‘Jack of All Trades and Master of None’?
Exploring Social Work’s Epistemic Contribution to Team-Based Health Care

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Abstract

From its inception, the social work profession evolved in tandem with public health, and has historically contributed to public health efforts to restore, protect and promote public health principles. In recent times, however, the most prominent role for health-related social work is in hospital-based, multidisciplinary teams. Curiously, scant attention has been paid to the place of social workers’ knowledge—their ‘epistemic contribution’—within this medical context. This article reports the findings of a scoping review that examined the role and function of social work knowledge in healthcare teams. Thematic analysis of the literature revealed four key themes: (i) a lack of clarity and visibility—‘Ok, what is my role?’; (ii) knowledge Hierarchies—‘Jack of all trades and master of none’; (iii) mediator and educator—‘Social work is the glue’ and (iv) public health principles—‘We think big’. Findings show that despite social work’s epistemic confidence, and alliance with broader public health principles and aims, its knowledge can be marginalised and excluded within the multidisciplinary team context. The article introduces Fricker’s theory of ‘Epistemic Injustice’ as a novel framework for inquiry into health care teams, and the mobilisation of social work knowledge within them.

Keywords: epistemic injustice, health social work, multidisciplinary teams, social justice, social work knowledge

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Introduction

For over a century, social work has maintained a place within the health care practice of many western industrialised countries (Auslander, 2001; Cleak and Turczynski, 2014; Saxe Zerden et al., 2019). At the profession’s inception in the late nineteenth century, concern with the health of the urban poor was a central focus of its broad ‘improvement and citizenship’ mission (Webb, 2007, p. 46). Like public health, social work’s roots lay in the social hygiene movement of the same era, which would evolve into social medicine (Rosen, 1948). Indeed, social workers have historically led, and contributed knowledge towards, public health efforts aimed at promoting social change, by combining clinical, intermediate and population-based approaches to enhance health outcomes, sharing public health’s commitment to restore, protect and promote the health of individuals, populations and communities (Bachman, 2017; Ruth and Marshall, 2017).

With the rise of the biomedical model in the twentieth century and the decline of social medicine (Turner, 1990), public health became a subspecialty of a more individually focused medicine. Social work developed as a distinct profession with a broad welfare agenda; however, its role in health care became delimited. The most visible contemporary health-related role for social workers is in ‘hospital social work’, where social workers typically work alongside other professions in a multidisciplinary team led by a medical doctor. Scant attention has been paid to the role of social workers’ knowledge—their ‘epistemic’ contribution—in these teams, and the impact of power, norms and culture within the team on how their knowledge is perceived and utilised. In particular, the extent to which social workers are able to maintain a public health focus in contemporary medically dominated health care environments remains unclear.

Contemporary health care environments are known to be highly bureaucratic, characterised by power differentials between professions and discord between diverse disciplinary approaches (Currie and White, 2012). Specifically, professional cultures, power and sociohistorical forms of legitimacy underpin health care hierarchies, privileging certain views and approaches over others. It is widely recognised that the medical profession dominates health care, deriving authority in part from its claim to specialised knowledge and the scientific rigour of the western scientific tradition (Glasby and Beresford, 2006; Turner, 1995), while perspectives that align with the social sciences and humanities are marginalised (Greenhalgh, 2018). In this dominated space, other health professions tend to defend their jurisdictions and maintain boundaries that hinder knowledge sharing and preserve power differentials (Ferlie et al., 2005; Hall, 2005; McNeil et al., 2014).
At the same time, integrated models of care promote ongoing, active and collaborative practice between multiple medical and social care agents, to better meet the needs of the populations served. This is based on a recognition that best health practice lies beyond the boundaries of a single professional group, incorporating multiple perspectives, skills and knowledge (Witteman and Stahl, 2013). However, team-based practices are also complex and dynamic, and discord between the philosophies of various professions may hinder integrated approaches to healthcare delivery (Peterson, 2012; Vodde and Gallant, 2014). Research suggests a lack of knowledge flow between different professions (Currie and White, 2012), and a need for further consideration of social structures as a barrier to the brokering of knowledge between professions (Greenhalgh et al., 2004).

Within this integrated context, social work’s foothold is yet to be fully established, with a lack of evidence pertaining to the key outcomes and effectiveness of the profession’s knowledge contribution (Kitchen and Brook, 2005; Steketee et al., 2017). Gould (2006) suggests, unless social workers are able to clearly articulate their epistemic contribution to integrated care, and to public health more broadly, they will remain at a distinct disadvantage in relation to their health care colleagues and their knowledge will be at risk of marginalisation.

To address this issue, we conducted a scoping review to examine the current state of evidence regarding social work’s epistemic contribution to team-based health care. The overarching aims of the review were to explore: (i) the role social work knowledge plays in integrated health care teams; (ii) whether and how public health principles are conceptualised and reflected within this knowledge base and (iii) the context, enablers and barriers for mobilising social work knowledge in integrated public health practice. To our knowledge, this is the first review to examine the question: ‘What is known about the role and function of social work knowledge in health care teams?’ In discussing the findings of the review, we introduce Miranda Fricker’s concept of ‘Testimonial Injustice’ as a novel framework for future inquiry into the mobilisation of social work knowledge in health care.

Method

The aims of this article lent themselves to an inclusive, interpretative and expansive review method that sought ‘clarification’ and ‘insight’ from the literature (Greenhalgh, 2020, p. 5). Accordingly, a scoping review method was chosen as ‘a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area
or field by systematically searching, selecting, and synthesising existing knowledge’ (Colquhoun et al., 2014, pp. 1292–1294).

Literature searching occurred in November 2019 as part of the first author’s (H.C.) PhD research, and was updated in July 2020. Author H.C. conducted an initial broad search of Google Scholar, followed by a search of relevant databases, including, MEDLINE, Scopus, CINAHL and Taylor & Francis. Keywords were combined using Boolean logic consistent with the limits of each database, including: ‘social work*’ AND ‘public health’ OR ‘health care’ AND ‘integrat*’ OR ‘collaboration’ OR ‘multidisciplinary’ OR ‘interdisciplinary’ OR ‘interprofessional’ AND ‘team’. Forward and backward snowballing identified additional literature. Papers were included in this review if they were: (i) written in English; (ii) peer-reviewed (to enable mapping of the scholarly enquiry); (iii) focused primarily on team-based health care and included social work as a key actor within the team; (iv) published after 2009 (reflecting the contemporary health context); and (v) reported or reviewed empirical research findings. There were no restrictions on the geographical origin of the papers.

Themes were derived by H.C. using Braun and Clarke’s (2006) phases of thematic analysis to inductively code the data. This process involved moving cyclically through the six phases, discussing and analysing with co-authors M.H. and C.B. to agree upon a set of emergent themes.

Findings

The search returned a total of thirty-six publications (see Supplementary data, Table S1), which mostly originated from the social work discipline. Additional insights were derived from fields including interprofessional care, organisational studies, medicine and social science. The papers predominately employed qualitative methodologies and thematic or interpretative analyses. Articles included in this review originated from a range of countries, including the UK, USA, Australia, Saudi Arabia, Canada, Israel, New Zealand, Sweden and Northern Ireland. They focused on a range of practice contexts, such as community and mental health, primary care and clinical research trials. Yet, the majority of papers reported studies of hospital-based teams.

The review revealed four key themes, that we have anchored with insightful quotes from the literature: (i) a lack of clarity and visibility—‘Ok, what is my role?’; (ii) knowledge Hierarchies—‘Jack of all trades and master of none’; (iii) mediator and educator—‘Social work is the glue’ and (iv) public health principles—‘We think big’.
A lack of clarity and visibility—‘okay, what is my role?’

A prominent theme across the literature was the uncertain and fluid nature of social work’s role within multidisciplinary health teams, which both enabled and hindered its mobilisation of knowledge. Our definition of the term ‘role’ aligns with that of Fraser et al. (2018, p. 180), who described it as ‘a set of related functions or tasks that require both knowledge and skill’ (Delany et al., 2017, p. 508).

A consistent observation in the literature was that social workers can find it challenging to clearly articulate their competencies, role and contribution (Ambrose-Miller and Ashcroft, 2016; Morriss, 2017; Ashcroft et al., 2018). Indeed, Svärd’s (2013, p. 515) Swedish study of social workers’ contribution to hospital teams depicted social work as a ‘blurred profession’. Social workers were also referred to as ‘boundary spanners’ (Moore et al., 2017, p. 111); expected to fulfil a broad scope of roles in the context of an American emergency department. In a paediatric Australian hospital, social workers experienced ethical conflict about their dual roles of supporting families and protecting their privacy, and sharing knowledge to inform the team’s clinical care decisions: ‘People are telling me the raw story...they feel safe with us...but what do we do with that information? It’s a lot of power’ (oncology social worker) (Delany et al., 2017, p. 507).

Ambiguity about the social work role extended to the wider multidisciplinary team, with team members frequently expressing uncertainty about the scope and contribution of social work practice to patient care (Keefe et al., 2009; Connolly et al., 2010; Sims-Gould et al., 2015; Abendstern et al., 2016; Glaser and Suter, 2016; Ambrose-Miller and Ashcroft, 2016; Moore et al., 2017; Ashcroft et al., 2018; Nicholas et al., 2019; Yamada et al., 2019; Mitchell et al., 2020). Uncertainty was also identified at the organisational level, manifested in expectations to perform multiple roles and duties outside of social work’s expertise (such as dispensing medication) (Craig et al., 2015; Ashcroft et al., 2018). Consequently, social work can ‘be anything’ and was referred to as an ‘invisible’ trade; often misunderstood and overlooked by other team members, and the wider health care system (Craig et al., 2015, p. 437; Morriss, 2017, p. 1347). This can lead to a misalignment in expectations about social work’s contribution, with one study finding that social workers experienced pressure to ‘fix entrenched and multisystemic problems’ at the institutional level (Moore et al., 2017, p. 110).

Interestingly, the integrated team context was found to evoke a reciprocal lack of clarity between health and social work professionals, who each believed that their responsibilities, duties and governance were not fully understood by the other (Mitchell et al., 2020). While this may be mitigated by the co-location of social workers with the integrated team (Ashcroft et al., 2018), or by thoroughly documenting the social work
contribution in client charts, paperwork or referral forms (Beddoe, 2011; Connolly et al., 2010; Ambrose-Miller and Ashcroft, 2016), a physical shared presence may not always signify effective integration: ‘We all work in the same office in isolation . . we talked about being an integrated team but I don’t know whether we actually are’ (mental health social worker) (Bailey and Liyanage, 2012, p. 1121).

The literature suggested that the integration of diverse professional groups in teams led to concerns about professional identity amongst social workers. The psychosocial health care domain was described as a crowded and competitive space in which social workers felt the need to protect their profession from ‘role creep’ (the blurring of boundaries) and ‘turf battles’ with other professional groups (Craig et al., 2015). In a Canadian study (Gachoud et al., 2012), nurses and social workers both claimed to hold responsibility for patient-centeredness. Bailey and Liyanage’s (2012) UK ethnography of specialist mental health teams found that social workers, as ‘mental health coordinators’, experienced role creep by nurses and occupational therapists. Fraser et al.’s (2018, p. 190) systematic review found that social workers shared functional titles, such as ‘depression specialists’, with psychologists and nurses. Further still, a participant in Beddoe’s study (2011, p. 35) suggested that social work is at risk of becoming ‘part of the clinical system of mental health’ and ‘just another mental health worker’. Consequently, the social work identity and the foundational principles to which it is tied, such as social justice, may be weakened or diluted within the multidisciplinary team context. One reason for this ‘role creep’ may be that, with increases in interdisciplinary care, social work administration responsibilities and control of discipline specific roles has fallen under the domain of managers from other disciplinary areas, who do not necessarily understand the professional knowledge and skills of social workers (Judd and Sheffield, 2010).

Notwithstanding these obstacles, integrated care has the potential to facilitate ‘closer collaboration’ amongst multidisciplinary team members and, in doing so, promote ‘a deeper understanding of each other’s roles’ (Mitchell et al., 2020, p. 4). Indeed, it appears social workers who were critically cognisant of their unique role were able to assert a distinct social work perspective within the health care team and organisation (Ambrose-Miller and Ashcroft, 2016; Nicholas et al., 2019). This required a robust knowledge base, an understanding of topics salient to the area of practice, patient and family-centred care, and a strong theoretical foundation. Social workers also emphasised the need to ‘discern and communicate’ the scope of their practice and their unique contribution to team-based care (Nicholas et al., 2019). Conversely, Ambrose-Miller and Ashcroft (2016, p. 104) proposed that social workers can find freedom in the lack of rigid role constraints, and that role fluidity may function as an asset in addressing clinical complexity and filling critical
service gaps: ‘I think we pride ourselves in ambiguity so that there’s still a place for complexity’ (social worker).

Knowledge hierarchies—‘jack of all trades and master of none’

The colloquialism, ‘jack of all trades and master of none’ was an overarching theme in the literature on social work knowledge. The broad knowledge claim of social work was understood as both a strength and a hinderance. On the one hand, it allowed the profession to engage across a wide spectrum of health contexts, whilst on the other, social workers were perceived to be lacking ‘tangible skills’ (Craig et al., 2015, p. 427), and clear expertise or ‘smartness’ (Beddoe, 2011, p. 31) in comparison to more powerful health colleagues. Consequently, social workers were highly cognisant of their knowledge status within the integrated context, and the impact of power, norms and team culture on this status (Beddoe, 2011, p. 35).

Power asymmetries appear particularly stark within the integrated care context, with professions aligned with the biomedical model (such as doctors) holding a great deal of authority and power over other professions (such as social work) (Currie and White, 2012; Fouche et al., 2013; Albrithen and Yalli, 2015a,b; Craig et al., 2015; Ambrose-Miller and Ashcroft, 2016; Baum et al., 2016; Delany et al., 2017). For social work, these power asymmetries resulted in issues such as salary disparity (Bailey and Liyanage, 2012; Ambrose-Miller and Ashcroft, 2016), unequal access to resources and funding opportunities (Beddoe, 2011), stigma and lower status (Ashcroft et al., 2018), a sense of powerlessness (Moore et al., 2017), a lack of leadership opportunities in multidisciplinary research partnerships (Pockett et al., 2015) and limited professional esteem (Craig et al., 2015). Significantly, it is not uncommon for social workers to ‘sit silently’ through multi-disciplinary hospital meetings, due to the prioritisation of medical issues (Giles, 2016, p. 29). Indeed, social work’s knowledge contribution can be actively dismissed or suppressed by doctors, leading to a reduction in decision making power and autonomy for the profession (Jones et al., 2013; Giles, 2016; Delany et al., 2017; Peterson et al., 2018). Consequently, Beddoe (2011, p. 32) concluded, social workers often lack a place ‘at the table’.

At the heart of this power asymmetry are epistemic considerations about what knowledge counts, and whose knowledge matters. Gachoud et al. (2012) described the ‘struggle for predominance’ amongst the health care professions via symbolic ‘contests’ to defend the legitimacy of their field (Gachoud et al., 2012, p. 488). While this does not necessarily result in ‘actual friction’, evidence suggests that professions which are afforded less power, such as social work, engage in activities that resist or mitigate, the dominant knowledge hierarchy. For example, in the
hospital context (Beddoe, 2011; Craig et al., 2015), social workers described the team as a ‘battlefield’ requiring them to ‘fight’, ‘battle’ and ‘struggle.’ In this context, credentialing via postgraduate social work study was posited as an ideological weapon to strengthen their knowledge claim (Beddoe, 2011). Some social workers also mitigated the hierarchy through diplomacy (Delany et al., 2017), collegial relationships (Fouche et al., 2013), and ‘backstage’ activities (away from direct patient care) via ‘informal’ interprofessional communication (Lewin and Reeves, 2011). In contrast, a small portion of Swedish social workers were accepting of their ‘passive’ position and placed their trust in the hierarchy, relying on the ‘expertise’ of doctors (Svård, 2013). Nevertheless, the evidence overwhelmingly pointed to social workers’ actively looking to defend the legitimacy of their knowledge contribution.

Social workers also provided key insights into the ways in which their epistemic legitimacy could be promoted within integrated health care discourse, reflecting a belief that agency and change are possible despite the profoundly hierarchical context. Mental health social workers, for example, called for change and shared a sense of disappointment that ‘in the last 10 years social workers have been badly let down by their leaders’ (Bailey and Liyanage, 2012, p. 1124). Macro level advocacy, which seeks out opportunities to assertively highlight social work’s valuable knowledge and skills (Ashcroft et al., 2018), was identified as a means to overcome hierarchical barriers to collaboration: ‘If we didn’t have to keep tap[ping] on their shoulders to keep telling them why we’re so important, then services would be different. We need to push for more’ (social worker) (Ambrose-Miller and Ashcroft, 2016, p. 105). There were calls for research to clarify, articulate and measure the effectiveness of social work’s contribution to integrated care (Craig et al., 2016) including patient and family-centered care in hospital teams (Craig et al., 2015).

**Mediator and educator—‘social work is the glue’**

The literature evidenced the important ‘backstage’ contributions social workers make to the overall functioning of health care teams, using their relationships within the team to provide support, education and mediation in an ongoing, dynamic fashion (Craig et al., 2013, p. 10).

Relationships with health care colleagues offered a key opportunity for social workers to facilitate knowledge sharing, utilising meetings, case conferences, training and other formal and informal methods of collaborative consultation and knowledge exchange (Ambrose-Miller and Ashcroft, 2016; Ashcroft et al., 2018). Social workers in the UK expanded the community mental health team’s awareness of social service resources and processes (Abendstern et al., 2016). In Australia, social workers educated medical professionals on client-centred practice, and...
addressed misalignments in expectations and perceptions amongst health professionals and clients (Delany et al., 2017, p. 507). In New Zealand, social workers assisted pharmacists to understand the importance of psychosocial issues in medical management (Fouche et al., 2013). There was also evidence that social work’s foundational values may have a positive impact on the practice of health teams: ‘There’s so much emphasis on addressing the clinical, [issues] but [we are] also under a short-term model, so it reinforces the department’s motto of hope, wellness, and recovery, as well as helping the clinicians really fine-tune how they manage time, feeling comfortable with setting boundaries and setting limits’ (clinical supervisor describing social work contribution to integrated medical care) (Yamada et al., 2019, p. 527).

Social work knowledge was found to contribute to maintaining positive team practice and relationships, and mitigating challenges. Employing conflict resolution skills, social workers are able to resolve group tensions (Sims-Gould et al., 2015; Nicholas et al., 2019), and provide ‘embedded therapy’ (informal, situated encounters) for team members (Craig and Muskat, 2013). Social workers described themselves as the ‘glue’; preserving connections and communication between the team, patients and families. Similarly, in clinical research teams, social workers functioned as a ‘conduit’ between the divergent perspectives of the team, the patient, and the patient’s family: ‘I do discharge planning, and I talk to a lot of different people [on the team], and I have to juggle and coordinate what all these people are saying the patient needs. Sometimes I say, “No, this is not what I heard. This is what I heard”’ (social worker) (Peterson et al., 2018, p. 696).

**Public health principles—‘We think big... far reaching’**

The literature in this review elicited salient public health competencies of social workers within integrated health teams, with evidence suggesting that social work’s professional tenets and epistemology enable a comprehensive approach to health care provision that addresses the social determinants of health. Of importance, social work knowledge was highlighted as uniquely able to contextualise health issues within the broader social, structural and systemic ‘big picture’ environment (Craig et al., 2015, p. 426).

The review findings suggested that social workers seek to enrich health care provision by moving beyond narrow, biomedical conceptions of health: ‘We look at the human aspect, both individual and society’ and ‘humanising practice is my role’ (social workers) (Ambrose-Miller and Ashcroft, 2016, p. 104). In primary health care, social work’s contribution was conceptualised as essential to improving individual health behaviours, and addressing the impact of external environmental factors
on people’s engagement with health services and health care preferences (Rowe et al., 2017). Social work’s ability to offer a broader conception of health was highlighted as differentiating it from other ‘psychosocial’ professions (Pickett et al., 2015; Giles, 2016; Glaser and Suter, 2016). Numerous studies also highlighted social work’s ongoing commitment to promoting patient-centred care (Gachoud et al., 2012; Giles, 2016; Abendstern et al., 2016; Delany et al., 2017; Nicholas et al., 2019; Yamada et al., 2019).

Additionally, this review found that social workers tend to align their practice closely with the rights of patients and their families, advocating for their voice, needs, wishes and worldview within the team (Craig and Muskat, 2013; Ambrose-Miller and Ashcroft, 2016; Delany et al., 2017; Peterson et al., 2018; Yamada et al., 2019; Saxe Zerden et al., 2019). Broadly, the profession has been said to operate from ‘an ethic of social justice’, extending beyond the medical model (Abendstern et al., 2016, p. 69). For example, social workers in Nicholas et al.’s study (2019) fostered an awareness of ‘gaps’ in health care, and provided pivotal support and advocacy for patients and families in navigating them. Indeed, within the ‘brick walls’ of hospital bureaucracy, social workers were said to act as patient navigators, empowering people with knowledge about their rights (Fouche et al., 2013; Delany et al., 2017). Social workers also ensure people do not ‘slip through the net’ during discharge planning (McLaughlin, 2016, p. 146) and challenge instances of structural oppression, such as classism, racism or cultural exclusion stemming from team members (Moore et al., 2017; Peterson et al., 2018). This big picture thinking was not necessarily a concern shared by medical colleagues: ‘once we [as physicians] take care of, whatever is wrong, medically . . . we throw them to social work to deal with the rest of their lives’ (Craig et al., 2015, p. 426).

Social justice and advocacy were, however, said to be at risk within the narrow parameters of hospital institutions; clinical ‘systems’ shaped by the biomedical paradigm and bureaucratic accountability. Consequently, the profession’s political and social justice ideals can remain unrealised (Beddoe, 2011, p. 35). There was also evidence that health care services may not be fully cognisant of the benefits of bringing a broader social perspective to practice with individuals and families. In Evans et al.’s (2012) study of UK mental health teams, while social workers were valued for their social perspective—in addressing social complexity, deprivation or inclusion—there was overall a greater emphasis on the financial incentives and historical precedent of including social care. Cost-containment and maximisation of profit were highlighted as core concerns of western policy makers, yet there was a dearth of evidence regarding how social work interventions reduce long-term health care costs (McLaughlin, 2016; Fraser et al., 2018). This was noted as an urgent research imperative, if the profession is to avoid being deemed
non-essential or expendable. Indeed, successful health care integration is currently measured via narrow and prescribed performance indicators, which marginalise and ignore social work’s public health contribution: ‘But the bigger thing is, we will talk about improving health outcomes, enabling people to live longer. Well, in terms of the prevention work, and some of the stuff that we’re doing, there’ll be no deliverables [affecting hospital admissions/stays]’ (social worker integrated neighbourhood team) (Mitchell et al., 2010, p. 5).

Discussion

In examining what is known about the role and function of social work knowledge in health care teams this review included a diverse collection of contemporary, scholarly literature reflecting a range of knowledge, voices and professions. It highlighted the challenging, messy and iterative ways in which social work knowledge merges and interacts with other forms of knowledge in health care teams, reinforcing the claim that achieving integrated health care may be ‘harder than we think’ (Groen, 2016).

Models of integrated care are rooted in principles of epistemic pluralism and the assumption that one profession’s knowledge will not be eclipsed by that of a more powerful group. Yet, our findings provide insight into the messy reality of collaboration in integrated care contexts, and the powerful hierarchies that determine what knowledge counts, and whose knowledge matters within these contexts. Accordingly, the first two themes reflected uncertainty about the visibility, recognition and understanding of the social work role, and the perceived lack of depth, or mastery of, social work knowledge in comparison with other, more powerful, health care actors. However, the final two themes suggested that social work knowledge leads to benefits for patients and families, for the health care team and for public health more broadly, through its alignment with public health principles of social justice and advocacy. Miranda Fricker’s theory of ‘Epistemic Injustice’ offers a novel framework for exploring the experience of social workers as ‘knowers’ in health care settings, and the influence of power on their knowledge contribution.

To be valued in any setting, a person must be recognised in their capacity as a trustworthy conveyer of knowledge. This recognition, Fricker (2007, p. 44) argues, is an essential component of epistemic justice. Epistemic injustice occurs when someone is wronged in their capacity as a knower. Fricker describes two types of epistemic injustice: hermeneutic and testimonial, and we focus here on the latter. Fricker argues that testimonial injustice occurs when prejudice leads a ‘hearer’ to attribute a lower level of credibility to another person’s speaking or reporting—
their ‘testimony’. In essence, testimonial injustice is concerned with the relationship between power and epistemic participation. It, thus, offers a philosophical structure to explore human relations and how they might be influenced by certain social, political or ethical conditions. While Fricker’s theory of testimonial injustice has been applied both in social work (Lee et al., 2019a, 2019b), and in the wider health care literature (Ho, 2009; Carel and Kidd, 2014; Kidd and Carel, 2017), to the best of our knowledge this is the first time it has been used in the context of team-based health care.

Applying Fricker’s theory, the integrated team may be perceived as one ‘epistemic domain’ of knowledge and experience, in which social workers and their health care colleagues interact, collaborate, contest and resist. Indeed, there was evidence that social workers seek to challenge their ‘epistemic exclusion’ (Daukas, 2012), and ‘identity-prejudicial credibility deficit’ (Fricker, 2007), within hierarchical integrated team contexts. The literature revealed that social workers employed epistemic resistance—using epistemic resources (for example, credentialing and usurping their position) alongside professional skills (for example, relationship building and backstage activities)—to challenge and undermine oppressive power imbalances. Furthermore, the social work literature repeatedly called for research, advocacy and discourse surrounding the value of social work’s contribution in health care contexts. This speaks to an innate epistemic confidence within the profession; a self-relation or intellectual ‘self-trust’ regarding their capacity as ‘knowers’ (Fricker, 2007, p. 168).

This self-trust can, however, be hindered or subdued by oppressive social relations (Fricker, 2007, p. 47). In this review, epistemic confidence resonated from medical professionals, due to their ‘credibility’ as speakers (Fricker, 2007, p. 18), while social work was often depicted as a ‘jack of all trades’ lacking depth and mastery of knowledge. This brings to the fore wider epistemic debates in health and medicine, in which the ‘soft’ social sciences are often depicted as inferior to the ‘hard’ medical sciences, leading to the marginalisation of qualitative methodologies in public health and medical journals (Greenhalgh et al., 2016). In this context, social work’s longstanding critique of the prescriptive orientation and hierarchical epistemic culture of evidence-based medicine as inappropriate to the kinds of social and emotional problems faced by social work (Webb, 2001, 2002), may be seen as further evidence of the profession’s resistance to epistemic exclusion.

One potential avenue for strengthening social workers’ claim, and confidence, as ‘knowers’ in integrated health care contexts may be to reignite, and make explicit, the profession’s alliance with public health aims. Evidence from this review suggests that future research exploring the ‘big picture’ lens of social work, as a public health resource ‘within’ the integrated health care team, offers a potential avenue to legitimise the profession’s epistemic contribution. Fricker’s theory of ‘Epistemic
Injustice’ offers a useful framework to guide future consideration of the role and contribution of social work knowledge by researchers, practitioners and representative professional bodies. After all, pluralistic approaches are needed for contemporary public health issues (McCarthy, 2010), which in their inherent complexity, call for medical treatment and approaches that promote equity and the social determinants of health.

**Conclusion**

The findings reveal that social work knowledge can be marginalised and excluded in integrated health care teams, despite evidence of the profession’s considerable contributions across a range of health care settings. The review evidenced a continuation of the profession’s historic alliance with public health, and, its promotion of public health principles and ‘big picture’ thinking ‘within’ clinical, biomedical environments. Critically, it highlighted that when social workers are confident in their epistemic abilities, they are able to challenge and resist oppressive structures, and extend the narrow scope of the medical model through an ethic of social justice. As such, this review represents an important stepping stone towards achieving greater esteem for the profession’s epistemic contribution to team-based public health practice, as a jack of all trades, but one with considerable mastery.

**Limitations**

This review has several limitations. First, it only included peer-reviewed journal articles and excluded grey literature. It is therefore likely that additional information regarding policy, legislation and practice standards for social workers was missed. The search was also limited to the past 10 years, meaning older studies and historical issues may not have been captured. Finally, data extraction did not involve a quality appraisal of included papers. While this is consistent with a scoping review methodology (Munn et al., 2018), it means that conclusions cannot be drawn about the methodological rigour of studies included in this review.

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Supplementary material

Supplementary material is available at British Journal of Social Work Journal online.

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