerous times. There may be a standing order of protection between them.

I speak with the district attorney researching the crime. He asks me to call him when Sam is able to speak. This will take seven weeks. It takes me days to reach the Federal SSD office to ask about any next of kin. They say there is none. It takes more days to reach his landlady to ask whether his apartment can be held without rent being paid. No one can access his bank account. His Federal SSD monies will be reduced while he is hospitalized. He may lose his apartment and all his belongings.

Seven weeks hence, Sam will rise from his bed and return to life. Meanwhile, social work will make countless efforts to keep the threads of his life from fraying.

Emergency Escort

While 22 medical professionals perform life sustaining measures on Wilma, 66, in the trauma bay, I meet with her husband, Alvin, in a small, private family room. There, I try explaining some of the procedures being used to save her life. I ask Al for any of Wilma's medical history, his wife's doctor's name, her medications, and recent hospital stays. I know the ED attending physician will need this information.

I also make sure to ask about next of kin and any advance directives wishes. I promise to return in moments with a physician to give him the most current details about his wife's condition. He asks for coffee and help making some long distance calls, because he left his cell phone at home in the emergency rush to the hospital. As he speaks with relatives, I sit near to help answer the many questions they have that Al is overwhelmed by. I try to anticipate his other needs. I am the bridge between his interminable wait and the staff's assiduous efforts to keep his wife alive—and between the hospital and the far flung family he's trying to inform.

Mediator

Rebecca arrives on the ICU without any family accompanying. Her boyfriend, Tim, arrives hours later with a cheesecake for staff (!) and Rebecca's health care proxy form, naming him as decision maker.

He warns us she has nine children, "none of whom are mine." He rolls his eyes summarizing the trouble several of her adult children recently gave the previous hospital—interfering with care, arguing with nursing, force feeding Rebecca against nursing directives, fighting over who could visit. He warns nursing to expect trouble.

"They don't much like me, her kids, but I am her health care proxy, as you can see."

Nursing decides, "Let's call social work." I decide to be proactive and call the daughter listed in Rebecca's chart to make initial contact. I want to explore what issues we might expect. "You know she and Tim are not married," Marielle, the eldest daughter, tells me. While guarding confidential information, I listen and provide some clarification.

"She appears to have a valid health care proxy," I say.

"Well, we haven't seen it. Is Tim there? He's not going to do this again!"

How can we help your family? I ask. What would your mom want? Let's try thinking from her point of view, since she cannot.

Silence.

Marielle, let's make a time to have a family meeting this week.

Translator I

I'm with Brian's family—his wife, parents, brother, and sister—as two neurosurgeons describe his brain injury. The subarachnoid hemorrhaging is distinct from the hematoma and intracranial bleeding.... An orthopedic fellow explains his bone fractures. We'll stabilize the tibia and further scan his anterior descending...all following his fall from a roof. A trauma surgeon explains Brian's general course of care. Each specialist has tried to be as helpful as possible, giving maximum information. Once they've all left, I can easily discern how overwhelmed the family is. They need translation.

"Tell me what you heard them say," I say.

They look at one another and seem lost. "They can't work on his leg until later, and he's breathing on his own..." his sister says. I affirm that, then ask, "Did you hear the neurosurgeons discuss his scan? That his injury is extensive—beyond what surgery can help?" Silence, as they absorb this.

His sister speaks again: "I heard them say the bleed in his brain must be watched for several days and that it will take a long time to assess any permanent effects." They nod. Now they remember. I review the expected course of care, the initial ICU experience. They seemed to hear very little, or did they? Are they unable to restate what was said, or are they too afraid to say things aloud.

Impromptu Good Samaritan

While on my way to lunch, I encounter a woman leaving the stairwell convulsed in tears, "They told me come here, to the emergency room. They said my mama's here. That she was probably dying." She is choking back tears, unraveled. "I'm lost! Can you help me!? Which way is it?"

With my arm around her, we walk the long hallway, the many confusing turns, to be directly at her mother's bedside. All the way I comfort, assure, and accompany. I had had no moment of indecision; we virtually walked into one another—her need and my knowledge and readiness. Lucky me.

Advisor on Advance Directives

Theo needs a kidney donated for his failing ones. He and his wife, Susan, are undergoing the assessment and evaluation stage for recipients. Susan is willing to donate one of her kidneys, if she can be matched to Theo. I ask whether they have named Health Care Proxies (HCP).

“Well, Theo has done his,” Susan tells me, “But not me.”

I realize in an instant that should Susan undergo surgery for kidney donation, she too will need to name an HCP. This suddenly complicates matters. Rather than Theo simply naming his wife, they both must consider third parties, as they may both be incapacitated by surgery at the same moment. They cannot name one another as many spouses do.

A lengthy discussion ensues in which they consider no less than five different family members—their adult daughter, Susan’s brother, Theo’s brother, their close and devoted neighbor, and Theo’s cousin. I guide them through an evaluation of each candidate. Who is most decisive? Who knows them both best? Who might live far away? Who may be uncomfortable in hospital settings? Who is feeling yet objective? Who, in their gut, do they trust?

This discussion elicits many deeper issues the couple had yet to face, early in their search for an organ donor. Who may outlive whom? What advanced measures will they each accept or not? When does life really end? What makes life worth living? The couple confronts their aspirations, wishes, and fears together in a frank and soul-searching manner. I am privileged to help and advise.

Social Worker

Bette and Lionel, a married couple in their late 70s, were driving Christmas day when black ice on a rural road led to a head-on crash that killed Lionel. Social work is asked to meet their son and daughter in the ED. Bette has arrived with multiple bone fractures. The adult children are in shock, torn between concern for their mother and grief for the dad. They have questions for the physicians about the mother. They have worries about the dad. They were told an autopsy was mandatory, but they object.

It’s Christmas Day and otherwise quiet. I have the entire day to devote to their crisis. I liaison with the remote sheriff’s office on accident details, including where their dad’s body is. I try to obtain answers about the autopsy. I orient them to our immense unknown hospital. They are fatigued, wrung out, isolated, and drained. I help attend to little things and big things—a glass of water, an attorney’s possible motive, how to convey the awful news to younger family members.

Bad Cop

Toby is unresponsive and intubated on ICU following a truck rollover. His wife has told us the only visitors she will allow are herself and her son. Her estranged husband’s girlfriend is not to be allowed to visit.

Later that day, I see the girlfriend at bedside. I need to introduce myself and inform her of the wife’s wishes. I need to delicately ask her to leave. She is tearful and accusatory, “Even though she stole his car? Even though they have not been together in years! She gets to decide this?”

Bad Cop II

“I have heard your telling of the accident, Ms. Rafft, but the physicians here feel the story of your daughter’s injuries are not consistent with the x-rays and the scans. They wonder whether there may be some abuse—either intended or unintended—that has occurred to your daughter.”

“I don’t mistreat my kids!!”

“I hear that. It might be someone outside the family—someone you haven’t suspected. As a hospital, we have an obligation, a duty to involve Child Protective to really, really find out.”

“You saying it’s my husband?!”

“I’m saying we don’t know. You’re saying you don’t know. Child Protective will help us find out.”

“We don’t mistreat our kids! I don’t know what you’re trying to say. I’m gonna get out of here...right now.”

Good Cop

The district attorney and the local police need me to page them as soon as Arnold awakens, so he can inform law enforcement and the DA who shot him at the convenience store where he works. Arnold has been made an alias—his real name disguised and replaced by three letters—to shield him from unknown visitors who may do him harm. Nursing calls for me when strange visitors are seen strolling the ICU hallway asking for him. Staff are unable to even verify his presence. I seek out the visitors to explain the circumstances without revealing Arnold’s presence here.

“We’re looking for Arnold.”

“I’m social work. Can you tell me who you are?”

“We’re his friends. We need to see him. We heard he’s up here somewhere.”

“Well, we can’t disclose anything, but what can you tell me about him and the situation that we should know?”

“What you mean?”

“I mean right now he needs protection, wherever he is. I don’t think the perpetrator has been found. Unless you have heard otherwise. We don’t know who is coming up here. What can you tell me?”

And so on, back and forth, juggling patient protection with visitor needs and our need for information, while not revealing anything to needy, agitated, unknown loved ones.

Bed Finder

Social workers know the available regional psychiatric hospitals best. It’s a good thing. Our own hospital’s psychiatric unit is often full. Other city hospitals, likewise. Patients needing psychiatric care, both adults and children, must frequently be sent out of town for care. No other ailing patient group, presenting with an emergency, is shipped out. It is a major failing of our region’s mental health system. It goes unaddressed.

The result? Social work is relied upon several times weekly to find outlying beds for suicidal, psychotic, and seriously mentally ill patients in our emergency department for whom there is no available treatment at the hospital. This requires untold social work hours on the phone, hours faxing clinical records, negotiation, case presentation, arrangement of transport, bargaining, careful timing, facilitating nurse to nurse and Dr. to Dr. consult phone calls, hours of insurance pre-certification checks by phone, and more. Deficiencies in the local mental health system are masked by these efforts. Mental illness does not have parity with routine emergency medical treatment. This disparity is fixed, patched over, ameliorated daily by diligent social work effort, and thus preventing the systems-change needed.

Writer

Writing about the wide ranging needs social work addresses helps clarify and convey our mission. Finding the words to describe what we see and what we are called upon to resolve is to capture the complexities of hospital work and make our profession more visible. Crises pass by in a blur, one after another, blending into one another, becoming indistinct.

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