Social work and general practice

A report of a three-year attachment

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SUMMARY. Much has been written about social worker/general-practitioner collaboration, particularly about conflict of roles, differing functions, avenues of accountability, and problems of distributing scarce resources.

We suggest that if the two professions are to work more comfortably together, then it is imperative that both also share the despair, hopelessness, anxiety, and anger that are the occupational hazards of each. We suggest ways in which doctors and social workers can look at the pain their patients are suffering to the benefit of the patient and their own working relationship.

Introduction

We present our view of a social work attachment to a large London group medical practice. The attachment forms part of a larger research project initiated by the Community Unit of the Adult Department of the Tavistock Clinic about four years ago.

(a) The Project

Brook and Temperley (1976) describe the aim of the project " To study the contribution that can be made to group medical practices by the presence in the surgery of a professional worker with specialised training in a psychotherapeutic approach." They hoped by close co-operation and mutual education to increase the psychotherapeutic resources of the practice.

As part of the project, several Tavistock Clinic workers, drawn from different disciplines, but all having training in psychotherapy, were attached for one session a week to group practices in the vicinity, usually for a period of two years, but in this practice for three.

Brook and Temperley have also described the type of referrals made to the attached workers in the project. Because of the workers' psychotherapeutic bias it might be expected that many referrals would be for emotional and relationship difficulties, especially in younger patients, who were more likely to be at a stage in their lives when relationships were in a state of change, e.g. marriage, or parenthood. Later in the attachment, however, problems of physical illness and disability were also referred to the worker.

We note that in our work together there was a tendency to select those cases for referral where the general practitioner knew he needed support; where the task was of such a dimension that one person working alone could not be expected to listen, understand, treat, and manage the problems.

Such referrals, e.g. marital problems particularly, were a deliberate attempt to use the social work resource to diminish the confusion and wastage through a meagre understanding of the meaning of the presenting problem, e.g. depression, anxiety, or psychosomatic symptoms. When the general practitioner and social worker worked

together it was easier to recognise the locus of a problem, and to avoid being misled by the patient's perception of his problem.

(b) The Practice

The practice in which we worked (one of four in the project) has: 17,500 patients, six partners, two assistant general practitioners, one trainee general practitioner, 12 reception and administration staff (many part-time) and two health visitors (liaised). It is a large practice and is administered like a health centre. This provided opportunities to explore and understand the complexities of liaison, referral, and shared care of patients. It was common, for instance, for case conferences to take place in the practice, attended by local authority social workers, educational psychologists, psychiatrists, and teachers, thus adding weight to the philosophy of whole-person medicine with the local general practice serving as a central base for patient-care and decision-making.

(c) The Attachment

The social worker attended the surgery for half a day a week, when he saw one new referral and one or two old clients for about an hour each. The remaining time was spent in consultation with the referring general practitioner who retained at all times medical responsibility for the patient.

The attachment in our experience confirms the view " of the crucial importance of giving time and thought to advance planning " Brook and Temperley (1976). The social worker and referring doctor(s) agreed to discuss all cases before taking any action. These discussions helped us to determine how to proceed—either for the social worker to see the patient; the patient to be seen jointly by the general practitioner and social worker; to include other members of the patient's family; or where the general practitioner felt, after discussion, that he understood something additional about the patient, to continue independently, secure in the knowledge that support was available to him.

In addition to these discussions between social worker and individual general practitioner, an alternative way of communicating between the attached social worker and general practitioners was through regular practice meetings, partly to discuss cases and partly to monitor the experience of the attachment.

In preparing this paper, we were aware of the many limitations imposed upon us by a purely personal account and we wish to point out that there are many circumstances unique to this form of attachment which we have not touched upon, e.g. the social worker (M.S.) had no statutory responsibilities. There were other facets of interaction within the group practice which, while important, we considered not to be relevant here.

There are, of course, implications in this paper for social workers who carry statutory duties, and who liaise with general practitioners in order to mobilise more immediate and tangible social provisions, such as: housing, caring for the physically disabled, or the mentally ill. Social workers need to develop an understanding of what they, as workers from a different agency, using different skills and ways of relating to people, can offer the patient and the practitioner.

With heavy pressures on both social workers' and doctors' time and emotional resources, the need for careful exploration of the patient, his problem and his environment, before acting, becomes even more important. Precipitate action, before the problem is fully understood, we know, often leads to the rejection by the patient of the help offered.

General practitioners and social workers, the care-givers, can easily feel themselves to be acting out of role because they have unrealistic expectations of each other and the patient often has unrealistic expectations of both. This can confuse them and the patient, resulting in everyone feeling frustrated and angry and unable to collaborate profitably.

Sharing work

In this section we will show that we tried to develop a variety of planned interventions in the care of patients. We illustrate this with examples how we have worked together with patients in different ways.

Patient 1

Miss K, a young single librarian, brought to her general practitioner the problem of depression arising from lack of feminine sexual characteristics, *viz.* flat chest and a masculine-type physique. She readily told of her difficulties in maintaining stable relationships with men. The practitioner felt unable to like this angry young woman, by whom he was pestered. She revealed intriguing insights into her relationships with men, and, in particular, with her father. He felt that further exploration of the relationship with her father was appropriate, but was unable to take up these issues directly with the patient, because he feared that to do so would interfere with a well-entrenched though neurotic relationship with her father, and would probably invite an angry response towards himself.

Discussions between the general practitioner and social worker took place. We decided that the social worker would see the patient in order to try and understand with the patient some aspects of the relationship with her father. She was therefore seen alone by the social worker for five sessions, during which it emerged that she was inevitably drawn to men who were inferior to her, and had severe emotional problems themselves, and even though she was aware of the tendency, could not bear to be apart from them. She felt she had to " make the going " in all her relationships, because if men showed any interest in her she was convinced there was something unstable about them.

Unwittingly, she chose men she knew would never gain the approval of her parents. Indeed, she knew her parents would be hurt by her choice. Miss K felt that she was just getting over her irrational need to hurt her parents but she feared that at 30 she might have left it too late to sort out her conflicts. She saw herself heading for a long and bitter spinsterhood.

In describing her family, Miss K saw her mother as a weak, ailing and demanding woman holding on to her husband through illness. Their marriage, she claimed, was empty and they stayed together only for the children. She expressed warm and protective feelings towards her father whom she felt she needed to save from a sterile marriage.

It seemed clear that the close relationship with her father and the disparagement of her mother may, in fact, have been a denial of the anger that her parents were more important to each other than she was to either of them, and, in addition, a denial that the original longing may have been for her mother. The first indication of these angry feelings was the subjective experience of " unlikeability " felt by the general practitioner before the referral to the social worker and may even have precipitated the referral.

She returned later to the doctor with more physical complaints and expressed anger towards the social worker for unreasonably concentrating on the underlying aspects of the relationship with her father. Nevertheless, when more openly challenged this time by the practitioner, she acknowledged that she was less depressed and had been able to limit, without feeling too guilty, the extent to which her alcoholic boyfriend sponged on her. She was able to question the belief in her parents' lack of sexual sufficiency, which made her feel unrealistically responsible for them. She saw that maintaining such a position had prevented her during adolescence from seeking and receiving adequate attention and help from her parents when because of her masculine sexual characteristic, she felt so desperate and lonely.

She could only call attention to her psychological needs then by adopting an aggressive, demanding stance which alienated her family. Over the five sessions with the social worker the patient was able gradually to disengage herself from her parents as well as her current boyfriend, and after a period of some months she returned to the general practitioner asking directly for referral for psychotherapeutic help.

Discussion. The general practitioner referred this case to the social worker because he felt troubled by the patient's anger towards him. This had stirred his own anger which threatened to interfere with his capacity to offer her help. Discussion of these feelings with another person (the social worker) had freed the doctor-patient relationship of some of its hostility, which in turn allowed the patient to be angry and ask for additional help.

Patient 2

A family, Mr and Mrs N, with three children, where Mrs N had originally presented herself as a physically diseased, depressed alcoholic with murderous feelings towards her children, husband, parents and parents-in-law. The general practitioner introduced the social worker because the case frightened him.

He had been warned by a psychiatrist, who previously had seen Mrs N, not to accede to her request for psychotherapy. She was thought to have minimal defences to cope with the horrors and enormous deprivation experienced in her childhood which included rape by her alcoholic father.

For these reasons the general practitioner and the social worker decided to suggest to Mrs N that she and her husband should attend a joint consultation with a view to seeking and strengthening her supportive network in the immediate environment. Their appearance made quite an impression—Mr N was well dressed in jacket and tie and a neatly trimmed beard conveying an attitude of a dutiful schoolboy.

Mrs N arrived late with many apologies, dressed in dirty jeans, broken sandals and unkempt hair. In this contrast the workers were struck by Mrs N's need to cling to the depressive aspects of her past and present life, and by her fascination with the brutal and destructive aspects of society, representing the state of her inner feelings, e.g. racial tensions and nuclear destruction; whereas Mr N, with ample reason to be depressed himself coming from a disturbed family background with early separation from his parents, maintained a detached, almost carefree attitude. It seemed to us that Mr N's feelings of anger and depression were off-loaded onto his wife, who was left unsupported in her misery and chaos.

This process of getting rid of painful feelings left Mr N free to indulge in his pleasurable pastimes away from home without feeling too guilty.

Behind Mrs N's near-madness lay a desperately sane plea for a need to be separate from her husband and in-laws and not be exploited in her very vulnerable state. To this end the workers supported Mrs N's desire to remain in her private and independent domestic world with practical support from the health visitor, social worker, and general practitioner, and strongly discouraged further invasions into the privacy of her feelings through psychotherapy, which Mrs N was requesting and Mr N pushing her towards.

Mr N appeared unable to face his own depressed feelings and did not attend further meetings. Mrs N was supported in her role as a woman and mother. A year later with the help of occasional fairly calm contacts with her general practitioner, Mrs N was still working as an art teacher and caring adequately for her family, but without her husband, who had left.

Discussion. This case illustrates the difficult dilemma often facing general practitioners and social workers, i.e. to resist the enormous pressures from the families of patients and even from the patients themselves, to regard them as mentally ill requiring immediate and intensive psychotherapy or hospital care. Resisting the pressure and adopting a different treatment plan for the patient can infuriate the other members and even lead to the break up of the family, as happened in the case of Mr and Mrs N.

Should the general practitioner collude with the diagnosis of "mental illness" in Mrs N, admit her to hospital, separating mother from children; or should he act independently on his judgment and provide enough environmental support for a vulnerable and deprived woman so that she can cope a little better, and risk the husband leaving?

Either way the decision is awesome, since other people are affected and will react. This chance impinges upon the general practitioner's philosophy about mental illness, families staying together, and mothers remaining with children. These issues were discussed fully with the social worker and the general practitioner was helped to face the guilt and anxiety arising from whichever decision he took.

Patient 3

This case describes the experiences of a general practitioner (HG) who felt crushed by the tragedy of a very promising ballerina of 23, Miss D, who became permanently tetraplegic, after breaking her neck on stage.

The practitioner was much involved in the management of the physical aspects of the patient's care, e.g. electronic aids, chairs, lifts, and retraining. He suddenly realised, after a light-hearted reference to suicide by Miss D that he was ignoring the full extent of her despair and hopelessness which was beginning to overtake him, too. He sought consultation with the social worker, who like himself, felt the horror of the tragedy and experienced a wish to "do" things, irrespective of whether they were realistic.

After reflection, both realised that it was necessary to face the patient with the implications of a bleak and depressing future openly and honestly. This decision was given added weight because the general practitioner had responsibility for her general medical care, and the patient would turn to him in despair when she realised how vain her hopes were of ever walking again. It was agreed that the social

worker would act as a consultant to the general practitioner so that he could understand his sense of inadequacy stirred by her tragic situation. The social worker would also be available for certain crucial joint interviews, in order to monitor and regulate the pace with which Miss D was confronted with her feelings of depression and despair. One particular joint interview was arranged to coincide with the first anniversary of the accident—a time especially painful for the patient, since there had been no apparent improvement in her condition.

Both practitioner and social worker soon discovered, when they nearly dropped Miss D trying to carry her upstairs, how easy it was to be blind to the limitations which her disability imposed. The patient valued these interviews extending over three months, in which her feelings of rage, resentment, and despair were understood and accepted, rather than denied, as they tended to be by others around her. Later, having acknowledged the unlikelihood of walking again, Miss D successfully applied to study art. She still retained an interest in the world of ballet in the different, but more appropriate, area of set design, and the development of adequate safety standards for ballet dancers.

Discussion. This case illustrates how such a tragedy can almost overwhelm a general practitioner and lead to the disavowal of the truth of a dreadful disablement. Sharing these feelings through discussion with a colleague enabled the practitioner to spot and check his impulse to take flight. The case also underlines the practitioner's continuity of care and responsibility for the patient, which extends beyond the merely physical aspects of the condition, important though these are. Doctors and social workers would like to give comfort and put things right. Tragically, there are conditions one cannot always put right, and when this is discovered there is a danger of abandoning the patient. The social worker's presence in a number of crucial interviews helped bring into the open some of the harrowing feelings overlooked by both the patient and doctor; it also strengthened the practitioner's ability to grasp and talk honestly about the very disturbing emotions aroused in all three by the permanently crippled life of a young person.

Summary. These three brief examples give some idea not only of the variety of problems presented in general practice, but also different styles of collaboration between the professionals concerned. The common factor in all the cases was in the general practitioner identifying feelings that were bewildering and threatening to the doctor's normal decision-making abilities and his capacity to offer help.

The result of the consultations was to free the general practitioner from a frustrated position and help him regain a clearer perspective of the doctor-patient relationship. The nature of this relationship was different in each case. In the first case the practitioner felt uneasy on account of his anger towards a difficult young woman. He handed the case to the social worker who dealt directly with her angry feelings and this removed some of the hostility from the doctor-patient relationship. In the second case, involving joint marital interviews, the practitioner was shocked by the violence of the material. Through joint interviews a more practical appraisal of his contribution became possible. Care was exercised not to be over-enthusiastic, nor dwell upon morbid and destructive thoughts and ideas.

In the third case, both general practitioner and social worker shared the horror and despair of a young person whose hopes and ideals had suddenly been dashed. The practitioner was nearly submerged by the patient's enormous despair when the realities of her future dawned upon both. Working together helped contain the threat to the practitioner's integrity, as well as provide the patient with opportunities to face her dreadful situation honestly by people who understood and accepted her position, in ways that others had not.

The help given in all the examples consisted of increasing the general practitioner's capacity to listen and be responsive to the patient's mode of communicating, thereby helping the patient take stock of himself and think seriously about his life, problems, and attitudes.

EXPERIENCES OF WORKING TOGETHER

We have indicated how the attachment of the social worker provided the practice staff and the patients with an additional resource for dealing with psychological problems. It is common for general practitioners to offer help to patients with emotional and relationship difficulties. Through this attachment they were themselves helped to recognise the danger of persisting on their own too long and possibly getting out of their depth with the patient. Equally, the general practitioners were in many instances encouraged to support patients further, rather than refer them to specialist agencies in the belief that specialists could offer something more masterful.

In considering the nature of the attachment and what it offered to the professional workers, we need to look at what we started with—a doctor, primarily trained in the physical aspects of medical care and a social worker with psychotherapeutic skills and an understanding of relationships.

The workers had different philosophies about human behaviour, different methods of care, attitudes to use of time, and the giving of advice.

Ratoff, Rose and Smith (1974) drew attention to the inevitable feelings of dependency aroused by the fact that everyone since childhood has had direct experience of doctors as patients, while the reverse is not always the case. In addition there is the complex relationship between the doctor and the social worker with rivalry and envy—the social worker's envy of the doctor's capacity to make quick decisions, his status in the community, and apparent ability to make the patient " better ". To the doctor, the social worker's seeming detachment, his ability to work with the patient in painful and disturbing areas, his very different usage of time, and his ability to check the need for " quick cures," seemed cold and unfamiliar.

We are trying to des(ribe our subjective experiences in a situation that was new to us, i.e. sharing in the care of patients and their families, bearing in mind the traditional possessiveness of the helping professions; the competition to be the one who is seen to be doing the best for the patient; the irrational hurt felt when the patient reveals an intimate piece of information to one professional and not the other; the anxiety caused when one's method and techniques of working are scrutinised by the other; or simply when one wants to be rid of a problem—the pressure exerted on the other to take the problem away.

Difficulties and rewards

What are the difficulties and rewards of working together?

(1) For the general practitioner

A. Professional gains

(a) Novelty and challenge

For the general practitioner the attachment provided an almost infectious excitement as well as an extension of interest and understanding—a chance to view a patient's problems from a perspective that was negligibly dealt with at his medical school.

The desire to know more about the patient's psychological composition can lead into complex and threatening areas. It can also sharpen one's powers of observation and deepen the understanding of the doctor-patient relationship. Collaboration and consultation with a worker skilled in psychodynamics can be taxing, but it can also strengthen the general practitioner to be sensitive to, but not overwhelmed by, the patient's emotional difficulties.

Close working with a colleague allowed for a greater ' reality testing '. The danger of crossing of personal boundaries could be appreciated and this awareness often led

to the setting of appropriate limits against intrusion by the patient of the doctor and *vice versa*. This point is particularly relevant where general practitioners live in the same locality as their patients and are likely to be related to them in other ways, e.g. where their children attend the same school, where the doctor is the patient's shop customer, and friend.

The mixing of social and professional contacts can prevent the general practitioner setting reasonable limits in his work. For example, the doctor, without the help of the social worker present, felt unable to tell a married patient, known to him socially, and on first name terms, that by insisting on having extra-marital relationships he was acting irresponsibly and sadistically towards his depressed wife, even if, for her own reasons, she had given him permission to do so.

(*b*) *Use of time*

This type of attachment obviously demands time, rather differently from the shorter interactive interview (Balint and Norell, 1973). Spending 45–60 minutes with a patient/couple/family and then a further 15–30 minutes in discussion afterwards means considerable changes occurring elsewhere in the practice. This may lead to other partners carrying an enlarged workload or the receptionist holding all but the most urgent calls.

The resentments created amongst the rest of the staff by this deployment of time have to be faced and dealt with. There was a feeling of unease amongst other staff when doctors had " special " patients, particularly when being " special " meant extra duties and burdens for others.

On those cases where joint work was undertaken, the time was well spent. We found that the social worker's support had a kind of ripple effect, enabling the doctor to help other patients with similar difficulties at a much earlier stage and working independently. A common example may be the unresolved grief reaction after bereavement where a patient may, without some psychotherapeutic understanding, continue in a state of minor ill-health for months or even years.

(*c*) *Pressures on the doctor*

Often the doctor tries to give the patient the experience of being understood, and then without fully realising it, gets taken up by the patient's account of the story, and subsequently has difficulty resisting the pressure to *do* something. " Doing something " may mean writing out a prescription, referring another member of the family to a specialist, or simply offering the patient further unnecessary interviews.

Very often the attempts by the doctor " to do something " may mask a degree of uncertainty, a lack of understanding of the problem, a sense of helplessness, masked by adopting an " I know-it-all " attitude. On the other hand, the doctor may become very excited about, and get caught up in the psychodynamics of the patient, particularly when they seem very clear to him. In such instances, sharing the care of the patient with the social worker, can be a useful way of re-establishing distinct professional roles as opposed to personal ones, that will make future help to the patient possible, since the doctor also has to take care of the intimate physical aspects of his patients.

There are subtle defences used by many doctors to resist pressures which may also prevent a full understanding of the patient, and instead keep him at a distance. These defences can aggravate a stressful situation even further. These may be expressions of phony cheeriness, or the offering of placebos given unknowingly by the doctor for himself as much as for the patient, or premature advice, or an attempt by the doctor to unload the whole unmanageable problem onto someone else.

When this happens the patient may feel he cannot talk honestly to the doctor, feels rejected and unaccepted, that his problem is too great or too messy or even too

lurid to handle. Prior discussion between the social worker and the doctor on the effect the patient has on his own feelings has been useful. When anxieties can openly be admitted and discussed they are much less likely to interfere with the doctor's capacity to cope and he can make greater use of his resources.

B. Difficulties in learning and sharing (Inter-professional problems)

Close attachment of this kind is certainly not without its difficulties and indeed may be too threatening for some doctors and social workers. The difficulties described are probably those that would emerge in any sharing relationship, i.e. feelings of rivalry and competition, doubt about one's own as well as the other's competence, anger aroused by disagreements, and different points of view.

The doctor, for instance, often wanted to protect the patient from what he perceived to be the cruelty of the psychodynamically-oriented social worker. We found our working relationship bedevilled by all these emotions and more. Working on the principle, however, that what we were experiencing inwardly may in part have been the result of what the patient was unconsciously trying to make us feel, we were able, with considerable gratification, to gain a clearer picture and understanding of many additional aspects of the doctor-patient relationship.

Thus it was common for the doctor to put pressure on the social worker to see the patient, a request which arose from the patient's pressure on the doctor to do something active. Sometimes the social worker felt the referral was inappropriate, but as an alternative offered comments on what he thought was happening between the patient and general practitioner. The doctor sometimes felt this approach was unhelpful and disappointing and was saddled with a frustrated and restive patient, with whom he alone would have to cope. The referral may at first have been made, not because the patient requested it or even needed it, but because the doctor may have been unclear about the nature of the problem, or about how to proceed; he may have been anxious about veiled threats of suicide, or the patient's children coming to harm; he may have been at a loss to deal with a patient's apparently unreasonable fears, or how to explain a man's repeated headaches or other bodily pains for which no abnormality could be detected.

In these situations, we often found it more fruitful to consider our own fears, anxieties, and sense of helplessness. An understanding of these feelings in ourselves was often more effective in helping the patient than an outright referral. This, however, placed some strain on the relationship between social worker and doctor because of the angry feelings aroused when the general practitioner's initial request was questioned. It made the doctor feel foolish asking for the referral in the first place; it made him think carefully about subsequent referrals. Furthermore, as so often happens, referral posed many more problems than it solved. It was often seen as opening a Pandora's Box—many more dreadful and difficult problems could be exposed—doing so could make one feel despairing; on the other hand, it could also make the task more gratifying insofar as one was dealing with the whole person and not one isolated aspect of the patient's life. The doctor gained a better understanding of the meaning of referral both for himself and the patient. He was better equipped to decide whether to leave the problem well alone, to explore a little further on his own, or to refer the patient directly to a psychotherapist.

(2) For the social worker

A. A new learning situation

For the social worker member of this attachment the exercise provided an opportunity to work in consultation with colleagues in a new setting. New skills and techniques of working had to be developed, since the pressures and demands were different from

those experienced in the setting of specialised psychotherapy. In addition, a broader range of patients were seen at earlier stages of their problems thus allowing short-term interventions of about six sessions, or fewer, in which some therapeutic clarification could be accomplished without grander and more costly psychotherapeutic strategies.

The attachment provided an opportunity to explore relationships between members of various disciplines: nurses, doctors, health visitors, and social workers. We feel that this experience can contribute to the advanced training and education of the relevant disciplines at postgraduate level.

The attachment generated much anxiety in the social worker over fear of failure, or arriving with too many expectations. Prior discussion between the surgery members and the attached worker, we believe, is essential in determining ways of future working together, particularly to clarify what the social worker could or could not do.

Nevertheless, there still remained a sense of discomfort because of the untried and new situation, mixed with feelings of uncertainty, self-doubt, and magical notions of being able to solve everything.

The social worker came with the authority of his psychodynamic skills plus the authority of the Tavistock Clinic, but nagging at the back of his mind was the fear that he might be called upon to do the impossible—to cure long-standing psychiatric problems, and mend marriages instantly. These fears were matched by a wish to do all things and to show the practice that he had something tangible to offer.

One of the complications in the practice was the antipathy towards the Tavistock Clinic for the very high degree of selectivity they used in choosing referrals. It was easy to veer between being " too smart " and a sense of being lost in the alien world of general practice, coupled with a sense of envy and amazement at the doctor—his quick-thinking, ability to make snap decisions, the enormous responsibility he carries on behalf of his patients, the invisible, tangible repertoire of techniques and helping processes at his disposal.

There was a constant worry whether it would ever be possible to give the help expected, and, when the social worker was not in a position to give help, to explain it in a way that was not rejecting, but left the door open to alternative suggestions.

On the other hand, in those situations where one could help, there was a fear of being " sucked dry " by a demanding needy group of people. Interestingly enough, their behaviour had the effect, and maybe the unconscious design, of making the social worker feel what it was like to be on call 24 hours a day. While on one hand it may have been very gratifying to be needed by such important people, on another level there was the fear of appearing incompetent by not being able to " deliver the goods ".

B. Management of the task and its emotional aspects

Because the demands of a large group of doctors could never be met in an attachment of one session per week, a system of allocation became necessary, with its consequent rivalry and competition for the social worker's time and skill. Having to set limitations on the numbers of referrals accepted left a sense of guilt, especially when it was known that the doctor could not do the same with his patients.

However, we all felt that working through these problems of allocation of time and work had its more beneficial effects when we had to face the patient with his demands on the doctor to offer more than he could.

For example, the repeated introduction of a child in the mother's appointment time showed itself to be, in a joint family interview, a disguised demand by the father to cope with the sleeping problems of his daughter and her intrusion into the marital bed at his expense. To have regarded the child as the patient may have been the easiest

way out, but not necessarily the most honest or effective and we felt that facing the limitations in ourselves of what we could offer each other, helped to diminish our sense of guilt when having to do the same with our patients.

Behind the guilt there was a degree of mutual envy between the social worker and the partners, a familiar aspect of any new situation. This was often masked by overt expression of admiration and gratitude followed by the referral of an almost impossible case, as if conveying a feeling of " if you're so marvellous, try solving this one ". First referrals are often of the " testing out " type and constituted the difficult patient who was continually pestering the surgery. Even though we had previously discussed the type of referrals most likely to benefit from seeing the social worker, an explanation of this might be an underlying wish to force the social worker, to witness and even experience the never-ending care of the most intractable patients which is the doctor's lot. The social worker felt that he was being got at, even disliked, for working within well-stated boundaries, using different time scales in his work, and acknowledging his limitations. In doing so he ran the risk of being accused of being cold-blooded, heartless, aloof, or uncaring.

Conclusions

The benefit of collaboration far exceeded the price we all had to pay for it. We were trying to develop new ways in which the psychodynamically-trained social worker could work in general practice. This required modification of therapeutic skills more appropriate to the setting of a specialist clinic. With gratification, we witnessed one another's adaptation to these skills, and provided we could withstand the expectations, external and internal, to produce magical cures, we also observed the patient's response to a doctor with enhanced psychodynamic understanding.

By establishing a close working relationship, in which experiences were shared, and feelings freely expressed, we believe we managed to avoid the traditional split functions of the medicosocial team, where each member has a rather limited view of the patient and his family. We believe that we had a more balanced effect on one another; that our respective roles were reinforced, rather than undermined.

In actively working together in this way we presented to the patient a model of a successfully integrated medico-psycho-social system that offered better therapeutic opportunities to the patient than when separate parts of the system operated apart.

(1) This paper only touches on the broader aspects of social work attachment to general medical practice (Goldberg and Neill, 1972; Ratoff, Rose and Smith, 1974). We have attempted to examine more deeply the nature of the experiences of the members of two different disciplines working together.

(2) Patients were able to bring and explore their emotional problems in the relatively non-threatening setting of their local general practice. We found that attending to what lay behind the symptoms of the patient often resulted in a reduction of the number of attendances at the surgery. If this was done early enough formal referral often became unnecessary.

(3) The attachment provided opportunities for lively discussion of case material (not always leading to direct contact of the patient by the social worker) and these discussions, we believe, are absolutely crucial to the establishment of agreed goals of treatment.

(4) The development of a relationship between two caring professionals allowed them jointly to share and begin, we hope, to understand the anger, despair, uncertainties and psychic pain experienced by the patients and by themselves. The setting of general practice allowed the confused or fearful patient to return with reduced apprehension at a time of his own choosing.

(5) We believe that the attachment of psychodynamically-trained workers to general practice could be officially recognised and lead to the employment of social workers in general practice because it might be expected to strengthen and enhance the service which a general practitioner offers to his patients. We also recognise not all doctors or all social workers would find sharing of care an easy experience.

(6) Although it might appear that time spent in discussion between the care-givers is time lost, our evidence was to the contrary. Misuse of the practice by patients was substantially reduced and experiences gained by the general practitioner were more widely used.

Acknowledgements

We wish to thank the Chairman of the Community Unit Project at the Tavistock Clinic, supervisors, colleagues and secretarial staff for all their help and support throughout the attachment, as well as the partners and staff of the group practice in Highgate, London, whose forebearance and assistance is much appreciated.

Biographical notes

Dr Hilary Graham and Mr Mannie Sher are both married men, fathers and in their middle 30s. They have been working in their respective disciplines for a similar length of time.

Dr Hilary Graham qualified in medicine at London University in 1968 having taken a B.Sc. Degree in Anatomy at University College in 1964. His interest in general practice medicine and community care was confirmed by a year as a vocational trainee general practitioner to the Caversham Centre in North London. After this he became a partner in the Highgate Group Practice where he is currently working.

Mr Mannie Sher graduated with a Bachelors Degree in Social Work from the University of the Witwatersrand in 1964. After working in the Family Welfare field for three years he trained as a Psychiatric Social Worker at the London School of Economics in 1968, followed by three years at the London Borough of Barnet Child Guidance Centre. He has been at the Tavistock Clinic since 1961 doing the multidisciplinary training in Adult psychotherapy. His present post consists of a combination of clinical work, teaching, and consultation.

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USE OF BACTERIOLOGICAL INVESTIGATIONS BY GENERAL PRACTITIONERS

THE numbers of vaginal swabs, faecal specimens, throat swabs, and urine specimens submitted by 104 city general practitioners to the bacteriology laboratory at Aberdeen differed widely. The doctors who made most use of the laboratory service rarely did so equally for all four investigations, but usually for only one or two. Similarly, those who used the service least often made frequent use of one particular investigation. Further studies are needed to identify and evaluate the reasons for the apparently substantial disagreement among general practitioners concerning the values of these different bacteriological investigations in general practice.

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