Medical Social Work Special Topic Research

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Abstract

Background In highly specialized healthcare systems, medical social workers face dilemmas such as role ambiguity, marginalization, and instrumentalization. No current research has systematically analyzed the effectiveness of medical social workers in multidisciplinary collaboration or clarified development pathways for overcoming collaborative dilemmas. Objective To explore how medical social workers can play an effective role in multidisciplinary collaboration, reveal the influencing factors and realization mechanisms of their effectiveness, and provide mechanistic pathways and practical experience for the professionalized collaboration and sustainable development of medical social workers. Methods A single-case study method was adopted. Based on typical cases of medical social workers participating in multidisciplinary collaboration at Hospital E in Shanghai from 2012 to 2025, and in combination with the IMOI model, this study proposed the generative mechanism and practical pathway of medical social workers' effectiveness in multidisciplinary collaboration. Results Against the background of policy-driven promotion, the embedding of medical social workers in clinical diagnosis and treatment stems from the influence of multilevel conditions, including the macro environment, organizational environment, team structure, and member composition. The interactive tension formed by medical social workers between "passive embedding"and "active integration"continuously reconstructs the dynamics of practice boundaries and professional positioning, laying a practical foundation for emotional trust, behavioral coordination, and cognitive co-construction in multidisciplinary collaboration. Through positive outputs in patient-side gains, team efficiency improvement, and organizational expansion, team collaboration optimization is promoted via re-input driven by endogenous stimulation and exogenous impetus, continuously advancing multidisciplinary collaboration toward greater safety, professionalism, and efficiency. Conclusion This study constructs an integrated framework, based on IMOI theory, for the generation of effectiveness among local medical social workers in multidisciplinary collaboration, revealing that the effectiveness of multidisciplinary teams is generated through a dynamic interactive process.

Full Text

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Effectiveness of Medical Social Workers in Multidisciplinary Collaboration—A Case Analysis of a Children' s Hospital Based on the IMOI Model

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【Abstract】 Background Within highly specialized medical systems, medical social workers face circumstances such as role ambiguity, marginalization, and instrumentalization. At present, no studies have systematically analyzed the effectiveness of medical social workers in multidisciplinary collaboration, nor clarified development pathways for breaking through collaborative dilemmas. **Objective** To explore how medical social workers can play an effective role in multidisciplinary collaboration; to reveal the influencing factors and realization mechanisms of their effectiveness; and to provide reflections on institutional pathways and practical experience for the professional collaboration and sustainable development of medical social work. **Methods** A single-case study method was adopted. Based on typical cases of medical social workers' participation in multidisciplinary collaboration at Hospital E in Shanghai from 2012 to 2025, and in conjunction with the IMOI model, this study proposes the generative mechanism and practical pathway for the effectiveness of medical social workers in multidisciplinary collaboration. **Results** Against the background of policy-driven promotion, the realization of medical social workers' embedding in clinical diagnosis and treatment is influenced by multilayered conditions, including the macro environment, organizational environment, team structure, and member composition. The interactive tension formed between medical social workers' "passive embedding" and "active integration" continuously reconstructs the boundaries of practice and professional positioning, laying a realistic foundation for emotional trust, behavioral coordination, and cognitive co-construction in multidisciplinary collaboration. Through the positive outputs of patient benefit, team efficiency improvement, and organizational expansion, and through reinvestment driven by endogenous activation and exogenous forces, team collaboration is optimized, continuously promoting multidisciplinary collaboration toward safer, more professional, and more efficient evolution. **Conclusion** This study constructs an overall framework, based on IMOI theory, for the generation of effectiveness among local medical social workers in multidisciplinary collaboration, and reveals that the generation of multidisciplinary team effectiveness is a dynamic interactive process.

【Keywords】 social work; medical social work; effectiveness; multidisciplinary collaboration; multidisciplinary collaborative diagnosis and treatment; IMOI model

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The Effectiveness of Medical Social Workers in Multidisciplinary Collaboration: A Case Study Based on the IMOI Model

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【Abstract】 Background Within highly specialized medical systems, medical social workers often face challenges of role ambiguity, marginalization, and instrumentalization. To date, few studies have systematically examined the effectiveness of medical social workers in multidisciplinary collaboration or clarified the mechanisms through which they overcome these barriers. **Objective** This study aims to explore how medical social workers play an effective role in multidisciplinary teams, identify the influencing factors and mechanisms underlying their effectiveness, and provide insights and practical implications for professionalized and sustainable interdisciplinary collaboration. **Methods** Adopting a single-case study design, this research analyzes the representative practice of medical social workers at Hospital E in Shanghai from 2012 to 2025. Grounded in the Input–Mediator–Output–Input (IMOI) model, it constructs a theoretical and practical framework for understanding how effectiveness is generated in multidisciplinary cooperation. **Results** Under policy-driven initiatives, the integration of medical social workers into clinical practice is shaped by multi-level contextual factors, including the macro environment, organizational setting, team structure, and member composition. The interactive tension between passive embedding and active integration continuously recon-

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structs the professional boundaries and positions of social workers, forming a dynamic foundation for emotional trust, behavioral coordination, and cognitive co-construction within teams. Through positive outputs at the patient, team, and organizational levels, and via cyclical feedback between endogenous motivation and exogenous drivers, multidisciplinary collaboration evolves toward greater safety, professionalism, and efficiency. **Conclusion** This study develops a localized IMOI-based framework for understanding the generation of effectiveness among medical social workers in multidisciplinary settings. It reveals that team effectiveness emerges as a dynamic and interactive process rather than a static outcome.

【Key words】 Social work; Medical social work; Effectiveness; Multidisciplinary collaboration; Multidisciplinary clinical practice; IMOI model

Studies have shown that multidisciplinary collaborative diagnosis and treatment jointly involving medical social workers is conducive to improving the efficiency of medical services, reducing patients' medical expenses, and bringing about better health outcomes[1]. The *Action Plan for Enhancing Humanistic Care in Medicine (2024-2027)* (NHC General Office Medical Emergency〔2024〕No. 18) clearly states that medical and health institutions should enrich the content of medical social work services and advocate that medical social workers play roles in diagnosis and treatment, daily living, legal affairs, assistance, and other areas. However, alongside development, medical social workers face multiple challenges in clinical practice: the effectiveness and stability of medical social work services remain insufficient[2]; the professional model of medical social work and the medical model conflict in terms of ethical values, rights and status, role positioning, and other aspects[3-5]; and some hospitals assign medical social workers to administrative tasks unrelated to their professional attributes, further weakening their function of directly participating in diagnosis and treatment[6-8]. As a result, medical social workers face the predicament of role ambiguity, marginalization, and instrumentalization[6,9], making it difficult for them to truly integrate into the medical system. Existing studies have rarely conducted in-depth analyses of the action pathways through which medical social workers become integrated into multidisciplinary diagnosis and treatment, and discussion of the mechanisms by which they effectively play their role remains lacking. On this basis, amid the tension between theory and reality, this paper raises the following core questions: In the organizational environment of Chinese hospitals, how should medical social workers exercise effective professional functions in multidisciplinary teams? How is the collaboration mechanism between them and clinical teams manifested? What factors promote or hinder the realization of collaborative effectiveness? Through what mechanisms do these factors exert their effects? Through a case study, this paper analyzes how medical social workers play an effective role in multidisciplinary collaboration. Drawing on the "Input-Mediator-Output-Input" (IMOI) model from organizational psychology, it proposes a theoretical framework suited to the localized cultural and practical characteristics of medical social work, and conducts an in-depth analysis of the influencing factors and realization mechanisms of effectiveness, with the aim

of providing a systematic and guiding experiential paradigm for improving the quality and efficiency of medical social work services in China.

1 Materials and Methods

1.1 Analytical Framework

To systematically analyze the role-practice mechanism and pathways through which effectiveness is generated when medical social workers participate in multidisciplinary collaboration, this paper introduces and modifies the IMOI model from the field of organizational psychology. On the basis of the traditional "Input-Process-Output" (IPO) framework[10], this model emphasizes the mediating mechanisms and dynamic feedback processes in team collaboration, with particular attention to the roles of three types of "emergent states" —team affect, behavior, and cognition—in the process of cooperation[11]. This theoretical framework has been validated in settings such as interprofessional medical teams and children' s advocacy centers for its capacity to identify key input elements, affective-cognitive mechanisms, and pathway relationships with collaborative outcomes[12–14]. However, in the field of medical social work—especially in multidisciplinary collaborative diagnosis and treatment involving medical social workers—its adaptability and explanatory power remain insufficient, and it lacks empirical validation and model extension based on the Chinese medical context. On this basis, by combining cases of multidisciplinary collaboration involving a medical social work team in a children' s specialty hospital, this study adjusts and expands the model' s key variables and their interrelationships, enabling it to better reflect the characteristics and challenges of collaboration between medical social workers and clinical teams.

The IMOI model reshapes the process mechanism through which team effectiveness is generated, emphasizing the nonlinear characteristics of team collaboration and its complexity as it evolves over time[15], thereby providing an analytical framework for this study' s in-depth examination of the effectiveness of medical social workers. To avoid tendencies toward abstraction and over-theorization in the model, this paper adopts a dual pathway of theoretical deduction and practical induction in the process of model construction, integrating definitions of model variables with practical case materials to form a structured analytical framework. The development of the IMOI model follows the logic below: first, core variables in team effectiveness research are extracted from existing literature in management and social work. Second, institutional documents, action records, and observation notes concerning medical social workers' participation in multidisciplinary collaboration at Shanghai E Hospital from 2012 to 2025 are integrated, from which repeatedly occurring contextual elements and key mechanisms are distilled. Through cross-validation between theoretical and practical dimensions, a modified model is formed that includes four input elements, three categories of mediating mechanisms, three levels of output dimensions, and cyclical feedback through re-input.

The input dimension includes member composition, team structure, organizational environment, and macro-environmental factors. Together, these four form a system with hierarchically nested features and jointly constitute the antecedent variables affecting team effectiveness. The mediator dimension focuses on three processes through which team members autonomously construct emotional connections, behavioral pathways, and cognitive consensus, thereby jointly realizing interprofessional collaboration and promoting the effective attainment of team goals. The measurement indicators of the output dimension can be summarized into three aspects: patient-side gains, team efficiency improvement, and organizational expansion. Finally, the re-input dimension promotes the optimization of team collaboration through both endogenous activation and exogenous driving forces, continuously advancing the multidisciplinary collaboration of medical social workers toward greater safety, professionalism, and efficiency.

Figure 1. The IMOI model of the effectiveness of medical social workers' participation in multidisciplinary collaboration

Labels shown in the model:
Input: macro environment; organizational environment; team structure; member composition.
Mediator: learning / communication / coordination / decision-making / response; behavior; cognition; emotion; consensus / norms / information sharing; psychological safety / trust / respect / cohesion.
Output: organizational expansion; team efficiency improvement; benefits for patients.
Re-input.

1.2 Research Methods

This study adopts a single-case study method, using literature research and participatory observation as the main forms of data collection. Taking Hospital E in Shanghai as the case, it focuses on the typical practices of its medical social work team in participating in multidisciplinary collaboration since 2012. The hospital is a well-known tertiary Grade A children' s specialty hospital in China. Its institutionalization of medical social work began early; it has diverse service types and comprehensive collaboration pathways, and thus possesses a high degree of typicality and representativeness. It is suitable for in-depth analysis of the theoretical model and for testing its applicability. To better present the organizational characteristics of the case and the institutional foundation of medical social work, this paper systematically reviews the organizational structure, staffing, and service scope of the Social Work Department of Hospital E (Table 1). Table 1 not only reveals the characteristics of the medical social work department of the case hospital in terms of organizational hierarchy and post system, but also reflects the maturity of the team in multidisciplinary collaboration, providing empirical support for the subsequent analysis of the organizational and structural elements in the "input dimension."

Table 1. Development of medical social work in the children's hospital

Item	Specific situation and figures
Department setup	A first-level administrative-function department
Staffing	The department has 15 staff members, including 8 hospital-appointed social workers and 7 foundation-appointed project social workers; 8 intermediate-level social workers and 5 assistant social workers; 8 staff members with a social work background and 7 without a social work background; 10 with master's degrees and 5 with bachelor's degrees.
Service scope	The hospital's outpatient and emergency departments, inpatient departments, and 26 clinical specialties
Service functions	Clinical service intervention, charitable donation management, connection with public-welfare activities, volunteer management, employee care and support, etc.
Multidisciplinary collaboration status	Medical social work services cover 26 clinical specialties in the hospital, carrying out routine clinical casework, group work, community services, and other services. At present, the team has participated in six inpatient and outpatient multidisciplinary joint consultations, including palliative care, hematopoietic stem cell transplantation, syncope, transgender-related care, and eating disorders, involving approximately 190 pediatric patients.

Note: The data are drawn from internal documents of the Social Work Department of Hospital E and 2025 statistical data.

2 Results

2.1 Antecedent Variables for Medical Social Workers' Participation in Multidisciplinary Collaboration

The generation of team effectiveness first depends on the sufficiency of input conditions and hierarchical coordination. The classic input variables in the IMOI model include member composition, team structure, and organizational environmental factors[16], which together constitute the antecedent variables affecting team effectiveness. Compared with other types of teams, the professional development and service implementation of medical social work are situated within a more complex system[17]. Therefore, in combination with ecosystem theory, the input module of the IMOI model for medical social workers' participation in multidisciplinary collaboration is revised and expanded into four dimensions: member composition, team structure, organizational environment, and macro environment. The four have clear hierarchical embedding and inclusion logic, influencing the overall operation of the team respectively through policy, systems, collaboration mechanisms, and individual attributes, and forming bidirectional pathways through top-down institutional promotion and bottom-up professional practice.

2.1.1 Macro Environment

The macro environment is the external environment for the development of medical social work, including the political, cultural, economic, and social environments. This level plays a key role in the development of medical social work through mechanisms such as policy formulation, resource allocation, and cultural construction. Taking Shanghai as an example, in February 2012, the former Shanghai Municipal Health Bureau issued the *Implementation Opinions on Promoting the Construction of a Medical Social Work Talent Team (Trial)* (Shanghai Health Personnel 〔2012〕 No. 80)[18], proposing the construction of a professionalized and occupationalized medical social work talent team, and further incorporating the implementation of medical social work into hospital grade-evaluation standards. This rapidly promoted the exploration of social work posts in many hospitals in Shanghai, including Hospital E. In the field of pediatric care, the exploratory transformation of the traditional medical model, the profound foundation of hospital organizational culture, the abundant supply of public-welfare and charitable resources, and the special needs of children' s physical, psychological, and spiritual development jointly provided favorable conditions for the rapid activation of the "institutional embedding"of social work and the acquisition of development resources. They also provided a basis for Hospital E to establish social work posts, build a mechanism for collaboration with social resources, translate policy goals into an operable support network, and transform macro-level authorization into practical momentum.

2.1.2 Organizational Environment

The organizational environment determines the positioning and functional boundaries of medical social workers within multidisciplinary teams. Top-down policy promotion provides foundational support for the professional operation of medical social work. First, by studying relevant systems concerning medical social work, Hospital E grasped national-level policy orientations and specific implementation requirements, and issued corresponding internal appointment systems, proposing to formally re···

Named the Department of Social Work, the unit was equipped with independent space and a budget; corresponding work systems were formulated and improved; and social workers were hired by creating internal posts. Compared with a project-based social-work system, this measure was more conducive to the effective integration of the medical social-work team into the hospital' s formal and informal systems. In addition, at the hospital level, the embedding of concepts [19] was regarded as an important organizational activity. Hospital E quickly contacted its affiliated university, established a practicum base with the university' s department of social work, explored the provision of professional services through medical-school cooperation, held academic seminars, and learned from the development experience and concepts of more advanced regions. Meanwhile, at the organizational level, medical social workers proactively participated in system building and process optimization, promoting the connection between policy requirements and internal hospital management. For example, the team formulated the *Medical Social Work Case Referral System*, including standards and procedures. Within the framework of organizational authorization, medical social workers explored ways to resolve path dependence and expand service space through resource integration and diversified collaboration, thereby achieving a bottom-up proactive response.

2.1.3 Team Structure

Team structure determines how tasks, responsibilities, and power are allocated in multidisciplinary collaboration, and is also an important precondition for whether medical social workers can effectively participate in collaboration. Top-down organizational design provides a basic framework for interprofessional collaboration through clear post settings and institutional procedures. On this basis, the medical social-work team gradually promoted the deepening of collaborative relationships through bottom-up practical strategies, such as exploring professional demonstration models through clinical pilots; forming a part-time medical social-work team and establishing a service system [20]; organizing cross-departmental training and joint case intervention; jointly carrying out health-education activities and organizing patient clubs, thereby strengthening team members' willingness to cooperate. Top-down structural support and bottom-up relationship building interacted with each other, enabling team operations to possess both institutional standardization and interactive flexibility, and providing an organizational foundation for emotional linkage and behavioral coor-

dination at the mediating level.

2.1.4 Member Composition

Member composition is the complex combination of team members' characteristics, such as personality, abilities, values, and cognitive capacities. It reflects the individual traits and capability structure of a multidisciplinary team and is an important input condition that determines collaborative effectiveness and professional trust. Hospital E clarified educational and professional requirements for social-work positions and incorporated the management of medical social workers into the organization' s administrative management system, thereby maintaining a relatively stable team structure. At the same time, through bottom-up professional actions, the medical social-work team continuously enriched the team' s capability composition and value identification. For example, members participated in industry skills training, expert-supervision seminars, and joint clinical ward rounds, continuously improving professional competence and clinical collaboration capabilities; with the help of university teaching and industry-training platforms, they provided training for clinical medical and nursing personnel preparing for the social-worker certificate examination, promoting the dissemination and advocacy of professional concepts.

2.2 Core Pathways for the Acquisition of Medical Social Workers' Practice Authority and the Generation of Effectiveness

The effectiveness of services in practice still needs to be verified through endogenous mediating mechanisms—namely, the three processes of cognitive consensus, emotional connection, and behavioral pathways—so that the achievement of team goals is facilitated through interprofessional collaboration. By demonstrating practice effectiveness as a feedback mechanism, medical social workers further obtained the medical team' s recognition of the profession [21]. As multidisciplinary collaboration became routinized, medical social workers, through continuous participation in clinical collaboration, service-process optimization, and professional reflection, realized a transformation from passive inclusion to active participation. The practice effectiveness of medical social workers was no longer limited to auxiliary affairs; rather, through professional intervention in high-risk and highly complex situations, their professional value was made visible within the medical system. The core mechanism of the practice pathway is reflected in a threefold progressive relationship: the generation of emotional trust, the consolidation of behavioral coordination, and the formation of cognitive consensus. Together, the three promote the evolution of multidisciplinary collaboration toward a higher level of effectiveness.

2.2.1 A Feedback Pathway Characterized Primarily by Emotional Linkage: From Relationship Crisis to Trust Reconstruction

In the early stage of multidisciplinary collaboration, medical social workers entered clinical practice by relying on the ward-based part-time medical social-worker mechanism, and gained the trust and recognition of medical and nursing teams through professional intervention in individual cases. Medical and nursing personnel gradually clarified the timing and role functions of medical social-work intervention, and became willing to refer complex cases to them for follow-up.

In 2015, Hospital E experienced an incident in which "the family member of a child patient threatened violence against medical staff," and the hospital contacted the Department of Social Work to request urgent intervention. After receiving the referral, the medical social workers quickly initiated a crisis assessment. Through active listening and clarification of identity, they contacted the director of the child' s department, the attending physician, the bed physician, the responsible nurse, and the child' s parents to collect information. The assessment found that the tendency toward violence against medical staff was a comprehensive reflection of factors such as nonacceptance of treatment, lack of social support, maladjustment in coping with psychological pressure, and lack of effective doctor-patient communication. Therefore, the medical social workers promptly coordinated with the Medical Affairs Department and the ward director, and decided to change the attending physician in order to shift the family' s focus of attention. In the specific intervention, the medical social workers, on the one hand, supplemented the medical team' s understanding of the family members' psychological dynamics and actual cognition; on the other hand, they analyzed for the family the unmet psychosocial needs behind their expressions of dissatisfaction, created an atmosphere of empathy and openness, rebuilt channels for doctor-patient communication, and translated the demands of both sides into shared cognition and a common language, effectively achieving relationship reconstruction and trust reconstruction. After sustained intervention, before discharge the child's family members took the initiative to apologize to the attending physician, and the doctor-patient dispute crisis was effectively resolved [22].

Doctor-patient disputes are a prominent pain point and management difficulty in medical-service settings. As a third-party role, medical social workers intervene, and their effectiveness in crisis intervention is mainly reflected in three mechanisms: first, an emotional mechanism, in which a sense of safety and trust is established through a neutral stance and clear role boundaries, providing an emotional foundation for initiating collaboration; second, a behavioral mechanism, in which coordinated execution by the interprofessional team and real-time communication ensure the effectiveness of intervention; and third, a cognitive mechanism, in which role consensus and clear boundaries allow trust to be consolidated.

The core of the emotional mechanism lies in the generation of reparative trust: it not only resolves immediate emotional conflict, but also reshapes psychological safety and emotional resilience among teams, enabling crisis response to gradually evolve into an internal driving force for relationship reconstruction and sustained trust. To further enhance collaboration in behavioral coordination and cognitive construction within the team' s mediating mechanisms, the medical social-work team of Hospital E engaged in reflective learning and further adjusted the service boundaries of its intervention in medical disputes, limiting them to issues not involving medical fault. The team also fed this back to hospital managers and clinical medical and nursing personnel, thereby avoiding role ambiguity and ethical risks caused by "embedded development," and steadily improving the coordination of team decision-making and the sense of psychological safety.

2.2.2 A Feedback Pathway Characterized Primarily by Behavioral Collaboration: From Dispersed Cooperation to Close Coordination

In 2018, based on the interdisciplinary characteristics of organ-donation work and the hospital

Figure 2. Mediation mechanism dominated by emotional linkage: from relationship crisis to trust reconstruction

Text shown in the figure:

- **Crisis**: family members of the child patient threatened to harm medical staff.
- **Start the emergency-intervention mechanism for medical social work**
- **I–Input**
  - **Input**
  - **Team composition**: medical social workers, medical staff, management
  - **Team structure**: referral system
- **M–Mediator**
  - **Emotion (core)**: trust, sense of security, emotional adjustment
  - **Behavior**: coordinated execution, real-time communication
  - **Cognition**: understanding role boundaries
- **O–Output**
  - **Team effectiveness**
  - Family members' emotions improved
  - Physician–patient trust rebuilt
  - Hospital crisis defused
- **I–Re-input**

At the level of strategic planning, Hospital E formally incorporated medical social workers into the core organ-donation team at the institutional level, jointly assisting organ coordinators and medical teams in providing services throughout

the entire process. Institutional authorization enabled medical social workers to enter medical settings with high ethical sensitivity and high collaborative complexity, allowing them to play a role in psychosocial support and coordination throughout the donation process and providing an opportunity to optimize the behavioral mechanisms of team collaboration.

Organ donation is of great significance to both the medical system and patients' families [23]. The core organ-donation team consists of attending physicians, organ coordinators, medical social workers, family-support nurses, and others, who jointly follow the entire process of organ donation from intention assessment to completion of donation. In practice, the team faces challenges such as professional overlap, ethical differences, and blurred role boundaries; members' insufficient understanding of intervention timing and responsibilities affects collaborative efficiency. In response, medical social workers at Hospital E promoted the optimization of collaboration through three types of behavioral strategies: learning, communication, and coordination.

First, learning and reflection. Medical social workers actively studied donation procedures, clinical knowledge, and cultural perspectives, thereby improving their professional and cultural competence; through supervision they clarified their own positioning, formed a complementary division of labor with organ coordinators, and focused on support links such as trust building, intention assessment, emotional comfort, and bereavement counseling. Second, communication and exchange. The organization carried out interdisciplinary training to clarify role positioning and processes, improve the standardized recognition rate for referral among medical and nursing staff, and promote smoother collaboration and optimized decision-making. Third, team coordination. During service delivery, medical social workers dynamically fed back the wishes of donor families to the team, coordinated the provision of medical and social resources in a timely manner, and built multidisciplinary services centered on the needs of children and their families, thereby providing continuous and integrated family support [24]. Medical social-work interventions for children' s families achieved significant results: after multidisciplinary cooperation, the number of donation cases rose from the previous 1–2 cases per year to 5 cases per year. On this basis, in August 2022 the hospital was approved for national qualifications in heart, liver, and kidney organ transplantation.

In this process, behavioral, cognitive, and emotional mechanisms intertwined and advanced together. Cognitively, in a situation where team members had asymmetric understandings of intervention timing and role division, medical social workers proactively calibrated the logic of collaboration—such as breaking the habit of "intervening only at the time of donation" —and reached early-intervention consensus through continuous communication. Emotionally, under high-pressure conditions, the team formed task-oriented cohesion; medical social workers promoted physician–patient emotional dialogue and coordinated decision-making through empathy and trust, strengthening the team' s psychological resilience and organizational efficacy. The core of the behavioral mecha-

nism lay in action-driven collaborative evolution: the medical-social-work team used learning, execution, and reflection as a cycle, achieving the leap from individual action to organizational learning and providing structural support for the sustained release of multidisciplinary collaborative effectiveness.

2.2.3 Feedback pathway characterized by cognitive co-construction: from initial collaboration to standardized collaboration

Multidisciplinary diagnosis and treatment mainly targets patients with complex needs, providing them with specialized, standardized, and individualized treatment plans [25]. Since 2016, Hospital E has established a number of distinctive multidisciplinary diagnosis-and-treatment programs, and medical social workers have gradually been incorporated into multidisciplinary diagnosis-and-treatment teams [26], becoming an indispensable component of multidisciplinary care. In 2021, the Department of Endocrinology, Genetics, and Metabolism at Hospital E initiated the establishment of a cross-gender multidisciplinary outpatient clinic. Team members included professionals from psychology, endocrinology/genetics/metabolism, urology, the Social Work Department, and other departments; after review by the hospital ethics committee, the clinic was formally established and put into operation.

In the context of interdisciplinary multidisciplinary diagnosis-and-treatment cases, whether the professional role of medical social workers can be fully 发挥 depends on the extent to which the following three types of cognitive consensus are reached: consistency of the shared vision, operability of standardized procedures, and diversity of information sharing. First, the consistency mechanism of the shared vision was established through team discussion around a service philosophy of "centering on the child patient and family," clarifying that the purpose of the clinic was to help alleviate gender anxiety among transgender children and adolescents, guide families in establishing a correct understanding of transgender identity, ease parent-child conflicts within the family, and create a supportive family environment so as to restore and promote the child' s physiological-psychological-social functioning. The achievement of consensus enhanced the team' s shared understanding of work direction and division of responsibilities. In the multidisciplinary outpatient clinic, medical social workers mainly carried out systemic interventions around social support and family empowerment; it was precisely under the guarantee of this consensus mechanism that they obtained clear positioning and support distinct from that of clinicians and psychologists. Second, the operability mechanism of standardized procedures ensured the continuity and executability of team collaboration. Through operations such as constructing multidisciplinary joint consultation pathways [27] and medical social workers' recommendations for improving the medical-record system, the team clarified "medical social work and psychology

"the boundaries of physicians" and "key areas for medical social-work intervention," thereby effectively improving collaboration efficiency and service integration. Third, diversified mechanisms for information sharing—through rapid pre-

consultation assessment and information feedback by the medical social-work team, on-site case discussions, and dynamic online communication—provide the team with opportunities for conflict coordination and collaborative improvement, promoting the establishment of trust, tacit cooperation, and a shared work rhythm formed after role boundaries gradually become clearer.

The generation of the cognitive mechanism is not an abstract fusion of consciousness, but rather a practical process of co-construction built on shared goals, standardized processes, and knowledge exchange. Through sustained professional interaction and institutionalized feedback, the multidisciplinary collaboration at Hospital E gradually formed a stable cycle of collaborative decision-making. In this process, medical social workers achieved the systematic integration of their professional value, providing cognitive support for the long-term maintenance of multidisciplinary collaborative effectiveness. In actual operation, emotional and behavioral mechanisms provide continuous support for cognitive co-construction: at the emotional level, members of the interdisciplinary team, through mutual respect and the establishment of psychological safety, formed an atmosphere of open expression and equal discussion, enabling divergent opinions to be heard and integrated; at the behavioral level, joint consultations and multidisciplinary decision-making discussions became key carriers of cognitive co-construction, as the team continuously adjusted its understanding of goals and role boundaries while formulating diagnosis and treatment plans for specific cases. The synergistic action of the three-dimensional mechanisms enables the team both to maintain norms within the institutional framework and to realize the dynamic updating of consensus in practice.

3 Discussion

From the perspective of the agency of medical social workers, this study focuses on the key yet relatively under-researched area of the effectiveness of medical social workers in multidisciplinary collaboration. Using the IMOI model as its theoretical basis, and through case analysis, it constructs an overall framework for the mechanism through which the effectiveness of medical social workers in multidisciplinary collaboration is generated. It demonstrates how medical social workers play an effective role in multidisciplinary collaboration, reveals the factors influencing the exertion of their effectiveness, and provides reflections on mechanism pathways and practical experience for the professionalized collaboration and sustainable development of medical social work.

3.1 Input Level

Based on embeddedness theory, the development of medical social work can be viewed as development achieved under conditions of embeddedness; this view has become a consensus in existing research

. Top-down structural embeddedness is mainly manifested in the government granting legitimacy to medical social work through institutional documents and evaluation systems. Its advantage lies in enabling social workers to quickly obtain an organizational position and space for survival, yet such institutional authorization does not necessarily translate into effective practice. Under the influence of real-world problems—"policies lacking systems, organizations lacking structures, teams lacking coordination, and capacities lacking core substance"—medical social workers often fall into shallow embeddedness or an administratively dominated development model

. Practice indicates that, to resolve this

Figure 3. Mediation mechanism dominated by behavioral collaboration: from fragmented cooperation to intensive coordination

Diagram text:

- Interdisciplinary, highly complex task
  (organ donation)
  Ethical sensitivity + professional intersection + high collaboration difficulty
- **I–Input**
  - **Input**
  - Organizational environment: institutional authorization
  - Team composition: attending physicians, organ coordinators, medical social workers, family-support nurses
  - Team structure: clearly defined positions, process formulation, and a foundation for normalized collaboration mechanisms
- **M–Mediation**
  - **Emotion**: team cohesion
  - **Behavior (core)**: learning, communication, coordination
  - **Cognition**: calibrating the timing of intervention
- **O–Output**
  - **Team effectiveness**
  - Improved experience of patients' families
  - Enhanced collaborative efficacy
  - Completion of team tasks
  - Organizational expansion and service upgrading
- **I–Re-input**

Figure 4. Mediation mechanism dominated by cognitive co-construction: from preliminary collaboration to normative coordination

Diagram text:

- Promotion of the multidisciplinary diagnosis-and-treatment system (establishment of a transgender outpatient clinic)
- **I—Input**
  - **Input**
  - Team composition: endocrinology, psychology, social-work department, urology, etc.
  - Team structure: joint outpatient-clinic system, consultation process
- **M—Mediation**
  - **Emotion**: trust, respect, psychological safety
  - **Behavior**: joint decision-making
  - **Cognition (core)**: consensus, norms, sharing
- **O—Output**
  - **Team effectiveness**
  - Improved patient adherence
  - Formation of family support networks
  - Stabilization of team collaborative decision-making
  - Innovation in multidisciplinary collaboration mechanisms
- **I—Re-input**

The key to resolving the dilemma lies in constructing a two-way pathway of "top-down adaptive embedding" and "bottom-up autonomous practice." Concrete practical recommendations may be developed at four levels. At the macro-environmental level, the policy support system should be improved. Departments such as the National Health Commission, the Ministry of Civil Affairs, and the Ministry of Human Resources and Social Security need to jointly formulate systems for professional-title evaluation, post appointment, performance assessment and promotion, and compensation for medical social workers, and incorporate these into the evaluation standards for medical institutions so as to safeguard the career development of the talent team. At the organizational-environment level, the structure of medical institutions should be optimized. Hospitals should attach importance to the professional attributes of medical social work, separate it from burdensome administrative work, clarify its professional jurisdiction, service content, personnel qualifications, and assessment standards, and incorporate such indicators as the number of patients served and service-effectiveness evaluation into the appraisal system. At the team-structure level, embedding into the clinical system should be promoted. Taking Hospital E as an example, medical social workers can advance their own embedding into multidisciplinary diagnosis and treatment through bottom-up pathways such as resource linkage, relational integration, capacity building, and the establishment of referral mechanisms; at the same time, they can form operable service systems, job responsibilities, and collaboration processes, thereby providing action

references for similar practices. At the membership-composition level, professional capacity and identity should be strengthened. Medical social work teams should uphold professional values, use professional methods to provide services, and strengthen their understanding of their own professional positioning and development tasks; meanwhile, they should enhance professional competence through regular training and supervision[30–31], ultimately gaining team trust and further empowerment by virtue of their professional ability to solve practical problems.

The formation of conditions for multidisciplinary collaboration does not derive from a single condition, but is a dynamic process produced by the interweaving of multilevel structural inputs and individual agentic practice. The key lies in the interactive tension formed by medical social workers between "passive embedding" and "active integration," which continuously reconstructs the dynamics of practice boundaries and professional positioning, laying a practical foundation for the subsequent mediating mechanisms of emotional trust, behavioral coordination, and cognitive co-construction.

3.2 Mediating Level

The key to the generation of multidisciplinary collaborative effectiveness by medical social workers lies in their transformation of external institutional embedding into sustainable cooperative practice through emotional linkage, behavioral coordination, and cognitive co-construction. The practice of Hospital E shows that when multidisciplinary teams handle complex and high-risk events, medical social workers, through emotional support, behavioral intervention, and cognitive co-construction, have built a complete chain of team collaboration—from trust building to behavioral coordination and then to consensus consolidation. This effectively supplements research on how multidisciplinary collaborative interactions affect team effectiveness and reveals the mechanism through which their effects are realized.

First, the efficient operation of a multidisciplinary team itself depends on trust, respect, and emotional connection among team members[32]. The emotional mechanism lays a psychological foundation of trust and safety for team collaboration. A sense of psychological safety and an atmosphere of empathy not only alleviate role tensions among members from different professions, but also provide an open space for information exchange and the expression of viewpoints. When team members receive positive responses in cooperation and form consensus through reflection, the team's sense of safety is consolidated and transformed into lasting confidence in collaboration. Second, the behavioral mechanism is the practical carrier of team collaboration. The significance of behavior is not limited to the execution of professional tasks; rather, through joint communication, coordination, and cooperation, it forms experiential consensus within the team. This experience not only responds to the need for trust at the emotional level, but also promotes dialogue within cognitive structures. Finally, collaboration at the cognitive level emphasizes team members' sharing and understanding

of knowledge about goals, division of labor, and operational norms, enabling different professions to act collaboratively within the same logical framework[33]. When the medical and nursing roles in the team recognize that the intervention of medical social workers can ease provider-patient tension and improve communication efficiency, and when medical social workers understand the cognitive barriers and structural predicaments behind provider-patient conflicts, the team' s cognitive co-construction is truly realized. At this point, collaboration is no longer task-based cooperation, but a process of value consensus and knowledge complementarity. The stabilization of the cognitive mechanism enables collaborative experience to be standardized and also provides support for the continued participation of medical social workers.

3.3 Output Level

In the classic IMOI model, the output dimension of team effectiveness is not clearly defined, and the construction of its measurement criteria is closely related to team attributes. The experience of Hospital E shows that the participation of medical social workers extends the output of multidisciplinary teams from the individual level to collaborative outcomes at the team and social levels, including comprehensive performance in patient-side gains, team efficiency improvement, and organizational expansion. This is mainly manifested at three levels.

At the level of problem solving and patient experience, the outcomes of collaboration are reflected in the simultaneous improvement of patients' physical, psychological, and social functioning. In the process of diagnosis and treatment, multidisciplinary teams integrate medical, psychological, and social resources, enabling patients not only to receive treatment for disease, but also to benefit in emotional regulation, family support, and social adaptation. The collaborative mechanism has promoted a transformation in the service logic of being "patient-centered" —from unidirectional medical behavior to a holistic care model. The improvement of service effectiveness is reflected not only in health outcomes, but also in the increased treatment adherence of patients' families and the formation of social support networks.

At the level of provider-patient communication and collaboration enhancement, collaborative effectiveness is manifested as an improvement in the team' s overall capacity to handle problems. Multidisciplinary collaboration enables information to flow fully within the team, realizing the transformation from individual professional action to collective collaborative decision-making. When facing complex events, the addition of medical social workers supplements the professional perspectives of psychological and social dimensions and promotes communication and understanding within the team under pressure. The team' s overall communication quality, conflict-mediation capacity, and decision-making coordination are thereby improved, reflecting the systemic effectiveness of collaboration in solving problems and repairing relationships.

At the level of organizational expansion and service upgrading, the outputs of

collaboration rise to the organizational level of resource expansion and management innovation. The collaboration between medical social workers and medical teams not only solves individual case problems, but also promotes the optimization of institutional processes, the proactive handling of ethical issues, and the integrated use of multiple resources. It has become an important trend for hospitals in responding to complex medical problems.

3.4 Re-input Level

The IMOI model emphasizes that team effectiveness is not generated in a single instance, but is a dynamic cyclical process based on continuous feedback. Although medical social workers have already formed a bottom-up practice pathway, and even though their practical results are significant, their auxiliary and marginal position within the organizational structure and their insufficient fit with the clinical system still affect the dynamic cycle of team effectiveness at the overall level. The goal of re-input is to drive the redevelopment of the team[34]. The key lies in transforming the output results of multidisciplinary collaboration into momentum for renewed cooperation. Specifically, this can be achieved through dual pathways of exogenous driving and endogenous activation, among which endogenous activation focuses on the team' s internal system and injects developmental momentum into collaboration. First, a cross-disciplinary knowledge-sharing mechanism should be constructed. Relying on interdisciplinary training, case supervision, and scientific research, medical social workers

cooperation and online interaction platforms, promote the flow and sharing of knowledge among team members, and consolidate the professional foundation for collaboration. Second, a quantitative assessment system should be established. In view of the knowledge-diversity characteristics of multidisciplinary collaboration, quantifying and standardizing assessment indicators is central to achieving homogeneous management.[26] Medical social workers may work jointly with medical teams to conduct research and combine process-oriented and outcome-oriented evaluation indicators—such as patient satisfaction, success rate of dispute mediation, amount of arrears in hospitalization expenses (excluding malicious arrears), patient quality of life, and loss-to-follow-up rate—to evaluate the effectiveness of diagnosis-and-treatment models. Third, service standardization should be promoted. Through reflective practice and research synthesis, service norms, expert consensus, and operational guidelines should be developed, and successful experience should be transformed into standardized processes, post settings and training content, and supervision systems, so as to realize systematic management, regulation, and dynamic adaptation for the various roles—for example, clarifying role positioning, boundaries of authority and responsibility, and priorities.

On the other hand, exogenous drivers point to systems outside the team and provide support and safeguards for it. The specific pathways include the following. First, expert role support for multidisciplinary collaboration should be

strengthened. Hospitals need to separate medical social workers from non-core administrative affairs and focus on cultivating interdisciplinary professionals with clinical, managerial, research, and teaching capabilities. Medical social workers with intermediate or higher professional titles, rich clinical experience, and strong communication and collaboration skills should be encouraged to participate in multidisciplinary diagnosis and treatment, thereby providing talent support for collaboration. The management and performance-evaluation mechanisms for multidisciplinary collaboration should be improved. By establishing standardized management processes and service pathways, the standardization, professionalism, and comprehensiveness of diagnosis-and-treatment work can be enhanced. Third, collaboration efficiency should be optimized through information platforms. A social-work case referral mechanism based on the electronic medical record system should be developed to help multidisciplinary teams obtain patient information in real time and provide one-stop integrated services around patients' needs. Finally, top-level policy planning should empower the development of medical social work. On the one hand, the Health Commission should issue policies to include medical social work services in the medical-insurance catalogue and clarify fee standards, thereby promoting implementation of services. On the other hand, multiple departments—including civil affairs, the Health Commission, the Disabled Persons' Federation, the Women's Federation, and the Education Commission—need to jointly build a social collaborative network for children with serious illnesses and financial difficulties, promote multiparty linkage among "family, school, hospital, government, and community," and facilitate the transformation of medical social workers from auxiliaries within the medical system into coordinators of comprehensive services, thereby realizing a return to their social essence.

3.5 Research Generalizability and Limitations

The *Action Plan for Improving the Medical-Care Experience and Enhancing Patient Experience (2023–2025)* (National Health Medical Administration [2023] No. 11)[35] clearly states that hospitals at the secondary level and above should establish systems for medical social workers and volunteers, enrich the content of medical social work services, and promote the systematization, specialization, and standardization of medical social work services. The practical pathway for medical social workers in multidisciplinary collaboration based on the IMOI model proposed in this study aligns well with the policy's requirements for a "patient-centered" Chinese-style modernized medical service model, and its generalizability is also reflected in differentiated pathways applicable to different medical institutions. Specifically, relying on their level of medical technology, tertiary hospitals can focus multidisciplinary collaboration on precise diagnosis and treatment and whole-process management services for patients with acute, critical, severe, difficult, and rare diseases. In such settings, medical social workers emphasize how to integrate into the multidisciplinary collaboration framework—for example, by constructing standardized referral and collaboration mechanisms—thereby promoting the production of practice-based knowledge in

medical social work and building a full-chain, multidimensional social support service system. In secondary and community hospitals, multidisciplinary collaboration involving medical social workers adopts an integrated "hospital-community-family" service model, giving play to preventive, coordinating, and supportive functions in areas such as chronic disease management and hospice care, and promoting the downward extension of multidisciplinary services. Medical social workers place greater emphasis on integrating government and community resources, as well as on coordinated linkage within regional social support systems. This tiered promotion and differentiated implementation based on the collaborative characteristics of medical social work will help form a pathway for multidisciplinary collaboration in medical social work that fits the structural characteristics of China' s medical system.

At the same time, this study also observed research directions that require further exploration. First, as a single-case study, the findings remain constrained by context and cannot cover differences among regions at different levels of development, hospitals at different levels, or team structures. Second, the study focuses more on internal organizational mechanisms and lacks systematic tracking of how patients and families influence team effectiveness. In the future, based on the model framework of this article, the number of case samples can be increased, and validation and supplementation can be conducted across multiple institutions and scenarios, so as to further explore the influencing factors and action pathways of effective collaboration mechanisms for medical social workers in different medical institutions.

4 Conclusion

Taking Hospital E as a case, this study explored the process through which the effectiveness of medical social workers in multidisciplinary collaboration is generated, based on the IMOI model. In terms of theoretical contribution, this study constructed a localized analytical framework based on the IMOI model and revealed that the generation of effectiveness among medical social workers in multidisciplinary collaboration is a dynamic interactive process. By improving the IMOI model and systematically integrating the four links of input, mediator, output, and re-input, the study verified the practical effectiveness of medical social workers in multidisciplinary teams and provided a new analytical perspective for the theoretical development of medical social work in China.

In terms of practical application, the study found that the formation of medical social workers' effectiveness depends both on institutional support and on team interaction and professional practice. Through practice-based verification and theoretical deduction, this study puts forward three implications: first, strengthen the combination of institutional embedding and professional integration to consolidate the foundation for collaboration; second, give play to the linked effects of emotion, behavior, and cognition to improve the quality of teamwork; third, attach importance to the feedback role of the re-input link to promote experience accumulation and continuous optimization. This study

provides empirical evidence for understanding the role practice of medical social workers in multidisciplinary collaboration, and also offers practical reference for improving the construction of medical social work systems and collaborative models in China' s medical institutions.

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