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RESEARCH ARTICLE

Social Nurses' Descriptions of Nursing: A Qualitative Study of What Social Nursing is and Does?

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Abstract:

Background:

In the meeting between socially marginalised patients and somatic hospitals, healthcare systems often encounter complex challenges related to health inequalities that are difficult to resolve. To help reduce these challenges, a nursing approach employing a nurse (RN) with in-depth knowledge of socially marginalised patients and competences in rehabilitation ("social nurse") has contributed to diminish health inequalities. However, further insight into the potential benefits of social nursing is required.

Aim:

To examine how social nurses describe and experience the social nursing approach situated at somatic hospitals.

Methods:

A qualitative study of social nurses' descriptions and experiences with a social nurse approach included eight Danish hospitals. One male and 12 female nurses (*n*=13) employed as social nurses at somatic hospitals participated. Thirteen semi structured interviews were conducted using the methodological frameworks of phenomenology and hermeneutics. The interviews were analysed employing a method inspired by the French philosopher Paul Ricoeur's theory of interpretation.

Results:

Four themes emerged from the analysis: 1) A unique expertise encompassing experience and evidence-based knowledge 2) coordination towards a common goal to reduce patients' vulnerability, 3) to see and understand patients as whole persons, thereby assuring successful treatment and 4) working with the system to avoid losing the patients.

The themes describe a unique expertise emerging from focusing healthcare efforts on the socially marginalised patients and the system in charge.

Conclusion:

The study indicated that the social nurse approach is a holistic nursing approach. Applying this approach allows for optimised treatment that fosters a more equal outcome across the spectrum of socially marginalised patients. The social nurse approach may contribute to diminishing health inequalities.

Keywords: Harm reduction, Health disparities, Inequality in healthcare, Nursing, Qualitative method, Social marginalisation, Ricoeurean interpretation.

1. INTRODUCTION

Socially marginalised patients with addictive problems are characterized by multi-morbidity including both somatic and psychiatric diseases and have a significantly higher degree of mortality and reduced life expectancy of 19 years compared with the Danish background population [1 - 3]. The healthcare systems often encounter complex challenges relating to health inequalities that are difficult to resolve. Socially marginalised patients are often stigmatised and perceived as complex patients when admitted to somatic hospitals [3, 4]. Most modern healthcare settings are familiar with social workers [5].

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However, a health-related nursing approach (social nurse), situated at somatic hospitals, aims to ensure socially marginalised patients the same rights and access to care, treatment and dignity as the background population is, so far, a novel approach. It is based on in-depth knowledge of socially marginalised patients and competences into rehabilitation that may diminish health inequalities [3]. Further insight into the potential benefits of this social nursing approach is needed.

Social marginalisation and health inequality are global phenomena representing major challenges in today's societies [1 - 3]. Social marginalisation refers to processes due to which some individuals and groups face systematic disadvantages such as poverty and poor housing and socioeconomic conditions that may, in turn, lead to health inequalities [4, 2]. Health inequality is defined as differences in health resulting from a systematic lack of resources; they are thus socially produced and unfair [5].

European studies have shown a relationship between socioeconomic deprivation and increased mortality [6]. In Denmark, the estimated number of socially marginalised persons is around 180,000 persons [7]. Their overall health condition is inferior to that of the general population, as illustrated by a 5-6-fold increased number of emergency department visits and a mean life expectancy that is reduced by 19 years [8, 9]. Thus, social marginalisation and health inequalities are complex concepts painting a bleak picture of a population with a significantly increased risk of disease due to intricate life circumstances [10, 8, 9].

Reducing health inequalities and improving overall population health conditions are core goals in many countries [11]. The World Health Organization (WHO) highlights the need for health professions to act to tackle social and health disparities worldwide [12]. Studies indicate that socially marginalised individuals face several social stress factors complicating their coping with disease and reducing their ability to complete hospitalisation [13, 14]. Moreover, as patients, socially marginalised people often encounter barriers - *e.g.* healthcare providers' poor knowledge of the effects of social marginalisation - that make it more difficult to achieve treatment and care goals. These studies highlight a need to combine a clinical focus with specific actions to handle these challenges. It has been suggested that the nursing profession may be in a position to address these challenges [1]. Hence, Reutter and Kushner (2010) argue that nursing has a mandate to promote health equity [15].

Internationally, numerous approaches exist. A British study argues that harm reduction as an overall approach in hospital settings may reduce health inequities by allowing consumption of drugs and/or alcohol as well as by providing access to clean needles and syringes during hospitalisation [16]. Furthermore, the authors stress that healthcare professionals lack the skills and ability to work from a harm-reduction perspective. They propose the implementation of a discharge programme designed to ensure that socially marginalised patients retain the improvement gained during hospitalisation post discharge [16]. A Taiwanese study concludes that nurses can be the key figures in working with patients suffering from harmful alcohol misuse. However, the study shows that nurses in hospitals lack knowledge and education to handle these tasks [17]. Moxley and Washington (2016) underline that working with vulnerable groups poses significant and unique challenges for nurses as they do not feel competent to identify marginalised patients' needs. The study proposes collaboration between nurses and social workers to identify both health-related and social needs [18].

In Denmark, a unique nursing approach was introduced in 2006 to ensure more equal outcomes for socially marginalised patients in somatic hospitals [19, 20]. This initiative is based upon the principles of harm reduction and an appreciative inquiry and thus aims to assure a connection between society, everyday life and the patient [20]. The target population includes patients with substance abuse and/or alcohol consumption and patients at risk of social marginalisation admitted to somatic hospitals [20]. It is worth mentioning that The Danish healthcare system is tax financed and therefore free of charge for Danish citizens. Hence, hospital admissions does not depend on socio-economic status or insurance. A nurse working with this unique approach, a "social nurse" contributes with specific knowledge about marginalisation, disparities, health inequalities, pain and/or abstinence treatment, and with a profound understanding of the unique problems marginalised patients are often facing [20]. A social nurse has years of experience working with socially marginalised patients. Besides the social nurse has experience from the established healthcare system. A local evaluation has been conducted, indicating a positive impact for both patients and healthcare professionals [21]. Still, it remains unknown specifically what social nursing is and does. The present study aims to examine how social nurses describe and experience social nursing situated at somatic hospitals.

2. MATERIALS AND METHODS

2.1. Methodology

A phenomenological hermeneutic approach inspired by the French philosopher Paul Ricoeur's theory of interpretation was chosen for this study [22]. The study aimed to explore social nurses' descriptions of and experiences with the social nursing approach. One way to capture life experiences is to let participants talk about their lives thereby disclosing their life worlds [23]. Thus, qualitative semi-structured interviews were chosen as the data collection method. Using this Ricoeur-inspired method for interpretation of interviews transcribed as text, researchers endeavour to explain and understand the meaning of participants' narrated life experiences, whereby the findings obtain credibility and reliability [22].

2.2. Participants

By mid-March 2018, 15 social nurses were working at eight somatic hospitals in Denmark. To achieve the widest possible range of nuances and variations of social nursing, all 15 nurses were included in the study. The inclusion criterion was a minimum of 0.5 years of experience with social nursing. One participant did not meet this criterion. Thirteen nurses agreed to participate (*n*=13). Both genders were represented, and participants were aged between 27 and 56 years.

The social nurses were contacted after obtaining permission from local managements. Prior to the interview, the participants received information about the study and a declaration of consent. In addition, the first author (TLD) contacted them by telephone to inform them of the study and schedule an interview date. All participants were very engaged in describing the social nursing approach; thus, the process of conducting the interviews went smoothly.

Table 1. Participant characteristics.

N	Age	Years of experience	Years of experience with social nursing
1	35	8	2
2	35	10	4
3	46	22	1
4	40	15	2
5	53	27	5
6	53	26	8
7	56	30	1.5
8	42	13	4.5
9	49	23	5
10	29	6	1
11	27	5	0.5
12	41	18	2.5
13	44	19	4

2.3. Data Collection

Data were obtained from individual interviews [23] undertaken by TLD at the participant's workplace. All participants were familiar with the first author prior to the interview owing to the first author's background as a social nurse.

A semi-structured interview guide was designed. Questions were intentionally broad to allow participants to bring forth spontaneous and rich descriptions in which they shared what they found essential in relation to the phenomena being studied. Data were obtained from 26 February to 8 March 2018. Interviews ranged from 30 to 60 minutes and were recorded, transcribed verbatim and transferred to the qualitative data analysis software, NVivo (QSR International 11.00) for further analysis.

2.4. Data Analysis

Data from this study are the texts from the transcribed interviews. The interpretation of the texts is inspired by Ricoeur's theory of interpretation [22, 24]. The Interpretation took place in three steps: first a naïve reading, then a structural analysis and, finally, a critical analysis and discussion. The naïve reading is the first reading of the text, which is an immediate understanding of the meaning and acquires a general sense of the whole [24]. Thus, the structural analysis was carried out at three levels: what was said; quotations across all interviews, what it spoke about; that is how the participants describe social nursing as a story and, finally, combining *what it speaks about* and *what is said* into a theme (Table **1**). The theme is illustrated by a poetic story, which embraces all interviews (Table **2**). The structural analysis continued the interpretation by relating to both the quotes from the interviews and the story, and thereby achieved a comprehensive understanding. [25, 24]. The interpretation continued in the critical discussion where relevant literature and pre-understandings were used to argue in favour of one or several suitable interpretations. Ricoeur describes this as a new sort of being-in-the-world [22]. The analysis was carried out in Nvivo 11.0.0.

Table 2. Poetic narratives across data.

Themes illustrated as poetic narratives
A unique expertise
Prospects are bleak. Positions are entrenched. The treatment options offered by the ward are not working for the patient, who is considered a "hopeless case". The patient is both distrustful and angry. The patient smokes on the balcony; simply helps himself to stuff in the linen depot, taking whatever he wants. The nurses are frustrated. Drawing on my experience, I put into words what I see: a patient who is working against the system, who was raised under conditions where violence and threats formed part of everyday life, and who only speaks the language of the street. A group of nurses to whom the everyday life of the patient is distant and hard to comprehend. A ward that is struggling to embrace the patients' needs.
Coordination
Hours of hard work are starting to pay off. I have tracked down a support-and-contact professional. The home care services have agreed to attend the patient in the allotment garden even though he does not officially reside there. Drug dealers have taken over the home address due to a drug debt. Even the general practitioner is back on the case despite the fact that the patient had an attendance ban following an unfortunate case about threats. Today, the handling of active abuse during hospitalisation will be discussed with the heads of ward. I know it has been a source of great frustration on both sides of the table and that it has now come to a head. I find the patient in front of the hospital; he is yelling that they went through his belongings and that they are a bunch of useless idiots. The tension is palpable. It will be difficult to get everyone to meet.
The whole-person concept
A series of swearwords are flying through the air indicating that I am in the right place. My patient is leaving the ward *again*. He points to the doctor and tells him to take a hike. I get the patient's attention and keep him focused. He is on a fluid restriction and has therefore replaced 20 strong beers with a bottle of vodka. The doctor informs me through clenched teeth that treatment is out of the question. Swearwords of the worst kind fly back at him. I feel like I am walking a tight rope as I suggest that we put together a new plan.
The system and the marginalised patient
The voice at the other end of the call is fast and shrill. How do I convince her not to release the patient? I sigh and ask if I can come over and talk to her. She agrees. The patient wants surgery; but he is completely incapable of cooperating with the staff. His behaviour frightens the staff. I get a sense that the doctor wants to help; all is not lost. We go to see the patient together. In a regretful tone of voice, the patient accepts his part of the responsibility. Yet, on his way out to smoke, the patient yells far too loudly: *"See ya!"*

Table 3. Excerpt from the structural analysis.

Meaning	Meaning	Theme
What is said	What is spoken about *The case is portrayed*	-
" We have to know what we are looking for to look for it. A specific knowledge and a strong instinct are required. A knowledge that sums up the words which express the patient and the experience we have" (I:9) *" To encounter a patient who's never been hospitalised and is unknown to the system requires a knowledge of how to help him. It is a unique combination of nursing basics and that which extends beyond areas of specialisation and unified in knowledge of marginalisation.* (I:9) *"I try to help the unit realises that if a specific treatment is to work, well it's all good that you can fix this fractured leg, but if the patient's not to put his weight on it for six weeks, we can't bloody discharge him to the streets, right!"* (I:6) *Unique nursing speaks to the person, not the patient. Because the patient does not want to be a patient and does not understand how to be a patient. Therefore, we ought to meet persons on their terms, on the basis of their understandings and their language"* (I:1) *Well, a great deal is actually about knowledge. What can be offered? How can it be accomplished?"* (I:5) *We must know the pitfalls. We know that the drug addict who bunks down at different locations might not be at the given address two days after discharge. We are to know all solutions and need to think more than two days ahead. Otherwise, the district nurse can't find her. We must be thoroughly versed in the target group.* (I:4)	Social nursing is based on years of experience with marginalised persons. An experience that allows nurses to build a good appreciation of socially marginalised persons' complex life circumstances. The complexity inherent in caring for marginalised persons manifests itself in various ways. Partly, the complexity relates to differences in linguistic and communicative skills, partly it relates to how the patient is met and to the general understanding of the conditions under which the patient can be hospitalised. Furthermore, when the patient is offered treatment, the offer needs to make sense to all parties involved. Social nursing offers a comprehensive knowledge of social marginalisation and the diversity of the issues that occur due to hospitalisation, including how it may be ensured that the treatment offer is not simply defined as stand-alone medical treatment. The social nurse function strives to establish some common ground between the system and the patient. This is achieved by serving as the system's representative while at the same time drawing on knowledge of the patient, thus bridging the gap between patient and staff.	-

3. RESULTS

3.1. The Naïve Reading

The social nurse is moved by the opportunity to help a group of patients who may find it difficult to navigate in the hospital system. Working as a social nurse, the hospital system represents two partially contradicting functions. On one hand, the system represents the knowledge and expertise needed to help the patient during the admission and/or treatment. However, the system often also represents a set of inflexible conditions that are unsuitable for socially marginalised patients.

Among the social nurses, there is a mutual understanding that the complexity of the healthcare system exacerbates marginalisation of already marginalised patients.

An essential task for the social nurse is first to discover and then to articulate those of the patient's resources that can come into play and thereby shape the offers available in the system to maximally suit the patient. Social nursing embraces a relational dimension, which is referred to as both easy and difficult; easy regarding the patient, where knowledge of the life lived outside the hospital is a significant element; difficult regarding the hospital system as an overall framework and the healthcare professionals whose participation is key to treatment success.

3.2. The Structural Analysis

In the structural analysis, the descriptions of social nursing are illustrated by a poetic story (Table **2**). Meaning is sought during the structural analysis. To explore what was being said, the interviews were read again in order to seek out meaning and obtain a more comprehensive understanding. (Table **3**) illustrates how the theme *A unique expertise encompassing experience and evidence-based knowledge* derived in the analysis.

The structural analysis revealed four themes (Table **4**). The themes are interwoven, and together they describe the social nursing approach.

Table 4. Themes.

Themes.
To see and understand patients as whole persons, thereby assuring successful treatment
Coordination towards a common goal to reduce patients' vulnerability
Working the system to avoid losing the patients
A unique expertise encompassing experience and evidence-based knowledge

Table **4** illustrates the 4 themes derived from the analysis.

3.2.1. To See and Understand Patients as Whole Persons, Thereby Assuring Successful Treatment

Seeing the whole person is a core value in nursing and is pivotal to social nursing. The social nurse strives to: *"covey a clear image - both concerning the reason for admission as well as what may be the cause of the admission"* (I: 2). Translated into practice, a core value can be: *"a doctor who gives a thermos to a lonely and isolated patient whose only desire is a*

hot cup of coffee" (I:3) and in doing so makes all the difference in achieving that the patient considers that he is seen and heard; and thereby makes room for the common goal of ensuring that the treatment is successful.

The social nurse is aware of the importance of establishing good relations, acknowledging that poor relations are often associated with poor experiences, which can be a barrier to treatment: *"working with relations is essential in understanding the person before us. The relation can, indeed, be key to treatment"* (I: 10).

Social nursing calls for a nursing practice in which the information that is important to the treatment course is acted upon. This practice seems to be under pressure in a highly specialised healthcare system in which: *"our production focus quickly and completely makes you forget that we are dealing with a real human being"* (I: 6)" The social nurse translates the unique story behind the person into information useful to the system. Hence by understanding the person, the system's ability to acknowledge the patient improves. The social nurse thereby helps the healthcare professionals solve the full range of tasks related to the patient. If our ability to see the entire person is reduced, we can create situations where attitudes foster stigmatisation.

> *"The attitude is sort of that there is a them and an us. And there is always trouble with **them**, they cost a lot of money, take too much time and they make no progress. Using social nursing, I try to show a different direction and help my colleagues understand what stigmatisation does to people"* (I:12)

The social nurse seeks to make room for the person's story to be told and heard. Doing so, she further seeks to see the entire person and she reduces the risk of making decisions related to treatment that do not take the socially marginalised patient's life circumstances into consideration. Healthcare professionals in charge of treatment who lack insight may make unsuitable decisions that seem appropriate only when treatment alone is considered but cannot be accepted by the patient.

Social nursing brings into play a knowledge that socially marginalised patients may require more admissions to achieve successful treatment: *"…to which I think, oh well it's damn good that he actually came back. And then we will just have to give it another try"* (I:5)

The social nurse actively brings knowledge of the whole person, the human being, into play and does so in a constructive manner that frames new ways in which treatment may succeed.

3.2.2. Coordination Towards a Common Goal to Reduce Patients' Vulnerability

The social nurse is thoroughly versed in the hospital system's highly specialised and complex reality; a complex system in which work procedures can have an unintended and limited focus and hinder healthcare professionals from acting

upon knowledge of the patient that is essential to treatment completion:

> *"The nurses are, of course, interested in knowing whether she is coming for her treatment or not. And I want to find out how she will reach the hospital (...). Does she have any money for transportation, and who can help her if she stays elsewhere than at her home address, as transportation can only be ordered from her home address?"* (I:6)

Thus, the patient's attendance is complicated by obstacles within the system. To the social nurse, it is all about being aware of the complexity of the system and: *"to pave the way for everyone"* (I:13), knowing that: *"coordinating where a dog should be staying during the patient's hospitalisation is as essential as arranging and planning the entire treatment. Because the dog can be the key to the whole collaboration"*. (I:13). Concurrently, social nursing embraces an acceptance that the *"system is what it is"* (I:8), and to the social nurse: *"(…) the essence is to shift focus from **if** it is possible to **how** it is possible"* (I:8). Therefore, knowing all relevant players becomes vital, because: (…) *if we discharge someone to follow-ups and more blood sampling and the patient's general practitioner is 100 kilometres away, the marginalisation is only increased"* (I:4). Within the system, the social nurse and healthcare professionals make room for a focus that points towards: *"being treated equally with all other patients"* (I:11) because *"it's their healthcare service as well"* (I:8). Thereby, they ensure that the marginalised patient is not further marginalised *by* the system during the course of treatment. Working towards diminishing marginalisation, the social nurse must often coordinate the course of treatment. The social nurse's coordination task has many different facets and is, among others, rooted in the fact that: *"if no one follows up and kind of is in control of this, it means a readmission, and that's simply a waste of money; and, furthermore, a waste of the patient's health"* (I:5) Thus, in general, coordination is about diminishing the risk of poorer health for the patient, readmissions and the ensuing financial costs. In addition, it is important to know areas within the system that can represent obstacles to the healthcare professionals and to know which resources exist within as well as beyond the system in order to bring these resources into play. Prior to a successful treatment course, the social nurse often faces a complicated task in which the patient's network is outlined and relevant parties are involved. Accomplishing this task demands knowledge of the healthcare system and that the social nurse knows that: *"everybody has some resources somewhere and then it's sort of like Sherlock Holmes to work out were, right*?!" (I:5). Therefore, coordination in social nursing is about gathering all relevant parties and making them work towards the common objective: to diminish marginalisation through a patient-centred focus. During the entire treatment course, the social nurse has: *"a harm-reductive approach"* (I:13), which takes its starting point in a: *"collaboration with the patient and receptiveness towards the staff"* (I:11). In this process, the social nurse offers advice based on specialist knowledge about marginalisation,

pain and withdrawal symptoms, as well as drug and alcohol consumption. Through a well coordinated course of treatment: "*where the whole situation is handled*" (I:10), the social nurse is able to minimise marginalisation and thus direct all involved parties towards working towards the common goal of reducing marginalisation.

3.2.3. Working with the System to Avoid Losing the Patients

The social nurse approach forms part of the healthcare system's service, but it is also aligned with the socially marginalised patient's needs. Hence, the social nurse is working within a system that is in charge of providing treatment and at the same time setting the boundaries for such treatment. Working within the system facilitates an understanding that "*in fact, perhaps it's not so much the patients I work with but actually more the healthcare system's efforts and approach towards the patients who are either already marginalised or become so in the system during their hospitalisation*" (I:6).

The healthcare system is characterised by a processual treatment-course mind-set in which certain treatments are offered as part of standardised treatment programmes. This mind-set generates effective and accelerated courses of treatment, but it also requires that patients fit into a specific box to be able to receive relevant treatment. Socially marginalised patients can appear difficult to help. For example, active and damaging alcohol abuse can produce conflicts between extant knowledge of the effects of treatment and the patient's wishes and treatment options. Furthermore, the healthcare professionals expect that the patient restricts to the plan. In case of the contrary, surprise, astonishment or disdain can emerge. In this situation, the social nurse tries to operate within the principles of harm reduction: "*Then we try to make those boxes somewhat rounder and more dented for our patients to fit into them*" (I:2). The social nurse tries to work the system and the patient in a manner that assures continuous, mutual cooperation about the treatment. In order for a socially marginalised person to adhere to a specific course of treatment, many external circumstances must be taken into consideration: "*…then one realises just how much needs to fall into place in order to adhere to a course of treatment*" (I:7). If these external circumstances are not taken into consideration, the risk of losing the patient and therefore of lacking treatment adherence increases.

Acting as the link between the system and the patient, the social nurse seeks to avoid situations where a simple injury is handled without taking the patient's situation into consideration and where: "*the doctor has said that now you go home and rest your leg. Well she's got no home. So, if the leg is to rest for a week, we must work out something else*" (I:3). Hence, the very lack of a home can be significant to determine which treatment can be offered and to which extent the patient will benefit from the treatment. At times, the system and the healthcare professionals' lack of understanding of the patient's complex life situation appears in situations where the staff scolds the patient to make the patient quit substance abuse: "*it's a lost cause to scold them. We must understand that some people live on the fringes of society and make sure that the*

system can help them, so they don't fall off the edge" (I:4). The system's ability to understand thus becomes crucial to whether the patient gives up treatment.

The social nurse needs to master the language of the system as well as that of the patient and hence convert the patient's stories into tangible facts that the system can relate to and act upon. "*My job is to help the staff solve the issues concerning the patient in order to make the admissions succeed*". (I:13). The social nurse thus works within the system to make it understand to the patient, thereby joining all parties in the pursuit of the joint cause: treatment focussed on embracing the patient's needs within the system.

3.2.4. A Unique Expertise Encompassing Experience and Evidence-Based Knowledge

Social nursing is based on many years of practical experience with socially marginalised persons. The social nurse's knowledge brings about an appreciation of the complexity of the marginalised person's life. "*To encounter a patient who's never been hospitalised and has been left on the fringes of society requires (…) a unique combination of all specialist nursing basics that extends beyond any single specialty and is combined with a knowledge about marginalisation*" (I:9). This combination enables the social nurse to: "know *the pitfalls (…) and know solutions a, b and c as well and always think ahead*" (I:4).

The experience-based focus is all about handling the experience of socially marginalised persons at the hospital. Social nursing is about being very knowledgeable but also about being able to reflect on how the specific knowledge is most successfully applied while providing the best available treatment option. "*Well, it's really all about knowledge, right! What can be offered and how can you help them*?" (I:6). Thus, social nursing is based on extensive practice-related and evidence-based knowledge. In cooperation with the ward, the focus is on combining a highly specialised treatment with the social nurse's knowledge and through that ensure that the patient is offered a treatment option that he or she is capable of receiving.

Owing to experience, the social nurse attaches importance to being curious about the patient's background when a socially marginalised person is hospitalised, and stresses that: "*we must have the guts to ask*" (1:8). Furthermore, "*we must know what we are looking for in order to actually look for it. It takes a specific knowledge and a strong instinct. A knowledge that sums up the words by which we label the patient and the experience we have*" (I:8).

From that perspective, the social nurse and staff try together to: "*address the person on his or her own terms and with the person's understanding and language*" (I:1) and in that way foster a mutual understanding of the terms of treatment. In a wider perspective, the social nurse acknowledges the importance of having an eye for factors such as use of drugs and/or alcohol, housing, transportation to/from treatment, *etc*., as these factors are crucial to the patient being successfully hospitalised. The social nurse draws on a unique expertise and on basic nursing principles, including a profound respect for the human being and empathic insight into the

patient's perspective and world.

The social nurse's wide-ranging previous experiences have both generated a knowledge that stresses the importance of coherence between all parties involved and an understanding of the life lived outside the hospital. Both are necessary for the treatment to succeed.

To assure that the treatment is not the only service provided, the social nurse offers a comprehensive knowledge of the life of marginalised persons and the diverse issues that can occur during hospitalisation. The social nurse is aware of these issues by virtue of his or her experience. This experience is rarely shared by the remaining staff. Thus, the aim of social nursing is to ensure that all parties have a mutual interest in ensuring that the treatment can, indeed, be accomplished and that there is a plan for further treatment courses. Thus, the social nurse's task ranges from knowledge and experience to aligning the efforts made by the system and the patient.

4. DISCUSSION

The study shows that social nursing is based on a unique expertise accrued through years of experience with marginalisation. By virtue of this unique expertise, the social nurse incorporates reflections on his or her experience with marginalisation into a health context. Hence, a professional approach to healthcare rooted in nursing experience emerges. This approach encompasses unique knowledge of marginalised persons' often complex needs and life conditions. This approach is comparable to the patient-centred approach proposed by Guirguis-Younger *et al.* [14], where the nurse combines prior experiences with present practice. In doing so, the nurse becomes capable of identifying situations requiring immediate action and of prioritising the patient's care needs [14]. In line with the *patient-centred approach*", the social nurse's unique expertise is instrumental in identifying and acting upon situations that could otherwise have become an obstacle and restricted the patient's range of relevant treatment options.

The findings of the study also indicate that lack of knowledge of the consequences of marginalisation is common within the healthcare system. Such a lack of knowledge can create barriers for staff in their exercise of nursing and treatment. Concurrently, situations may arise in which the available treatment option does not make sense to the marginalised patient, who therefore often does not complete treatment. This is comparable to Guirguis-Younger *et al.*'s findings that suggest that healthcare professionals often lack knowledge of complex conditions such as multiple diseases and hard-to-solve social issues which unfold when marginalised persons are hospitalised [14]. In line with our findings, Guirguis-Younger *et al.* highlight that lack of knowledge creates neglect of needs, which may, in turn, result in mortality rates among socially marginalised persons being several times higher than those observed in the general population [14]. It is therefore essential that the social nurse draws on prior experience with and knowledge of social marginalisation integrates this into current nursing practice.

The close connection of social nursing to standard nursing is evident as social nursing is rooted in knowledge and

experience gained while exercising both fundamental and specialised nursing tasks. Social nursing, therefore, requires a combination of specialist nursing knowledge and understanding of socially marginalised persons' often multi-faceted problems that can make them unable to care for themselves and unable to satisfy their most basic human needs. Seiler & Moss described this kind of nursing as "*the true art of nursing*" [26], *i.e.* when the nurse provides healthcare and makes a difference to marginalised patients based on extensive knowledge and experience [26]. Seiler & Moss argue that this experience requires an encounter between nurse and patient characterised by an understanding that by virtue of his or her experience, the nurse has obtained great insight into the socially disadvantaged individual's daily practice, which is an advantage for both parties [26]. The unique expertise described herein is thus in line with "*the true art of nursing*" and enables nurses to embrace a unique group with equally unique demands. Combining nursing with an appreciation of the characteristics of marginalisation enables the social nurse to serve as a link between the healthcare system and the socially marginalised patient. This link can ideally assure that the ward providing the treatment can offer dignified and complete services

In the present study, coordination of socially marginalised patients' treatment courses was highlighted as one of the social nurse's key tasks. Hence, adequate coordination was vital in diminishing marginalisation. Thus, a well-coordinated treatment course is based on the ideology that we need to embrace the entire human being. This ideology has limited clout in an output-oriented healthcare system where streamlining and acceleration are often perceived as being identical to good treatment, even if such an approach might limit the staff's opportunity to gain insight into and therefore truly understand the patient's complex situation. The study indicates that lack of or incorrect coordination can thus increase the risk of further marginalisation during hospitalisation. According to Seiler & Moss, healthcare professionals' experience that it is difficult to act on coordination tasks related to the patient's course. This may be due to several factors. Dr. Josephine Watson points out that the causes are likely related to the narrow perspective on the complexity of the patient's situation due to lack of knowledge. According to Dr. Watson, this fosters stereotypical images of socially marginalised persons which can shift focus away from seeing the individual, thus, limit the opportunity to take a holistic approach. According to Dr. Watson, a holistic approach is essential in resolving tasks related to the marginalised patient [27]. According to Seiler & Moss, other causes are related to structural limitations such as finances, referral options, lack of suitable discharge locations and a general lack of knowledge [26]. Stereotyping fostered by the system can - according to Dr. Watson - be reversed through greater knowledge about marginalisation [27]. Seiler & Moss believe that this knowledge can make healthcare professionals better at handling structural limitations [26].

Thus, the social nurse's coordination task is important in reducing marginalisation. Coordination of the marginalised patient's treatment course requires considerable insight into the marginalised patient's lived life and way of handling everyday

life. The social nurse has such insight because of the knowledge he or she has acquired and because of his or her extensive professional networking. Hence, a holistic perspective becomes essential to achieving a productive collaboration between the hospital and the marginalised patient where understanding of the patient's situation is integrated into the healthcare system's provision of healthcare services.

The study indicates that the social nurse works according to a holistic and reflected perspective where social nursing is carried out with respect to any information that can be significant to the individual's lived life and lifeworld. Meanwhile, the social nurse reflectively handles information that could be important to the admission course and contribute to the nurse's ability to see the marginalised patient as a whole person.

Dr. Watson argues that healthcare professionals who grasp what social marginalisation can mean to health are capable of offering a wide-ranging and holistic treatment and become advocates for a healthcare system that seeks to diminish marginalisation [27]. To diminish marginalisation and ensure access to care and treatment for all who experience injustice and inequality in health are, according to Professor L. Kushner, within *"the nursing mandate"*. Kushner argues that through this mandate, nurses can achieve change through collective action, advocacy and empowerment of vulnerable communities and thus engage in the struggle against inequalities [15].

Social nursing's holistic and reflective approach is thus vital to the individual's hospitalisation. Simultaneously, it adds to the nursing mandate by addressing inequality in health. Hence, social nursing functions at two level; an individual level where a holistic approach contributes to diminishing marginalisation of the patient; and a community level where the nursing mandate contributes towards reducing inequality in health and marginalisation during hospitalisation.

In a future development of social nursing, it will be important to study how social nursing is managed in a hospital setting.

CONCLUSION

The social nursing approach encompasses experience and evidence-based knowledge; knowledge about how to orchestrate efforts to reduce patients' vulnerability and always with a holistic approach, trying to see and understand patients as whole persons; an experience working with the system to avoid losing the patients and thus assuring successful treatment.

The study shows that the social nurse helps the healthcare professionals navigate in the patient's world and *vice versa*; and that this navigation task is particularly difficult for the system. It is vital to adapt and develop the healthcare system, which harbours the main challenges in relation to ensuring successful treatment. The social nurse is instrumental to furthering this end by creating the frame within which the healthcare professionals and the patient can meet in mutual understanding, which increases the probability of treatment adherence and success.

The study concludes that the social nurse works according

to a holistically based nursing perspective essential for solving all tasks and fundamental to the general approach to both socially marginalised patients and the hospital system. Doing so, the social nurse draws upon the nursing mandate and contributes to the effort to reduce inequality in health and marginalisation during hospitalisation.

Applying the social nursing approach as a general approach allows optimised treatment that fosters a more equal outcome across the spectrum of socially marginalised patients. Hence, the social nursing approach may contribute to diminishing health inequalities. However, this needs to be further examined in future research.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

HUMAN AND ANIMAL RIGHTS

Not applicable.

CONSENT FOR PUBLICATION

Informed consent was obtained from each participant prior to their interview.

AVAILABILITY OF DATA AND MATERIALS

The data that support the findings of this study is restricted. The data cannot be shared publicly.

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CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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