Medical-social teamwork in the clinic

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MEDICAL-SOCIAL teamwork in a general practice is a relatively new development in this country. The first attempt was made in 1963 in the Kibutz–Galuyot Sick Fund Clinic in Haifa (figure 1). A detailed study of this work was published in 1966 (Kupat–Holim Centre). The Netka clinic in Tel-Aviv was the second one in which medical-social teamwork was started in 1964 by introducing a part-time medical-social worker (MSW) into the staff of the clinic. Her helpful activity was soon appreciated by the doctors, as well as by the patients who received her assistance, sometimes more important than the medical attention. Four years later the working atmosphere in the clinic had undergone an impressive change: no arguments in the reception office, no jostling pressure at the doctors' and nurses' doors, evident improvement in the patient-doctor relationship and also a new social approach to the patient from all the workers in the clinic.

Figure 1

The problem of how to evaluate the medical-social teamwork is difficult. The contribution of the MSW's activity in a group practice was widely studied by Forman and Fairbairn (1968), her help being mainly therapeutic (59.4 per cent of the referred cases) and providing a link with social services (62.3 per cent), but also diagnostic (10.3 per cent) and prophylactic (34.2 per cent). However, they did not study the influence, if any, of this three-year experiment on the general pattern of the practice, serving 14,400 patients. Goldberg and her co-workers (1968), analysing the problems of 492 patients referred to the MSW in the group practice of the Caversham Centre in London, conclude that general practice is a good 'pick-up' point for identification of psychosocial problems among all social groups, the MSW being a link and co-ordinator with different

social agencies and a case worker within the practice. Also in this interim report no attempt was made to evaluate the effect of the MSW's activities as reflected in the general pattern of the practice.

The working hypothesis of the present survey is that the team—family physician, MSW and nurse—dealing with the social and the emotional problems of the patient, reduces the family stress and discomfort and, as a consequence, the frequency of doctor-patient contacts decreases not only within the family treated, but also within the total population which is influenced by this approach. The expected implication in the practice, after four years of teamwork, is a fall in the number of visits to the clinic with a parallel decrease in prescriptions, injections, consultations with specialists and probably also hospital admissions. These aspects may be tested and compared with those of another similar practice in which there is no teamwork.

The objective of the present survey was to compare three aspects of the medical work of the Netka clinic with that of the neighbouring Kfar Shalem clinic: visits to the clinic, prescriptions and injections. The comparison of other aspects, such as x-ray films and laboratory tests performed in the central clinic, consultations with specialists and hospital admissions was not carried out because of technical difficulties in collecting the data.

Method

The data were collected from different sources; visits to the clinic—from the reception office records and the doctor's daily contact book. Prescriptions—from the pharmacies of the two clinics in a ten-day sample of items. The figures relating to injections were kindly sent to us from the Department of Research and Statistics of the Sick Fund Centre. The one-year sample of the MSW's activities was also analysed statistically by the same department.

Visits to the clinic

A three-month sample—October, November and December—of the visits to the Netka Clinic in 1964 was compared with those in 1967. The comparison between the two clinics was made only for 1967 because of lack of records in 1964 in the Kfar Shalem clinic. All the figures relate to the surgery contacts with the family physician. The contacts with the paediatrician and the specialists were not collected. The contacts reported from the Neve-Zahal population were collected from the doctor's daily contact book for a period of four years: 1965–1968.

Prescriptions

According to the statistical methods in the Sick Fund, one prescription is each individual item appearing on the prescription form without reference to the quantity of the preparation. For example: 20 tablets of aspirin are regarded as one prescription, as are 200 ml of expectorant mixture or 10 g of petroleum jelly. Prescriptions of injections were not included since they are reported separately. Only the prescriptions of the family physicians were collected and divided into 11 groups.

Injections

A survey was carried out in 1966 by the Sick Fund Centre in different Tel-Aviv clinics with the purpose of obtaining information about types and rates of injections. Every injection administered was regarded as one unit. The figures relate, as above, to the injections prescribed only by family physicians from the two clinics.

The neighbourhood, the population, and the clinics

In the area of the two clinics there are three separate residential quarters in the southern suburbs of Tel-Aviv with a total of 11,110 registered patients, most of them (86 per cent) of a low socio-economic level.

Neve-Zahal. A relatively new residential quarter with about 1,500 people. There are 24 three-storey buildings, each made up of 18 three-roomed apartments. The

density per room is approximately 1.2. The sanitary conditions are good. The population is of middle socio-economic level. The men are mainly salaried workers such as clerks, policemen, permanent army or industrial workers. There are no social welfare cases.

Hatikva quarter. This is an old residential area, extremely congested, with narrow streets, one- or two-storey buildings and poor sanitary conditions. The population is of low socio-economic level: multi-problem families, large number of children, unemployment, poverty and delinquency. The population density is high, in some cases up to 10 persons per room (exact data were not obtained). More than half the cases referred to the MSW were from this area.

Kfar Shalem. Once an Arab village, this is at present an extremely dilapidated area awaiting demolition. The socio-economic problems are the same as in the Hatikva quarter: high population-density, multi-problem families, low income level. A part of this quarter is called 'Shanty Town'. About 85 families live here in miserable shacks resembling old packing crates. There are no streets or numbers to the homes, no sanitary services from the municipality and the inhabitants do not pay municipal taxes.

About one-third of Kfar Shalem is served by the Netka clinic, and the remainder by the Kfar Shalem Sick Fund clinic.

The Netka clinic, established in 1963 next to Neve–Zahal, is a modern building of two storeys, erected by the Sick Fund to serve in the future 20,000 people. The medical staff is composed of four family physicians, a paediatrician and two specialists (gynaecologist and dermatologist). At the end of 1967 the total of registered patients from six years of age upwards was 5,720, or an average of 1,430 per family physician. The children up to the age of six are treated by the paediatrician (1,011 children).

The Kfar Shalem clinic, about one kilometre from the Netka clinic, has a smaller staff: two full-time and one half-time family physician and a paediatrician treating the 710 children up to the age of six. At the end of 1967 there were 3,672 registered patients or an average of 1,468 per full-time family physician. A part-time MSW began her activity in 1966, but not on a teamwork basis as in the Netka clinic.

The method of teamwork in the Netka clinic

The team is composed of the family physician, medical social worker (MSW) and head nurse, the general practitioner being the head of the team (figure 2). The referral of new patients to the MSW is generally made by the family physician. The head nurse knows all the patients referred by all the doctors. Patients are free to contact the nurse who serves as an active link between doctor and the medical social worker. Information about the patient and his family is exchanged verbally among members of the team. The patient is invited by the MSW for a first talk in which social data are recorded on a special card. In the following meeting of the team combined medico-social care is planned after discussion of the possibilities of improving the patient's situation.

The complicated and difficult cases are discussed by the extended team, in which all the general practitioners, the paediatrician, the MSW and head nurse participate. According to the need of the case other people are invited to assist, such as industrial doctor, psychiatrist, social workers of the municipal welfare department. The meeting of the extended team, generally fortnightly, is a useful form of mutual exchange of views and also serves as in-service training in this relatively new field of activity.

The nature of the MSW's activities

The MSW in the Netka clinic is a member of the staff and a worker of the Sick Fund. She has a reception room in the clinic and contacts the patients generally by appointment. The activities of the MSW may be divided into two categories:

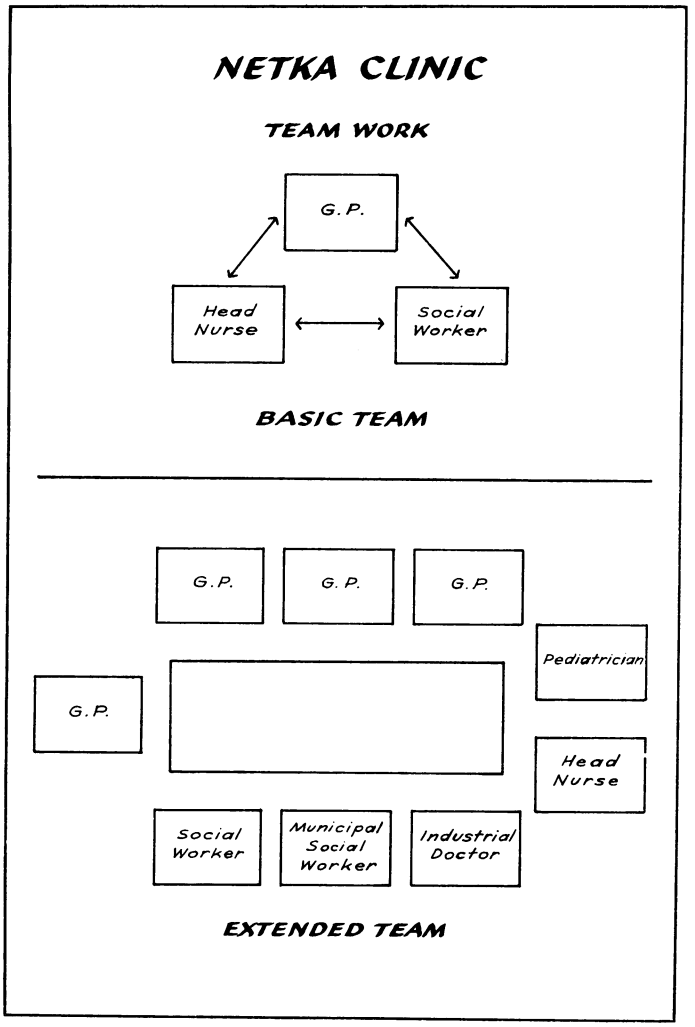

Figure 2

1. *Liaison officer.* The MSW forms a link between the clinic and the various institutions and agencies with the purpose of effective mobilization and co-ordination of their services. The link is realized by correspondence, telephone and personal visits.

2. *Case work.* Explanation, advice and guidance are given to the patient, taking into account the family's complex problems. In this way the patient learns to correct his relationship with the situation created with the objective possibilities of social improvement and also learns to change his aspirations or demands.

During 1965, 365 cases were under the care of the MSW (table I). More than two-thirds of them (270 cases) have had long-term care, which continued also in 1966. About three-quarters of the MSW's activities in the clinic (72.5 per cent) are the contacts with patients and their family members.

Table II lists the type of help given to 95 patients who had treatment closed in 1965. About 25 per cent of the cases were treated by explanation, advice and guidance, i.e. by case work only, and despite the low socio-economic level of the population only 11 cases received financial help (11.5 per cent).

TABLE I

THE MSW'S ACTIVITIES DURING 1965

Cases under care, total		365
Cases with treatment closed		95
A. Visits to various agencies		132
B. Activities in the clinic	*Absol no.*	*Per cent*
1. Contacts with patients (under care)	483	*63·0*
2. Contacts with other family members	73	*9·5*
3. Arrangements with Sick Fund departments	180	*23·5*
4. Arrangements with outside agencies	31	*4·0*
Total contacts and arrangements	767	*100·0*

TABLE II

TYPE OF HELP GIVEN TO 95 PATIENTS WITH TREATMENT CLOSED IN 1965

1.	Arranged children in institutions	15
2.	Arranged rest home	10
3.	Arranged work, etc.	8
4.	Explanation, advice, guidance	25
5.	Financial assistance	11
6.	Medical assistance	8
7.	Sent to various agencies	12
8.	Use of medical services, etc.	6
	Total	95

The nature of the MSW's activities is only illustrated in the two tables reported. 'Treatment closed' is a practical and simplified definition of short-term care or of an episode in the continuous assessment of the family, which cannot be 'closed'. This illustration is reported as an aspect of the teamwork, the basic purpose being to evaluate the influence of this work on the total pattern of general practice in the clinic.

Findings and discussion

1. *Visits to the clinic* (figure 3)

Four years after beginning the teamwork, the number of visits at the Netka clinic dropped by 25 per cent from 6.4 visits per person-year to 4.7. Although a fall in visits had been expected, the extent of this decrease was indeed surprising. The comparison between the two clinics—Netka and Kfar Shalem—in 1967 (figure 4) shows a similar difference in the frequency of visits, the annual rate per person in Kfar Shalem (6.1) being near to that of Netka clinic in 1964 (6.4).

The home visits made by the family physicians in both the clinics were calculated for 1967, but no practical difference was found: Netka—17.6 visits per 1,000 persons monthly and Kfar Shalem—18.8 visits.

The doctor-patient contacts in Kfar Shalem clinic were also expected to be higher. The comparison shows 30.3 per cent more contacts monthly per doctor at the Kfar Shalem clinic (figure 3). The average number of patients per doctor in Kfar Shalem is slightly higher (2.6 per cent), but this difference is not significant and may be ignored. The individual differences between one doctor and another are not only numerical and they will not be discussed. It is important only to point out that the doctor at the

Kfar Shalem clinic has less contact with the patient timewise and, therefore, less opportunity to enter into and deal with his psychosocial problems than the doctor at the Netka clinic.

The fall in visits in the Netka clinic raises the following question: Can it be that the Neve–Zahal population (middle socio-economic level) is responsible for this fall and not the 'problematic' population of the other areas?

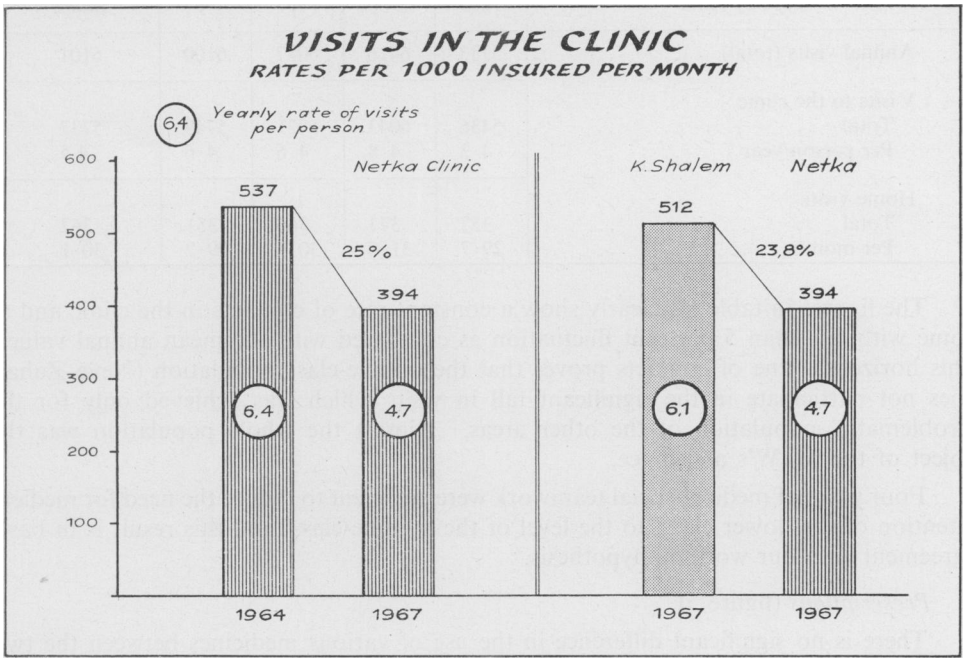

Figure 3

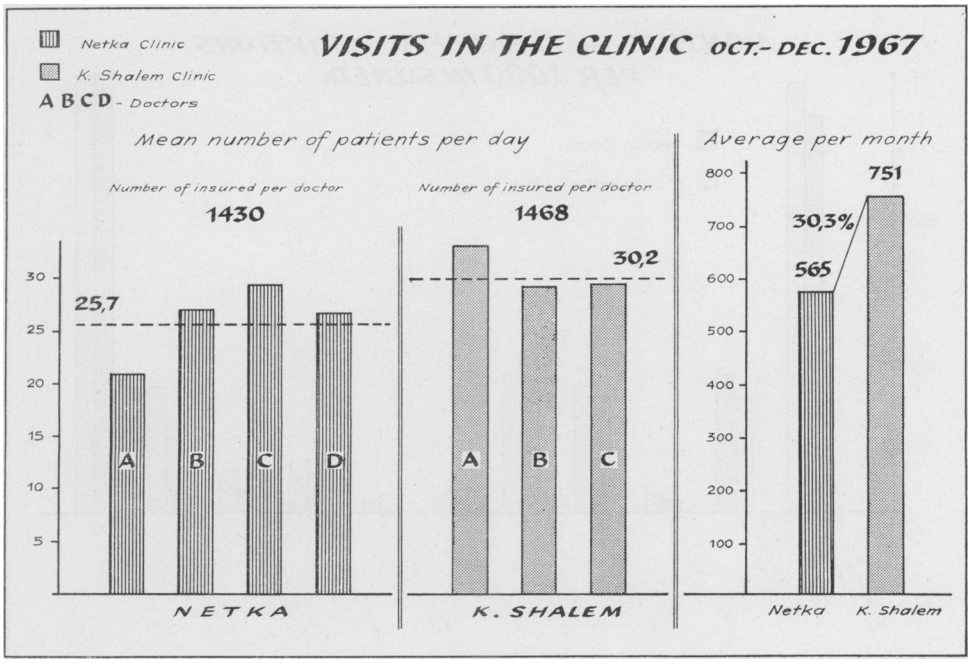

Figure 4

TABLE III

CONTACTS WITH THE FAMILY PHYSICIAN

NEVE-ZAHAL HOUSING QUARTER (1,250 PEOPLE)

Type of visits	*1965*	*1966*	*1967*	*1968*	*Mean annual values*
Annual visits (total)	5793	6416	6087	6100	6101
Visits to the clinic					
Total	5436	6043	5721	5749	5737
Per person/year	4·3	4·8	4·6	4·6	4·5
Home visits					
Total	357	373	366	351	362
Per month	29·7	31·0	30·5	29·2	30·1

The figures in table III clearly show a constant rate of contacts in the clinic and at home with less than 5 per cent fluctuation as compared with the mean annual values. This horizontal line of contacts proves that the middle-class population (Neve–Zahal) does not participate in the significant fall in visits which was achieved only for the 'problematic' population of the other areas. Almost the whole population was the object of the MSW's assistance.

Four years of medical-social teamwork were sufficient to reduce the need for medical attention of the 'lower class' to the level of the 'middle-class' and this result is in basic agreement with our working hypothesis.

2. *Prescriptions* (figure 5)

There is no significant difference in the use of various medicines between the two clinics, the total pattern of the figure being similar for both. At the Netka clinic the

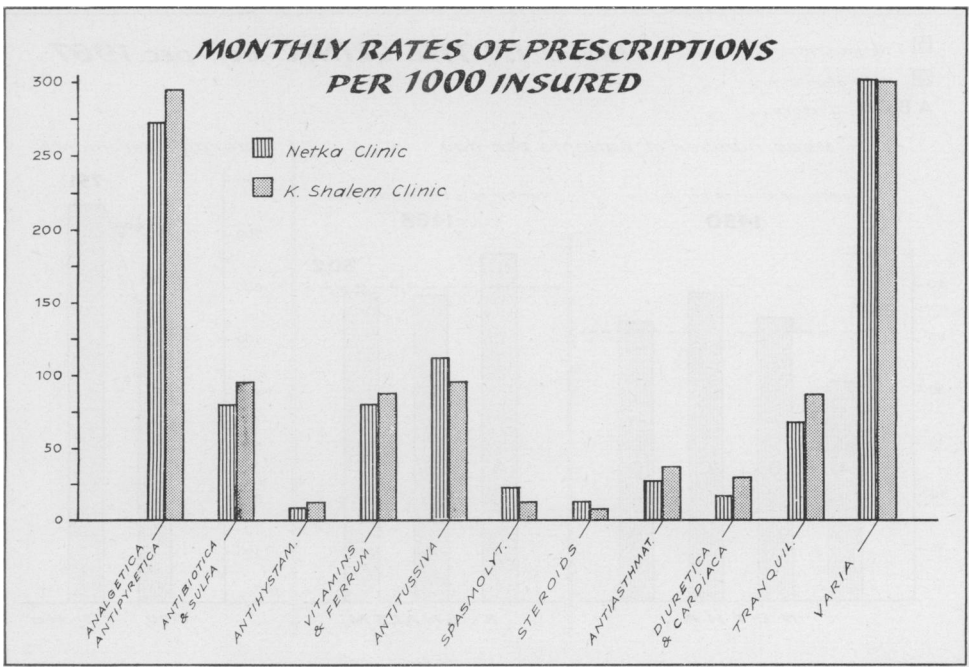

Figure 5

monthly average of prescriptions is 1,067 per 1,000 patients and at Kfar Shalem—1,259 or 18 per cent more. The smaller use of medicines at Netka is a consequence of the lower rate of visits. However, these two parameters are not proportionate because injections are not included in this calculation.

Generally, the use of medicines is high and the problem is not only national but probably world-wide. The different aspects of this overuse will not be discussed.

3. *Injections* (figures 6 and 7)

A survey of five clinics of the Sick Fund in south Tel-Aviv (1966) demonstrated the lowest level of injections at the Netka clinic—6.1 per 1,000 patients daily. The mean rate of all the clinics was 15.6. This is again a direct outcome of the teamwork as there is no other factor different in all these clinics and in the social composition of the population. A similar rate of injections was found in Haifa in 1965 (Department of Research and Statistics, Kupat-Holim Sick Fund Centre, 1966): 6.6 injections daily per 1,000 patients in the Kibutz-Galuyot clinic, in which there is a medical-social team at work, as against 12.5 and 11.9 injections in two other clinics without teamwork.

The patients in the Kfar Shalem clinic receive almost five times more injections than in the Netka clinic—714 as compared with 153. In absolute numbers one single doctor there prescribes more injections per month than all four doctors at the Netka clinic (figure 6).

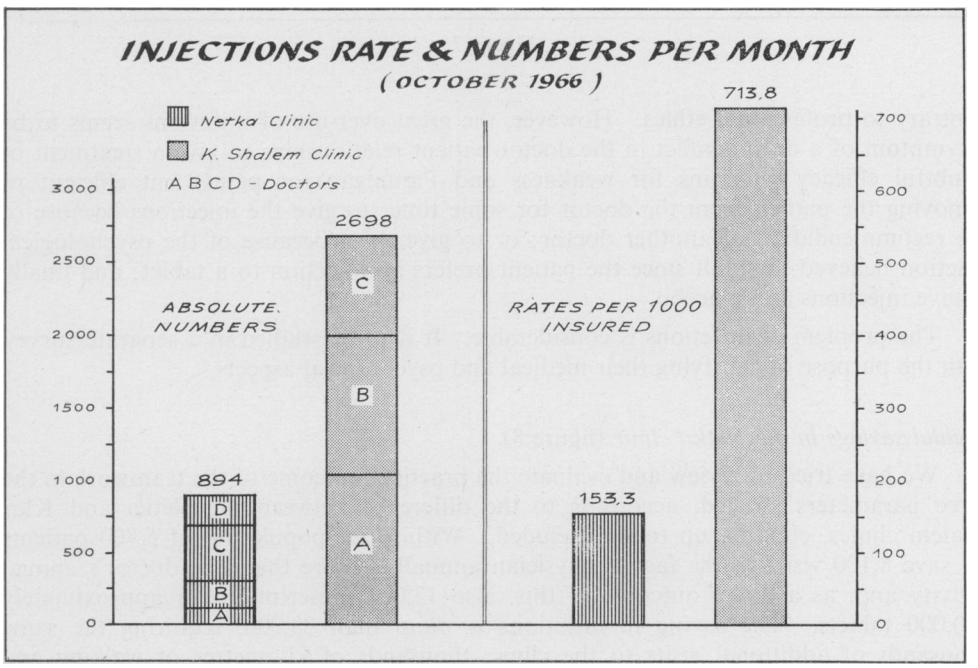

Figure 6

Two-thirds of all the injections given at the Kfar Shalem clinic (figure 7) are vitamins and Pantalgan (an analgesic preparation). The use of penicillin and streptomycin rises up to ten times more than at the Netka clinic.

A difference in the use of injections was expected, as in other prescriptions, due to the lower rate of visits at the Netka clinic, but there is no obvious and convincing explanation for this great difference. Once more, we ignore the individual problems of each doctor in order not to enter the dangerous field of medical criticism which is

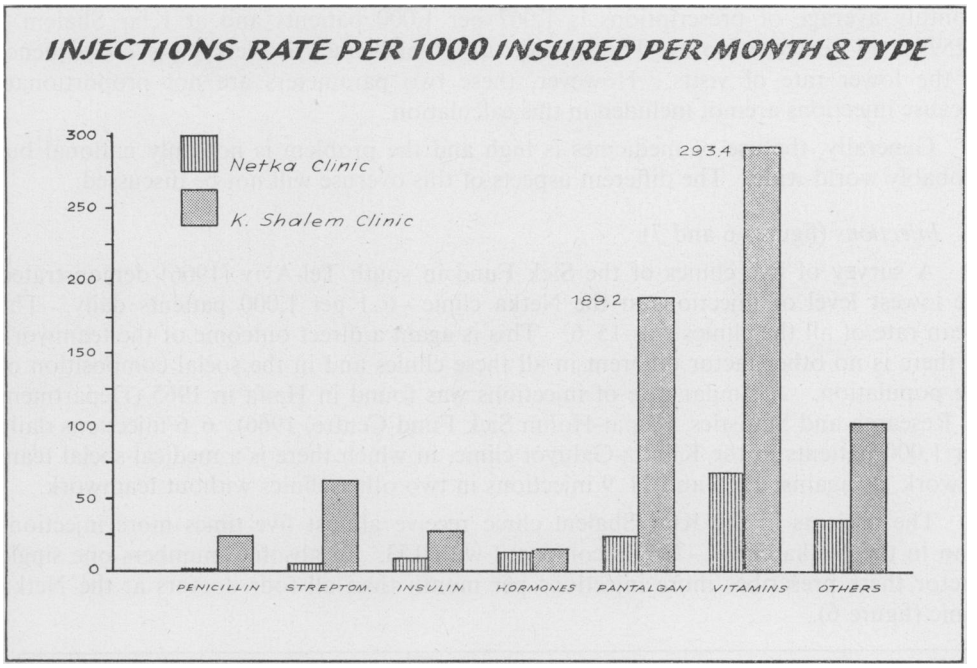

Figure 7

contrary to professional ethics. However, the great over-use of injections seems to be a symptom of a deep conflict in the doctor-patient relationship: to give a treatment of doubtful efficacy (vitamins for weakness and Pantalgan for pains) but efficient in removing the patient from the doctor for some time; to give the injections because of the recommendation of another doctor; or to give them because of the psychological reaction believed to result since the patient prefers an injection to a tablet; and finally to give injections as a placebo.

The problem of injections is considerable. It is to be studied in a separate survey with the purpose of clarifying their medical and psychosocial aspects.

Annual savings in the Netka clinic (figure 8)

We have tried to review and evaluate the practical outcome of the teamwork in the three parameters studied, according to the difference between the Netka and Kfar Shalem clinics, children up to six excluded. Within our population of 5,700 patients we save 8,100 visits to the family physician annually—more than one doctor's annual activity and, as a direct outcome of this, also 13,000 prescriptions or approximately 250,000 tablets. The saving in injections is more than 38,000, requiring the same thousands of additional visits to the clinic, thousands of kilometres of walking and thousands of waiting hours.

The medical-social teamwork in our practice has many other implications apart from the practical outcome quantitatively assessed here. Behind the patient's complaint or presenting symptom we have learnt to see more clearly the psychosocial impulses motivating him to contact his doctor. This social approach has gradually resulted in an improvement in the doctor-patient relationship with a decrease in symptomatic treatment with medicines and injections. We have learnt to co-operate with the MSW and to appreciate her positive contribution in more comprehensive care of the family. This satisfaction of the doctor cannot be expressed in figures. The same goes for the

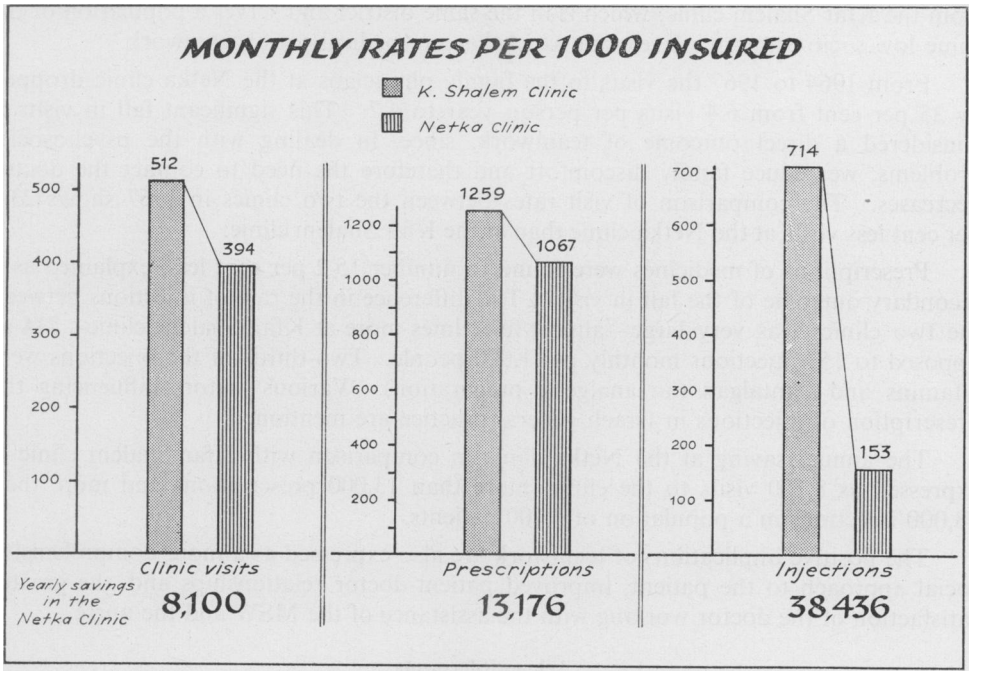

Figure 8

good feeling of the patient who can easily contact the nurse or the MSW in the clinic, as well as the doctor and who is therefore less frustrated.

So far our teamwork has not been planned in advance. It was concentrated almost entirely on the population of low socio-economic level. The middle-class family has been excluded from our attention not only because of priority given to the multi-problem families of the lower class, but also because the middle-class patient does not easily accept the intervention of the MSW in his problems, due to prejudices regarding this profession. His incorrect and simple objection is: 'I am not a social case! I am able to arrange my affairs myself!'

We are now trying gradually to approach these families too, while maintaining their self-respect, since psychosocial problems exist at all levels in our society.

Summary

The Netka clinic, in the suburbs of Tel-Aviv, serves a population of low socio-economic level. A medical-social worker (MSW) was included in the staff of the clinic and began her activities in 1964. A system of teamwork was organized, the basic team consisting of three members: family physician, MSW and head nurse.

The MSW functioned as a liaison officer with the various agencies and as a case worker in the clinic. Her activities in 365 cases referred are reviewed: 72.5 per cent of them are contacts with the patient and his family. In more than 25 per cent of the cases with treatment closed in 1965, the assessment given by the MSW was only explanation, advice and guidance.

The effect of our teamwork, after four years' experience, was studied in relation to three parameters of medical work in the clinic: visits to the clinic, prescriptions and injections. Comparable samples of the same parameters were taken and analysed

from the Kfar Shalem clinic, which is in the same district and serves a population of the same low socio-economic level, but which has no medical-social teamwork.

From 1964 to 1967 the visits to the family physicians at the Netka clinic dropped by 25 per cent from 6.4 visits per person–year to 4.7. This significant fall in visits is considered a direct outcome of teamwork, since, in dealing with the psychosocial problems, we reduce family discomfort and therefore the need to contact the doctor decreases. The comparison of visit rates between the two clinics in 1967 shows 23.8 per cent less visits at the Netka clinic than at the Kfar Shalem clinic.

Prescriptions of medicines were found to number 15.2 per cent less, explained as a secondary outcome of the fall in visits. The difference in the rate of injections between the two clinics was very large—almost five times more at Kfar Shalem clinic—714 as opposed to 153 injections monthly per 1,000 people. Two-thirds of the injections were vitamins and Pantalgan (an analgesic preparation). Various factors influencing the prescription of injections in Israeli general practice are mentioned.

The annual saving at the Netka clinic in comparison with Kfar Shalem clinic is expressed as 8,100 visits to the clinic, more than 13,000 prescriptions and more than 38,000 injections in a population of 5,700 patients.

The positive implications of teamwork are also expressed as a more comprehensive social approach to the patient, improved patient-doctor relationships and the greater satisfaction of the doctor working with the assistance of the MSW and the nurse.

Acknowledgements

I am grateful for the information received from the Department of Research and Statistics of the Kupat-Holim Sick Fund Centre and especially to the chief statistician Mr N. Strulovitz for his personal advice and help. I am indebted to Professor J. H. Medalie, Tel-Aviv University family medicine department and to Miss S. Shahor, chief social worker of the same department, for their constructive criticism and guidance; to Dr H. Doron, head of the medical department of the Sick Fund Centre; to Miss Zipora Horowitz, the first MSW in the clinic for her outstanding work; to Miss Pnina Sacks, formerly head nurse of the clinic, for her unobtrusive and devoted assistance in organizing the teamwork; and to my co-workers in the clinic, who helped me in gathering information for this study: head nurse Ora Judaikin, pharmacist M. Lemonsky and secretary M. Baitel.

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OF SNEEZING

Concerning Sternutation or Sneezing, and the custom of saluting or blessing upon that motion, it is pretended, and generally believed to derive its original from a disease, wherein Sternutation proved mortal, and such as Sneezed, died. And this may seem to be proved from Carolus Sigonius, who in his History of Italy, makes mention of a Pestilence in the time of Gregory the Great, that proved pernitious and deadly to those that Sneezed. Which notwithstanding will not sufficiently determine the grounds hereof: that custom having an elder AEra, then this Chronology affordeth.

SIR THOMAS BROWNE. *Pseudodoxia—The works of Sir Thomas Browne.* Vol. 11. 1904. London. Grant Richards. p. 144.