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Interdisciplinary collaboration between medical and non-medical professions in health and social care

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Abstract

OBJECTIVES: This paper addresses the issue of interdisciplinary collaboration between medical and non-medical professions in health and social care. The introduction defines basic terms such as interdisciplinary cooperation, interdisciplinary team, and health and social care. Additionally, it highlights the significance and contribution of interdisciplinary collaboration in the care of the patient/client in health and social care.
The aim of the paper is to identify factors influencing the process of interdisciplinary collaboration between, in particular, social workers and physicians. In compliance with the main goal of the research, the following partial goals were included: 1) to identify factors that limit the process of interdisciplinary collaboration between social workers and physicians, and 2) to identify factors which support the process of interdisciplinary collaboration between social workers and physicians.
METHODS: Based on the research goals, a systematic review was selected as the research method for the paper. The research dataset consisted of articles obtained from the following databases: EBSO, PUBMED/MEDLINE, SCIENCE DIRECT and SCOPUS. The databases were search using the following keywords: interprofessional cooperation, interdisciplinary, collaboration, social work, and physicians/doctors.
RESULTS: Using the results, the following factors supporting interdisciplinary collaboration were identified: acknowledgement of colleagues' expertise, recognition of roles, positive level of communication, and mutual respect. Factors that limit interdisciplinary processes included the following: varying professional perspectives, theoretical differences, lack of knowledge, and poor communication.

ORIGINAL ARTICLE

INTRODUCTION

Collaboration is one of the pillars upon which social work rests. Social workers have a long tradition of cooperating with other specialists.

According to Musil (2013), collaboration with workers from other supporting disciplines arises from the focus of social work on using various types of prospects and overcoming various types of obstacles, and managing problems in interactions between clients and their social environment. Collaboration with workers from other supporting disciplines and intermediating their assistance to clients is an essential part of social work.

The idea of an interdisciplinary team in healthcare comes from the renowned physician, Richard Cabot. Cabot (1909) suggested that social workers, physicians, and educators work together on a patient's problem.

"Interdisciplinary collaboration is defined as an interpersonal process leading to attainment of specific goals that are not achievable by one team member alone" (Bruner 1991). This definition focuses on the synergy, which emerges from collaboration, and identifying it as an active, ongoing, productive process.

Baggs and Schmitt (1988) identified collaboration as the most important aspect in team care of clients. Gray (1989) describes collaboration as a dynamic process that included the synthesis of various perspectives that allowed a better understanding of complex problems. Gray views collaboration to be the result of the development of integrated solutions and he stresses that these solutions exceed the framework of an individual's perception of a problem and, therefore, it is not possible for them (solutions) to be identified and implemented by an individual, and in some cases not even by one organization, which shows the indisputable contribution of collaboration.

According to Levická and Levická (2012), in terms of collaboration, it is necessary to distinguish between multidisciplinary collaboration and interdisciplinary collaboration.

Multidisciplinary collaboration can be defined as work shared by a number of representatives from varying disciplines. Even though team members may work in a common workplace and, paradoxically, consider their own work team to be interdisciplinary, in reality that is not the case. Their work is missing elements that transform a multidisciplinary team into an interdisciplinary team. This mainly lies in the fact that not all members of a multidisciplinary team are equally interested in achieving the final goal (Levická and Levická 2012).

Hyer (2007) defines an interdisciplinary team as "a group of people from different disciplines who assess and plan care in a collaborative manner. A common goal(s) is established and each discipline works to achieve that goal. Care is interdependent, complementary, and coordinated. Joint decision-making is the norm. Members feel empowered and assume leadership on the appropriate issue depending on the patient's needs and the members' expertise".

Trends in social problems and specialist practice demonstrate the difficulty of effectively serving clients without collaboration between professionals from various specializations (Bronstein 2003, p. 297).

Research studies also stress the necessity and importance of collaboration between social workers and physicians. Some studies, from the 1960s, of collaboration between physicians and social workers, compare social work and physician perceptions of the social work role (Olsen and Olsen 1967; Carrigan 1978; Lister 1980). In those studies, social workers tended to identify their roles quite broadly, particularly in relation to the provision of counseling and mental health services, while physicians viewed the role of social workers to be much narrower. In recent studies (1980s and 1990s), increasing numbers of physicians acknowledged the social work role in counseling patients and families (Gross and Gross 1987; Cowles and Lefcowitz 1992, 1995; Netting and Williams 1996, 1998; Badger *et al.* 1997; Egan and Kadushin 1997).

Smith (1985) included the following in the advantages brought by interdisciplinary collaboration: more effective work organization, improved services for clients, synergy effects, team education, mutual support, and improvement in the quality of the team. Schofield and Amodeo (1999) emphasized that interdisciplinary collaboration also brings increased awareness of one's own discipline, more regard for and understanding of other disciplines, and the opportunity for joint research.

Model of interdisciplinary collaboration

The conceptual framework for this article relies on a model (Bronstein 2003) developed from four theoretical perspectives: 1) a multidisciplinary theory of collaboration, 2) services integration, 3) role theory, and 4) ecological systems theory. The model is designates or identifies components of successful collaboration between social workers and members of other disciplines. This framework is composed of interdisciplinary processes in five core areas: 1) interdependence, 2) newly created professional activities, 3) flexibility, 4) collective ownership of goals, and 5) reflection process (Bronstein 2003) – Figure 1.

Factors influencing interdisciplinary collaboration

Bronstein (2003) specified four groups of factors that create the conditions for interdisciplinary collaboration in social work.

1. Knowledge of one's own **professional role** is essential for all team members, particularly in the caring professions. According to Bronstein (2003), the ideal form of this factor includes commitment by a particular organization, loyalty to social work as a profession, respect for colleagues, and an ecological and holistic approach to practice as it relates to the profession of social worker.

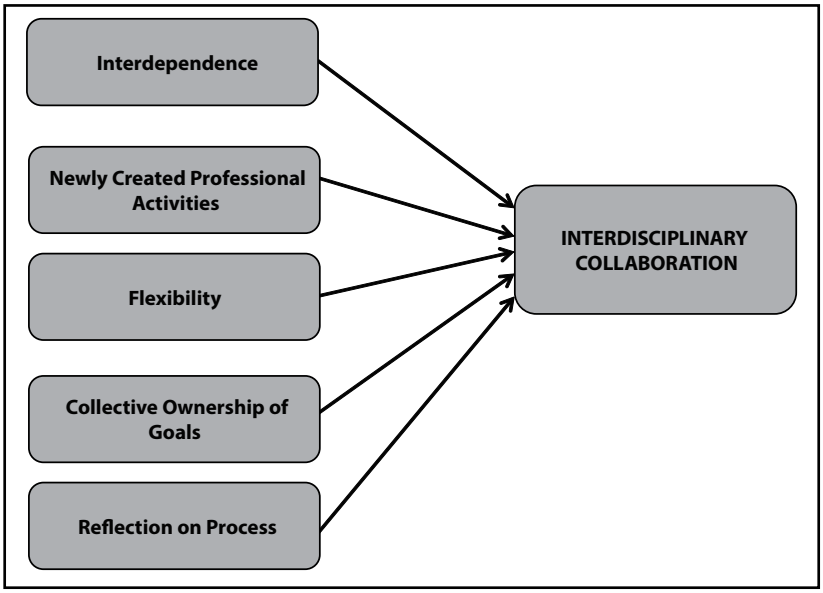

Fig. 1. Model of interdisciplinary collaboration (Bronstein 2003).

2. **Structural characteristics** include interdisciplinary collaboration for case management and casework. An organization's culture must also be supportive, i.e. necessary administration, autonomy of individual professions and sufficient time and space devoted to collaborative interventions.
3. **Personal characteristics** of team members also play an important role in the success of interdisciplinary collaboration. Trust and respect for all professional roles represented on an interdisciplinary team is critical.
4. The **history of collaboration** reflects the experiences of each member of a specialist team as it relates to interdisciplinary collaboration within a given organization. Bronstein (2003, p. 304) emphasizes that a tradition of collaboration in an organization determines its use/non-use in the intervention process. Positive experiences of specialist team members, together with a history of mutual collaboration within the organization, strengthen professional relationships and increases the effectiveness of interdisciplinary collaboration during an intervention (Figure 2).

According to Leipzig *et al.* (2002) at least five variables fundamental to effective medical teamwork have been identified: definition of appropriate goals, clear role expectations for members, a flexible decision-making process, the establishment of open communication patterns and leadership, and the ability of the team to "treat" itself. However, in real world practice, team collaboration can still be difficult to achieve. A literature review, from the perspective of the social worker, identified several well-documented sources of team conflict, including differing professional and personal perspectives, role competition and turf issues, differing interprofessional perceptions of roles, variations in professional socialization processes, physician dominance of teams and decision-making, and the perception that physicians do not value collaboration with other groups.

Health and social care

In previous years, the significance of social medical, or medical social, care has been steadily growing, mainly in its significance in providing practical, generalized, services to individuals in need. Practically everywhere healthcare is provided, it is also necessary to ensure and provide social care.

The whole of the previous period was characterized by efforts to strictly divide issues into either health care or social care, without any need for cohesion. Even now, there remains a division between health and social issues. This division is often due to a misunderstanding of the entire sensitive area, but it is also due to the current economic approach and departmentalization of client care.

If we look at the development of how health is defined, there is clear trend from a "state of non-presence of a disease or physical defect", which is the medical definition, to the current definition "the ability to have a socially and economically productive life", i.e. full perception of the social spectrum with activity in the economic area of each individual's life (Vurm 2007).

Health and social care of a patient cannot be categorically divided. Just the opposite is true; the relatedness of these types of care is fundamental and must be recognized. Individual types of care for patients must complement each other and be mutually interlinked. We cannot say that patients just need health care or just need social care (Mojtová *et al.* 2013).

Obstacles to interdisciplinary collaboration include:

- Structural obstacles (fragmentation of responsibilities between individual disciplines, within individual sectors, and between each other).

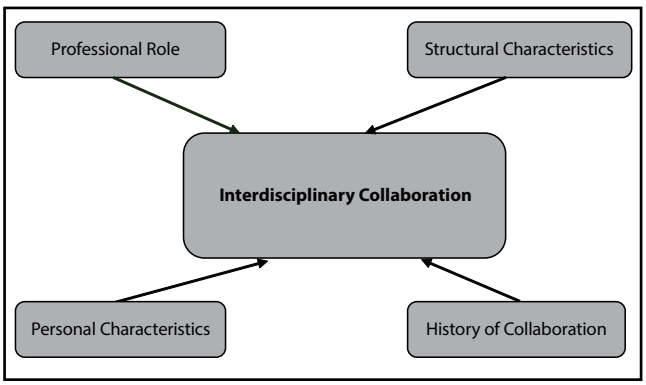

Fig. 2. Factors influencing interdisciplinary collaboration. (Bronstein 2003)

- Procedural obstacles (differences in planning goals and cycles, differences in budgeting cycles and methods, differences in information systems and reporting, if of a confidential nature and approach).
- Financial obstacles (differences in financial mechanisms/principles, differences between stock and flow of resources).
- Professional obstacles (one's own professional interest and autonomy and interdisciplinary competition for domains, competitive ideologies and values, threat of unemployment, differing opinions about the interests and role of the client/consumer).
- The status and legitimacy of obstacles (one's own professional interest and autonomy and interdisciplinary competition for domains, differences in the legitimacy between selected and designated agencies).

Principles for strengthening the strategic approach to collaboration include:

- A common vision (which particularly states what should be achieved in terms of goals focused upon the user, clarifies the aim of collaboration as a mechanism for achieving such goals and mobilizes efforts related to goals, results and mechanisms).
- The lucidity of tasks and duties (it states and confirms "who does what" and suggests organizational measures by which the tasks and duties should be fulfilled).
- Suitable motivation and remuneration (supporting conduct by organizations in compliance with agreed aims/duties, the use of one's own interest for meeting collective goals).
- The responsibility for working jointly (to monitor achieved success in relation to the stated vision, such that individuals and agencies are responsible for fulfilling pre-determined tasks and duties, and to provide feedback and control of the vision, duties, motivation and their mutual relationships) (Repková *et al.* 2011).

The main aim of this study was to identify factors influencing the process of interdisciplinary collaboration between social workers and physicians. In compliance with the main aim of the research, the following partial aims were included:

1. To identify factors that limits the process of interdisciplinary collaboration between social workers and physicians.
2. To identify factors that supports the process of interdisciplinary collaboration between social workers and physicians.

MATERIAL AND METHODS

Based on the research goals of this study, a systematic review was chosen as the most appropriate research method. A systematic review, as a form of scientific statement, means a summary of the latest developments in theoretical or empirical research in a given area (Hendl 2005, Bryman 2012). This study focused upon summarizing empirical research in the area of

Tab. 1. Basic information about articles included in the study.

Authors	Research aim	Participants	Research strategy	Reported outcomes
Abramson and Mizhari 1996	To understand the factors contributing to positive and negative collaboration	53 social workers 50 physicians	Qualitative methods Quantitative methods	Physicians generally give lower priority to collaboration than do social workers. Physicians were less likely to be familiar with issues and the language of the study than social workers.
Cowles and Lefcowitz 1992, 1995	To compare interprofessional expectations of the medical social worker role in the hospital	174 physicians, 273 registered nurses 40 medical social workers	Quantitative methods	Medical social workers expect their role to have more to do with counseling psychotherapy psychosocial problems, emotional and behavioral problems (affective-expressive tasks) which is contrary to what other health professional groups expect with regard to this role. Physicians and nurses expect hospital social workers to be environmental manipulators and perform instrumental tasks such as providing assistance for transportation and locating nursing homes and to be more active in the area of providing concrete services.
Abramson and Mizhari 2003	To identify key components of collaboration (Who was central to decision making? Who coordinate the case? Was the team helpful? What was the social work role?)	50 pairs of social worker-physician collaboration	Qualitative methods Quantitative methods	Typology of collaborators: *Traditional physicians* *Traditional social workers* *Transitional physicians* *Transitional social workers* *Transformational physicians* *Transformational social workers*

interdisciplinary collaboration between social workers and physicians.

Research data consisted of articles obtained from the following databases: EBSO, PUBMED/MEDLINE, SCIENCE DIRECT and SCOPUS. The databases were searched using the following keywords: *interprofessional cooperation*, *interdisciplinary*, *collaboration*, *social work*, *and physicians/doctors.* The articles, which also included research focusing upon interdisciplinary collaboration between social workers and physicians as well as in which social workers and physicians were selected as respondents, were included as research data. In this way, we obtained three research articles that met the study's stated criteria. Table 1 provides a review of these articles. The table is inspired by the research by Reeves *et al.* (2010).

Research findings from the selected articles were analyzed and categories were created. Categories were further collated and included either factors supporting or limiting interdisciplinary collaboration. Schemes showing individual categories and the relationships between them were created for each group of factors.

RESULTS

This part presents the results of the research, which was to identify factors that support and limit the process of interdisciplinary collaboration between social workers and physicians. The results are displayed using schemes (Figures 3 and 4).

DISCUSSION

At present, there are wide ranging discussions on collaboration between social workers and physicians regarding what works or does not work relative to the health and social care of clients/patients.

Several authors (Křivohlavý 2002, 2009; Dhooper 2012; Gehlert and Browne 2012) have emphasized the significance of a patient's wider social environment, i.e. network of relationships, support of family and friends, psychological condition, and this subsequently influences their overall health. For this reason, we can state that collaboration between social workers and physicians is the basic prerequisite for the total care of clients/patients.

The aim of this study was to ascertain which factors limit and support the process of collaboration between social workers and physicians, whose field of activities come into contact, in healthcare facilities such as hospitals and hospices, and social services facilities, such as facilities for senior citizens, etc.

Based on our research, various professional and theoretical perspectives were found to be factors that limit the process of interdisciplinary collaboration between social workers and physicians.

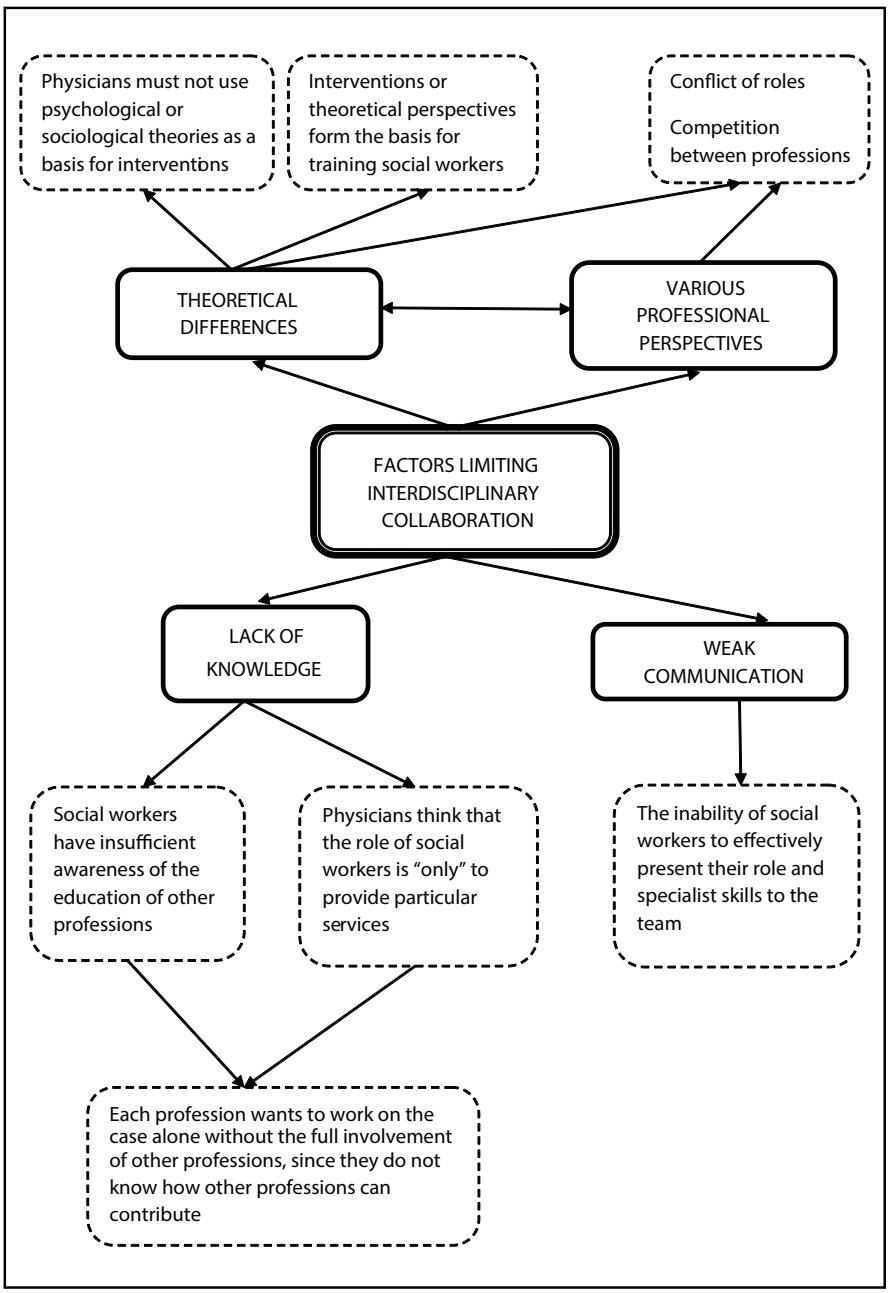

Fig. 3. Factors limiting interdisciplinary collaboration between social workers and physicians.

The development of starting points for collaboration between social workers and physicians was described by Simpkin (2005) in terms of a two-member scheme in which, on one side, there is the bio-medicinal attitude of physicians and, on the other side, there is the holistic attitude associated with social workers, which includes the psycho-social aspects of health and sickness. Collaboration between both these caring disciplines is more limited by declarative attitudes than the factual attitudes of physicians toward a holistic perception of disease and health.

The lack of awareness of the contributions made by co-workers was also seen as a limiting factor. Several pieces of research (Cowles and Lefcowitz 1992, 1995; Abramson and Mizrahi 2003) showed that there is no consensus among specialists regarding the role of social work and social workers in the health care system, nor is there consensus regarding how social workers should contribute in an interdisciplinary team. According to Kuzníková *et al.* (2011), the position of a medical social worker in a team of specialists is not clearly defined. Additionally, there are problems that stem from difficulties in mutual communication and in stating powers and working roles.

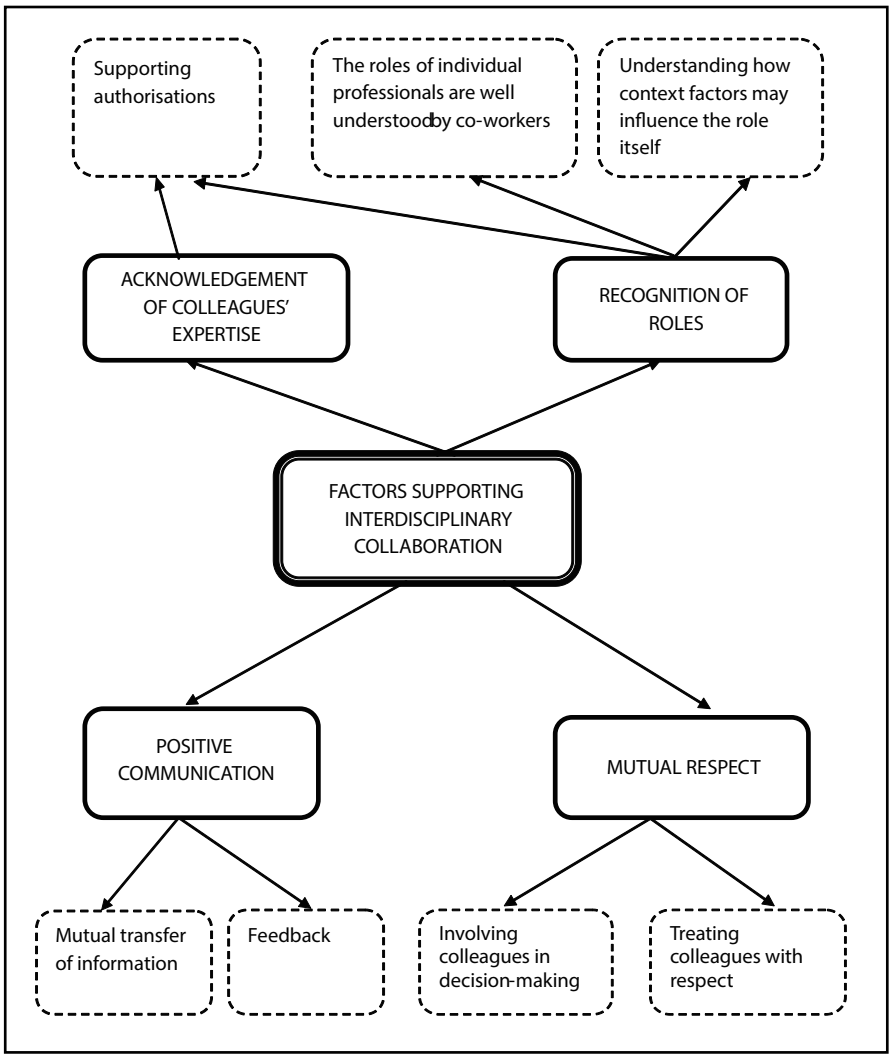

Fig. 4. Factors supporting interdisciplinary collaboration between social workers and physicians.

The role of social workers in health care needs to be respected and social workers need to feel that they are a member of a team of professionals and have a representative role in the collaboration process. Therefore, social workers must effectively communicate (1) their role on the team and (2) the special expertise they bring to the team.

In the execution of their responsibilities, social workers must follow the Code of Ethics for Social Workers in the Czech Republic. One point of the Code of Ethics addresses the relationship between social workers and their colleagues: "A social worker respects the knowledge and experience of their colleagues and other experts. They seek and widen collaboration with them and, thereby, increase the quality of the social services provided" (Code of Ethics for the Social Worker of the Czech Republic 2006, p. 2). Mutual respect between participating professionals has a positive influence upon the interdisciplinary collaboration process.

The purpose of social work in health care is mainly to help patients/clients, their families and the patient's wider social environment to suppress or eliminate the negative social effects of disease. The task of social work is to use the psychosocial sphere to influence an ill patient with the goal of achieving better adaptation, helping to overcome difficulties, facilitating treatment compliance and cooperation, all of which results in a better quality of life for the affected individual (Kuzníková *et al.* 2011).

According to Hudson (2002), physicians are perceived as "full" professionals since they possess all the attributes defined by Greenwood (1957): systematic theory, authority accepted by clients, authority accepted by society, a culture, and ethical codes.

The medical profession is traditionally ranked amongst the prestige professions in society, requiring specialized, demanding, and continuous education. They are given exceptional responsibility, which includes distinct ethical and legal requirements stated

in medical ethics standards, professional codes, and healthcare law (Bártlová and Matulay 2009, p. 56).

The situation in the area of social work is somewhat different. Discussions about whether social work should be an independent profession have been ongoing since 1915. Flexner (1915), in his account, *Is Social Work a Profession*, reached the conclusion that social work was not a profession. According to Flexner, unlike renowned professions such as medicine, law, architecture, and construction, social work has no clearly defined boundaries for its specialization.

Since 1915, there have been significant changes in society and in the field of social work. These changes have also influenced the discussions on social work as a profession.

Some authors (Toren 1972, Etzioni 1969) still do not consider social work to be a profession and label it a semi-profession. According to these authors, social work only partially fulfills the criteria for a profession. It is argued that social work is not a profession with a firm theoretical base and social workers do not have a monopoly on any of the special skills to which they make a claim. Additionally, they claim that society's attitude to the profession of social worker is ambivalent and, therefore, social workers do not have great social authority.

Other authors (Matulayová and Krystoň 2001, Reichert 2007, Ife 2008) state that social work can be considered as a profession with all the attributes defined by Greenwood (1957).

The ambiguity of whether social work is a profession combined with the explicit inclusion of medicine as a prestige profession should be considered another limiting factor in interdisciplinary collaboration.

According to the results of the research, acknowledgement of the expertise of colleagues and a recognition of the significance of their roles should be considered a factor supporting the interdisciplinary collaboration process. Team leaders should clearly state the team's standards for respecting the knowledge and expertise of other team members. Orientation to the role of each team member / profession is important not only to promote team competence, but also to understand how contextual factors can determine one's own role (Kulys and Davis 1987). Such orientations can be included in the training of new staff members (Lister 1980) or in continuing education programs.

CONCLUSION

This study identified factors that support (acknowledgement of the expertise of colleagues, recognition of roles, and a positive level of communication and mutual respect) and limit (theoretical differences, varying professional perspectives, lack of knowledge and poor communication) interdisciplinary collaboration between social workers and physicians. Recognition of factors influencing interdisciplinary collaboration can contribute to improving mutual relationships and communication between team specialists, in particular social workers and physicians, and in achieving joint goals, i.e. resolving patient/client situations.

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REFERENCES

1 Abramson SJ, Mizhari T (1996). When Social Workers and Physicians Collaborate: positive and Negative Interdisciplinary Experiences. Soc. Work. **41**(3): 270–281.
2 Abramson SJ, Mizhari T (2003). Understanding Collaboration Between Social Workers and Physicians: Application of a Typology. Soc. Work Health Care. **37**(2): 71–99.
3 Badger LW, Ackerson B, Buttell F, Rand EH (1997). The case for integration of social work psychosocial services into rural primary care practice. Health Soc. Work. **22**(1): 20–29.
4 Baggs GJ, Schmitt HM (1988). Collaboration Between Nurses and Physicians. J. Nurs. Scholarsh. **20**(3): 145–149.
5 Bártlová S, Matulay S. (2009). Sociologie zdraví, nemoci a rodiny. Martin: Osveta, 142 p.
6 Bronstein RL (2003). A Model for Interdisciplinary Collaboration. Soc. Work. **48**(3): 297–306.
7 Bruner C (1991). Thinking Collaboratively: Ten Questions and Answers to Help Policy Makers Improve Children's Services. Washington: The Education and Human Services Consortium. [online] [cit. 2014-04-30]. Available from: http://www1.cyfernet.org/prog/comm/98-thinkco.html
8 Bryman A (2012). Social research methods. New York: Oxford University, 2012. 766 p.
9 Cabot RC (1909). Social service and the art of healing. New York: Moffat, Yard and Company. 192 p.
10 Carrigan Z (1978). Social workers in medical settings: Who defines us? Soc. Work Health Care. **4**(2): 149–164.
11 Cowles L, Lefkowitz M (1992). Interdisciplinary expectations of the medical social worker in the hospital setting. Part I. Health Soc. Work. **17**(1): 57–65.
12 Cowles L, Lefkowitz M (1995). Interdisciplinary expectations of the medical social worker in the hospital setting. Part II. Health Soc. Work. **20**(4): 57–65.
13 Dhooper SS (2012). Social work in Health Care. London: SAGE Publications, 341 p.
14 Egan M, Kadushin G (1997). Rural social work: Views of physicians and social workers Soc Work Health Care. **26**(1): 1–24.
15 Code of Ethics for the Social Worker of the Czech Republic (2006). 7 p. [online] [cit. 2014-05-10]. Available from: http://socialnipracovnici.cz/public/upload/image/eticky_kodex_sspcr.pdf
16 Etzioni A, ed. (1969). The Semi-Professions and Their Organization. New York: Free Press, 328 p.
17 Flexner A (1915). Is social work a profession? New York: The New York school of philanthropy, 25 p.
18 Gehlert S, Browne T (2012). Handbook of Health Social Work. New Jersey: John Wiley & Sons, 702 p.
19 Gray B (1989). Collaborating: finding common ground for multiparty problems. San Francisco: Jossey-Bass, 329 p.
20 Greenwood E (1957). Attributes of the Profession. Soc. Work. **2**(3): 45–55.
21 Gross AM, Gross J (1987). Attitudes of physicians and nurses towards the role of social workers in primary health care: What promotes collaboration? Fam. Pract. **4**: 266–270.
22 Hendl J (2005). Kvalitativní výzkum: základní metody a aplikace. Prague: Portal. 408 p.

23 Hudson B (2002). Interprofessionality in health and social care: the Achilles's heel of partnership? J. Interprof. Care. **16**(1): 7–17.
24 Hyer K (2007). Module 20. Interdisciplinary Collaboration for Elder Care. New York: John A. Hartford Foundation Institute for Geriatric Nursing. 16 p. [online] [cit. 2014-04-30]. Available from: http://www.evidence2practice.org/topics/index.htm
25 Ife J (2008). Human Rights and Social Work: Towards Rights-based Practice. 2nd ed. New York: Cambridge University Press, 258 p.
26 Křivohlavý J (2002). Psychologie nemoci. Prague: Grada, 200 p.
27 Křivohlavý J (2009). Psychologie zdraví. Prague: Portal, 280 p.
28 Kulys R, Davis MA (1987). Nurses and social workers: Rivals in the provision of social services? Health Soc. Work. **12**(2): 101–112.
29 Kuzníková I. *et al.* (2011). Sociální práce ve zdravotnictví. Prague: Grada Publishing. 224 p.
30 Leipzig MR, Hyer K, Ek K, Wallenstein S, Vezina ML, Fairchild S *et al.* (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline. J. Am. Geriatr. Soc. **50**(6): 1141–1148.
31 Levická K, Levická J. (2013). Spolupráce na makroúrovni sociální práce. In Janebová R, ed. Spolupráce v sociální práci – bulletin from the conference IX. Hradec Days of Social Work. Hradec Králové: Gaudeamus, p. 336–342.
32 Lister L (1980). Role expectations for social workers and other health care professionals. Health Soc. Work. **5**(2): 41–49.
33 Matulayová T, Krystoň M. (2001). Kontinuálne vzdelávanie ako prostriedok profesionalizácie súčasných sociálnych pracovníkov. Práca a sociálna politika. **IX**(9): 16–17.
34 Mojtová M, Sedlárová K, Šrank M. (2013). Zdravotne sociálny pracovník v praxi. Nitra: Faculty of Social Science and Healthcare. 262 p.
35 Musil L. (2013). Sociální práce a jiné pomáhající obory/profese. In: Matoušek O *et al.* Encyklopedie sociální práce. Prague: Portal, p. 506–509.
36 Netting EF, Williams FG (1996). Case manager-physician collaboration: Implications for professional identity, roles and relationships. Health Soc. Work. **21**(3): 216–224.
37 Netting EF, Williams FG (1998). Can we prepare geriatric social workers to collaborate in primary care practices? J. Soc. Work Educ. **34**(2): 195–209.
38 Olsen KM, Olsen ME (1967). Role expectations and perceptions for social workers in medical settings. Soc. Work. **12**: 70–78.
39 Reeves S, Zwarenstein M, Goldman J, Barr H, Freeth D, Koppel I *et al.* (2010). The effectiveness of interprofessional education: Key findings from a new systematic review. J. Interprof. Care. **24**(3): 230–241.
40 Reichert E (2007). Challenges in Human Rights. A Social Work Perspective. New York: Columbia University Press, 286 p.
41 Repková K *et al.* (2011). Dlhodobá starostlivosť o starších ľudí na Slovensku a v Európe (3). Správa, riadenie a financovanie. Bratislava: IVRP, 230 p.
42 Schofield R, Amodeo M (1999). Interdisciplinary teams in healthcare and human service settings: Are they effective? Health Soc. Work. **24**(3): 210–219.
43 Simpkin M (2005). Holistic Health Care and Professional Values. In: Shardlow S, ed. The Values of Change In Soc. Work. London and New York: Tavistock/Routledge, p. 57–76.
44 Smith N (1985). Social work in team practice. In: Lecca PJ, McNeil JS, eds. Interdisciplinary team practice: Issues and trends. New York, NY: Praeger Publishers, p. 97–123.
45 Toren N (1972). Social Work: The Case of a Semi-Profession. Beverly Hills: Sage Publications, 256 p.
46 Vurm V (2007). Vybrané kapitoly z veřejného a sociálního zdravotnictví: pro studující ZSF JCU. Prague: Triton, 125 p.