Social workers in primary health care: the general practitioner's viewpoint

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SUMMARY. The success of general practitioner/social worker collaboration in primary care depends largely on how the doctors perceive the attachment.

We examined the replies of a group of general practitioners to a series of questions about such an attachment. Although the collaboration may lead to more work for the doctors, it was much appreciated by them.

Introduction

THE importance of collaboration between general practitioners and social workers is now well recognized (Department of Health and Social Security, 1968 and 1974; *Lancet,* 1975), and reports are available from a number of social work attachment schemes in primary care (Collins, 1965; Forman and Fairbairn, 1968; Ratoff and Pearson, 1970; Goldberg and Neill, 1972; Brook and Temperley, 1976).

However, there is a wide gap between acknowledging the importance of such schemes and their general implementation: narrowing that gap depends in part on the attitudes to and perceptions of social work by general practitioners. The Seebohm Committee (DHSS, 1968) observed: "survey after survey has shown that many family doctors do not seek help from social workers nor use social services that are available: they often do not know about them, or do not understand or value them." There seems to have been little change in this situation, as six years later, Ratoff and colleagues (1974), in a discussion of problems in general practitioner/social worker liaison, noted that "overall, relationships between general practitioners and social workers are poor".

However encouraging the results of experimental social work attachment schemes, they cannot be effective if doctors do not accept them, for it has been demonstrated that judgements are made and decisions implemented on the basis of attitudes to and perception of information, rather than on information itself (Shelly and Bryan, 1964). It is thus vital to study general practitioners' perceptions and acceptance of social work in primary care, and this paper reports such an investigation.

The General Practice Research Unit at the Institute of Psychiatry has been operating a social work attachment scheme in collaboration with a South London health centre for the past four years. A varying number (from one to four) of part-time social workers have attended the Health Centre daily to have discussions with the doctors and other staff, to take referrals from them, and to see clients.

Aim

Using this background, we attempted to answer five questions:

1. How far does the doctors' perception of their use of the scheme correspond to the extent of referral?
2. What are the doctors' perceptions of the attachment scheme?
3. What difficulties have arisen as a result of the scheme?
4. Do the doctors believe that the attachment scheme has influenced their management of patients with psychological and social problems, and if so, in what way?
5. How do the doctors perceive the role of the social worker in relation to that of the health visitor?

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Method

The nine general practitioners working at the South London Health Centre were each given a semi-structured interview by one or other of the authors. Each was told that his opinion was being sought on "the management of psychological and social problems in general practice". The interview consisted of general questions about the doctor and the practice, questions about the management of patients with psychological and social problems, and questions specifically relating to the social work attachment scheme. The records of the social workers were then examined to derive figures for referrals in 1977.

Table 1. General practitioners' referrals to the social work attachment scheme, 1977.

General practitioner	Estimated number of referrals	Actual number of referrals	Percentage inaccuracy of estimate
A	100	30	+233
B	50	23	+117
C	40	38	+5
D	40	13	+208
E	52	24	+108
F	16	19	−19
G	30	27	+11
H	20	17	+18
I	30	25	+20

Results

Seven of the practitioners were men and two women. The median age was 50 years (range 32 to 69 years) and the median length of time in general practice was 20 years (range five to 39 years). The number of patients on the list of the Health Centre was over 20,000, and the number for which each doctor was personally responsible varied from just under 2,000 to over 3,000. Their replies are presented in terms of the five questions.

1. How far does the doctors' perception of their use of the scheme correspond to the extent of referral?

The general practitioners were asked to estimate how many patients they had referred to the attached social workers in the previous year, and these figures, with the actual referrals, are given in Table 1. The estimates ranged from 16 to 100, and there were significant negative correlations with age and years in general practice (for both correlations, Spearman's r with correction for tied ranks was $-0{\cdot}73$, $p < 0{\cdot}05$). Six of the doctors felt that their referral pattern had changed over the years. One doctor believed that she made fewer referrals than previously, because of her awareness of the pressure of work on the social workers, while another five felt that they were making increasing use of social work referral, the reasons given being in terms of developing confidence in them and finding the service increasingly helpful. One doctor commented that referring patients to the attached social workers had become a "habit", although he in fact referred the fewest patients in 1977.

The social workers' records showed that the nine general practitioners actually referred 216 patients in 1977, individual figures ranging from 13 to 38 (Table 1). There was no relationship between estimated and actual referrals and, unlike the estimates, the actual referrals did not correlate with age or length of time in practice. All but one of the doctors overestimated the number referred, by amounts varying from five per cent to 233 per cent. The 'reasonable estimators' (Drs C, F, G, H, and I) were in an older age group, had been longer in practice (median test, $p < 0{\cdot}05$, both variables), and gave lower estimates (Mann-Whitney $U = 0$, $p < 0{\cdot}05$) than the 'inaccurate estimators' (Drs A, B, D, and E).

2. What are the doctors' perceptions of the attachment scheme?

The unanimous opinion was that the attachment scheme had been "very helpful". Particularly valued was the "new light" which a social worker could throw on a problem, because of her different approach and the greater amount of time she could spend with a patient. One doctor, who valued the social worker attachment particularly highly, felt that he had been able to share with them the emotional burdens engendered by particularly demanding patients. On the whole, the doctors believed that young patients with acute problems, particularly marital conflict and depression, benefited the most from social worker involvement, whereas patients with chronic intractable problems were felt to benefit the least (as one doctor expressed it, "those who benefit least from any treatment"). Two doctors, however, stressed the importance of the social worker providing support for such patients, one likening this role to that of a "sherpa".

3. What difficulties have arisen as a result of the scheme?

The general practitioners were asked if there had been any "disagreement or conflict" between them and the social workers with regard to (a) confidentiality of information, (b) primary responsibility for patient care, and (c) arising from differing concepts of illness held by the two professions. The unanimous opinion was that no conflict had arisen, but five of the doctors referred to disagreements and differences of opinion which had been resolved by direct discussion. All the doctors felt that involvement of a social worker with a patient could lead to more time being spent, for example, in case discussions or seeing patients at the social worker's request. None of them objected to this, the extra time being regarded as well spent.

4. Do the doctors believe that the attachment scheme has influenced their management of patients with psychological and social problems, and if so, in what way?

The doctors were asked: "Have you found that having a social worker attached to the practice has affected your management of patients with psychological and social problems, and if so, in what way?" All of the doctors answered affirmatively. One said that he now tended to hand over patients with social problems rather than dealing with them himself, but six of the general practitioners felt that the social workers had increased their awareness of social problems generally, and in relation to specific patients, the increased knowledge and fuller understanding of the social situation derived from the social workers allowed them to provide more comprehensive care. One doctor felt that general practitioners in general tended to shy away from patients with emotional problems, but that the presence of the social workers had helped him personally to avoid doing this. Another doctor commented that collaborating with members of another profession led to increasing awareness of one's own professional standards, and helped to keep one "on one's toes".

In relation to specific methods of management of psychological and social problems, two doctors felt that social worker referral was to some extent replacing the use of psychotropic drugs, and two felt that patients who would previously have been referred to a psychiatrist were now being referred to the attached social workers. Two general practitioners believed that referrals to the health visitors had decreased since the start of the attachment scheme, but all of them believed that referral to the local authority social services team had been totally replaced by referrals to the attachment scheme.

5. How do the doctors perceive the role of the social worker in relation to that of the health visitor?

Each doctor was given the list that the social workers used to classify their clients' problems. Each was asked to indicate the problems he thought could "appropriately be managed by a social worker". He was then given a similar list (the same problems, but a different order of presentation), and asked to indicate the problems he thought could "appropriately be managed by a health visitor". The number of doctors so indicating each problem was summed, so that two scores (the 'social worker score' and the 'health visitor score') were derived for each problem (Table 2). The social worker scores were higher than the health visitor scores (Wilcoxon matched pairs signed ranks test $T = 25 \cdot 5$, one tail $p < 0 \cdot 005$), but there was a significant negative correlation between the two sets of scores (Spearman's r with correction for tied ranks, $= -0 \cdot 53$, $p < 0 \cdot 05$).

A quadrant analysis about the medians revealed three problem clusters:

1. Those with high health visitor and low social worker scores—educational difficulties, bereavement, mental handicap in the family, physical disability and handicap, psychological or social problems associated with reproduction or pregnancy, and difficulties with child care.

2. Those problems with low health visitor and high social worker scores—financial problems, criminal problems in the family, difficulties with wider family relationships, difficulties with other social relationships, employment problems, and housing problems.

3. Those problems with above median values for both scores—marital problems, family break-up, social isolation, and loneliness.

The remaining problems had scores on one or both of

Table 2. Doctors' perceptions of the appropriateness of health visitor and social worker referral in the management of psychosocial problems.

Problem	Number of doctors regarding the problem as suitable for health visitor referral (health visitor scores)	Number of doctors regarding the problem as suitable for social worker referral (social worker scores)
Educational difficulties	5	3
Marital problems	5	8
Bereavement	6	5
Mental handicap in family	6	6
Financial problems	2	9
Problems with cultural adaptation	2	7
Physical disability and handicap	8	5
Family break-up	6	9
Criminal problems in family	2	8
Emotional problems or mental illness in patient or family	2	7
Psychological or social problems associated with reproduction and pregnancy	7	3
Difficulties with wider family relationships	2	8
Difficulties with other social relationships	2	8
Child neglect	7	7
Social isolation and loneliness	2	8
Problems with home and family management	6	7
Employment problems	0	8
Delinquency in family	3	7
Housing problems	1	9
Practical problems (transport, clothes)	1	7
Difficulties with child care	8	4
Problems with formal institutions and government departments such as DHSS	0	7

the medians, no problem receiving below median values for both scores.

Discussion

Within the limitations of this study (the small number of respondents and the relatively subjective nature of the inquiry), it is possible to make some general observations about the impact of the social work attachment scheme from the doctors' point of view.

The scheme was perceived very positively: all the doctors thought it was "very helpful", all claimed that it had influenced their practice, and interprofessional conflict was thought to be absent. Forman and Fairbairn in their study of a North Devon attachment scheme (1968) had similar findings: the social worker was thought not to have been helpful in only 5·6 per cent of cases referred.

It is possible that these positive opinions give rise to a 'halo' effect surrounding the activities of the social workers. This is suggested by the degree to which the doctors overestimated their use of the scheme (in one case, by more than 200 per cent), although the more experienced doctors were more accurate in their estimations.

The main reason that the doctors felt so positively was the personal contact that they had with the social workers: they stressed the importance of face-to-face discussion and the lack of formality in the referral procedure. More impersonal social work referral facilities are perceived rather differently. Corney and Briscoe (1977a) compared this same attachment scheme with a "liaison scheme", also in South London, in which social workers took telephone referrals from general practitioners and visited them fortnightly. They found that in the liaison scheme referrals were more formal and less flexible, whereas informal discussions with the Health Centre team were an important part of the attached social workers' activities. Also, they found that the physical presence of the social worker in the practice led to more involvement with and referrals from other members of the health care team, than when a liaison-only service was provided. These findings question the assumption that reorganizing social workers into area-based teams would in itself result in improved client access, but support the view of Smith and Ames (1976), who suggested that closer liaison between social workers and other professional groups (such as general practitioners) might be more important. This view is further supported by the effect of the attachment scheme on referrals to the local authority social workers, which have virtually ceased since the start of the scheme. Also, patients who would not otherwise receive social work help are referred to the attachment scheme (Corney and Briscoe, 1977b).

The relationship that developed between the doctors and the social workers may also have helped to reduce interprofessional conflict. The doctors made reference to differences of opinion that had been resolved by discussion, and one can speculate that similar differences of opinion arising in a less congenial setting might easily escalate into conflict, with subsequent deterioration in relationships between the two disciplines. However, it would be unrealistic to suggest that problems never arise. Graham and Sher (1976) in their account of a North London attachment scheme, reported feelings of rivalry, competition, and envy between the disciplines, but it may be that these difficulties were, at least in part, a reflection of the intensely psychodynamic nature of that particular working relationship.

Developing a working relationship takes time, and all the general practitioners felt that more time was expended when a social worker was involved with a patient. Forman and Fairbairn (1968) estimated that each general practitioner expended an extra one to one and a half hours each week, but commented that in the long run, the social worker would save the practitioner more time than this. It is probably ill conceived to regard the social worker's function as saving the doctor's time, implying that it is inherently more valuable or that the problems undertaken by the social worker are of secondary importance: perhaps the only justification for this is that doctors' time costs more.

The doctors' views on the relative roles of the social worker and health visitor require comment. The Seebohm Committee took the view that the functions of the health visitor and social worker were distinct, and possibly incompatible in one person, and they deprecated the view that the health visitor should act as a social worker in general practice. Conversely, dealing with social problems has long been regarded as amongst the health visitor's responsibilities (Fry *et al.*, 1965), and Hicks (1976) cites a study by Jeffreys and colleagues who found that "family problems : psychosocial" was the reason for contact in 25 per cent of patients seen by health visitors attached to a group of metropolitan practices.

In our study, many of the problems on the checklist (problems which the social workers themselves regarded as constituting the bulk of their responsibilities) were seen by the doctors as appropriate for health visitor management. Some problems (cluster three above) were seen by the majority of doctors as more appropriate for health visitor than social worker management. However, the roles of the two professions were not seen as identical, as indicated by the negative correlation between "health visitor scores" and "social worker scores", and the distinct groups of problems regarded as appropriately managed by the two professions: problems associated with physical illness (cluster one above) by the health visitors, and practical and relationship problems (cluster two above) by the social workers.

It is not only doctors who have difficulty in distinguishing between the roles of the health visitor and social worker: the same issue arises within the two

professions. There is a striking degree of overlap between the responsibilities of the health visitor as detailed by the Mayston Report (DHSS, 1969), and those of the social worker as defined by a working party of the National Institute for Social Work (Goldberg and Fruin, 1976). This highlights issues of the appropriate training and effective deployment of these two types of health worker for optimal patient management in primary care, which can be settled only by future research.

More research is also needed into other aspects of social work attachment schemes; for example, outcome (Cooper *et al.*, 1975), and the effect of such schemes on variables such as psychotropic drug prescription, psychiatric referral, and other parameters of general practice.

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Addendum

A copy of the interview schedule may be obtained on application to Dr P. Williams, General Practice Research Unit, Institute of Psychiatry, de Crespigny Park, London SE5.

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Communicating medical information

A house surgeon, while taking the history of a young woman admitted with acute appendicitis, asked if she was on the Pill. She replied that she was. After the operation she went into a coma. It was thought that she might have had a cerebral arterial thrombosis, as a complication of the general anaesthesia and predisposed to by the contraceptive pill. In fact, the coma proved to be diabetic. The pills that the patient had been taking were chlorpropamide.

The physician who supervised the restabilization of the diabetic state remarked to the patient that it had been rather unintelligent of her not to tell the house surgeon that she had diabetes. She allowed her quick Irish temper a little rein and replied that it was rather unintelligent of the house surgeon not to have asked her what pill she was taking. The houseman grumbled that the most basic lack of intelligence had been that displayed by the family doctor in not mentioning that the patient was diabetic when he sent her for admission with appendicitis.

The surgeon who had taken out the patient's gangrenous appendix, bored by the chain of recrimination, was looking through the patient's notes. He silenced everybody by reading aloud from the family doctor's letter, which began: "This patient is a well stabilized diabetic. She takes chlorpropamide tablets, 200 mg daily, and this keeps her well controlled. She seems now to have acute appendicitis. This started . . .".

Afterwards, the physician said to the surgeon, "It wasn't very intelligent of you to operate without reading the doctor's letter, was it?" The surgeon agreed.

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