ANXIETIES OF A SOCIAL WORKER IN A MEDICAL SETTING*

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ANXIETY, both by definition and good authority, is a negative feeling. The Latin definition, as given in the Oxford English Dictionary, derives the word from the Latin verb *angere*, to choke. St Paul, as translated in the Prayer Book version, is reputed to have said "in nothing be anxious". Psychiatric practice has coined the phrase 'anxiety state' to describe the patient who is so disabled by an accumulation of troubled thoughts that he is incapable of constructive activity.

My biggest anxiety in preparing this paper was that I could not remember a single major occasion, or a succession of minor occasions in my job when I was anxious. That, of course, is me. I am certain there have been situations when I ought to have been anxious but my way of dealing with obstacles in my path is to try first a small shot of explosive, and if that doesn't have any good effect, either go underneath or round them by an unobtrusive route, preferably backwards. This sort of activity keeps me too busy to be anxious—at least I am not being choked, although if some people had their way I would be!

That there are anxieties, however, is evident from the writing about social work in the medical setting and writing by doctors and others about the relationship between themselves and social workers. I was thinking particularly of material that is contained in reports which are recent and readily available. In the report on the recently-qualified medical social workers by Marjorie Moon, which goes under the title *The first two years*, 54 of the 74 participants in the research felt inadequately prepared for the job they were doing, although in the course of their education and training they had spent considerable periods in hospitals. Particularly, they seemed unsure of themselves when it came to dealing with staff, although they felt they were

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capable of understanding their patients. Similar material came to light when Marion Crawford and Ann Crichton, of the University College of Cardiff, interviewed a selection of staff in the Whitley Council's P. and T. category in the hospitals in South Wales. Here the workers felt that their potential was unrealized by their colleagues and the administrative and medical staff. In the Porritt Report on the future of general medical services we see the other side of the coin. In paragraph 469 we find "the position of medical auxiliaries in the field of mental health is unsatisfactory. There has been a tendency for medical auxiliaries to develop their own ideas on training and function without sufficient control by the medical profession". That some members of the medical world do regard the professional social worker as a threat became evident to me from audiences at two previous meetings. At a joint meeting between social workers and general practitioners in Swansea three years ago, and at a seminar which I took last year for about-to qualify medical officers of health, great apprehension was expressed about the growing number of holders of certificates in social work who were entering the public health services and who would not have any sense of loyalty to any doctor, but who would act on their own initiative and, as they said, leave us to carry the can. This was a new line of argument to me. Having been reared in the hospital tradition it would be second nature to consult with the referring member of the medical staff as often as possible even though I would still feel it my responsibility to make decisions on social work policy—but I can quite see that in an organisation where communication is slower and more difficult it would be very easy for a feeling of "we don't know what these social workers are doing" to build up. As hospitals become more and more specialized it could happen in hospital too, and so is to be taken into account.

The thing that thrills me today is that representatives of three professions, two very old, and one comparatively modern, for all it has reached its three score years and ten, since its establishment, can get together, can admit there are anxieties, and from there can, I hope, set about dealing with them constructively. As regards my own profession, that is a pretty remarkable evolution. I qualified in 1948, just in time for the beginning of the Health Service, but I had had eight years of voluntary dabbling in medical social work before, so that the contrast between the old and the new was very obvious. In 1948 we were conscious of the great opportunity for the development of professional skills, but a bit uncertain how to make use of it, and rather wishing somebody would tell us exactly what was expected of us. I remember much correspondence about the need for a definitive circular which would clarify our role, particularly in relation to workers outside the hospital. The circular

was never issued, and we have lived to be grateful for that, since it has meant that as long as we do not contravene medical policy or break the law of the land we have been free to attempt what we felt would be best for our patients, and I am sure that it is this freedom to think and act independently while at the same time having the support of an institution and the incentive of being part of a team that has kept many medical social workers in hospital, in spite of the economic disadvantages.

I remember also two other things which were not so healthy. We tended to over-identify with the medical staff with whom we worked. 'Our' consultant, or in most hospitals collection of consultants, was more important than anyone else's, and their goodwill, and good opinion, meant a great deal to us. The result of this was that we tended to build up a collection of skills which dovetailed with the medical skills of those consultants who gave us any encouragement or accorded us any appreciation, while those who seemed unconcerned or unappreciative got reciprocal treatment from us, and we chose to work instead with the ward sisters, housemen, or anybody who we felt to be on our wavelength. As a result of this, we were not too much concerned with skills needed to build up a social service department. Somebody suitably advanced in years was recognized as Head, and she coped with such things as sick notes, white coats, leave entitlements, and coming in late and could be consulted about minor frustrations or gaps in knowledge. A 'good' Head let you sign your own letters, and did not interfere too much, and kept decently in the background. Our appreciation of our responsibility to the community was at about the same unsophisticated level. We recognized loyalty to patients, consultant, hospital and colleagues, but after that it tended to be 'my country, right or wrong', and there was a distinctly jingoistic flavour to the way in which we used our Samaritan Funds to fill the gaps in the public services; and an almoner's Samaritan Fund was her most precious possession.

Discussion of anxieties, such as we had, was strictly in camera. The sort of things we talked about were how to get referrals, how to get salaries which we felt were comparable with the jobs we were doing, at a time when the profession was beginning to take in people who were frankly salary earners and in need of those salaries in order to keep body and soul together. We talked about the best way to train young staff—Should we train them in the techniques of social manipulation or should we train them to appreciate the importance of the extended knowledge of human growth and behaviour and its practical application, which was filtering in from America? We were concerned about the people who called themselves almoners but who, in fact, had had no training for the job

they were doing and whose duties were mostly administrative. Should these people be allowed into the profession, or should they be kept outside? In the end we compromised and had a 'C' register of people who, we felt, were almoners in name only. We were concerned about people who *would* do administration when we were no longer compelled to do it. We were concerned about the efficiency of the jobs that had once been ours, but which were no longer part of our province, things like hospital car service and ordering wheel chairs. We were concerned when we felt that these services were being run on lines more like the civil service, or a public utility company than in accordance with the patient's welfare. We got in a panic when we thought there was a likelihood of being asked to take on administrative duties. I remember at the time that charges were re-introduced for wigs and teeth and elastic stockings, a really vociferous general meeting about how we should deal with the situation if we were asked to start collecting money again. We talked about people who worked in other services, but only in terms of whether or not they were co-operative and whether or not they were easy to get on with, or whether or not they would do what we wanted them to without too much question. The evolution, therefore, has been in the recognition of a wider range of responsibilities and of having more in common with other workers and the recognition that medical social work is concerned with people rather than problems allied to medical conditions.

We also recognize now the need to make choices between possibilities for action, since the volume of demand is too great to meet in full. At the same time we have developed an awareness of the solidity of 70 years of history which gives us enough security to be able to admit, on occasion, that we have anxieties with which we need help, and with which we are prepared to take help. If awareness of need for help is a mark of adulthood, then I think we are at last beginning to grow up.

Social work in a medical setting is part of an inter-disciplinary activity, whether the location is hospital, the health centre, the public health department, or the general-practice surgery, and the anxieties that arise are characteristic of inter-disciplinary activity. I think it would be as well to identify the stock situations in such an environment, where anxiety may result. The first one, I think, is uncertainty of expectation. What do they want of me? What can I expect of them? Some of the young workers in Marjorie Moon's survey had gone full of joy to a new job, only then to sit and wait for somebody to want them. This uncertainty of expectation, I think, stems from a second factor, that is from lack of knowledge on all sides. Knowledge of the nature of the job being done by the others, of the special attributes and skills needed to do them, and the special strains which

these jobs impose, and of how they all fit together, and therefore what is left to do. It is as much our fault as anybody else's if we let this remain a source of anxiety. Third, I think a feeling of incapacity for doing the job, once identified, is unsettling. This feeling may be caused by lack of knowledge, of some part of procedure, lack of experience, either local or general. It may be lack of tools for the job—it may be lack of time. Any one, or a combination of all of them, can produce a state of tension. If lack of tools, or lack of time, it probably means that somebody at policy-making level does not appreciate your special attributes, skills and strains. Fourth, is the feeling that your integrity is being called in question, or that somebody else is not playing quite straight. Fifth, divided loyalty. I am thinking particularly of having to make decisions when facilities for hospital aftercare are insufficient, and sixth, lack of appreciation, which over a long period, can lead to a don't care attitude.

First of all, I want to apply these to medical social work as experienced in hospital, since that is the setting about which I know most, and then touch more briefly on the other locations.

Most social workers find hospital a much harsher place than they ever expected, and it takes years to develop a balance in thinking between objectivity, business efficiency and humane consideration, and to learn that one's patient of the moment is only one of 421,000 new admissions and therefore a small speck in the mass of suffering, and yet has the right to have the service tailored to fit when need arises. Even the things that happen in hospital every day can be quite painful to bear for an onlooker whose interest is aroused by the personal aspect and not the technicalities of disease. When I first began attending medical case-conferences, I used to hope that nobody had died since last week, as I was sickened by the discussion of the pathologist's report on somebody whom I had known only as the mother of seven children, or the old chap who kept the sweet shop on the corner. Fortunately, one member of the firm sensed my discomfiture and from then on in making referrals took the trouble to explain the scientific side of the problem as well as indicating where I might come into the process of solving it. Natural curiosity and a good memory continued the process of education, so that in time I could switch to amateur scientist from humanitarian and back again when need be.

The problem of the patient in pain, or in gross discomfort, is less easy to deal with, since all one has to offer seems irrelevant in the circumstances. Obviously one would not choose to discuss personal difficulties with a patient who was already preoccupied with physical discomfort, but I think that it is not sufficient just to "leave them alone till they're better", but that the assurance that you do care and

will come when they are ready for you may even help a bit to ease the stress of pain.

I still have to screw myself up tight to go and talk to a patient whom I know to be dying, and I think that the common policy of "the patient must not know" makes it even harder. I have found that the only way I can cope is to let the patient make the running in the conversation. If he gets round to the direct question "Am I dying?", then the old technique of turning the question round to "Does that mean that you think you are? Do you want to talk about it?" can usually keep us both on an even keel. Sometimes I think I can help but more often than not I wish I was somewhere else.

How to ensure that she is used to the best advantage is a problem that every medical social worker has to meet every time she changes jobs or every time there is a major re-shuffle of staff in the firms with which she works. It is common policy now for the medical social worker to wait either for patients to be referred to her or to seek her advice and help directly. Routine interviewing except for research purposes is out. Wondering whether one is getting enough referrals early enough or whether they are 'good' enough, that is, whether they show an appreciation of the extent of the worker's skill, can be a cause of anxiety, because one wants so much to be able to share in the process of curing, relieving and comforting that it hurts to be left out. In a big department personal prestige suffers if referrals diminish in quantity or quality, and in a small hospital to be underoccupied also means loneliness, and it is easy for the social worker to conclude wrongly that a particular batch of medical staff don't care. If we stop to think we realize that the factors conditioning referrals are extremely varied and complex, ranging from the amount of demand for medical service, that is whether or not the doctor has time to stop and think, to his conception of his own role and how far it extends, which is largely conditioned by his education and his experience of life outside the world of hospital sciences. I remember hearing a broadcast by my chairman in which he recalled that when he first tried to interest doctors in psychological factors in illness they said this is nothing to do with us. Later in his career when trying to discuss the possibilities of counselling as an adjunct to medicine they said this is nothing to do with you.

I have seen almost the same happen in medical social work. Twenty years ago a common reaction to a problem of relationships was, this is a social problem, solve it. Now this is a very deep situation I think we'd better refer to the psychiatrist!

Social workers could make things a lot easier for themselves and their medical colleagues if they would go out to meet the doctors and say "Where do you see me fitting in?" By this means the social

worker can be reckoned among the team's positive resources and not just the last resource. After all, appreciation of human problems and of social implications of illness does not play a great part in the training of the people with whom we have to work. Most jobs look easy till you try them, and as most of our colleagues have never tried ours, it's not surprising that they do not have much appreciation of what goes into our work, or the possibilities of it, but we also are pretty clueless of what goes into theirs. We grumble about young housemen who adopt a 'couldn't-care-less' attitude to the problems of chronic sickness and dying, or about ward sisters who try to jolly along a psychoneurotic patient, but we don't stop to think that the act of withdrawal which goes with the realization that a patient is incurable and will probably die, or the attempt to strike a balance between the needs of a ward full of individual patients may be quite traumatic even though it happens every day. We tend to see our role as part of diagnosis, therapy and aftercare for the patient. As I have grown older in hospital service, I think that sometimes the more appropriate role is diagnosis, therapy and aftercare of the problems of our colleagues, so as to enable them to give the best of themselves.

Incapacity for doing the job

The more you know, the more you know you don't know. Our demands these days on ourselves are greater. Clients' demands are greater, as a result of increased knowledge and increased possibilities of helping. The same is true for all our colleagues. Very few feel able to take life easily, and it doesn't take much to cause an accumulation of tension, and the inevitable explosion. Everybody's expertise is growing, so that the gaps between our various sections of knowledge are also growing and we often find ourselves in the position of thinking that somebody else ought to be dealing with a certain problem, or recognizing that it is now our province when in fact they can do neither. For all the helping professions the gap between the practitioner and the client is much narrower than it has ever been before. Our reasoning and our decisions are liable to be questioned and it is quite common these days to feel that we have nothing to give, whereas when the gap which separated us from our client, intellectually and socially, was a large one, this kind of feeling did not arise. Professor Richard Titmuss, who seems to have the capacity for saying more rude things to the medical profession and getting away with it than anyone else I have ever come across, went to town on this theme in his address to the British Medical Association some two years ago. He spoke at length about the appearance of the non-traditional patients, who were now forming a very critical section of the doctor's clientele. I was very aware, when I read that article, that many of the hazards which Professor

Titmuss saw for the medical profession also applied to us.

Incapacity for doing the job may also involve lack of sheer practical know how, especially at the beginning of one's career, or in a new area, or when there are substantial changes in legislation. More important is the fact that the social worker based in hospital cannot do it all, but is dependent on people and services over whom she has no control. Very often one feels like a very thin piece of meat in a toasted sandwich—under extreme pressure from both sides. It is very difficult until one knows the others involved on a sure personal basis to find a way of putting a case convincingly without either assuming authority that one does not have, or being guilty of breach of confidence, and then again if the services that a patient needs do not materialize the tendency is to feel inefficient and to assume that one's colleagues will also draw this conclusion.

At present there are still only a minority of social workers in the public services who have our background and training, so that in negotiating we are not really able to deal with our opposite numbers. Learning to temper one's request for a service according to the likely recipient of the letter is a technique that comes only with practice and after a few resentful answers from principal officers. It may be no fault of the medical social worker that Mrs X has to occupy a bed in the convalescence annexe for six months waiting to go into an old people's home, but at the end of six months it feels to her like her fault, and may appear to be her fault to her colleagues.

Lack of material equipment to do the job is a minor source of anxiety but it is one we tend to overlook until it becomes a major complication in some other issue. This is closely allied with a more obvious anxiety, lack of time to give adequate service. I think in the past we have been too secretive about our methods of work, and have been so concerned to create a good impression that we have not been frank about the amount of effort particularly that went into the solution of a comparatively simple problem. I consider that if one knows that a certain public service will only operate as the results of written requests then these must be turned out with maximum speed and efficiency, and pleasant as it is to have one's own shorthand typist, dictating letters 'live' is less efficient than using a dictating machine and far more expensive, since two people's time are involved. I think the choice lies not between doing letters today or tomorrow but between whether one recruits the non-professional members of one's department at a level that will enable them to take delegated responsibility or whether one goes for cheap labour supplemented by mechanical aids. This is quite a difficult case to put across to our administrators or committee who are only too well aware that the consultants have to make do with basic grade typists from the pool, but to train a social worker for five or six years, pay

her the best part of £1,000 per annum and then prevent her from working at top efficiency seems to me false economy.

The interviews with the patient are only the beginning of the process, and the social worker should be free to use these interviews as the basis for thinking, planning and acting. The speed of the modern hospital reacts on us and we are having to be more skilful in planning our time, and more skilful in making up our minds what is wrong and what is to do about it, if we are to avoid the anxiety of being under constant exhortation to 'unblock' beds, or facing the constant challenge—what can you do about it. Sometimes to this is added the anxiety of a little judicious defiance if one knows that the service which the patient needs cannot be made immediately available, or one feels that the recommendation made is inappropriate. Usually the argument runs that it costs £6 a day to keep a patient in this ward, but I find that the counter argument—are you going to throw away last week and the week before, for the sake of only a couple of days, is reasonably effective. In dealing with highly complex personal situations which often present as no more than an underlying hunch when the medical need is acute, one has to develop the ability to relate, diagnose and plan almost all at the same time. The anxiety engendered by wondering if one has all the essential material for even a preliminary assessment is quite considerable.

Questioning one's integrity is fortunately not a common source of anxiety but it does happen sometimes. When it happens it is usually indicative of dis-ease in the other party to the situation. One comes across the patient who lumps the social worker with the great mass of unfriendly 'them' against whom he perpetually battles and who says he supposes if he were able to make it all right for one, things would be different. I found it very hard to bear when I first came to Wales that patients would not take my 'no' for an answer but went to the trouble of checking up with my superiors, even the hospital administrator to make sure of the truth.

A more likely dilemma is whether it is justifiable on any grounds to be party to a wangle. Does one ' lobby ' to get a service in short supply or does one suppress the knowledge of the history of epilepsy or mental instability so as to obtain a convalescence vacancy and clear a bed in a ward? How far does one check up on a situation presented by a patient when one suspects that much of the story is fabricated, and yet the service which the fabrication will achieve is something essential to his re-establishment? I think particularly of an ex-serviceman with a chronic illness who wanted to apply for a place in a sheltered work settlement—his only chance of work and accommodation suitable for his family all in one place. I knew because I had been at the assizes to give evidence for the prosecution that he had a criminal record which would probably debar him from

going to the settlement. He did not disclose his history to me, and as the question of prison record did not appear on the application form, I did not ask. We just agreed that it would be better that he did not give my name as a referee.

Divided loyalty is one of the penalties of working in a complex institution, which is itself part of an even more complex system. Does one out of loyalty to the hospital press for priority of service for hospital patients—patients and medical staff often assume that one should—or does one try to see hospital patients as part of society? Mrs Buggins frequently admitted with asthma may have her mother who lives upstairs as part of her problem, but should one press for rehousing her on social grounds, thereby hoping to reduce her need for medical care, when one knows that there are families living in utter squalor in the redevelopment areas, but who do not happen at the moment to be hospital patients? One hopes that greater integration of services will make it easier to get to grips with such problems.

If one looks at what is happening in community health and general practice, there is a slightly different slant to the problem.

Since both are by comparison with hospital new settings for highly skilled and specialist social work the problem of uncertain expectation is large since one has to deal not only with uninformed colleagues but an uninformed clientele into the bargain. One therefore works against a double anxiety of knowing that for every problem that comes to notice there are probably two more, equally pressing, which are still hidden. This creates the dilemma—Is it better to deploy staff to assess the extent of need for the service one represents or to give a good service to the few clients who can establish eligibility? Against such a background it is even more difficult to get the tools for the job unless one is prepared to do a lot of quiet propagandizing and if financial resources are limited one has a conscience about that at least to start with! A further problem in any service which derives its authority from a politically elected body is how to cope with the lay members of committee who have the responsibility of deciding on policy.

In general practice, the first thing a social worker has to learn is how important the doctor-patient relationship is to both doctor and patient, and that to extend it into a triangular relationship involving a social worker needs skill and an exquisite sense of timing. I am looking forward with great eagerness to the report* that will come from the Bear Street survey at Barnstaple. Dr Sholto Forman, who is one of seven general practitioners in a group surgery in Barnstaple,

**Sound casework in general practice.* Oxford. Forman and Fairbairn. 1968. 12s. 6d.

had a Nuffield Trust grant which enabled him to employ a social worker and in a sense followed on my own research project. He has been able to take some time looking particularly at the question of interpersonal relationships, and the part that this plays in successful treatment of a patient.

What are we going to do about it, having admitted that anxieties can exist? I have a feeling that if we are anxious, it is quite likely to be our own fault, and that dealing with these anxieties really boils down to a higher standard of interdisciplinary communication.

Admitted, the greatest job satisfaction in any of the helping professions comes from giving help directly to somebody who needs it, and seeing later that it was the right help given at the right time. But there are very few situations left in our professional lives where our help alone is all that is needed, and the minute we acknowledge the need for other skills we also acknowledge the responsibility for enabling these skills to be effective, and they can't be effective unless we understand them, if only a little. I think therefore that all of us need to consider whether we shouldn't be spending a little more time and energy helping the other members of the team in which we find ourselves, helping with teaching and joint enterprises particularly, but also trying to understand the point of view and the anxieties of the man on the job. Colleagues are rarely as spontaneous in their acclaim and gratitude as are one's patients, and it is often a temptation to indulge in little attention-seeking gimmicks and demonstrations of expertise just to keep up one's morale. I remember once losing my temper with a senior member of the medical staff and saying "sometimes I wonder if you know I'm here". There was silence, and then a smile and "but I would know if you were not" and that in 15 years of collaboration was the nearest I got to a word of praise from him. I think that social workers have more than an ordinary amount of responsibility to see that any team in which they are involved works smoothly—because after all understanding human situations is their stock in trade and they ought to be able to make the best even of a bad job.