The role of part-time social workers in general practice

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As an ardent supporter of the use of social workers in general practice, I want to describe the advantages of having, not a full-time social worker, but a team of two or more part-timers working in a practice.

For the past year and a half, four part-time social workers (one whole-time equivalent) have been employed in our three-partner health-centre practice. This is part of a research scheme funded by the Department of Health and Social Security to evaluate the practicalities of employing social workers who can only work part time (Eastman, 1975; Hall and Hall, 1975). The four are all experienced, the leader an ex-psychiatric social worker and former lecturer in a university department of sociology, and the other three all are medical social workers who have young families.

The scheme ends early in 1977, and will be described fully later. A wide spectrum of referrals has been made, with a particular demand for the supportive and counselling skills of the team, a service which the doctors do not feel is so readily, and effectively, available from other sources. All problems which require statutory intervention are referred to the Social Service Department of the local authority.

The advantages of part-time staff

The advantages to a general practice of having such a team, rather than a single full-time social worker, are:

Flexibility

As the team is made up of workers with differing skills and personalities, the doctor has the opportunity to match the patient to the worker who seems most suitable. Also, the team allows the workers to share patients among themselves according to the size of their individual caseloads, holidays, and illness.

Shared resources

Each social worker brings particular skills, contacts, and other resources, all of which can be shared by the rest of the team.

Efficiency

In a crisis, when speed of contact can be important, at least one of the team is available at short notice, in contrast with the difficulties that may arise if, say, a single worker is ill or on holiday.

Mutual support and enthusiasm

There is a danger that a single worker on her own, like a single-handed general practitioner, may become isolated from her peers. The members of our team found great value in being able to discuss problem cases among themselves.

The advantages of having social workers within the practice team have already been well argued (Forman and Fairbairn, 1968; Cooper, 1971; Goldberg and Neill, 1972; Ratoff, 1973; Graham and Sher, 1976). They can be summarised as follows:

Communication

Patients are more readily referred to colleagues whom one knows personally, and whose work can be seen to be good. Having social workers in the practice team allows for both of these factors. Discussion and collaboration about referrals is easy, and the doctor can maintain better control over what is being done for the patient than he would if an ' outside ' worker were involved.

Skill

Social workers with wide experience and skill who have wanted to continue " in the field " have

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had little opportunity to do so outside hospitals and voluntary social work agencies. General practice can now offer them a challenging alternative.

As far as the practice is concerned, such an experienced worker can almost certainly offer more skills in assessment, and provide more wide-ranging and intensive help more quickly, than can her counterpart in a district team from the Social Services Department. The latter will, of course, continue to be a necessary and valuable part of the community services, particularly in statutory work.

Liaison

Because of the continuing need for help from the local Social Services Department it is essential to maintain friendly communications. It has been shown that having a social worker in the practice helps to do this, and improves the use general practitioners make of the social services that are available (Goldberg and Neill, 1972; Ratoff, 1973).

Support and stimulus

Since our colleagues have been with us, we have been able to share the burden of caring for some of our more difficult patients. We have also been helped to rethink our attitudes to social intervention, and to recognise more easily when this is appropriate and possible. This has come through frequent contact with the team to discuss the patients referred.

Multidisciplinary teaching

Our team has been able to teach not only medical students and vocational trainees, but also trainee social workers and health visitors the value and skills of social work within general practice (Goldberg and Neill, 1972; Ratoff, 1973).

Economy

Although we are not carrying out a cost-benefit analysis of the scheme, it is clear that in some cases the expense of both psychiatric referral and admission has been avoided, and in at least one case the initiative and supportive help of one of the team prevented children being taken into care. On another level, patients have been saved bus fares to the local Social Services Department.

Patients' preference

An unfortunate stigma is attached to most local departments of social service and ours is no exception. There is no doubt that many of the patients referred to the team would have declined help, if it had meant them going to the Department. In fact, in the follow-up questionnaires sent to all " closed " cases, patients mentioned how glad they were that doctor and social worker were under the same roof.

These then, are some of the arguments for having a team of part-time social workers as an integral part of the practice team. There is clearly a growing interest in the use of social workers in general practice, and in various parts of the country they are seconded from the local social services department to fill this role.

The Derby scheme (Cooper, 1971) has shown that initial scepticism on the part of general practitioners about the value of such an arrangement soon gives way to enthusiasm, and there are now strong arguments for formalising attachment. It does seem, however, that directors of social service are going to find it increasingly hard to finance such attachments.

A preferable alternative would be for these workers to become integrated into the practice team, as are nurses and receptionists, and to be paid in the same way, i.e. by 70 per cent reimbursement through local family practitioner committees. This idea needs to be debated; if it comes into operation there will be no shortage of part-timers ready to come forward, nor will there be, for long, any lack of work for them to do.

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GENERAL PRACTICE IN THE FUTURE

" In short, hospital medical practice has become a vast system of applied scientific techniques related to the central figure, the patient. The question that needs to be asked is whether this highly elaborate and expensive system is necessary for the majority of illnesses patients have. Is this formidable backing necessary for an individual admitted to a hospital with a chest infection likely to respond to a course of antibiotics? What complex scientific support is required for the emergency appendicectomy, or even for the ' cold ' minor operations for hernia, piles, and the like? Is it necessary for a self-administered drug overdose, where a period of rest and simple nursing care is all that is required in most instances? It is astonishing to realise that in many big hospitals 30 per cent of the medical, as opposed to surgical, ward admissions may be " attempted suicides " from drug overdose. . . .

" It is doubtful whether 90 per cent of investigations in general wards need ever have been done for the welfare of the patient. Reliance on laboratory tests has undoubtedly diminished the clinical skills and self-confidence of the doctors in care of the sick. Possibly 80 per cent of patient/doctor time in the whole country involves general practitioners. The financial support on this basis has been woefully inadequate at the grass roots of medicine. Many general practitioners, in particular in densely populated areas, still work in totally inadequate premises and their facilities are little better than those of 30 years ago. Nevertheless they are state employed no less than the hospital doctor. It is only recently that specialised training as a general practitioner has been available anywhere.

" If any economic sense is to be introduced into the National Health Service, it seems essential to redeploy both manpower and technical resources. In these terms the greatest good for the greatest number will be to recognise that good clinical skill can manage most illnesses, with restricted and relatively simple technical backing. Although it can be argued that many patients admitted to hospital could be nursed at home, that has often become impracticable with the dispersion of families and both husband and wife working.

The solution may lie in developing low cost beds, with medical and nursing supervision, but mainly based on the minimum necessary domestic help and increasing self and mutual care—as would have happened in the home. The medical supervision would logically be by members of group practices looking after their own or their partners' practices in rotation.

" Only if a patient failed to respond to treatment, or if the initial presentation were too complicated, would specialist advice be sought. The general practitioner would in effect be the first line general physician, *and be so recognised* by both the Department and the patient, making it possible for the practitioner to fulfil his or her proper role."

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