THE TEAM 1

Communications between doctors and social workers in a general practice

PHILIP M. REILLY, MRCGP, MARY P. PATTEN, BA and JANET MOFFETT, BA, DIP.SW

SUMMARY. This study describes an investigation into the information and attitudes which were held by a social worker and general practitioners about the same clients, and records the communication between them about these clients.

Introduction

CONSULTATIONS between medical colleagues have an educative and social function as well as their obvious value for the patient. The referral letter, when more than the apocryphal "please see", forces the doctor to summarize his thinking about the patient's problem. If clerical help is available a copy of this summary may become part of the notes together with the formal reply from the consultant, which outlines his investigations, opinion and recommendations for management. Whatever the limitations of this written communication, its importance in a period of increased patient and doctor mobility should not be underestimated. The investigations may or may not add to what is known about the patient's condition. The opinion, however, is awaited with interest, selected parts of which may be discussed with the patient. Thus, further interest is stimulated and decisions may be taken with increased confidence to the satisfaction of both doctor and patient.

Often opportunities will be made to talk over the problems with the consultant, particularly when there is already social contact with him. Nevertheless, even the experience of having attended the same medical school does not guarantee that similar assessments will be made. Some measure of difference, if discussed effectively, can add a new dimension to the doctor's understanding. Effective and enjoyable discussion, however, is normally dependent on similarities in perception, conception and language, plus mutual respect. This is the context in which we explored some aspects of the referral of patients from general practitioners to a social worker.

Philip M. Reilly, Senior Registrar in General Practice, Department of General Practice, Queen's University, Belfast; Mary P. Patten, Sociologist, Lecturer, Department of Extra-Mural Studies, Queen's University, Belfast; Janet Moffett, Senior Social Worker, South Belfast District, Eastern Health and Social Services Board.

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Literature

The social worker's role in general practice has been widely discussed in the past decade. Goldberg and her colleagues (1968), Forman and Fairbairn (1968), Collins (1965), and Ratoff and Pearson (1970) have all emphasized the suitability of general practice as a control-point for the social worker, and this co-ordination in patient care should result from team work. Other reports have given support to the idea of a general-practice team (Royal Commission on Medical Education, 1968; Seebohm, 1968). Studies of such teams have been reported by Cooper (1971), Ratoff (1973), Lamberts and Riphagen (1975), Brook and Temperley (1976), and Graham and Sher (1976). In the latter study the benefits of partnership are seen as the sharing of the despair, anxiety, hopelessness and anger that are the occupational hazards of both professions. A benefit that is described by Brook and Temperley is the contribution made by the non-medical team member (in this case a lay psychotherapist) in planning the patient's care.

There is evidence of increasing sensitivity to the need to prepare if the partnership is to succeed. Lamberts and Riphagen illustrate steps in development of co-operation, and Graham and Sher examine alternative styles of collaboration. In a discussion paper prepared by Ratoff *et al.* (1974), the concepts of subjective and objective difficulties are used to classify types of difference that are inherent in the doctor/social worker partnership. Subjective refers to differences in feelings and attitudes, whilst objective includes more differences in method and tempo of work. These differences are explored in an interdisciplinary workshop and a study group reported by Lloyd *et al.* (1973) and Skelton *et al.*

(1975), in one case using an observer to note variations in approach. Recommendations are made by all these authors, with reference to undergraduate and post-graduate education, to prepare doctors more adequately for work in multidisciplinary teams.

The current study was carried out in a group practice of 9,000 patients in a suburban area of Belfast. The staff include the equivalent of four full-time general practitioners, practice nurses, district nurses, health visitors, clerical and reception staff, and one social worker who is attached full-time to the practice but is also a member of the district social service team. This arrangement means that she accepts referrals from the doctors of the practice, self-referrals from patients, and undertakes adoptions, fostering, and other field-work responsibilities. A social worker attachment has existed in this practice since 1968, though it was initially more limited. A survey carried out in 1972 by Reilly showed that all workers made referrals to the social worker, and staff have been reasonably satisfied with the arrangement believing it to be of benefit both to the patients and themselves. This study, which focuses on doctor/social worker communication, is limited to the scrutiny of cases referred by the doctors. Such referrals range from patients who need help with complex personal problems to those who require information of administrative help.

Aims

Objectives of the present study were to determine if:

a) Comprehensive records (including medical and social data) were available for those patients who had received treatment from both doctor and social worker.

b) Parallel sets of notes, compiled separately by doctor and social worker, contained cross references to the patient's social and medical problems.

c) The patient's history, personality, prognosis and management were perceived in similar ways by both workers.

Method

1. Analysis of records

Forty-two cases were included. The medical records were scrutinized with reference to the following questions:

1. Was any social and/or psychological material noted?	Yes/No
2. Were specific problems noted (in relation to the present referral)?	Yes/No
3. Was referral to the social worker noted?	Yes/No
4. Was a report from the social worker included in the patient's file?	Yes/No

The social worker's records were examined and the following questions were posed:

1. Was a note made of the general practitioner's reason for referral?	Yes/No
2. Was any medical condition noted?	Yes/No
3. Was an initial plan of management set out?	Yes/No
4. Was there reference to, or copy of, written reports to the general practitioner?	Yes/No

2. Questioning the professionals

Both doctor and social worker were then questioned systematically about each patient. They were asked to rate the patients on selected personality dimensions and to identify the patient's predominant mood, traits, and characteristic method of coping. They were also asked to rate intelligence and verbal skills. Questions were asked about the patient's health and about his personal and social circumstances. A group of questions explored the referral process, including what each saw as the social work task, the anticipated duration of treatment and outcome, the patient's feelings about referral, his motivation, and finally his satisfaction with the care he received. They were asked if they had spoken about or written to each other about the patient. The doctor was asked if he had profited from the referral with regard to information and/or new ways of thinking about the case.

Results

A referral book was kept in the health centre by the social worker and an entry made for each case, giving the patient's name, the name of the doctor referring the case, and the date and the reason for referral. In two-thirds of the cases a detailed file compiled by the social worker was available at the health centre for consultation by the general practitioners. Files also existed for an additional group of patients, in whose case the social work service had provided home-help, and these files are retained in the district social services office. Files had not been compiled when the social worker assessed the patient's need as being relatively simple.

Two points emerged from this stage of the survey: (1) although the files were available for consultation by medical staff, the doctors had not made use of them in any of the cases included in the survey; (2) where no file had been compiled, or where a file was retained at the district social services office, it was not the practice to indicate this.

The contents of the social worker's files were scrutinized. The medical condition of the patient was noted in just under half of the notes compiled by the social worker. A plan of management had been recorded for half. There were no references to, or copies of, written reports to the general practitioner in any of the cases.

The medical notes corresponded with this finding, in so far as there was no written material from the social worker. In three-quarters of the medical notes, social

and psychological problems were recorded, though the presenting problem at the time of referral was not inevitably included. The referral to the social worker was noted in the medical notes in one third of the cases. In summary, each set of notes was prepared as an aid to memory for the individual compiling it. Consequently, there is no comprehensive written record of total patient care.

In contrast to the written record, the recall of doctors about their patients was extensive and included psychological and social information, as well as health data. There were only minimal differences between the doctors and the social worker in their knowledge about the patient's history and circumstances. In two-thirds of the cases the prognosis anticipated by both workers was the same. Ideas about the strategy of management—whether the social worker should offer mainly practical help, mainly support or mainly casework—and the anticipated duration of this, were identical in slightly under half the cases. In the remainder, in many of which more than one category was recorded, the difference was one of emphasis.

In the perception of personality, however, considerable differences emerged between doctors and social worker in the perception and classification of behaviour and in the assessment of how well the patient functioned. These differences were so marked that in slightly less than a third of cases, two totally different pictures were drawn of the same patient. For example, the man whom the doctor saw as "quiet, sensitive, intelligent and stable", was to the social worker "reticent and evasive, unstable and of low intelligence."

In more than a third of cases there was agreement in the main areas of the assessment, and in the remaining third, different, but not necessarily mutually exclusive observations were made about the patient. In summary, information about the case and opinion about treatment are likely to be similar, but significant differences emerge in the perception and assessment of personality. A more detailed analysis of the comparison between doctors' and the social worker's perception and assessment of personality is shown in Table 1.

The social worker was more likely to describe the patient's personality in the context of a conceptual system of personality, using classifications such as "obsessional" and "paranoid-aggressive". The identification of predominant mood was more likely to appear as problematical to the social worker, with depression being perceived with greater frequency by the social worker than the doctor.

Table 1. Comparison on structured assessments.

1. Stability—neuroticism	
Agreement	24 cases
Difference	18 cases
Direction of difference: social worker more likely to perceive the patient as neurotic	
2. Introversion—extraversion	
Agreement	19 cases
Difference	22 cases
No consistent direction of difference	
3. Intelligence: high—low	
Agreement	27 cases
Difference	15 cases
No consistent direction of difference	
4. Descriptions of personality: identification of predominant traits	
Agreement	17 cases
Difference	22 cases
Not classifiable	3 cases
Direction of difference: doctors described their patients as "unassuming", "gentle", "appreciative", or "demanding", reflecting the doctor-patient relationship.	

Identification of characteristic methods of coping

This type of analysis proved so unfamiliar to the general practitioners that their responses cannot be compared directly with the responses of the social worker, which are given in terms of the psychodynamic processes—such as direct confrontation, denial, and projection. When the doctors were asked to think about their patients in this way, however, they showed themselves to be familiar with the theories underpinning the processes identified by the social worker, but they did not perceive maladaptive responses as occurring as frequently in their patients as did the social worker. Thus a patient with terminal illness was seen by the social worker as "denying reality." The doctor saw this patient as "understanding" and "accepting" and "facing up to her problem bravely."

The social worker's analysis was more complex than that of the doctor; what he identified as "strained relations", she analyzed as "hostile—dependent marital relationship". His comments are more personalized and usually positive; the patient is "brave", "deeply caring", "a fine person"; this affords a contrast with the technical and usually problematical description by the social worker.

Opinions about personality yielded the most striking differences. Other areas in which there was disagreement in more than a quarter of the cases were in what constituted a "significant event" in the patient's personal history, the assessment of socio-economic status, the degree of integration and support within the community, and the quality of physical health. The social worker was more likely to see the patient as being impaired by his physical condition, as being of lower social class, and as having less adequate material resources. She saw very few patients as isolated from the family or community, even though relationships may have been characterized by friction.

The doctor was less aware of support potentially

available to the patient, and he was more likely to focus on the patient's problems in isolation rather than her ability to use family and/or community. Thus he saw her as needing help and support from an agency for a longer period of time than anticipated by the social worker, who in the plan of management foresaw the possibility of strengthening natural support systems.

The doctor was generally optimistic about the referral and tended to be unaware of patient dissatisfaction in the few cases in which the social worker believed patients to be unhappy with the service. When the doctor was asked about his own gain in information or change in attitude, however, the replies were less positive. In less than a quarter of cases a gain in information was acknowledged, and in less than one in ten cases the doctor was aware of an alteration in perspective as a consequence of sharing the case with the social worker.

Discussion

The small number of cases (42), plus the fact that the survey was concerned with only one aspect of the work of one primary care team, limits the confidence that can be attached to the results. However, some points can be made about general tendencies which would seem to be important for the patient, the members of the primary care team, and finally, the educator.

It would seem that the price that the patient has to pay for a comprehensive record of his case is his willingness for medical and social data to be available to all staff. The commitment of highly personal material to a written record is in theory a protection for him against discontinuity of management or inconsistencies in care either between members of the primary care team or in the event of staff mobility. In practice, it is clear that documentation must be accompanied by case discussion, as staff from different disciplines interpret data differently. When differences in observation persist, and are interfering with the adoption of a team approach to care, joint interviewing may be indicated (as occasionally happens in this health centre). Strategies such as 'saving face' by distortion or concealment, and alignment or playing off one worker against the other, are no longer available to the patient. The subjective intimacy of the doctor/patient or social worker/client relationship may be modified by the introduction of a third party. Inevitably the knowledge that he is being discussed causes anxiety to the patient, and the extension of confidentiality may inhibit him. At the same time, however, the feeling that staff are fully informed about his case and are agreed in principle about management brings security. Inconsistency between professionals may be in the interests of a few patients, but to most it is perplexing and frightening.

The members of the primary care team functioned as a team in that referrals were made and patients therefore received a comprehensive service within the health centre. The comprehensiveness, however, was limited to the administration of their care. There was little evidence of shared perspectives between the professionals. Also, the referrals met an immediate need in patients and management was episodic. This is important when related to the fact that the study excluded those patients whose problem was so simple that no file was compiled, and many of the patients who were referred had bulky medical folders and had presented many similar problems in the past. An example is the patient who had been referred for the solution of a problem related to housing. This patient had presented on a number of occasions with different practical problems. It was unlikely that this single intervention by the social worker would lead to a change in the patient's behaviour. The request for a specific service may have led to less good use of the social worker's skill than joint consultation regarding why this patient was apparently unable to manage her affairs. A team decision about a strategy for treating subsequent demands made by her could then have followed.

Discussions about patients who were being treated by both members of staff were usually initiated by the social worker. In a quarter of cases no discussion took place, and in a further quarter the doctor could not remember if there had been discussion. This, and the fact that no written report from the social worker was expected or received, might suggest that there was little real consultation. Clerical servicing, which was very limited at the time of the study, and a place to meet might have increased effective communication, but sharing only takes place when staff believe it to be of value.

For the educator many questions are raised by the wide discrepancies in the perception of behaviour and the interpretation of observation. A programme of induction into general practice might be recommended for the generic trained social worker (this had been available for the social worker in this study) and ideally, some of this preparation should take place within the specific work setting. It is unrealistic to increase the quantity of medical knowledge within basic professional training, but it should be taught in such a way as to further develop the social worker's sensitivity to the implications of illness and medication on the patient's total functioning.

Conversely, it may be necessary to increase the psychological and social component of medical education. The evidence from this study suggests that the doctors tended not to formulate their observations of personality within a conceptual system. Compared with the method they would adopt to explore and classify clinical observations, their handling of personal and social data was unsystematic. The language they used was lay rather than technical. They were conversant with personality theory, but they had not translated knowledge into skills. This may raise questions as to why this learning was incomplete. In social work training, supervised interviewing, case recording and the growth of self-awareness through a tutorial system are the traditional methods of developing interpersonal

skills, as it is believed that emotional acceptance as well as intellectual conceptualization is necessary. This belief is also held by such medical writers as Balint (1964).

The difference between doctor and social worker in the relationship with the patient, however, is not only a difference in technical expertise, but also arises out of the nature of the task. To the social worker, the patient's personality is of prime importance, whereas to the doctor it may be marginal to his central task of modifying ill health. Thus the doctor spoke of patients as he might speak of friends, and the terms used, particularly in the case of patients who had undergone severe illness, terms such as "brave", "superb under stress", "deeply caring", arise out of situations in which doctors and patients work together against the illness. In some cases he may be missing the complexity of the patient's adjustment. It may also be true, however, that he is exposed to dimensions of the patient's behaviour that the social worker does not normally see. His unself-conscious involvement with the patient affords a contrast to her objectivity—and who can say which is better for the patient?

References

Balint, M. (1964). *The Doctor, his Patient and the Illness.* London: Pitman.

Brook, A. & Temperley, J. (1976). *Journal of the Royal College of General Practitioners,* **26**, 86-94.

Collins, J. (1965). *Social Casework in a General Medical Practice.* London: Pitman.

Cooper, B. (1971). *Lancet,* **i**, 539-542.

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

Goldberg, E. M., Neill, J., Speak, B. M. & Faulkner, H. C. (1968). *Lancet,* **ii**, 552-555.

Graham, H. & Sher, M. (1976). *Journal of the Royal College of General Practitioners,* **26**, 95-105.

Lamberts, H. & Riphagen, F. E. (1975). *Journal of the Royal College of General Practitioners,* **25**, 745-752.

Lloyd, G., Borland, M., Thwaites, M. & Waddicor, P. (1973). *Journal of the Royal College of General Practitioners,* **23**, 463-473.

Ratoff, L. (1973). *Journal of the Royal College of General Practitioners,* **23**, 736-742.

Ratoff, L. & Pearson, B. (1970). *British Medical Journal,* **2**, 475-477.

Ratoff, L., Rose, A. & Smith, C. R. (1974). *Journal of the Royal College of General Practitioners,* **24**, 750-760, and *Social Work Today,* **5**, 497-500.

Reilly, P. M. (1972). Unpublished report.

Royal Commission on Medical Education (1968). Chairman, Lord Todd. Report. London: HMSO.

Seebohm, F. (1968). *Report of the Committee on Local Authority and Allied Personal Social Services.* London: HMSO.

Skelton, D., Adams, S. & Payne, P. (1975). *Update,* **10**, 1103-1110.