ASPECTS OF SOCIAL WORK IN GENERAL PRACTICE

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THIS is a report on the experimental attachment of a medical social worker to a single-handed, full-list general practitioner in a heavily populated area in North Birmingham. The aim of the experiment was to provide some estimate of the feasibility and usefulness of such an attachment. The experiment was necessarily uncontrolled and was for a period of one year commencing April 1965. The attachment was fostered by the Birmingham Public Health Department (Mental Health Section). The report is based on a study done in retrospect at the year's end on the records made during the year. The medical social worker (MSW) was attached to the practice for three days per week and for the rest of the week was working for the local authority.

The setting

The practice has been established as a single-handed one for about 70 years and tends possibly to have a slight preponderance of older patients. It is compact (90 per cent of the patients reside within three-quarters of a mile of the surgery) and sits roughly astride the main road leading north out of the city towards West Bromwich. The bulk of the practice is in the Registrar General's classes III, IV and V.

The experiment

Aims. There were no clearly delineated aims set before us. The mental welfare section had not outlined any policy to be followed and it was left entirely to us to decide what our aims would be. The basic problem was to decide, therefore, what we wanted to do and as neither of us had worked in this pattern before, we decided that initially it would be politic to introduce the MSW gradually to the practice. To this end the MSW joined the general practitioner in

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surgery and in carrying out routine visits over a period of one month. During this period we discussed at length our own ideas about concepts of mental health, the relation of physical illness to psychological factors, the family as a unit, the problems of old age, overcrowding, immigrant difficulties, problem families, and so on, and made the following assumptions on which we based our work.

1. All illnesses have psychological and sociological consequences.
2. The seriousness with which these consequences are regarded varies considerably from doctor to doctor (Shepherd, *et al.* 1964).
3. It is not possible to offer help and advice on psychosocial problems to the vast majority of patients. This would be unnecessary, impractical, and be resented by many.
4. It was assumed that in order to deal adequately with a problem (social or psychological) adequate time and skill in this field is needed.

Based on these assumptions we can set out our aims.

1. To provide a co-ordinated personal service for some patients whose psychosocial problems were evident.
2. To offer a similar service to some patients where it was thought that psychosocial factors might well be a prime factor in the illness though this was not evident initially.
3. To accept for this service only patients who were thought to be in need at the time of referral and not to refer them to secure their inclusion in the study, simply because of past difficulties.
4. To evaluate the problems seen by discussion and to decide together what action would be most apt in each case. This action would take the form of physical treatment (e.g. antidepressants), superficial psychotherapy and environmental adjustments.

Methods

Following the initial month, the doctor and the MSW met at least twice weekly to discuss old cases and for new referrals to be passed on. Contact was made with the patient by letter and an appointment arranged either at the patient's home or the surgery. Four patients refused to see the MSW and they are not included in the subsequent figures. Others who would have been unlikely to accept were not offered the service. The clerical work was carried out by the doctor's secretary and the clerical staff of the family-care section of the local authority.

Case selection. This depended on the doctor's view of the situation though the MSW could deal with a patient at one interview and take no further action if she wished (three patients). The problem was how to limit the number of referrals and a rough method was to limit patients being referred to about three per fortnight. There was an obvious bias towards patients suffering from a psychiatric disability because of our leanings this way and the specific difficulties they presented in our field.

Case discussion. We discussed the cases prior to the MSW's first visit so that she would have as much background knowledge of the

medical and social situation as the doctor had gained over the years and a tentative evaluation would be made. Following the MSW's visit the case was fully discussed under the following headings:

1. Doctor's reason for referral.
2. Patient's view of problem.
3. MSW's view of problem.
4. Action to be taken.

We found it useful in discussing cases to attempt to analyse the impact of our own emotions on the problem (Balint 1957). We regarded the family as a unit (Howells 1963) and felt it necessary to widen our discussion to embrace all members of a family and would decide in each instance how important, or helpful, it would be for the MSW to see the others involved.

Classification

We decided to follow the practice of Collins (1964) in classifying the type of service given by the MSW as we had both been interested in her work. Collins classifies the service given into 'practical', 'complex', 'casework' (based on suggestions given in the Younghusband Report (1959).) 'Practical' refers to help given by the MSW of a purely advisory and administrative nature. 'Complex' to problems requiring more skilled help where the MSW co-ordinates different available services. 'Casework' refers to those problems requiring skilled help as defined in the Younghusband Report (1959), "a personal service, provided by qualified workers for individuals who require skilled assistance in resolving some material emotional or character problem."

Results

Patient referrals. During the year 67 referrals were made by the doctor to the MSW. Tables I and II show our method of subdividing them, and an estimate of the work involved. We have reviewed the problem mainly from a psychiatric framework because of our interest in this aspect of the work and because the project was sponsored by the mental welfare department. The term 'personality disorder' is used in its broadest sense and does not imply psychopathy as defined under the Mental Health Act 1959, and the term 'neurotic traits' is used to describe patterns of reaction which though on occasions approaching that of a personality disorder are not persistent or permanent but are frequently seen in these particular patients.

Sub-division. These are arbitrary and not necessarily exclusive. A patient was included in the group that seemed most appropriate on initial referral.

TABLE I

TYPE OF WORK DONE RELATED TO A CLASSIFICATION OF THE INITIAL PRESENTATION OF THE PROBLEM

Description of group	*Total*	*Practical*	*Complex*	*Casework*	*Medical diagnosis*
1. Primary psychiatric disability	25*		4	16	Depression (10) Schizophrenia (3) Personality disorder (5) Behaviour disorder (4) Drug addiction (2) Paranoid psychosis (1)
2. Physical illness	10*	2	3	5	Carcinoma (4) Dislocation of hip (1) Eczema (2) Hypertension (1) Chronic bronchitis (1) Rh. arthritis (1)
3. Old age	11*	7	2	2	Heart failure (4) Depression (2) Dementia (1) Obesity (1) Paranoid psychosis (1) Kyphosis (1)
4. Unmarried mothers	3			3	Neurotic trait (1) Depression (2)
5. Inadequate parents	5			5	Subnormality (2) Alcoholism (1) Neurotic trait (2)
6. Marital problems	3			3	Personality disorder (1) Neurotic trait (2)
7. Guidance in use of social agencies	10	3	7		Dementia (2) Subnormality (1) Asthma (1) Tuberculosis (1) Personality disorder (2)

1.* 5 cases—no action taken.
2.* 4 cases also showed neurotic traits and two personality disorders.
3.* 2 cases also showed neurotic traits.

Note: In group 3, one patient was seen and in group 7, three patients were seen in whom there was no medical diagnosis to be made at the time of referral.

TABLE II

AN INDICATION OF WORK DONE BY MEDICAL SOCIAL WORKER

Number of patients receiving social work help	
(*a*) Period of over 6 months duration	26
(*b*) Period 2–6 months duration	10
(*c*) Period under 2 months duration	16
(*d*) Patients seen only once	15
Approximate frequency of visits by social worker	*Patients*
(*a*) Weekly or twice weekly	10
(*b*) Fortnightly	12
(*c*) Monthly	6
(*d*) Intermittently as need arises	39

The following case history demonstrates some aspects of our approach and aims, i.e. regarding the family as a unit to be helped: necessity for detailed social history; joint involvement; fluid approach on practical and psychodynamic levels; long-term casework; and continual reappraisal of the altering pattern that presents to us.

Case *Reason for referral by doctor:* Frequent visits to the surgery with children suffering from behaviour disorders and mother suffering from attacks of depression and showing physical damage from the husband's assaults. *Classification*—Group V. Assessment of help given—Casework. Assessed result—Improved.

Mrs W., a thin garrulous woman—aged 38—mother of a girl aged four and a boy aged 11, who was unable to tolerate her husband's continuous abuse of herself and the children.

Family doctor's action. In order to corroborate the wife's story of her husband's behaviour the general practitioner visited one evening and confirmed the facts. The husband was a paranoid, and aggressive alcoholic. The case was discussed, especially in relation to the behaviour disorders shown by both children. Then the MSW made contact with Mrs W.

MSW's assessment. A detailed social history was obtained which showed the strong emotional dependency of the partners upon each other in the marital relationship and pointed to the reasons they were unable to separate in spite of their open conflict. The MSW visited regularly over a period of 12 months in order to support Mrs W during her frequent crises and to deal with practical and emotional problems. The major practical problems were finance and contraception. The first was resolved by finding work for Mrs W at a geriatric hospital where a sympathetic domestic superintendent was able to integrate her into the staff so that working hours suited her difficulties and where the little girl was able to spend time in the day nursery. To solve the immediate financial pressure a grant was obtained from a city trust. The fears of further pregnancies was discussed at length by the MSW and eventually an intra-uterine contraceptive device was accepted by the patient as a reasonable method, and an appointment was arranged and the device fitted. The major emotional problem was the husband's disorder of personality which it was unrealistic to expect to alter radically with treatment. The couple were interviewed singly or jointly on many occasions by the MSW. The wife has gained considerable insight but although her husband has not, his lapses into aggressive behaviour have lessened. The

effect on the children has been that the girl has withstood the turmoil well but the boy has produced various psychosomatic disorders and outbursts of hysterical behaviour but these have now considerably improved. The family is still receiving care both from general practitioner and social worker.

Assessment of project

Any assessment of this type of work must be made on subjective evidence as the very nature of the work makes complete objectivity impossible. In this report the various aspects of the work are divided into three groups.

1. *Preventive work.* Many of the patients referred, particularly those with psychiatric problems, received help earlier than they would have done had a social worker not been attached to the practice. Of the patients seen during the year, 33 required help of a preventive type. Had this help not been available it is likely that crisis situations could well have developed, which would have made increased demands upon the community in terms both of a social worker's time and material aid.

Sixteen of the cases were families with children. Of these, ten presented with abnormal behaviour patterns. Four are in group I and the others were discovered during contact with the family.

It is hoped that the help given at an early stage has prevented later referral to the child guidance clinic. In many cases it is essential that the help given should involve not only the child but the total family situation; this can be provided most efficiently where the doctor and social worker are working closely together.

Another three were problem families who had not yet come to the notice of the children's department, family care section or family service unit, but about whom anxiety had been expressed by both health visitors and social workers in the hospital service. As there were health as well as social problems the co-operative help of the doctor and social worker was very valuable.

Of the remaining patients in the group, nine were elderly people who were beginning to present particular problems either because of personality difficulties or environmental pressures. Three are physically handicapped and five are suffering from psychiatric disabilities.

2. *Crisis situations.* Twenty of the patients were referred to the MSW because of some specific crisis situation such as illness, eviction, unmarried pregnancy or psychiatric breakdown. In only two of these cases was a social worker already involved and in these cases the MSW acted as co-ordinator between the interested agencies and then withdrew. Two of the remaining patients were referred to more appropriate agencies and the MSW carried the other 16 cases, of which 11 needed frequent and prolonged help.

3. *Co-ordination of agencies.* One of the current problems in both social work and medicine is the lack of co-operation between different organizations involved in the treatment of the patient, particularly when different professions are involved. It was possible in the setting of a general practice for the MSW to fulfil the role of co-ordinator when several social workers and welfare organizations were treating the same patient. This was particularly valuable in treating a patient who was receiving prolonged hospital treatment while remaining in the community, as the MSW was able to keep in close contact with the hospital MSW's and the hospital staff treating the patient.

TABLE III

ASSESSMENT OF PROJECT

Group	*Improved*	In status quo	*Deteriorated*
1	9	7	4
2	5	5	0
3	11	5	4
4	3	3	0
5	5	4	1
6	3	3	0
7	10	6	4

Work done	*Improved*	In status quo	*Deteriorated*
Practical	10	9	0
Complex	4	5	3
Casework	21	7	3

Presentation	*Improved*	In status quo	*Deteriorated*
Preventative	17	14	2
Crisis situation	14	3	3
Co-ordination of agencies ..	4	4	1

In 5 cases no action was taken.

These tables are included to show the doctor's assessment of the situation at the end of the year. We in no way claim any scientific basis for them. No control group was used, so it is impossible to compare assessment of improvement with a similar group with similar problems who did not have a social worker's help. We are also aware that some of the situations may have improved for other reasons than the intervention of a social worker, and therefore submit these figures for their interest value bearing in mind their limitations.

Discussion

It is only in recent years that thought has been given to the attachment of social workers to general practice—this seems to be an anomaly if one considers the emphasis in the social work field placed on community care (1959 Mental Health Act) and the mantle the general practitioner is supposed to carry as a family doctor (Gillie report). It is well recognized that in general practice many patients present themselves with illnesses as a method of enlisting and obtaining help and advice in basic social problems. It is also generally accepted that the level of demand for services is steadily increasing (Baker 1966). If the general practitioner is to attempt to deal with this type of problem personally he needs someone to work alongside him. It is all too easy to jettison responsibility for this type of case by simply referring them to the appropriate social agency. Often a social worker may be working closely with a patient and may only have a superficial contact with the general practitioner who may also be heavily involved with the patient and his family.

If the attachment had been continued for longer than one year then a much better picture would have been obtained of the total problem and a clearer delineation between fresh and longstanding problems could have been made. This is a limitation of most papers in this field of work, and we hope that it may be remedied in the future.

1. *Co-operative function of doctor and medical social worker*

Bringing together two people trained in different disciplines and expecting them to work together in an ill-defined field needs co-operation and understanding on both sides. As a result of this project we have, now, a better grasp of the total field and of the possible contribution that each can make. On the doctor's side is the relief in being able to discuss at first hand a complex, changing, intimate family situation. The main advantage of this scheme was to be able to obtain help for these patients quickly and easily. There is no net gain in time for the doctor. Though certain cases are seen far less often in the surgery, other cases looked into by the

MSW involve the doctor more and more. A social history written out on paper is of far less immediate value than a full and frank discussion with a MSW of her findings and this inevitably leads to further discussion and a formulation of some sort of joint action. Both parties would meet at least twice weekly to pool their knowledge and decide on their future tactics to help the constantly shifting situation they were called to face. The constant interchange of ideas was of equal value to the MSW as for once she felt she was no longer working *in vacuo*. Much is made these days of the doctor-patient relationship and it is characteristic that in those cases where this is intense a similar relationship will develop with any other interested party. If, therefore, a social worker is involved it would seem far better for all concerned that doctor and MSW have a good working relationship themselves.

2. *Training function of doctor and medical social worker*

In this era of general dissatisfaction in general practice it is important that medical students should gain some idea of the complexity of general practice, together with its interests and it is equally important that social workers in training should regard general practitioners as approachable and having some insight into social problems. During the year the opportunity was taken to introduce two or three trainee social workers and medical students to the practice and outline our ideas to them. This could well be expanded on more concrete terms.

3. *Future developments*

It is realized that the value of having a MSW attached to a general practice has to be set against other claims when considering priorities in local authority departments. In the MSW's opinion the good practice of social work demands that the social worker should work within a framework where she can be stimulated and supported by colleagues of her own profession and participate in case consultations and discussions. On these grounds attachments such as the present are practicable only from a large department such as is found within a local authority. The concept of community care now pervades medical practice. We hope that local authorities will be prepared to accept and encourage attachments of this type even if they cannot be immediately justified from a purely practical standpoint.

4. *Attachments*

We do not advocate that every practice should have a MSW attached. There is an overall shortage of MSW's and this type of co-operative work will not appeal to many doctors whose interests are directed towards other aspects of general practice, though we do

argue that the problems outlined in this paper are fundamental to general practice. The experience of this project suggests that strong arguments could be made for supporting a few long-term attachments of this type. Our arguments would be based on the preventive aspects of the work and in particular, on the possibility of early intervention in crisis situations. The longer term benefits would be the possibility of developing future liaisons on a more economical framework, the education of both professions in this type of service, and the research aspects of community care.

Summary

1. For a year a MSW has been seconded on a part-time basis by the Public Health Department to a full-list, single-handed practitioner on the north side of Birmingham.

2. The doctor and MSW decided that the best use that could be made of such an attachment would be to offer a personal co-ordinated service to patients suffering from psychiatric or social problems and then to estimate its usefulness and feasibility in retrospect.

3. The cases were selected by the doctor because of obvious psychiatric and social difficulties together with patients presenting with illnesses suggestive of underlying problems in these fields.

4. It was regarded as vital to the success of the scheme that the doctor and MSW met at least twice weekly to discuss and formulate joint plans of action and that physical therapy, psychotherapy and environmental adjustment went hand in hand.

5. Sixty-seven cases were seen during the year and an attempt is made to grade the complexity of the action taken by the MSW. An arbitrary classification of the patients was attempted, accepting that there is overlap between the groups and that they do not form a homogeneous whole.

6. At the year's end, the cases were assessed by the doctor as improved, *in status quo*, or deteriorated, even though this is a subjective value judgement as oft times one is estimating intangibles. The figures show that 52 per cent improved, 31 per cent remained *in status quo*, and nine per cent deteriorated with regard to the total psychosocial situation.

7. The success of the present assessment has been due primarily to the constant personal contact of doctor and MSW and to their similar viewpoint in this field. Though this attachment has been eminently useful, the need for close co-ordination renders large scale attachments impractical especially as there is such a shortage of MSW's.

8. However, the possibilities of development in this field are vast

and we would advocate attachments on a small scale for a lengthy period to fully evaluate the situation.

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On the evils of bringing up children by hand

" On the other hand, disease and death are the usual consequences of the present erroneous method of bringing up children by hand. Scarcely one in four of these little innocents live to get over the cutting of their teeth; and the vitiated blood of those that escape, occasioned by improper nourishment, generally renders them infirm, or short-lived. Almost every complaint to which children are subject, appears to me to proceed originally from an improper management of them; for the young of all other animals are full of health and vigour.

"And moreover, independently of these misfortunes, the future happiness of the parent herself is greatly interested in this maternal concern; as it generally falls out that those children who are neglected by their mothers during their infant years, forget all duty and affection towards them, when such mothers are in the decline of life; and this contempt from a child is nothing less than plunging a dagger into the breast of its parent: and besides the cruel pangs which she must unavoidable experience from this want of duty, daily observation convinces us that widows frequently suffer not a little, even in the common conveniences of life, by the means of these very children who, if properly educated, would have probably become their support and comfort."

HUGH SMITH, *Letters to married women, on nursing and the management of children.* Sixth edition. 1792. Pp. 75–77.