ORIGINAL RESEARCH ARTICLE

# Psychosocial Dimensions of Medical Social Work Practice: Roles, Job Satisfaction and Organisational Role Stress

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## ABSTRACT

Medical social workers play a crucial role in addressing the psychosocial dimensions of healthcare, yet their practice realities remain underexplored in the Indian context. This study explores the various roles, functions, job satisfaction, and organizational role stress of medical social workers using the qualitative case study method. Participants from government hospitals, private hospitals, and palliative care NGOs were selected from Thiruvananthapuram district in Kerala. Semi-structured in-depth interviews were used for data collection, and the data were analysed using thematic analysis. The findings revealed that a wide range of psychosocial functions were performed by the participants, their nature varying across settings. The palliative care setting offered the greatest role clarity and autonomy, while private and government hospitals constrained their practice through institutional priorities and resource limitations. All participants reported higher levels of compassion satisfaction, which served as a protective factor against occupational adversity. Extrinsic dissatisfiers identified were lower remuneration, limited career development opportunities, and absence of professional supervision. Major organizational role stressors like role overload, role ambiguity, role erosion, and role inadequacy were identified, all of which created a psychosocial care paradox, where the medical social workers responsible for patient well-being operated within conditions that affected their well-being. This study, thus, calls for equitable career opportunities and professional status for medical social workers and the organizational adoption of a biopsychosocial model of healthcare, where psychosocial care receives equal importance as biomedical care.

**Keywords:** medical social work, psychosocial care, healthcare settings, job satisfaction, compassion fatigue

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## INTRODUCTION

Illness is not merely a biological factor but a lived experience embedded in social background, economic circumstances, emotional states, and cultural meanings. As defined by the World Health Organization, health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (World Health Organization, 1946). This acknowledges that clinical treatment alone cannot address the full spectrum of illness, as it includes several other domains too. To fill this gap between biomedical care and holistic well-being, medical social workers are equipped to operate at the intersection of healthcare and human welfare.

Medical social work is a specialized branch of social work that operates within healthcare settings to encompass diverse areas such as primary health care, public health, community-based interventions, palliative care, and hospital social work. At its core, the profession seeks to address the complex interplay between social factors and illness by facilitating the ability of patients to function at optimal physical, social, and psychological levels within the constraints of disease and treatment (Beder, 2010). This holistic care aspect underscores the relevance of medical social

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work in addressing the psychosocial dimensions that influence illness experiences, treatment decisions, and overall well-being. The profession of medical social work has a long legacy, starting from the earliest works of hospital almoners in the United Kingdom, which later expanded to countries like the United States, Australia, and India (Guite, 2019). Contributions of pioneers like Richard Cabot, Ida Cannon, and Ethel Cohen also played a crucial role in shaping the professional identity and scope of medical social work (Praglin, 2007; Chavan, 2007). In India, traces of holistic care, where attention was paid to social, psychological, and environmental dimensions of illness, can be seen in ancient healthcare traditions, especially in the practices of Vaidyas and Ayurvedic physicians, (Fahad, 2024).

The formal integration of medical social workers into the country's healthcare system was strengthened through key policy interventions, including the recommendations of the Bhore Committee and Mudaliar Committee, which emphasized the importance of including social workers in India's health system to address social determinants of health (Bhore Committee, 1946). The profession's identity was further strengthened through the establishment of the All India Association of Medical Social Workers, formed to unite the professional identity and collective voice of practitioners. In 2021, the National Commission for Allied and Healthcare Professions Act incorporated medical and psychiatric social workers under the category of 'Behavioral Health Sciences Professionals,' a recognition for their role in psychosocial dimensions of care (Ministry of Health and Family Welfare, 2021).

Despite these advancements, medical social work still faces challenges related to role clarity, professional recognition, and integration within the multidisciplinary teams. (KR et al., 2020) In this context, there is a growing need to examine the roles, functions, and challenges of medical social workers. This understanding helps in viewing the profession within a psychosocial perspective, as the effectiveness of healthcare delivery largely depends on providing holistic healthcare, which includes psychological, social, and emotional dimensions too along with medical treatment.

Kerala, a state with higher health indicators and literacy levels, also has an advanced social development context, which will offer a unique environment for understanding the integration of medical social workers in healthcare and their various roles. Hence, the present study explores the practice realities of nine medical social workers in hospital settings in Thiruvananthapuram district, the capital of Kerala.

## AIMS

The specific aims of the study are as follows: (i) To explore the functions of medical social workers (ii) To describe the contribution of the extrinsic factors such as pay, supervision, promotion, and relationship with co-workers, to the job satisfaction of medical social workers. (iii) To describe the contribution of the intrinsic factors such as work-life balance and compassion fatigue—to the job satisfaction of medical social workers. (iv) To describe the contribution of organizational role stress in medical social workers.

## METHODOLOGY

**Research Design:** A qualitative case study approach was adopted to understand the practice realities of medical social workers across various healthcare settings. As the objectives involved exploring the subjective experiences, and contextual factors influencing job performance and satisfaction, an in-depth understanding rather than quantification was considered most useful. The case study design further enabled an exploration of variations in experiences across various institutional contexts.

In this study, healthcare settings refer to organized institutions providing medical and supportive care services, including government hospitals, private hospitals, and palliative care centers, where medical social workers are engaged in clinical departments for patient care and support services. Palliative care centres were included, as they are an essential component in managing chronic and terminal conditions. They function in close association with hospital systems and involve similar multidisciplinary approaches to patient care. The nature of medical social work interventions in palliative care centres largely overlaps with hospital-based roles, as both settings require social workers to address complex emotional, social, and practical issues faced by patients and their families during serious illness. Hence, their inclusion ensures a holistic understanding of medical social work interventions across interconnected healthcare settings.

**Selection of participants:** A multi-stage purposive sampling technique was used to select participants. During the first stage, health care institutions from which the medical social workers were to be selected were identified. The criteria for selection of institutions were (1) the presence of a well-known and established medical social work department, (2) representation of various types of health care institutions, such as private, government, and specialized health settings, and (3) permissions granted to the researcher. Based on the criteria, 5 institutions were identified. Of the institutions selected, two were private hospitals, two were government hospitals, and one was a palliative care setting.

The second stage was to select medical social workers from these institutions. The selection criteria for medical social workers were (1) possession of a social work degree with medical and psychiatric social work specialization; (2) two years' work experience in medical social work practice; and (3) willingness to participate in the study. Thus, a total of nine participants were selected from three types of health settings as follows: three from government hospitals, four from private hospitals, and three from palliative care setting.

**Data Collection:** The data was collected through semi-structured interviews. An interview guide was prepared after refining questions through a pre-test. It contained questions based on the socio-demographic and professional backgrounds of participants, factors influencing job satisfaction (both intrinsic and extrinsic), experiences of organizational stress, the nature of the roles and functions they perform in hospitals, challenges encountered in practice, and suggestions for improving medical social work practice. Informed consent was acquired before each interview, which lasted 45–60 minutes. All interviews were conducted face-to-face, and they were audio recorded with the consent of participants. The recordings were transcribed, and all transcriptions were rechecked for accuracy.

**Data Analysis:** The transcriptions were analyzed thematically, and it resulted in the generation of four themes as follows: (i) Roles and functions of medical social workers, (ii) Extrinsic dimensions of job satisfaction, (iii) Intrinsic dimensions of job-satisfaction, and (iv) Organizational role stress.

## FINDINGS AND DISCUSSION

### Participants profile

The study included nine participants, six females and three males, with their ages ranging from 23 to 40 years. Five were below 30 years, reflecting an early-career workforce. Among the nine participants, three were in government tertiary hospitals, four in private tertiary hospitals, and two in an NGO providing palliative care services. Table 1, "Socio-Demographic Profile of Participants," presents participant profiles.

Table-1. Socio-Demographic profile of Participants

| Case | Setting | Age/Gender | Experience | Salary |
|---|---|---|---|---|
| A | Govt. Hospital | 38 / Male | 6–10 yrs | > 40,000 |
| B | Govt. Hospital | 40 / Male | 6–10 yrs | > 40,000 |
| C | Govt. Hospital | 32 / Female | > 6 yrs | < 20,000 |
| D | Private Hospital | 37 / Female | > 15 yrs | > 20,000 |
| E | Private Hospital | 25 / Male | < 5 yrs | < 20,000 |
| F | Private Hospital | 23 / Female | < 2 yr | < 20,000 |
| G | Private Hospital | 24 / Female | < 2 yr | < 20,000 |
| H | NGO (Palliative) | 25 / Female | < 5 yrs | < 20,000 |
| I | NGO (Palliative) | 27 / Female | < 5 yrs | < 20,000 |

## THEME 1: FUNCTIONS OF MEDICAL SOCIAL WORKERS

Medical social workers across the three settings performed a range of psychosocial functions. The key functions identified in the study are given below:

(I) **Psychosocial Assessment:** A comprehensive psychosocial and socio-economic assessment of patients and families was identified as one of the foundational functions of medical social workers. It involved gathering information on social background, family dynamics, economic status, emotional state, psychological well-being, and coping capacity of patients. This assessment served as a basis for planning individualized care and support. A better diagnosis and clinical decisions were enabled through this assessment, thereby making channels for identifying issues and finding means to resolve them. This reveals bio psychosocial assessment as the cornerstone of medical social work practice, the depth of which depends on settings. Palliative care practitioners conducted holistic and detailed assessments, while participants from government hospitals worked under time and caseload pressures that reduced assessment to a checklist function. In private hospitals, assessment was regular and it helped medical team to have a holistic understanding of patient whereabouts.

(II)C**ounselling and Emotional Support:** Counselling was a central and consistent task identified across all three settings. It included individual counselling for patients, family counselling, and crisis counselling. The main purpose of this was to help patients come to terms with their diagnosis, treatment options and prognosis. In a palliative care setting, providing emotional support was a major task of social workers, with strong emphasis on grief counselling, bereavement support and assisting patients and families through end-of-life processes. In government settings, it was done alongside large caseloads that often-limited depth of engagement. In private hospitals, counselling was often task-oriented, often associated with consent procedures, financial counselling, or discharge preparation.A participant from a private hospital narrated: "In private hospitals, counselling happens mostly around consent and payment. Patients need much more, but the system is not designed to give them that space." This reduction of counselling to a task-oriented process narrows the scope of the profession, and it is ethically concerning, as it places social workers as facilitators of institutional processes rather than therapeutic supporters of patients. Counselling was extended beyond patients to include family members as well, as they often bore the emotional burden of patients' illnesses. The participants also reported their role in helping patients and families adjust to hospital admission, possible role changes, and exploring their social and emotional responses to illness and treatment. Educating patients on the roles of healthcare team members, assisting patients and families in communicating with one another and with members of the healthcare team, and interpreting complex medical information were also reported functions of medical social workers.

(III) **Multidisciplinary team coordination:** Participation in Multidisciplinary team (MDT) meetings was commonly reported by the participants. In palliative care settings, social workers were fully integrated into the care team, contributing to psychosocial aspects of illness. In government hospitals, coordination was limited to referral and case management functions. In private settings, social workers were at times excluded from key decision-making processes due to limited recognition of these professionals by other medical team members. Participants mentioned that effective MDT meetings will ensure holistic care of patients by addressing bio-psycho-social perspectives of illness. The exclusion of medical social workers from MDT meetings in private hospitals reflects professional hierarchy within medical institutions that prioritize biomedical matters over biopsychosocial factors. When these perspectives are absent from treatment decisions, the psychological and social determinants of health go unattended, which will have direct consequences on patient outcomes. The complete integration of medical social workers in MDT meetings in palliative care settings shows how effective a treatment can be and how the well-being of patients can be addressed holistically.

(IV) **Psycho-Social Support:** In private hospitals, a medical social worker was connected with a specific branch of medicine in the hospital, such as nephrology, neurology, etc. The social workers had regular contact with each in-patient. As counselors, the participants educated patients and families on treatment, diagnosis, and prognosis. They played a crucial role in assisting clients in coming to terms with their illness and its aftereffects. Through facilitating patient support groups, the social workers provided pre- and post-treatment support to patients and their family members. In a palliative care setting, outpatient service was also provided in collaboration with a government medical college hospital, where patients referred by doctors were taken to medical social workers for psychosocial assessment and interventions. The socio-economic assessment conducted by participants was crucial in determining treatment costs and funds that need to be allocated from the hospital, mobilized from outside, and borne

by the patient. Based on this assessment, participants made financial arrangements in the form of concessions, subsidized treatment, and medicines. They were connected with government schemes, insurance schemes, hospital concessions, and external funding based on requirements. However, in private hospitals, resource mobilization was reported as limited, with institutional policies limiting the range of support that can be provided. Participants noted that the role of medical social workers as financial resource mobilizers ensured treatment adherence of the economically weaker category of patients. The connection between financial resource mobilization and treatment adherence is a potential finding. It reveals that in cases of economic vulnerability, social work interventions can aid in correcting systemic inequalities in healthcare access.

**(V) Resource Mobilization:** Medical social work departments have extensive networking and collaboration with various levels of doctors and government functionaries. The department partners with doctors extensively in providing care to patients, and this integration with interdisciplinary medical teams is the major reason for the success of many medical social work departments. Medical social workers also mobilize resources for patients from economically weaker sections of the society. This is done by networking extensively with various charitable organizations that support people from weaker sections of society in their treatments. In palliative care settings, material resources are raised for supplying families of poor patients. Patients eligible for financial support are provided monthly food kits, medicines, and, at times, educational support for children of palliative care patients. The breadth of resources described here that can be mobilized by medical social workers gives a picture of the wider welfare ecosystem of these professionals.

**(VI) Discharge planning:** Medical social workers assessed the home environment and family support of patients and coordinated with the treating team to ensure post-discharge care continuation. They also connected patients to community-based resources for continued support. In private hospitals, discharge planning was reduced to administrative tasks mostly, while in palliative care settings, it extended to follow-up care and home care visits. In government hospitals, discharge planning was not efficiently conducted due to heavy case loads and lack of time. Participants noted that inadequate discharge planning often led to poor treatment adherence and readmissions. The findings reveal that discharge planning has significant impact on patient welfare and treatment adherence. Effective discharge planning itself is a psychosocial intervention requiring assessment of conditions at home, economic stability of patient and family, assessment of community resources, coping skills of patients, and their emotional readiness for transition. Basso, Lipani, et al. (2015) validate these findings by stating that social work-led discharge planning is associated with reduced readmission rates and improved post-discharge quality of life. The absence of such a process in private hospitals reflects on its profit-oriented motive that requires further readmission than reduced readmission rates. In government settings also, this function was absent due to overburdened case loads.

**(VII) Community Outreach and Health Education:** Community outreach was an integral function of medical social workers, especially in palliative care settings. They conducted home visits. Organized awareness programs and family education sessions in the community. Palliative care social work said, "*When I visit a home, I understand things no hospital assessment can tell me. I see the living conditions, the isolation, and treatment adherence. That home visit changes everything about how we support the patient.*"Government hospital social workers participated in outreach activities related to disease prevention, health promotion, and resource connection programs. In private hospitals, community outreach was not efficient, as institutional priorities were directed towards in-hospital service delivery. Community outreach helps in revealing the social reality of the patient and their family, which they usually do not reveal in hospital assessments due to stigma or distrust. This can be aligned with strength-based and ecological theory that situates an individual within their living environment and acknowledges contextual knowledge as clinically relevant (Flückiger et al., 2023; Dickens et al., n.d.). The absence of community outreach in private hospitals reflects an institutional ideology of care that ends at the hospital.Critically summarizing the findings under this theme, the following discussions can be generated: Participants of the study were reported to engage in functions like conducting psychosocial assessments, providing emotional support to patients and families, coordinating resources, facilitating discharge planning, and conducting community outreach and follow-up. These functions align with literature on medical social work competencies (Shrivastava et al., 2014; Maramaldi et al., 2014; Alexander, 2017). In comparison, within palliative care these tasks are performed with greater autonomy and depth. This finding aligns with literature of palliative care social work as a crucial field of psychosocial care (Ragesh et al., 2017). This indicates how setting specific differences in the study gives another dimension of how integrated medical social workers are in each setting. The palliative care NGO

offered the richest experiences and independent psychosocial practice environment, with clearly defined roles and functions. Private hospitals, by contrast, prioritized throughput, patient volume, and institutional benefits over focusing explicitly on patient well-being. Such practices limited the role of medical social workers, at times making them do gatekeeping and admin functions. This study shows that the quality of psychosocial practice in an institution is determined by the degree to which an organization has understood the psychosocial model of care. Another recurring finding across all three settings was the tension between the biomedical model and the psychosocial model. Social workers in the study articulated the limits of the biomedical framework in explaining patient sufferings and their psychosocial backgrounds, which determined treatment efficiency.

## THEME 2: EXTRINSIC DIMENSIONS OF JOB SATISFACTION

Using the Job Descriptive Index (JDI) as a framework, the qualitative aspects of job satisfaction of participants were assessed across five domains: nature of work, interpersonal relationships at work, pay, promotion, and supervision.

**(I) Nature of work:** The helping nature of their work was regarded as satisfying by most of the participants, who valued it as meaningful and impactful. The participants described it as '*pleasant*,' '*worthwhile*,' and '*enjoyable.* Case F, a senior social welfare officer with over fifteen years of experience, articulated that his job was always superior and great as it gave immense satisfaction in dealing with life problems of patients and solving them. However, this was often affected by workloads and organizational demands, especially in private hospitals, which prioritized quantitative aspects of healthcare over qualitative.

**(II) Interpersonal relationships at work:** A supportive relationship with colleagues was reported by all participants, which contributed to an enhanced work experience. They described co-workers as responsible, stimulating, and supportive. Team cooperation and informal peer support acted as important psychosocial buffers in managing occupational stress. However, some participants reported a lack of role clarity about the role of medical social workers, which led to feelings of undervaluation and marginalization. Among the nine, four participants mentioned the narrow-mindedness and stubborn nature of a few colleagues, like doctors, nurses, and PROs, which stemmed from professional identity disputes. Case C narrated, "Even after the establishment of the medical social work department here for many years, some medical professionals still still question our necessity, even when we have clearly proven our worth. They believe that only physical care is needed in a hospital. This reflects the issue of limited interdisciplinary awareness of other health professionals, especially doctors and nurses, on the scope and contributions of medical social work. A biomedical dominance is persistent within healthcare settings, where psychosocial factors are often overlooked. This lack of understanding and acceptance creates barriers to effective team collaboration, ultimately affecting the quality of comprehensive care provided.

**(III) Pay and promotion:** Salary was the most consistently dissatisfying extrinsic factor. Except for the two government employees, all the others reported inadequacy in remuneration. The participants described it as underpaid and barely enough to live. It was a major concern of the majority of social workers, especially among early-career professionals in private hospitals. Opportunities for promotion and career advancement were also very limited. This lack of recognition in terms of pay affected their morale and professional identity. Eight out of nine participants reported promotional avenues to be very limited. Case I described her job as a dead-end job, as no growth or reasonable hike was there in her job. These cases altogether reflect the stagnation in the career ladder of medical social workers in Kerala.

**(IV) Supervision:** It varied among settings, with some participants reporting supportive guidance, while others indicated an absence of structured supervision systems. For those who had supervisors, they were described as supportive, knowledgeable, and appreciative. In certain private hospitals, supervisors for medical social workers were professionals outside social work, which included nurses and doctors. That kind of supervision was reported as inadequate as it lacked profession-specific guidance, case discussions, ethical monitoring, and skill development initiatives. The absence of supervisors with medical social work backgrounds reduced the quality of support and feedback, making it difficult for the professionals to navigate the complex healthcare system.The findings of theme 2 can be critically analyzed as, even when collegial relationships were mostly positive, the presence of professional boundaries and lack of awareness by medical professionals on the role of medical social workers generated conflict and distress. Absence of promotional pathways also affected the motivation of these professionals, especially those in mid-career positions. This is a relevant concern to be addressed, as this 'stagnation' will affect the entire productivity of the workforce. Another important finding of the study was a deficit of supervision in the medical social work field. In hospitals where non-social work supervisors (doctors, nurses, and administrators)

were present, participants reported inadequate guidance, lack of role clarity, professional isolation, and a feeling of getting undervalued in their capacities. These constraints limit the contribution of medical social workers in hospital settings. Lack of structured, discipline-specific supervision in health settings employing social workers represents a critical gap in the field.

## THEME 3: INTRINSIC DIMENSIONS

**(I) Work-life balance and quality of life:** The work-life balance framework was used in this study to assess this theme. Participants of the study reported work-life interference with personal life, which included long working hours and workloads that led to exhaustion and reduced family time. It also caused difficulty in maintaining personal routines. Neglecting family time, religious observance, and personal pursuits were reported by participants. Case A, who was a government hospital employee, mentioned a bidirectional interference where personal matters also affected their work life, making it 'hard to work.' He narrated:"I neglect personal needs and activities because of a heavy workload, and I am not satisfied with the quality of time I get to spend with my family, as thoughts of my responsibilities at work affect me constantly."Despite this negative aspect of work-life interference, another perspective was considered: a positive personal life experience that gave emotional energy and motivation for professional functioning. Few participants reported that support they received from their family and friends gave them motivation to perform well in their field. Findings related to work and life interference showed a pattern that occupational demands often encroached upon personal time and family relationships, affecting the participants negatively. Yet, majority participants described their personal factors like family and hobbies as a source of energy and emotional replenishment. A bidirectional pattern was seen here, where resources in the domain of personal life complemented productivity in the professional domain**.**

**(II) Compassion Satisfaction:** The ProQOL framework was used for analyzing compassion satisfaction, burnout, and compassion fatigue. A strong sense of compassion satisfaction was evident in all cases as participants reported an emotional fulfillment from helping patients and families to navigate crises and to witness their positive outcomes. This developed a sense of professional pride, purpose, and worthiness. Case H described it as:"I feel happy and proud to be able to help people."This finding was consistent in all nine cases regardless of experience level, salary, or setting. A strong sense of compassionate satisfaction was reported by all nine participants, irrespective of salary, experience, or settings. This aligns with the ProQOL model of Stamm (2010), which suggests that the erosive effects of burnout and compassion fatigue are prevented or controlled by compassion satisfaction that serves as a protective factor against adversities. It also aligns with motivational theories, which say commitment to human well-being provides durable intrinsic motivation (Bandhu et al., 2024).

**(III) Burnout and Compassion Fatigue:** Despite this high satisfaction, patients also reported episodes of burnout, including reduced energy levels, overwhelmed feelings, and emotional exhaustion. Compassion fatigue was reported in five out of nine cases where the participants had an inability to disengage from life stories of certain cases. Those from government hospitals reported higher compassion fatigue compared with the other two settings. Case B narrated:"Even though I'm satisfied with my work, I often feel drained and overwhelmed. It's hard to switch off from patients' stories, and at times, I feel emotionally exhausted."The findings here indicate that medical social workers experienced emotional strain due to continuous exposure to patient sufferings and their limited ability to detach from such experiences. Higher levels of compassion fatigue were seen among participants from government hospitals, indicating a strong relation between caseloads, resource constraints, and emotional exhaustion. Integrating findings of themes 3 and 4, Herzberg's two-factor theory of job satisfaction (1956) is reflected in this part as the findings distinguish between 'hygiene factors' (extrinsic conditions) and 'motivators' (intrinsic factors). Findings suggest that intrinsic factors like helping relationships, skill utilization, and feeling of purpose generate positive outcomes, while extrinsic factors like low payment and lack of promotion opportunities were major sources of distress. These findings echo studies by Chavan (2007) and Mishra (2018), which revealed that the professional commitment of medical social workers is compromised for structural deficits.

## THEME 4: ORGANIZATIONAL ROLE STRESS

The study employs the Organisational Role Stressors (ORS) framework by Pareek (2000) in the study to examine nature and dimensions of role-related stress experiences by medical social workers in hospitals. This framework covers both physiological and psychological aspects of stress. The ORS framework was applied across nine cases and ten distinct role stressors were identified. Table 2 describes the identified Organizational Role Stressors (ORS), and the distribution of Organizational Role Stressors is illustrated in Figure 1. Distribution of Organisational Role Stressors among Medical Social Workers.

Table 2: Description of Organizational Role Stressors (ORS) framework

| Role Stressor | Description |
|---|---|
| **Inter-role Distance** | Conflict arising from playing more than one role (e.g., organisational vs. family) |
| **Role Stagnation** | Lack of growth or advancement in one's role |
| **Self-role Distance** | Mismatch between personal aptitude/values and the role assigned |
| **Role Expectation Conflict** | Facing contradictory expectations from different people |
| **Role Erosion** | Important functions of one's role being reassigned or eroded |
| **Role Overload** | Too many or too high expectations placed on the role |
| **Role Isolation** | Lack of coordination or linkage with peers and supervisors |
| **Personal Inadequacy** | Perceived lack of skills or training to perform the role effectively |
| **Role Ambiguity** | Unclear expectations about one's role |
| **Resource Inadequacy** | Unavailability of resources needed to perform the role |

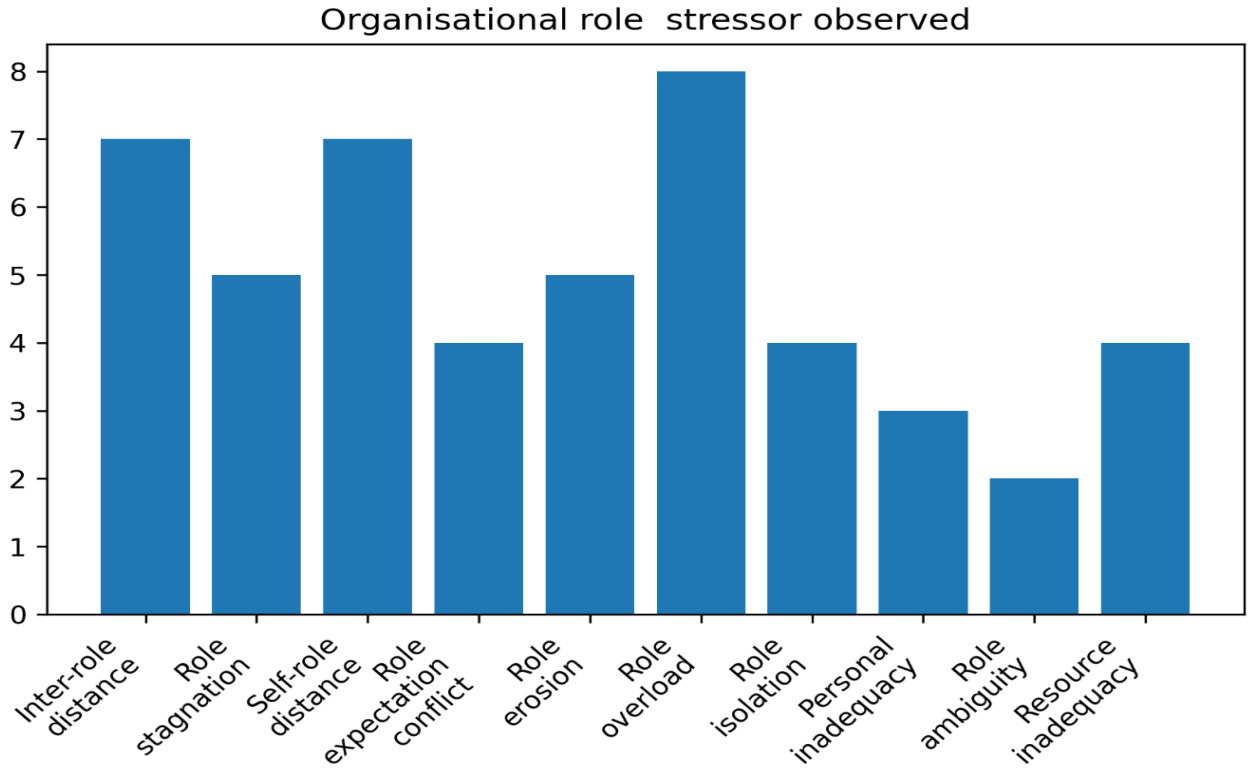


Figure 1: Distribution of Organisational Role Stressors among Medical Social Workers

The analysis revealed that role overload, inter-role distance and self-role distance were the most commonly experiences stressors, followed by role stagnation and role erosion. In role overload, burden of heavy workloads not only affected professional performance, but it also interfered with personal life of participants. Participants F narrated:

"*The amount of work I have to do interfere with the quality I want to maintain in my profession".*

Inter-role distance was visible in majority cases and it occurred when an individual is required to occupy multiple roles simultaneously. This was the primary bridge between occupational stress and domestic wellbeing of medical social workers. Complaints of family members and friends about time deprivation further underscores this dimension. Role stagnation was another concept where the participants got stuck in their roles, without growth or upward movement. Closely associated with this is, self-role distance, where an individuals aptitude, values and professional identity are getting disconnected with their actual tasks assigned. Substantiating this is the narration of Case C:

"*If I had the full freedom to define my role, I would be doing something different from what I do now".*

The narration indicates a systemic misalignment between academic expectations and practice realities of medical social workers. Role expectation conflict was the fifth concept in ORS framework where contradictory expectation on role where experienced from different stakeholders. Similarly, cases of role erosion, role isolation, role ambiguity, role inadequacy and personal inadequacy were reported.

Multiple stressors were operating simultaneously in most cases, and these stressors together produced a psychosocial care paradox, where the professionals responsible for helping with the psychological and social well-being of patients are themselves operating in settings that undermine their own well-being. Organizational role stressors and resource inadequacy affected the effective functioning of medical social workers, and these findings align with studies by Shah (1988), Chavan (2007), and Ngwu (2011). It suggests that many challenges faced by social workers are not just individual in nature but are a product of systemic failures at the organisational level.

## ETHICAL CONSIDERATION:

Informed consent was obtained from all participants prior to data collection. They were also assured of the confidentiality of their identities, and they have been protected through the use of case labels in the article. Participants were voluntarily sharing information, and they had the right to withdraw from the study at any stage. The study ensured ethical principles of respect, privacy, and non-maleficence throughout the research process.

## CONCLUSION

This study offered a clear account of realities of medical social work practice, foregrounding the psychosocial dimensions of functions they perform and the professional experiences they receive. The findings allow us to draw several conclusions. It was evident that medical social workers had a wide range of psychosocial tasks, including assessment, counseling, resource mobilization, emotional support, community outreach, and discharge planning, all of which are essential to holistic treatment. However, depending on the nature and policies of institutions, the performance of these functions varied, implying that institutional orientation has a significant role to play in determining the scope of medical social work practice. While in some institutions, there was functional autonomy and recognition for medical social workers, in others their roles are often constrained, under-utilized, undervalued or misused. Quality of psychosocial care was seen most with palliative care settings, while in private and public hospitals professional autonomy was affected due to resource constraints and organizational priorities. Significant contradictions were seen between professional expectations of medical social work and the structural conditions that regulate the profession. Even when the participants demonstrated intrinsic motivation, commitment to patients, and compassion and satisfaction, their professional functioning was restricted by certain challenges such as a low pay scale, limited promotion opportunities, lack of structured supervision, and role ambiguity. These factors affected job satisfaction of the professionals and effective use of their skills. Another key insight from the study is the coexistence of compassion satisfaction with compassion fatigue, highlighting the resilience of the professionals to the emotional demands of the role. Additionally, the presence of several dimensions of organizational role stress indicates the increasing influence of systemic challenges. To conclude, it is evident that medical social workers can contribute effectively to holistic care and play a significant role in promoting psychosocial well-being, especially in a facilitative work environment that recognizes, strengthens and integrates their practice.

## REFERENCES


Alexander, J. S. (2017). a competency based framework for social work education in india. 8.

Bandhu, D., Mohan, M. M., Nittala, N. A. P., Jadhav, P., Bhadauria, A., & Saxena, K. K. (2024). Theories of motivation: A comprehensive analysis of human behavior drivers. Acta Psychologica, 244, 104177.

Basso Lipani, M., Holster, K., & Bussey, S. (2015). The Preventable Admissions Care Team (PACT): A Social Work-Led Model of Transitional Care. Social Work in Health Care, 54(9), 810–827.

Beder, J. (2010). Hospital social work: The interface of medicine and caring. Taylor & Francis.

Bhore Committee. (1946). Report of the health survey and development committee. Government of India.

Chavan, B. (2007). Medical social work practices in hospital setting in Western Maharashtra. https://shodhganga.inflibnet.ac.in/handle/10603/140497

Dickens, C., Suarez-Balcazar, Y., Allen-Meares, P., & Brazil, E. (n.d.). Using Ecological Systems Theory to Enhance Community Health Literacy. HLRP: Health Literacy Research and Practice, 9(1), e29–e36.

Fahad, S. (2024). Indianization of Medical Social Work Discipline through Transformative Emancipatory Approach. 23, 48–59.

Flückiger, C., Munder, T., Del Re, A. C., & Solomonov, N. (2023). Strength-based methods – A narrative review and comparative multilevel meta-analysis of positive interventions in clinical settings. Psychotherapy Research : Journal of the Society for Psychotherapy Research, 33(7), 856–872.

Guite, N. (2019). Health Care Social Work in India. In R. Winnett, R. Furman, D. Epps, & G. Lamphear (Eds.), Health care social work. A global perspective (pp. 135–148). New York, NY: Oxford University Press.

KR, A., Cleak, H., Heaslop, G., & Tonge, A. (2020). Challenges to the development of a health care practice model for hospital social work in India (SLCTD). Social Work in Health Care, 59. https://doi.org/10.1080/00981389.2020.1719566

Maramaldi, P., Cadet, T., Sobran, A., & Scheck, L. F. (2014). Interdisciplinary medical social work: A working taxonomy. Social Work in Health Care, 53(6), 532–554.

Ministry of Health and Family Welfare. (2021). National Commission for Allied and Healthcare Professions Act, 2021. Government of India.

Mishra, A. (with Subbiah, K.). (2018). Ethics in Public Health Practice in India. Springer.

Ngwu, C. N. (2011). (pdf) the relavance of medical social workers in health care delivery: a study of selected hospitals in enugu state: researchgate. https://www.researchgate.net/publication/307545400_the_relavance_of_medical_social_workers_in_health_care_delivery_a_study_of_selected_hospitals_in_enugu_state

Praglin, L. J. (2007). Ida Cannon, Ethel Cohen, and Early Medical Social Work in Boston: The Foundations of a Model of Culturally Competent Social Service. Social Service Review, 81(1), 27–45.

Ragesh, G., Zacharias, L., & Thomas, P. T. (2017). Palliative Care Social Work In India: Current Status and Future Directions. Indian Journal of Palliative Care, 23(1), 93–99.

Shah, G. (1988). A study of medical social workers in the city of bombay.https://shodhganga.inflibnet.ac.in/handle/10603/22249

Shrivastava, S., Shrivastava, P., & Ramasamy, J. (2014). Medical social worker: Strengthening linkages between the hospital and the community. International Journal of Health System and Disaster Management, 2, 130. https://doi.org/10.4103/2347-9019.139074

Stamm, B. H. (2010). (PDF) The Concise ProQOL Manual: The concise manual for the Professional Quality of Life Scale , 2 nd Edition. Eastwoods, LLC. https://www.researchgate.net/publication/340033923_The_Concise_ProQOL_Manual_The_concise_manual_for_the_Professional_Quality_of_Life_Scale_2_nd_Edition

World Health Organization. (1946). Preamble to the constitution of the World Health Organization. WHO.