The social work externship

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PSYCHOLOGICAL and social factors affect patterns of illness (Weiss and English, 1957; Taylor and Chave, 1964). Morrell *et al.* (1971) report that 12 per cent of all consultations in general practice present with symptoms of ' mental, psychoneurotic and personality disorders ' and this correlates with morbidity studies (Fry, 1966). Crombie (1963) has estimated that ' the emotional component is as important or more important than,the organic in 27 per cent, and appreciable in a further 21 per cent of diagnostic situations.' Forman and Fairbairn (1968) support this, " it is impossible to practise domiciliary medicine without involvement in social and emotional problems ". The British Medical Association Planning Unit (1970) reports that " much of the ill-health dealt with by general practitioners stems from the failure of individuals to make appropriate adjustments to their life situations."

In 1965 the Royal College of General Practitioners made recommendations on vocational training for general practice, placing major emphasis on outpatient experience of psychological medicine. The membership examination requires knowledge of behaviour presenting to the general practitioner, behaviour in interpersonal relationships, behaviour in the family, and behaviour in the doctor-patient relationship, but there is little indication of how this personal discipline may be acquired (Royal College of General Practitioners, 1970).

A scheme is described in which a professional fieldwork course for social workers is adapted to the needs of a future general practitioner by adopting the role of a social work student. The method of evaluating personal skills is discussed.

The medical social worker's chief contributions in the eyes of her general-practitioner colleagues have been summarised by Forman and Fairbairn (1968):

(1) Casework skill in dealing with the more complex social and emotional situations arising in the course of their work.

(2) Knowledge of the whole range of available social services and skill in bringing them promptly and effectively into play.

(3) Influence on all members of the group practice in increasing their awareness of her subject.

I sought to achieve some familiarity with each of these.

The course

Graduates attending the course for the diploma in social work at the University of Birmingham are required to undertake fieldwork placements and undergo evaluation of the appropriate skills. The social work training unit of the South Birmingham Hospital Management Committee arranges placements for 20–30 students twice a year, and agreed for me to be incorporated in their programme.

Conflicts in role expectation were too great to allow a combination of social work with medical practice, so I accepted the role of social work student and undertook two simultaneous placements for six months. The first was that of social worker attached to general practice, and the second that of social worker to a geriatric rehabilitation ward. Close contact with supervisor and students enabled many inherent problems to be overcome, particularly those related to the role change, and attendance at university seminars provided an academic background.

Social work techniques

1. Casework skills

The basic principles of a casework relationship are individualisation, the purposeful expression of feelings by the patient, controlled emotional involvement by the worker, acceptance, a non-judgmental attitude, client self-determination and confidentiality (Biestek 1961). Gradually through examining interview techniques one can become more skilled at using appropriately direct questioning, free association and responsive questioning. The information so obtained relates to the personality, health, life history, social and environmental situations of the client. Based on this the psychosocial diagnoses, with short-term and long-term treatment plans, can be constructed.

Management of the multiple interview, and a range of group-work techniques were acquired, with awareness of my own strengths and weaknesses, and an ability to see how my own characteristics influenced matters.

2. Social services

There are several excellent guides to the national social services, statutory and voluntary (Willmott, 1971; Family Welfare Association, 1971) but local factors are so important that the subject is best studied in the area in which one hopes to practise.

Skill in implementing these resources is not readily acquired and requires substantial knowledge of administration as well as experience. Recording is an important tool, while an interview room, telephone and secretarial assistance are vital for efficiency and productivity in mobilising the social services.

3. Sharing knowledge

Individual and group casework skills combined with administrative knowledge enable the social worker to promote efficient mechanisms for sharing knowledge. In this way medical, nursing, social and secretarial information may be shared to the benefit of staff and patient alike, with clarification of roles and greater efficiency.

By accepting a wide range of personalities and behaviour patterns in colleagues one acts as a corner-stone in the cohesive process.

Social work in general practice

A two-man practice in central Birmingham has had social work students attached for three years and in spite of accommodation shortage and reduced secretarial facilities has provided the opportunities needed to enable training. In this practice I had 12 long cases and several shorter ones which presented initially to the general practitioner and were allocated to students at the weekly conference. The long cases are summarised below:

Complaint	*Social problem*
Acute agitation	Marital conflict involving police and knife fight.
Anxious depression	Marital conflict involving infidelity.
Recurrent depression	Marital conflict involving disturbed toddler.
Antenatal depression	Marital conflict.
Rheumatoid arthritis	Elderly widow, immobile, living alone.
Depression with severe heart disease	'Inadequate' personality.
Drug addiction	Mental subnormality. Hostel for destitute men.
Anxious depression	Wife of Borstal detainee.
Illegitimate pregnancy	Mother aged 18, schoolboy father aged 15.
Respiratory infection	Unmarried mother aged 14 with child in care of local authority.
Malaise	Wife of husband with personality change after head injury.
Anxiety neurosis	Rehabilitation after prolonged hospital admission for depression.

Gradually I learnt the nature and extent of social need in this setting and the limitation of resources. Short cases involved the discovery of agencies already involved, coupled with liaison and advice. Longer cases required detailed assessment, the introduction of other agencies, and the application of casework skills. There was not enough time to become involved with improving community services such as tenants' associations or babysitting clubs but the need for this type of work was apparent.

Social work in the geriatric ward

Admission to hospital is seen as an interim event in treatment and rehabilitation. With the assistance of the hospital medical social worker, I gradually became aware of the workings of the local authority social services department and a wide variety of voluntary and statutory agencies.

As the social worker for one ward I attended the weekly interdisciplinary case conference and saw the importance of efficient information exchange between team members, as well as the value of group discussion in individual cases and in local policy making.

The social structure of the ward was considered with regard to administration, interaction between staff and patients, and interaction among patients themselves.

Hours were spent in consolation, sympathy, understanding and sharing problems; in gently encouraging patients to accept the positive aspects of rehabilitation and continued living; in openly discussing feelings and phantasies and offering realistic hopes; in enabling old-fashioned, independent-minded patients to accept the full extent of social services necessary for continued independence; and in the use of persuasive techniques necessary to ensure efficient administration and expenditure of scarce resources for rehabilitation. By developing a ward club and a small discussion group, an attempt was made to foster an interest in the ward environment; to increase motivation for rehabilitation; to improve communication skills and ventilate problems; to develop each patient's senses of identity, self-acceptance and self-confidence; and to encourage a sense of group identity.

Evaluation of the externship

The term 'externship' has been adopted for a vocational training scheme related predominantly to medicine in the community. It contrasts with hospital-based rotating internships.

Assessment was continuous and multilateral, allowing the mutual adaptation of learning patterns with teaching methods. This was achieved by a one hour individual tutorial each week, and a one and a half hour group tutorial. The individual tutorial was devoted to discussion of individual cases and included examining my own reaction to clients as well as their reaction to me; the course was adapted continuously to maximise learning. The group tutorial involved nine students and a tutor discussing projects and evaluating effort and skills in an atmosphere of encouragement and advice. This continuous evaluative approach between a student, his tutor and peer students made possible a final assessment in which all three participated and agreed. A student who performed poorly was aware of the exact reasons from an early stage, and had opportunity for improvement. A tutor whose course was not fulfilling the need developed similar awareness. The tutor then reported results to the Board of Examiners, being required to justify them in order to ensure standardisation.

Topics discussed at the final individual session included social work method (casework relationships, fact finding techniques, psychosocial diagnosis, treatment methods, self-awareness, group work techniques, and management of the group interview), recording, administration, and the use of supervision throughout the course.

Relevance to general practice

Two case histories illustrate the use of knowledge gained in subsequent general practice:

Patient 1

Mrs A., an elderly widow, visited the trainee-assistant (Dr X) for a supply of barbiturates which she had been taking at night intermittently for 20 years, the last prescription being six months ago.

His mental reactions were as follows: Why has she needed hypnotics for 20 years? Why has she presented now, when the last prescription was six months ago? Why has she presented to *me*? How can I help her stop the habit?

Accordingly, Dr X tactfully elicited the fact of her husband's death 20 years ago, and the death of a friendly neighbour two weeks ago; now there was no one with whom to share afternoon tea, or to attend the local Darby and Joan club. She had approached Dr X 'to avoid troubling the other doctors' but increasing agitation displayed her fear that the prescription might have been refused. Noting the anxiety, Dr X wondered if there might be underlying depression associated with recent grief, and soon Mrs A was discussing early morning wakening, tearfulness, diurnal variation in mood, and loneliness. She would discuss her problems with the club's voluntary visitor whom Dr X agreed to contact. He prescribed amitryptiline tablets 10 mg tds, 'Triclofos' tablets at night, and asked to see her again in one week. On return, she said that she had not taken the tablets prescribed and wanted her usual barbiturates.

Dr X recognised that much of his resultant fury was due to feelings of rejection, and to the inadequacy of his own resources. After a brief discussion with the principal he gave her a warm smile, prescribed a small quantity of barbiturates and invited her to return again.

The case illustrates the concealed presentation of social and emotional problems, the correct use of a social work agency, the importance of discussion with colleagues, and the need for tolerance and self-awareness.

Patient 2

Mrs B brought her four-year-old son Tommy to Dr Y for advice about his flexural rash. The family usually saw his partner Dr Z and Dr Y sensed a certain atmosphere of anxiety, so he gave a warm welcome and enquired into the family's state of health. Briefly glancing through Tommy's notes, he discovered the atopic trait, and read about extensive investigations for failure to thrive in infancy. Tommy screamed and struggled as mother attempted to demonstrate the rash, and soon there was an agitated scene. In spite of this Dr Y recognised eczematous dermatitis, realised the emotional precipitant, and gave advice on general management before prescribing a dilute corticosteroid cream.

Mrs B said that Tommy was not as tall as other children and was not eating his food, but when Dr Y offered to weigh him she screamed "I'm not going through all that again. Once you start weighing and examining him you'll find all sorts of things wrong!", and rushed out of the room dragging Tommy with her.

Dr Y discussed the incident at the weekly practice conference in the presence of his partner Dr Z, the trainee, the social work student, health visitor, district nurse, secretary and receptionist. Much information was known about the family and it seemed that Mrs B might benefit from social casework which she had not received in the past. The health visitor agreed to make a friendly call, assess the situation, and enquire if Mrs B. would be willing to discuss her problems with a social worker. The receptionist agreed to ensure that future appointments were made with Dr Z.

The case illustrates the somatic presentation of a psychosocial problem, the importance of a continuing relationship with Dr Z and the health visitor, the correct introduction and use of social casework, and the importance of regular, confidential, interdisciplinary conferences in exchanging information and clarifying roles.

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REFERENCES

Biestek, F. P. (1961). *The Casework Relationship*. London: Unwin University Books.

British Medical Association (1970). *Primary Medical Care*. Planning Unit Report No. 4. Paragraphs 97 & 107. London: BMA.

College of General Practitioners (1965). *Special Vocational Training for General Practice*. Reports from General Practice No. 1. London: College of General Practitioners.

Crombie, D. L. (1963). *Journal of the College of General Practitioners*, **6**, 579–589.

Family Welfare Association (1971). *Guide to the Social Services*. London: MacDonald & Evans.

Forman, J. A. S. & Fairbairn, E. M. (1968). Social Casework in General Practice. London: Oxford University Press.

Fry, J. (1966). *Profiles of Disease*. Edinburgh & London: E. & S. Livingstone.

Morrell, D. C., Gage, H. G. & Robinson, N. A. (1971). *Journal of the Royal College of General Practitioners*, **21**, 32–45.

Royal College of General Practitioners (1970). *How to Become a Member or Associate*. London: Royal College of General Practitioners.

Taylor, Lord & Chave, S. (1964). *Mental Health and Environment*. London: Longmans.

Weiss, E. & English, O. S. (1957). *Psychosomatic Medicine*. Philadelphia & London: W. B. Saunders & Co.

Willmott, P. (1971). *Consumer's Guide to the British Social Services*. 2nd ed. Harmondsworth: Penguin Books.

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