Social workers and general practitioners—some problems of working together

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SUMMARY. Generally, relations between general practitioners and social workers are poor. Differences in approach, role perception, working situations and the organisation and staffing of the two professions may create difficulties. Conflicts of statutory roles, authority and accountability, record keeping, and confidentiality all produce problems. Finally unrecognised attitudes may also interfere with good co-operation. We hope to stimulate vigorous discussion of these important issues by members of both professions.

General practitioners and social workers have found that an effective working relationship based on mutual understanding and co-operation has proved difficult to establish. This discussion paper attempts to clarify the difficulties and problems which the two professions have encountered when working together. we also make some recommendations for improvements.

We hope the paper will prompt members of both professions to express and exchange views. Local interdisciplinary meetings could be arranged to help co-operation. If strong feelings are expressed, so much the better: honest communication is more likely to produce mutual understanding than unspoken irritation and resentment. At the end of the day, we would hope to see a growing awareness of each other's professional problems, close collaboration, and a willingness to develop a constructive exchange of feelings and ideas.

Although this paper focuses on areas of conflict between the two professions, it recognises that social workers and general practitioners are equally committed to a caring, helping role in society. The patient and client will often be the same person. The area social service teams with local general practices provide between them a comprehensive service to broadly similiar populations. The closest collaboration between members of the two professions is essential if the individuals they seek to help are to receive the best possible service.

The reorganisation of the National Health Service means that general practitioners and social workers will be operating in separate administrative and executive organisations while collaborating in health care planning teams. There is a danger that this organisational divergence will separate the professions to the detriment of all concerned. We hope, by stimulating discussion, to guard against this development and to increase interprofessional communication.

PROBLEMS OF WORKING TOGETHER

Social workers and general practitioners have a limited understanding of each other's professional role. There is little appreciation of the knowledge base, methods of working,

and the many difficulties inherent in the other's work. Co-operation in areas of mutual concern has therefore been adversely affected. There may be several inter-related reasons for this, including differing objectives, and irrational feelings. Elements of both may closely interact at work, but they must be differentiated, if improvement is to become a practical possibility. We now try to do this.

A. Objective difficulties influencing interprofessional relations

(1) *Differences in approach*

The training, knowledge, and skill of general practitioners and social workers are different. They are concerned with different areas of human functioning. While general practitioners normally concentrate on the health or sickness of their individual patients, always being aware of the wider family and community aspects of their problems, social workers are likely to lay more emphasis on relationships within the family, the community, and society as a whole.

Members of both professions will thus bring their own particular orientation to the problem with which they are concerned. The concepts which are used will necessarily reflect differences in approach and ways of thinking. Because of these differences in knowledge and approach, when the general practitioner and social worker need to talk about the same individual, they may find themselves at cross purposes. Communication within some common frame of reference may be difficult to achieve. Frustration and impatience on both sides, or a lack of understanding of what each is trying to communicate to the other may be generated. If this problem is not resolved satisfactorily, consultation between the two groups can break down.

Social work training places minimal emphasis on the biological sciences and until recently, the medical student received little instruction in behavioural sciences, psychological functioning, and the emotional responses to stress and illness. Social workers may thus be ill equipped to understand the significance of medical aspects of their clients' problems. Similarly, general practitioners may have missed or under-valued indications of psychological and emotional difficulties, while concentrating on their patients' physical malfunctioning.

There is little evidence to suggest that social work training takes this lack of knowledge into account. However, more doctors than ever before are being taught to diagnose their patients in three dimensions—physical, psychological, and social. Vocational training for general practitioners is increasing rapidly. Future general practitioners should be well grounded in these important areas of practice and have a better understanding of the approach and skills of their social work colleagues.

Although these changes in education are significant, there will still exist a basic difference in orientation between the two professional groups. This potentially hinders communication, perception of needs and priorities for action.

(2) *Perception of respective professional roles*

Until quite recently, medical students received little information about the nature of social work and rarely had the opportunity of meeting social workers. Doctors have thus been to a large extent unaware of the functions and skills of social workers. The Seebohm Report (1968) clearly identified this problem when it stated, " Survey after survey has shown that many family doctors do not seek help from social workers, nor use services that are available: they often do not know about them or do not understand or value them." Similar findings are provided by studies in the area of social work in hospitals (Moon and Slack, 1968; Brandon, 1970) and in studies of unselected general practitioners (McCullock and Brown, 1970; Harwin *et al.*, 1970).

General practitioners have tended to interpret the role of social workers in a limited

way, mainly in the terms of the provision of financial and practical help. They appear to be largely unaware of the therapeutic skills which social workers see as a significant component of their role. While social workers recognise their relationship to the total social situation and the individual's functioning within it, they are often frustrated to find that only a very limited part of this concern is appreciated by doctors. General practitioners in their turn may be impatient when social workers dwell on psychosocial functioning and are unable to evaluate the implications of some medical or surgical conditions.

Social workers, like other members of the community, are normally registered with their own general practitioner. They will thus have had some experience of the role of patient and the personal nature of such experience is likely to colour their attitude to general practitioners whom they subsequently meet as professional colleagues. It is probably true, however, that while general practitioners have limited expectations of the role of social workers in society, social workers may have exaggerated expectations of what general practitioners ought to be doing within the community. Thus, social workers often expect doctors to be more deeply involved in the care of the elderly, the terminally ill, or the handicapped because they do not appreciate the pressures under which doctors work and the calls which they have upon their time and resources.

Seemingly, general practitioners' and social workers' appreciation of each other's roles, and their related expectations, do not match. Such a lack of clarity leads to confusion, frustration, gaps in the provision of services, and mutual recrimination.

(3) *Differences in method and tempo of work*

Broadly speaking, doctors are trained to be decisive and to provide correct diagnosis and treatment as quickly as possible. The interviews of most general practitioners last no more than five to ten minutes and doctors are used to making rapid assessments and taking decisions. They are also accustomed to working with a variety of medical auxillaries who are more used than social workers to accepting their judgment and acting upon it rapidly. These auxillaries are skilled in communicating with doctors and better informed in medical matters than social workers are.

Many social workers also use the terms " diagnosis " and " treatment." For them, diagnosis may extend over a relatively long period while a relationship is established with clients. It will always be more tentative in nature than a diagnosis established by doctors. The appropriate form of treatment is often less obvious in social work than medicine.

Thus, while doctors engage in rapid decision-making and intervention, social workers need to proceed much more slowly and often wait to see how a situation is developing before taking action.

Such differences in the evaluation of problems, and the speed of making and implementing decisions often lead to much mutual frustration. Goldberg and Neill (1972) have shown that simple differences in the use of language lead to conflict. They suggest that words like " urgent " and " chronic " may have different relative meanings to the two professions. Doctors usually expect action to be taken within hours in " urgent cases", while social workers may think that more time is needed to assess the factors involved and the likely sequence of developments.

Doctors may be extremely frustrated, firstly by difficulty in making contact with social workers and the problem of conveying briskly the urgency of the need to them, and secondly by what they may consider to be the lack of immediate concern on the latter's part once the contact has been made. For example, in the case of an acute illness in one of a couple of elderly people, one of whom is bedridden, or again when a mother with young children is admitted to hospital and supportive services are considered essential

for the family. If immediate action is not taken by social workers to alleviate such difficulties, doctors tend to consider them incompetent.

In such cases as compulsory admission to a mental hospital, or the removal of a child at risk from its family, doctors may similarly expect rapid action. Once again, they may find that social workers wish to proceed more cautiously, and to spend time assessing the total situation. Doctors may often accuse social workers of confusing action on medical grounds with psychological or social factors which they may regard as irrelevant. Equally, many social workers are more aware than doctors of the social and emotional handicaps which can occur when individuals become institutionalised. They will try as far as possible to avoid removing them from their families and the community.

Doctors may have to depend on social workers to take steps which they consider imperative, but which the social worker may regard differently. Social workers may also have to rely on general practitioners to take action in some circumstances and are likely to be frustrated if the doctor does not agree with their professional evaluation. The impatience generated on both sides by such situations is a significant factor in the alienation of the two professions.

Although this area of conflict is largely related to different professional attitudes and methods of working, it should be emphasised that the resources available to social workers such as hostel accommodation, home helps, equipment for the disabled, and many others can limit the choice of action open to them. Political and economic decisions made at central and local government levels will influence the range and quantity of resources at the social workers' disposal.

(4) *Authority and accountability*

Doctors are allowed great power and authority by society, but in turn doctors are accountable to society and their own profession for their actions. Hence, professional failure may have to be answered in a Court of Law and at the same time, the doctors may well face censure by their peers on the General Medical Council, i.e. they have authority with accountability. Social workers also have statutory powers but at present, it seems that they are officially only answerable to their employing authority for mistakes. There is, as yet, no fully accepted code of ethics and no equivalent sanction similar to the General Medical Council. Hence, the authority they possess is without accountability.

The British Association of Social Workers' *Draft Code of Ethics* was published and circulated some months ago. Social workers were asked for their comments on it and there has been much controversy, both about its content and the suggestion that it should be used as a basis for disciplinary action. Social workers feel that they are accountable, not only to their employing body, but also to society, to their clients and indeed to themselves. They thus work under the very significant influence of informal, but nonetheless, stringent accountability. Doctors, however, may well feel that such an informal system is not enough and that they cannot have a full interchange of communication with social workers if the latter have no formally adopted code of ethics.

This area of concern with the nature of accountability and the related problem of a code of ethics for social work provides a point on which conflict between the two professional groups could become highly charged.

(5) *Conflict of statutory roles*

Social workers now carry much statutory responsibility for some clients; children, the physically and mentally-handicapped, the aged, and the mentally ill. Doctors are often unaware of the legal statutes under which social workers operate. In the case of the removal of an old person from his home, conflict could arise over the doctor's lack of understanding of the social worker's statutory responsibility and the latter's lack of

appreciation of medical aspects of the problem. Disagreement over the appropriate course of action often ensues.

Doctors may have little idea of the workload of social workers or appreciate the local problems caused by reorganisation of the social services. Social workers are equally unaware of pressure experienced by general practitioners.

(6) *Organisation and staffing*

The professions are organised very differently. The general practitioner is an independent contractor answerable only to the area health authority's family practitioner committee, with whom he has a contract of service. The social worker is a member of a hierarchy and subject to decisions by committees. Social workers are dependent on the agency to supply many of the resources needed for effective professional functioning. These resources, both physical and financial, vary from agency to agency and many, such as hostel accommodation for the elderly, sheltered workshops for the disabled and mentally handicapped, and meals on wheels and other services are all scarce. The lack of these resources can lead to much frustration among social workers and exasperation by general practitioners when expected services are not supplied. Despite the obvious limitations of bureaucracy in the social work field, the availability of senior social workers high in the hierarchy can, in fact, safeguard the standards of practice, a point not always accepted by general practitioners.

(7) *Records and confidentiality*

The degree to which confidentiality is debated is a good index of the level of misunderstanding of professional roles.

In inter-disciplinary general-practice teams, decisions about the recording and the exchange of information should be made on the basis of discussion and agreement on how the needs of patients can best be met. General practitioners and social workers should be encouraged to exchange relevant information, and such a process should be seen as essentially two way. This should be based on the mutually acknowledged principle that the confidential nature of such information will be respected at all times. Doctors and social workers will always have absolute discretion not to reveal information in circumstances where it would be damaging to the client/patient. but at the same time, will try to help care by other workers. These recommendations are made on the understanding that the client/patient is aware of, and accepts the need for this collaboration on his behalf.

(8) *Specific problems of collaboration*

Inter-professional hostility, which may be based on misunderstanding and feelings of mutual frustration and impatience, interferes with constructive collaboration. Inadequate or distorted communication often means that general practitioners and social workers are either both working separately with the same individual or that neither is working with the person in need, because each is waiting for the other to take the first step. Failure to know of the other's involvement (or lack of it), or failure to report progress or a change in the situation, can be a source of endless irritation to both professions. Failure to see the relevance of the other's role or the need for his skill in some situations can lead to hostility and conflict.

Conflicts over who should act first or take responsibility may well arise when there are disputes about the care of the elderly, children, or the mentally ill.

B. Subjective difficulties influencing inter-professional relations

The term " subjective " is used broadly to cover both recognisable feelings and unconscious motivations. It has been suggested that the subjective level should be considered here, because not all the problems experienced by the two professions in relation to each

other can be explained by purely objective factors. There is no concrete evidence to support the following assumptions, but this interpretative material may be helpful in elucidating some of the difficulties which general practitioners and social workers have in working together.

The doctor/patient relationship which most social workers have experienced at some point in their lives and which probably extends back into earliest childhood, is likely to colour their subsequent expectations of the general practitioner's role. Unconscious anger at the dependent role of " the patient " may still be influential when social workers and general practitioners meet as colleagues.

Literature and the mass media tend to project an indealised and omnipotent image of doctors' powers and may well unconsciously influence expectations of patients and social workers alike. Relationships between members of the two professions may flounder on the inability of general practitioners to live up to these expectations. The social worker may expect too much from the idealised version of the general practitioner. Similarly, social workers may have unrealistic expectations of the possibilities offered by medical skill in any given clinical situation, and this may be coloured by the same magical thinking that patients sometimes have of their doctor's abilities to " cure all ills".

In the confrontation between individual doctors and social workers, there is often evidence of feelings involved in the adolescent conflict as evinced between parent and child. The doctor sometimes tries to impose his opinions on the social worker, while the latter frequently rebels against these attempts to control him and reasserts his own will and decision-making ability. This interprofessional conflict is again reinforced in the field situation where the majority of general practitioners are middle-aged or elderly, while the mean age of social workers is more likely to be younger. In such a situation, the general practitioner may emphasise his own experience of life, gained over many years, as being a better basis for making decisions than the social worker's theoretical knowledge about the needs and behaviour of people.

The fact that society ascribes differing degrees of social status to social workers and doctors respectively, is reflected in both social attitudes and the rewards accorded to each profession. Medicine is an established profession with a sound knowledge base and this is widely recognised by patients and other professionals alike.

Social work is fast developing into an accepted profession and its practitioners are emphasising the importance of their own body of knowledge and skills. In decision-making, social workers may often disagree with general practitioners and will have their own professional status to support them in their position. The challenge to general practitioners is also seen in the increasing social status, rewards and responsibilities acquired by members of the social work profession, and may be preceived as a threat to their own professional and social status. Social workers, too are likely to be sensitive to the actions of other professionals which impinge upon their own work and their professional self-image.

Given this changing situation, and the difficulty of coping with it, general practitioners might deny the importance of social work while social workers may over-react in an effort to prove the essential nature of their contribution. A mutual denigration of each other's roles may thus replace a creative pooling of skills and resources.

C. Recommendations

(1) *Undergraduate education*

Medical students and social work students should have a period of shared training, incorporating joint teaching of shared areas of knowledge and skills. This is unlikely to be realised in the near future. The advent of teaching practices and the growth of

vocational training for general practitioners should also provide suitable placements for senior social work students. We feel it is equally relevant for medical students to be exposed to social work agencies in some depth and not simply provided with brief observational visits. The teaching general practice could be fashioned into an instrument for the training of social work, medical, nursing, and health visitor students, and be a place where they could meet, work and learn together both formally and informally.

(2) *Postgraduate education*

A variety of postgraduate opportunities is currently available to general practitioners. Further education and the exchange of knowledge and ideas would be greatly helped by the existence of continuing interdisciplinary teaching and discussion groups. Several such interprofessional seminars and " workshops " have already developed and the expansion of such undertakings could usefully be encouraged. Such arrangements would help to overcome many of the objective difficulties which we have discussed and by means of making both sides face facts could help to lessen the influence of some of the subjective factors.

Frequent face-to-face contact in the field is probably the most important single factor which would modify attitudes. Other inter-disciplinary study groups meeting regularly over a long period of time and devoted to exploring problems of mutual collaboration also need to be set up. Experience of such groups already exists and policy decisions by the Royal College of General Practitioners and the British Association of Social Workers could do much to implement the spread of such projects and the exchange of ideas between the professions.

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Addendum

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