The scope for co-operation between the medical social worker and the general practitioner*

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THERE is unlimited scope for a working partnership between the medical social worker and the general practitioner, but we have not come anywhere near a full understanding of how we can work with each other. We have so many common aims—we are trying to help people to live as full and as active a life as their health or ill health allows. We each have an expertise to offer in giving this kind of help.

What then is the problem? I work as a psychiatric social worker in the hospital and part-time in the local authority of Tower Hamlets Mental Health Department. This enables me to compare my rôle with family doctors from each of my fields of work. It is as though I were two different people—one a hospital worker, the other a community worker.

The title Medical Social Worker seems to cause some puzzlement when it comes to knowing what a medical social worker does. The label 'psychiatric social worker' conveys exactly what the worker does, and similarly the label 'mental health' carries with it a clarity of function. Uncertainty of our job seems to be one problem. The real problem in understanding and communication is the fact that the medical social worker suffers from being inside the hospital walls and that she is greatly affected by this whenever she tries to extend her work beyond these walls, particularly into the sphere of general practice.

Inside the hospital the medical social worker has spent a long time achieving recognition of her social-work skills, not just her ability to organize such community services for the elderly or disabled patient as money for the rootless or shelter for the homeless. Her skills in assessing a patient's problems and the part these play on exacerbating an illness and her experience in indicating what can be achieved in modifying a patient's attitudes or those of the family are now more widely recognized and accepted within the hospital. She is still dependent on the understanding of the medical and nursing staff for referrals, and for the encouragement and freedom to exercise these skills.

Understanding of this kind is built up by getting to know each other's ways of working and by mutal trust and professional respect. Each medical social worker is assigned to a group of consultants, or a special unit, for example, the dialysis unit, the paediatric and maternity units, and the members of the team come to know each other well as people, and thus respect develops.

There could be many points of contact between the medical social worker and the general practitioner. Most of our patients come up to the clinics or are admitted to the wards as a result of a letter or a telephone call from the family doctor. Most letters contain only the medical facts, though some may indicate social or emotional factors in the

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illness. Communication is between doctor and doctor, and there is seldom any contact between the general practitioner and the social worker at this stage.

If the patient is referred to the medical social worker by the hospital medical staff on admission or at the clinic, then she will read the medical notes; and the notes of the medical student which are invariably clear and contain relevant social history. The medical social worker will then have one or many interviews with the patient and where appropriate will talk with relatives and community social workers. She will then make her assessment of the problem and discuss this with the medical staff. How many times does she contact the general practitioner at this stage? I think it is seldom. But why not?

Doctor-to-doctor contact is the traditional system—so we tell ourselves that the family doctor will not come to talk with the social worker. Neither will he want to add anything to his original referral letter. We always feel that family doctors are busy and under enormous pressure. Every telephone call made when he is in the surgery means patients kept waiting. During out-of-surgery hours he is visiting. Is this fact? Or is it our way of making excuses for not telephoning?

The medical social worker has had some problems in her contacts with general practitioners. In some hospitals her skill is judged on her bed-emptying powers. She is often unhappy about early and rapid discharges. The family doctor may be even more unhappy, any attempt at discussion with him may end in critical and angry words which, though spoken to the medical social worker, properly belong to the ward doctors. Sometimes the medical social worker is asked to make plans for a patient with which the family doctor disagrees—for instance arrangements for terminal care and the medical social worker finds to her discomfort that she is having to ask the family doctor to order the transport.

Some of us have put our views about a patient to the family doctor in such a way that he feels the medical social worker has taken over his patient, or that she is implying that she has been more alert or more perceptive of the problems than he has.

To a doctor who has barely enough time to get round to all his patients and can only concentrate on the purely medical aspects of each case the medical social worker may be seen as someone who complicates his life and puts more problems on his shoulders. Thus rivalry and acrimony do seem to arise around that delicate phrase 'my patient'. Thus another valuable point of contact—the point at which the patient is discharged—is avoided.

This kind of problem is surely the result of two disciplines whose rôles have changed so considerably and rapidly, that they now have to be re-discovered in relation to each other. Both have had their problems in relation to the hospital service, and many frustrations are expressed in terms of criticism of hospital medical, nursing and social work staff. Medical social workers have had their frustrations in their dependence on the good relationships with hospital medical staff and, while knowing that their contribution to patient care would be more complete and their discharge plans more realistic if the family doctor were included, they cannot summon up the courage, the security of their professional knowledge—the energy to do this—and they continue to avoid the most valuable contact of all.

The future

The Seebohm Report and the first Green Paper accelerated our thinking about community care. Neither however placed the medical or psychiatric social worker inside or outside the hospital. The Seebohm Report gathering together as it does the social workers in each local authority into one single department makes sound sense, and gives a simplicity of referral and of application for help, and places responsibility

and accountability squarely on the one director of social services.

My own view is that the most important factor on which we, the hospital social workers, have to base our future is continuity of service for the patient. In this part of London, as far as the health services are concerned, I am quite convinced that the hospital workers should come out into the community. This will need to be achieved slowly and thoughtfully but if we were all under one roof we could be re-aligned more usefully. One of these re-alignments could and should be round general practices.

Many of the problems that arise around hospital admission could be better handled beforehand. For example, the care of children while mother is in hospital. Helping an elderly patient to face hospital admission and prepare for it. We could give a longer period of re-assurance and support to the patient who is afraid of hospitals because he or she does not understand what will be required of them. Indeed, since so much illness and hospital admission is due to social and emotional disturbance, the medical social worker whose knowledge of family relationships and the ways in which illness and troubles can affect people, could help to reduce those admissions that occur in social emergencies.

The social worker, whether she is a child care officer, medical social worker or psychiatric social worker, by giving a really live picture of the patient and his or her home background will be of far more help to hospital medical staff in assessing the patient's need for care, and in making realistic plans. The medical social worker, too, has many sources of knowledge and help in coping with practical problems.

Summary

We could be of far more help than we are now if we could banish some of our fantasies about each other by talking together face to face. I see our greatest contribution being made by our coming out of our hospital departments and being much more available in a comprehensive service which takes general practice as a focal point.

Value of routine multiple blood tests in patients attending the general practitioner. M. H. B. CARMALT, M.A., M.B., M.R.C.P., P. FREEMAN, M.B., Ch.B., D.Obst.R.C.O.G., A. J. H. STEPHENS, M.B., D.Obst.R.C.O.G., D.C.H. and T. P. WHITEHEAD, Ph.D., M.C.B., F.R.I.C. *British Medical Journal.* 1970. **1**, 620.

Two-hundred-and-ninety-six patients attending a general practitioner's surgery had blood taken for multiple biochemical and haematological tests which would not normally have been requested. In 16.9 per cent of patients a new diagnosis of clinical significance was made as a result of the tests.

Multiple blood tests of this type do not reduce the general practitioner's work-load but tend to increase it. In this series abnormal results were found in 21.6 per cent of patients which were still clinically unexplained after six months. In future, such tests may be used as screening procedures before referral to hospital outpatient departments but the ideal range and choice of tests is far from being known. Patients most suitable for multiple tests are those with obscure symptoms of uncertain aetiology, geriatric patients and possibly those on certain therapy—the 'pill' for instance.