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Attitudes of the medical profession toward the professional practice of healthcare social workers

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Abstract. This article main objective concerns on analyzing the attitude that medical profession takes towards healthcare social workers' professional practice. For its development, Serge Moscovici's perspective on social representation was used, mainly because is one of theoretical options with conceptual and methodological tools that allow us an approaching on subject's attitudes. Therefore, this is a qualitative study where an interview and a survey were used as instruments to compilate data among full time physicians and interns. These physicians work on different fields of medicine such as hospitalist, pediatric, gynecology, oncology, intensive care and pathology at Hospital General de Mexico, a public, second level of care institution. What can be found in this research was that for physicians, the importance of healthcare social workers' practice is limited to an administrative roll. On the eyes of physicians, this isn't necessary a negative attitude towards social workers practice, they even consider them as an important part of hospital staff because social workers must deal with an unpleasant hard work, solving mostly bureaucratic issues and procedures. However, physicians don't recognize social workers as a group of professionals who can give scientific advice in order to improve patient's health.
Keywords: attitudes, social representations, physicians, social worker, professional health practice.

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Introduction

This study it's a part of a doctoral dissertation, generated within Pedagogy Postgraduate Program from the Universidad Nacional Autonoma de Mexico (UNAM), which is named "*Los medicos y sus representaciones sociales sobre la practica profesional de los trabajadores sociales"* (Physicians and their social representations about social workers' professional practice). Its objective consisted on analyzing the social representations that physicians have about object of study. In the pursuit of submitting this as a scientific article, it will be revisited one of theoretical dimensions: attitude. The main objective is to show a thorough analysis of this matter in the perspective of this theoretical corpus.

As a part of substantiation, a limited number of papers in the matter were found, those papers retrieve the view on social workers practice from another professional group. Stand out works are Muriel et al., (2018), Minetto y Voragini, (2017), Rosacher (2015) y Pérez (2013), which were developed in different action fields and show how physicians, psychologists and teachers associate social workers' practices with philanthropic or charity actions that originated that profession.

On the other hand, Perez (2005), Barrantes (2003) and other studies showed a series of

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disqualifications and criticism related to lack of recognition, immediacy and shortage of reflexivity on services provided by social workers; likewise, they raise challenges within academic formation, collective identity and projection that must be confronted. It shows a persistent search for identity and the resignification of professional activity. It becomes necessary not only an analysis of his thoughts about practice but also recover points of view from other groups that have been bonded with social workers throughout history. On Martinez (2014), Pérez (2005) and Barrantes (2003) research they recover not only what social workers think of themselves but even what other subjects believe about them in order to discuss about social workers' identity and highlight certain characteristics that make them unique.

In the interest of contributing to this study field, the present paper tries to show what are the common thoughts on social workers from other professional groups. Therefore, health sphere was selected, because it is referred as the one with most history and implementation, where social worker professionals, technicians and students have developed their work and school practices for more than forty years, along with other health workers.

For Mexico, health field is regulated under the Health's General Law. Public health service is integrated by Instituto Mexicano del Seguro Social (IMSS), Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE), Petroleos Mexicanos (PEMEX), Secretaria de la Defensa (SEDENA) y Secretaria de Marina (SEMAR) and others. Furthermore, there are other institutions or programs that serve population with no access to those institutes, as hospitals from Secretaria de Salud (SSA), Seguro Popular de Salud (SPS) and others.

Health field breaks down to three attention levels: first one is composed by Family Medicine Units, Health Centers and Family Clinics, where basic services are provided and first contact or preventive actions are taken. Second level is integrated by federal, general, regional, integral and community hospitals, were patients referred from first level, who requires diagnosis, therapeutic and rehabilitation, get attention. Third one is constituted by a network of high speciality hospitals that give attention to more complex and high-risk illnesses that usually demand more specific attention, since they can provoke great degeneration on patient's health.

Users problems require help from different kind of professionals, these professionals must have excellent training, experience, knowledge and dominion on several fields of healing. World Health Organization (OMS, 2017) says that health staff consists of those people that are involved in health promotion tasks, this also must be their primarily goal. This staff is conformed by surgeons, specialist surgeons, normal specialists, silent doctors, interns, medical students, nurses, odontologists, nutritionists, psychologists, social workers and orderlies. Administration staff is composed by medical assistants, receptionists, secretaries, file clerks, pharmacy personnel, guards, cleaning staff and others.

Health field is recognized as the most important source of labour for Mexican social workers; there are most of Estate guaranteed job positions. According to Vázquez and Cid de León (2015) from 80 % of these professionals working on health field, 56 % has an Estate guaranteed job and the rest of them have federal kind of job positions. This staff is mostly located on second level hospitals at a rate of 49.2% seconded by high specialty (or third level) hospitals with 32.2% of them working there and finally 16.9% of them works in family medicine clinics (or first level). Their profile on health field is commonly associated with development of social education activities related to execution of preventing models and capacitation for sufferers, family and general community towards health restitution.

However, inside institutions where social workers perform their practices are organized under a clear hierarchy. This organization stablish relations both of coordination and subordination, according to health services structure. This also explains why deep salary differences exist between physicians and other professionals as an increasing number of health specialties, additional sophisticated equipment and complexity of diseases. Based on this, Health Secretary (Secretaria de Salud 2017), divides its staff as shown: for physicians it comes to two different branches, first one for specialists and general practitioners which at the same time are divided in four groups named "A","B","C" and "D". Designation of group is related to what kind of worker physicians are, such as executives, staff chiefs or coordinators. Second branch is

for operative staff and here is where we can find social workers which perform tasks such as Health Area Social Worker Supervisor, health social worker and social worker technician, also classified as "A","B" and "C". This nomination is supposed to differentiate staff with a professional degree and technicians, but this doesn't have any special denomination for post graduate staff.

1. Conceptual framework

Social representation theory was used for the development of this study. This is a perspective that has been used recently for being an actualized methodological option that explains how subjects see themselves and how they give sense to their own reality, based on their own referral system. It is used because it allows comprehension on how knowledge and common sense enables an individual in choice making and daily life behaviour.

Social representation theory was developed by a Romanian science philosopher, Serge Moscovici, in his PhD thesis *La psychanalyse, son image, son public.* (Moscovici, 1979, p. 27). In the first chapter of his book *Social representation: a lost concept,* he warned about problematics concerning the definition of that theory, by pointing out that social representations are easy to see, as they are almost tangible entities that "flow, cross and crystallize over and over again in our daily universe through words, gestures or encounters" but the concept isn't that easy. One of the first definitions from Moscovici (1979, p. 18) about social representations: "…it's an organized corpus of knowledge and a psychic activity that allows men's physical an social reality to be understandable, helps in groups integration and in daily exchange relationships, it also liberates imaginative powers"

Social representations appoint both a process and a content made of opinions, knowledge and beliefs of a culture in relation to social context objects. A good way of understanding the difference is social representations size, according to Moscovici (1979, p. 45) "they organize in different ways, according to class, groups or cultures and they set up as many universes as class, cultures and groups exists. Each universe, according to our hypothesis, has three dimensions: attitude, information and representation field or image".

Information is identified as a "-Concept or dimension- related to knowledge organization own by a group according to a social object" (Moscovici, 1975, p.45).

Representation field "it's the more complex idea, it express a notion of content organization: there is a representation field in anyplace where a united element hierarchy exists, but it's also important how diverse content is, qualitative and imaginative properties of representation." (Herzlich, 1975, p. 400)

Attitude, in this article context, is found more often than the last two. Maybe this also happen to be because it's the first one, from a genetic point of view, even when information is low or the representation field its not well organized, because there is background information and we represent things after a general orientation is taken, whether it is negative or positive, facing representation object (Moscovici, 1979; Herzlich, 1975).

The theory provided guidelines for analyzing physicians attitudes and the network of significations built around representation object, by enabling an approaching to social context, conduct, interactions and practices.

2. Method

2.1. Design and context

For the development of this study it turns out to be indispensable to enroll the object within an epistemological perspective in order to draw a path to inquire and interpret. For this reason, constructivism was chosen, because it starts interpretation directly from subject thoughts. This led attention to one particular school of social representations theories: sociogenic or processual, which according to Banchs (2000) it represents a qualitative orientation by giving special interest to sense comprehension, symbolic production and interactions.

Both epistemological and methodological positions were bonding elements that guide analysis to concern reality. This led to subject definition, object and space, as well as tools and strategies to get relevant information in the interest of this study development.

In that regard, scenario choose criteria were: social workers and physicians presence, entrance possibilities (not every health institute has the same allowance criteria for non staff members), researcher interests and

help networks for institutional access; so this is why Hospital General de Mexico "Dr. Eduardo Liceaga" in Mexico City (CDMX) was selected, it belongs to Health Secretary (SSA). It is a public institution, deconcentrated from federal government, it has one of the most numerous staff of physicians and social workers (1222 physicians and 116 social workers), this is needed due to an amount of patients that goes up to 70, 000 a year. Relationship between these two kinds of professionals happen in more than 44 hospital units, from high specialty health services.

Obtain access to this institution wasn't so easy, since its one of the most important health institutions in Mexican medicine history. At the time, obtaining access becomes one of the most challenging steps of study. To get trough that challenge it was necessary to subscribe a protocol to "Research and Ethics Committee" which is integrated by physicians who work mainly in biomedical, epidemiologic and clinical researches. This project was registered as a sociomedical study, a category often used by researchers coming from social sciences and humanities.

2.2. Actors

2.2.1. Sampling

Information collection was done starting with an intentional or convenient sampling, where participant selection was done matching goals of research, this is why physicians from HGM were selected according to their authority, power and knowledge, played in hospital field.

2.2.2. Inclusion and exclusion criteria

This process was built upon field access possibilities which were defined by authorities' decisions (survey was applied to 132 physicians and from those, 8 become interviews); however, there were some possibilities to outline population characteristics. Therefore, this was the criteria used to participant selection:

- Physicians whose specialities are linked to social workers professional practices.
- Full time or resident physicians in HGM.
- Physicians with at least one-year length of service in HGM.
- Physicians interested in being involved in this study.

2.3. Procedure and supplies

At the beginning a semi-structured survey was used as a way of approaching with large groups, as physicians at HGM are, its design offer the possibility of getting systematic and well organized information, that allow a subsequent interview to go deeper in research. Population characteristics were considered in the process of survey making, those are: a high demanded professional, with full agendas and exhausting work schedules; these characteristic led the survey to be in two pages with close answer questions that can be answered in no more than 10 minutes. This survey was made up by two sections: general data and four multiple choice questions, developed from attitude point of view, as is shown in Table 1.

Table 1. Survey questions' design

Questions	Analysis category	Source of information for answer options
Select which professional might be expendable in the hospital.	Attitudes	Hospital General de México (HGM, 2016). Cuaderno Estadístico de enero a septiembre del HGM.
What level of education do you think most of social workers have in this hospital?	Attitudes	López et al., (2007). El Trabajo Social en México.
What importance do you consider that social workers' professional practice has in the hospital?	Attitudes	López et al., (2007). El Trabajo Social en México.
How well prepared do you consider social workers in this hospital are in order to face patients' social problems?	Attitudes	López et al., (2007). El Trabajo Social en México.

Source: self-made with information from third column.

132 questionnaires were distributed, 105 among resident physicians and 27 with full time jobs and were applied as follows:

- On field work's phase one, hospital authorities assign groups of resident physicians from these specialties: intern medicine, oncology, pediatrics, gynecology and radiology. Quiz was taken along five not consecutive days, in previously hospital authorities' stablished hours.
- With full time physicians, survey was applied on three not consecutive days for four hours long each day. In order to achieve this activity, staff gathering places were previously identified such as pavilions, cafe, hallways, auditoriums and even parking lots.

Field work's second phase was interviewing some physicians as a way of going further in information that survey cannot reach. These interviews were focused but not in deep, because medical staff have severe time limitations. It's important to point out that 22 physicians accepted through survey that they would participate in an interview; nevertheless only eight were possible: five residents and three with full time physicians from different health specialties such as intern medicine, pediatrics, gynecology, oncology, intensive care and pathology. This research technic was paired with a semi-structured interview of five questions shown in table 2.

Table 2.Interview questions' design

Analysis category	Questions	What is expected to be found?
Attitude towards social workers' professional practice	• Do you consider the presence of professionals as social workers in this hospital important? Why? • Do you think that social workers activities should go beyond what they do at this time? • How well prepared do you think that social workers are in order to perform their tasks in this hospital and why? • Do you believe that social workers' professional practices are fairly valued in this hospital? • How would you describe social workers' professional practices in this hospital?	Positive or negative evaluations concerning social workers professional practices.

Source: Self-made based on attitude dimensions and Moscovici's social representations information (1971).

Interviews were made in day and hour decided by physicians at the time of invitation. This were audio-recorded with previous authorization and were made inside hospital installations (offices and common areas). These also work as evocative places to express their ideas, information, opinions, knowledge and experience about social workers' professional practices. It's important to point out that interviews lasted from eight to twenty-five minutes only, because their limited time.

2.4. Studies Ethical criteria

Before survey was applied and interviews were made, certain ethical considerations were stablished with the main purpose of generating a climate of confidence for knowledge searching, as well as respecting physicians' integrity (Kavle, 2011).Therefore, intention of survey and interview was let known; use of coding in order to save confidentiality; personal data and answers will be used for study purposes only; interviews' transcriptions will be sent by email to those who request for it so they authorize use and validate content; in addition there is a possibility of publishing the content guaranteeing anonymity.

2.5. Data analysis

For data compilation, inductive method was used, since research didn't want to look at statistic and probabilistic outcome or generalize what was found to the bulk of population but elaborate a deep analysis of expressions. This does not excludes the use of instruments like a semi-structured survey, which is not intrinsi-

cally attached to any epistemology. As Ducoing (2016) says, positivists don't own the numbers nor interpretivism qualities, therefore, selection was made upon problem's approaching, methodologic reference and population characteristics.

In that regard, survey results were processed inside a data base designed in SPSS (Statistical Package for the Social Science) where random codes from 1 to 8 were assigned according to answer, with an "omitted" alternative for those who didn't answer or selected more than one option.

Interviews were processed in a different way, first of all, they were transcript in Word; selected testimonies were shown, both for confidentiality and information organization, with following codes: (E) interview y (#) folio number. In relation to identification of the kind of doctor, (MB) was used for full time physician and (MR) for residents, followed by years of advance in their specialty (#). For example: E5-MB y E3-MR3.

Once the information was transcribed, it was systematized in a qualitative analysis software called *Atlas ti*. Then a hermeneutical unit was opened, and it allowed the use of certain software tools, such as: primary document administrator, family administrator and code administrator. Finally, as a result of methodological and epistemological study's point of view, interpretation begun by selecting as analysis the condensation of significance, developed in three moments:

1. **Meaning units:** from insistently repeated words and phrases by physicians, meaning units were determined, these are linked to attitude dimension.
2. **Direct way formulation:** a remake of denominated "natural meaning unit" was made in central topics, those were organized by topic from subjects' declarations, this implies the first interpretation records.
3. **Questioning meaning units:** as a result of this study's purpose, meaning units were questioned in the context of conceptual framework.

3. Results and disscucion

There was a question that allowed retrieve importance, trifle or indifference that physicians grant to the practice, it was: What is the importance of social workers' professional practice in the hospital? From there, other questions appeared: How well prepared do you think social workers in this hospital are in order to face patients' social problems? Do you consider the presence of professionals such as social workers in this hospital important? Why? Do you believe that social workers' professional practices are fairly valued in this hospital?

Attitude component in medical speeches was linked to values and norms in which physicians were traditionally educated: high competitiveness, responsibility, efficiency, confidentiality and others. Their opinions about object were expressed from their hierarchy place within HGM, it was correspondent to their elite guild perspective built around attachment to their profession tradition which has a clear distinctive criterion in face of other health professions.

In physicians' opinion, Social Workers' guild is pigeonholed to a subordinated position, being considered as a part of administrative staff that provides social services and not a chance to be considered as health professionals with any authority or specific knowledge that can contribute helping with psycho-social aspects of patients.

Social work has been related to other sciences as medicine, however, it has done inconsequential effort to build up its own scientific references. To notice this is enough to look at Latin American curriculums, which are primarily formed by subjects from other disciplines. As a result of being a consumer of knowledge and lack of specialization in Mexican health field are two of the reasons that results in the position inside the institution. Their participation in some services has been reduced to form fillings, giving practice an administrative category.

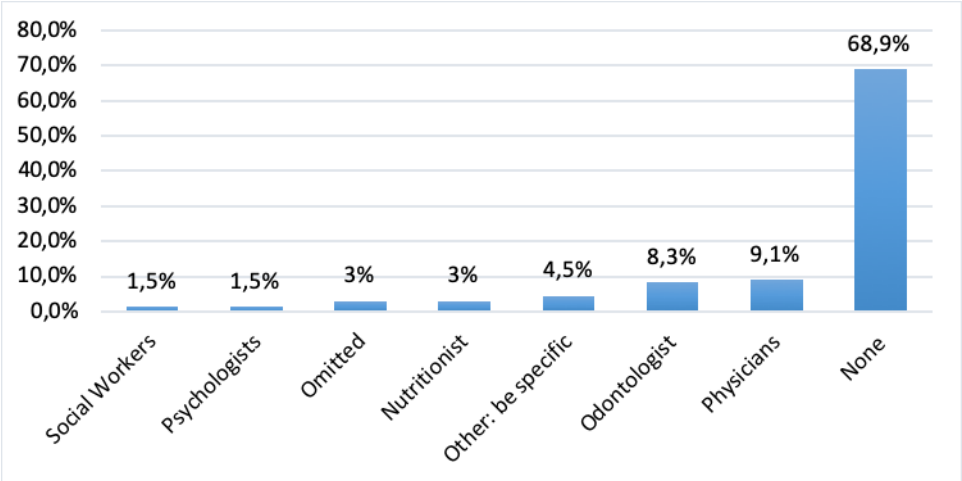
Culturally incorporated attributions to medical investiture have gave them a point of view that allow them to value, diagnose and suggest alternatives about different matters. That's why among full time physician coordinators' speeches a sort of "evaluation" was made, that even as a primary comment, point out how social workers' professional practice should be. Here's an example: "…there should be specializations, like what happens with nurses and their specializations or, that should also happen in social work: for intensive care,

emergencies, volunteer, because those are completely different issues…" (E2-MB).

In face of lack of recognition of an specialized knowledge on social workers , medical guild used a variety of commanding expressions such as: *it should… it requires… it lacks… it doesn't knows… just work as… their main function is…,* all these shown evidence of an authoritarian discursive construction, with far superior rank than those professionals.

When physicians where asked about which of the following professionals are expendable: psychologists, social workers, nurses, nutritionists, odontologists, physicians or others, 69% of physicians answered that none (look at figure 1), this is mainly because on the last decades we went from a centralization in medical attention to a socio-sanitary one, in other words, other professional groups has been integrated.

Figure 1. Select an expendable professional in the hospital



Source: Self-made based on survey collected data.

By not mentioning social workers as an expandable group, a positive, approbative attitude was anticipated. They are considered as a strategic worker in hospitals, thanks to be the one that makes the first contact in sanitary attention, primarily with low income groups.

For physicians, helping the needed an aiding action are the raison to be for social workers' practice in hospitals. Some of them, by having bio-psychosocial training, are far more sensitive about patients' social problematics and that's why they give more value to social workers by integrate them in sanitary related discussions.

Physicians stated that social workers staff is limited as a result of social needs of people, but they don't see a necessity regarding increase of staff numbers. Even in a time of increasing social requirements, growing of social workers staff has been short; from 2016 to 2017, only four job positions were opened in HGM, even with an excessive workload and overcrowding that they have while they perform their daily tasks.

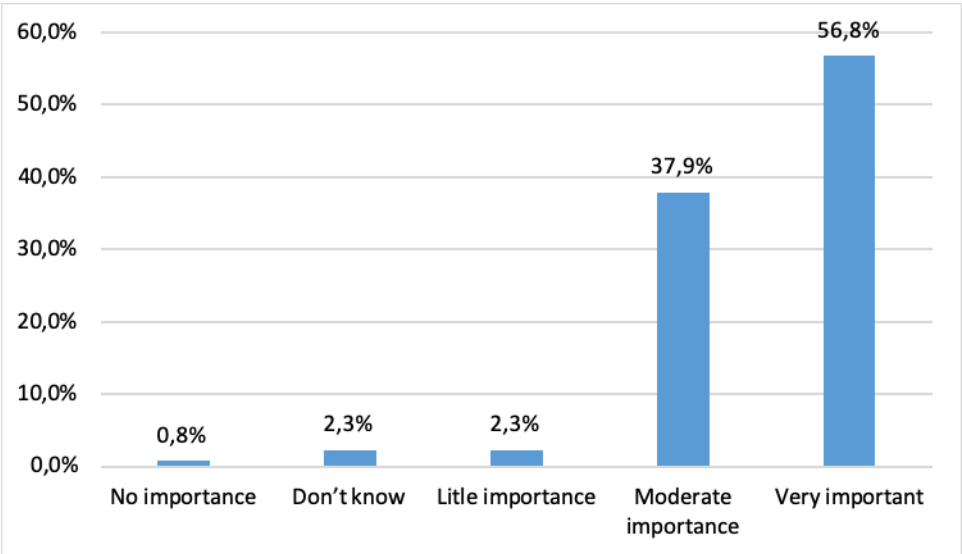
Due to health services requirements, institution has given offices specifically for implementation of social workers' practices, because they are first contact with population in order to evaluate their payment capacity. This area is responsible of focus, register and quantify monthly, the amount of socio-economic classifications. Therefore, inside HGM installations, there is an exclusive Social Work pavilion in ambulatory area, it has more than a dozen offices where endless queues of family members or patients can be seen all day long.

Likewise, physicians identified that social workers have an excessive amount of administrative process that constrain their participation in interdisciplinary work, however these activities are essential in public health institutions. For them, it's important to have this kind of staff in hand at the institution, because they are resolutive. When asked "If there weren't social workers at the hospital, who can

perform their tasks?" Some answer that their work can be done by secretaries or any other worker with social training, showing how they only value an administrative value to social workers practice.

Even when 54% of physicians recognize social workers' practice as very important and other 38% consider it of moderate importance, they don't see it as a practice with any kind of prominence as shown in figure 2. Although they recognize that social conditions influence patient treatments, these doesn't have a specific importance in medical diagnosis.

Figure 2. Importance given to social workers' professional practice in hospital



Source: self-made based on survey results.

In the other hand, it must be pointed out that within health staff, social workers are the ones with lowest income, this clearly places them in professional disadvantage in front of other groups. Their income reflects a technician training or bachelor's degree, even when some of them have higher degrees, on this matter, here's an opinion from a 22 years of experience physician:

> Social workers get paid almost like a factory worker, as an employee, it's ok, we all are employees, but it doesn't pay what for social workers value. Let's say that physicians or chemists or nurses have, let's suppose, a ten thousand pesos wage a month, social worker get's paid five or six thousand, I mean, they don't earn the same as other professions, and this happens not only in public institutions but also in private sector (E7-MB).

Professional hierarchy is a relevant sign because it limits relations inside institutions. This happens because physicians have the highest education levels among health workers, most of them have post graduate studies (specialists and subspecialties). Dissimilarities not only in academic grades but also income between health workers, are causes that influence attitudes and behavior, also when it comes to consider their opinions in matters of responsibilities, here is shown in a full-time physician testimony:

> A social worker can say: 'hey, look, I've been looking that in emergency room patients have a two days waiting queue and there are not optimal conditions for them to wait' He can even have evidence of patient laid in the floor, only with a blanket and without a chair, but there's not a single chance where he can say "I, a social worker, saw this" and that statement has the opportunity of changing those conditions (E2-MB).

as they have left some room to other groups, they still have the power in hospitals. Their leadership allows them to make decisions

concerning priority issues. These professionals have easily obtained high rank positions in hospitals: directors, sub-directors, coordinators, staff chiefs, research areas, operative positions and social services administrators; in the other hand, groups such as social workers haven't had open spaces to those critical positions, as they don't reflect professional authority. Consequently, organizational dynamic is one of the reasons why social workers' possibilities are limited and hardly can aim for nominations different than the ones in their category, this also have an impact in their professional recognition.

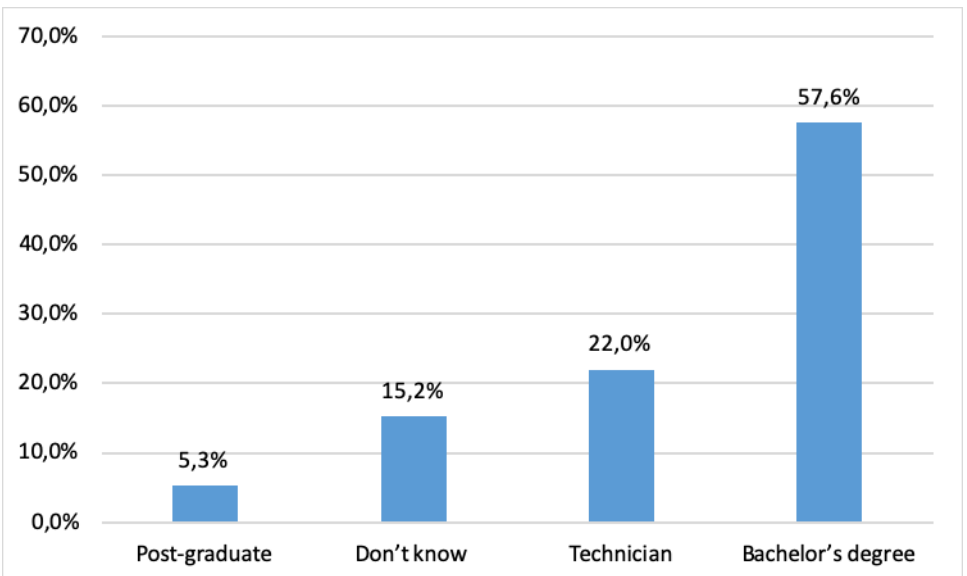
Another consideration to keep in mind regarding lack of recognitions is that most of social workers' staff is formed by women. According to Lorente (2018), gender condition in working environment had limited their access to high responsibility positions inside institutions; their tasks, being associated with help and care for others, are outside from what can be considered "prestigious tasks" so they can't thrive in their job.

This subordinated position determines visibility of other skills and makes harder retrieving recognition; while they doesn't have higher hierarchy positions, it creates a pigeonholing that feeds prejudices and stereotypes of what is expected from them, here is noted in a statement from a full time physician:

> In hierarchy, as a physician what can prove you that someone is your superior is by designation or academic level, this is what matters, what is transcendent, unless there is a shortage of equipment or a lack of money, we look at the one who pays or the one who's in charge of purchases. A very few times there's a situation where social workers can make decisions both with patients and empowered positions within health workers. If there is a troublesome patient it gets sent to social work… Social Work is deep down in hierarchy, but they could do many things if they were in upper positions, if they were in sub directions or as coordinators (E7-MB).

In traditional social work environments such as health, education, pursuit and administration of justice, technician profiles have been preeminent, and this is what different health workers perceive about social workers' possibility of action. For physicians, when asked about "What do you believe this professionals' level of education is?" 58% of them answered bachelor's degree, 22% technician, 15% didn't know and 7% said they were post-graduates, as shown in figure 3.

Figure 3. Social workers' level of education



Source: Self-made based on survey results.

Currently there's an important number of technicians on staff. Based on *Manual de Organización del Departamento de Trabajo Social y Relaciones Publicas del Hopital General de México* (Mexican General Hospital Public Relations and Social Work Department Organization's Handbook), we can tell that 72 of them have Bachelor's degree and 39 are technicians; whereas in postgraduates there's a noticeable shortage with only five members with a masters degree and not a single one with a PhD, just a few PhD students making their studies in other disciplinary fields.

Technician level of education used to be the more extended within this profession; according to a 21 years experienced physician in HGM, most of social workers were technician level professionals. Nowadays, technician level of education doesn't have the same social recognition as superior levels, that's why they are still undervalued and there's a lack of recognition from physicians, who believe that they have low education levels.

4. Conclusions

Physicians doesn't have negative or refusal attitude towards social work, they consider them as vital health staff members with a heavy load of work, they believe that social workers are resolutive in administrative process and tend to ease patients' stay in hospital. However, they're not recognized as a health professionals' group capable of contributing with scientific knowledge to improve patient's health, they are seen only as administrative staff.

For physicians it's clear that social workers professional practices don't stand out for their knowledge but for their service attitude. So, following expressions abut their professional practices were identified: *moderate, available, cooperative, resolutive, trustworthy, interested, not demanding, absent and limited showing of their work.*

In course of interviews with physicians some expressions stood out, these were related to: importance of social workers activities; disregard and invisibility of the work they do; misconceptions considering social workers activities from an asymmetric perspective that place these workers as subordinates.

On this matter, Perales and Vizcaíno (2007), explain that social representations towards attitude don't rely on object characteristics only but also in relations established by social systems. Hospital structure is configured on a hierarchy that shows classification of different professionals, according to employers' criterion about disciplines and subordinate relations based on social assets. The way health professionals organize their staff, recognizes the existence of disciplines with autonomous and alternative knowledge.

Within institution, social workers work as subordinates because they are conditioned to medical diagnosis, without this, they can't do anything. Inside institution's structure they don't have but a chief and any branch or administrative area, they rely on a medical branch for things like: staff hiring, work schedules, activities, resources and others. Their position doesn't have any power toward physicians since these have the higher ranks in structure. This is clearly shown in the way some physicians talk about social workers: "assistants or auxiliaries", such expressions portray their services as collaborative or assistive: *they help us handle bad temper of families… they help us go faster trough administrative procedures or they can even evaluate… and help us by being resolutive.*

Social Workers power spaces are few and are limited to their own department. Mexican General Hospital's authorities have entrusted social workers with social services administrative management, this has contributed with notarization of their work.

Therefore, physician attitude towards the object isn't unambiguous, it's a reaction to service characteristics and mainly to previous experience with social workers. On one hand, its positively oriented when they're described as sensitive, empathic and comprehensive about low-income population's needs when it comes to social assistance. On the other hand, a negative opinion concerning a low profile that doesn't prove their skills, lack of scientific accuracy in their interpretations, their limited schedule (even when hospital dynamics need more flexibility), their absence in discussions among other professionals.

In this regard, physicians describe social workers' personality as passive, as they are shy when it comes to prove how important their tasks are, this is recognised as one of the reasons their practices get undervalued. Even though physicians make remarks on how a good service attitude is important in social workers, they hardly would recognise another quality of their service. Ones that do recognise

their services are patients and their families, thanks to the ease they provide while the stay in hospital lasts.

In the end, in order for social workers to have a different take on traditional field such as healthcare, they should reinforce superior levels of education and try to create health focused specialities, this may have a direct impact on how social representations are configured about their professional practices. Lack of specialization and personal space defense might have influenced in social workers sticking to bureaucratic models and a social representation within those limits.

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