A course in collaboration for social workers and general practitioners

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SUMMARY. Patients have overlapping social and medical needs, yet social workers and doctors often have problems in working together to help with them. We planned a short experimental course which was to look at this situation and to help members of both professions learn about each other. This was to encourage attitudes of mutual trust and respect in order to promote future collaboration.

The social workers had all qualified within the past year and were working in their first appointment, based either in the community or in a hospital. The doctors were training to become general practitioners and were either members of a three-year vocational training programme or were working in a one-year attachment in local practices.

Each session started and ended with the whole course together, but the core of each meeting was case discussion among small mixed groups. In this way social workers and doctors were able to explore together mutual problems of patient care.

Introduction

THE difficulties that social workers and general medical practitioners have in working together have been reported by Ratoff and his colleagues (1974) and by Steel (1979), who also tried to outline what could be done to improve relationships between members of the two professions. Harris and Fletcher (1974) pointed out the need for joint training experience and described an attachment programme where training was shared. The Standing Liaison Committee of the Royal College of General Practitioners and the British Association of Social Workers (1978) have made suggestions about training objectives and have described the areas in which each profession seems to know least about the other. Schenk (1979) gave an account of a brief course held in Rotterdam which included trainee social workers and trainee general practitioners. This course emphasized the importance of sharing information and studied practical skills through rôle-play. However, when the course was evaluated, it emerged that the participants' original prejudices remained unchanged.

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Aims

Drawing on this experience, we accepted that only limited objectives could be achieved within a short course and recognized that only a limited amount of time was available. Nonetheless, we planned to try and modify the attitudes of social workers towards doctors and of general practitioners towards social workers, so as to foster mutual understanding and co-operation between them. Within the framework of an existing once-a-week training course in general practice, we set aside three consecutive afternoon sessions during which general practice trainees and recently qualified social workers worked together.

We defined four principal course objectives and circulated them to everyone who intended to come:

1. The participants will identify areas of doubt and misunderstanding about each other's way of working in order to promote relevant discussion of such difficulties.
2. They will discuss the impact of illness and treatment on their individual clients or patients in order to share the problems of trying to help.
3. They will attempt to reduce misconceptions by learning about each other's respective professional roles.
4. They will examine some of the legal responsibilities

of each profession in order to understand the formal professional and legal procedures used.

Method

The 17 doctors attending the Northwick Park general practice vocational training course included one-year trainees working in general practice and three-year trainees, some of whom were also working in general practice and some of whom were engaged in a variety of hospital jobs. They all had at least some experience of general practice work and were all used to regular participation in the weekly training course.

We invited all the qualified community or hospital-based social workers within the district who had been appointed to their first job during the past year to join the course. Time was made available for them to attend. In all, 18 put their names forward.

The two professional groups were of similar size and were made up of people who had completed their basic professional training and were working with a more or less comparable level of supervised professional independence. We hoped that they might, if given the opportunity, recognize each other as peers within the caring professions. This idea, of developing groups of peers out of the two disparate sections of the course, was central to our aim of influencing the attitudes of the participants towards each other. In order to get them to work quickly towards developing mutual understanding, the course members were invited to select the subject matter to be studied and to plan and present the discussion material. The structure of each session was, however, predetermined. The whole course met together for the first hour and then, after a break, was divided into three small groups of equal numbers of social workers and doctors. They had an hour and a half together for detailed case discussion, followed by a brief plenary session to end the day. These discussions were led either by a senior social worker or a general practice trainer with experience in leading groups.

The first day

The first session began with 'buzz-groups' of three or four people and with members of both professions in each group. They were asked to specify the topics which could be most helpfully dealt with during the next three weeks. After 20 minutes, views were shared and common threads of interest identified. The subject chosen by most of the groups was confidentiality, followed closely by problems to do with professional roles, and then by questions about statutory and contractual responsibilities. Uncertainties about how each profession was trained for its respective work also attracted attention and were chosen for immediate discussion during the time still available in that session. The doctors and social workers were asked to describe their views of how a member of the other profession ought to be educated. A general discussion then cleared the air of grosser misconceptions. After a tea break, the course divided into three small groups and for an hour and a half engaged in detailed discussion of cases currently under the care of the participants. There followed a brief plenary session to plan the next meeting and decide who was to research the main topics and to introduce them.

The second day

The second session started with a discussion of confidentiality and was introduced by course members. This provoked a lively debate during which it emerged that the social workers were far more worried than the doctors about team-work, shared secrets, access to records and clients' consent. There was then a presentation on statutory duties; this too was discussed by the whole course. After tea there were further small group discussions about cases.

The third day

In the final session we looked at differences in the professional roles of each group. This was again introduced by course members chosen at the previous session. They had chosen to role-play a brief consultation at a doctor's surgery and an initial interview in an area social services office. This very lively material provided ample opportunity to compare work styles, intentions, the use of time and the varied therapeutic options available. After further small group discussions of current cases, a final plenary session allowed each of the small groups to report on their work. We then held a discussion about what had been learned during the course.

Results

Small groups

An important feature of the course was the regular use of small groups in which the participants found themselves discussing in detail the cases that were currently under their care. They provided a forum for sharing the problems and stresses of coping with clients and patients. The first session seemed to have a rather competitive atmosphere as social workers and doctors vied to show how difficult their work was and how unlikely it was that the other would do any better. However, by the third meeting cases and problems were being shared and puzzled over with mutual concern and in all three small groups there was warmth and fellow-feeling.

Assessing the course

The final plenary session left no doubt that the participants had enjoyed the course, felt that they had learned about each other and had become more tolerant of each other's views. One of the social workers said that she

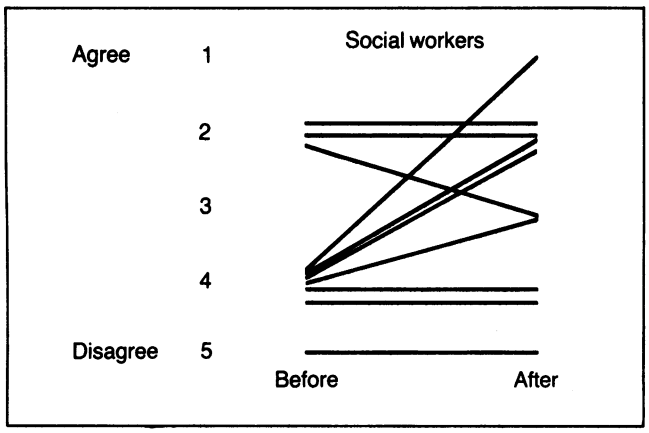

Figure 1. *Statement 13 "Despite having only five or six minutes for each consultation a general practitioner ought nonetheless be able to perceive and understand a disturbed family's reaction."*

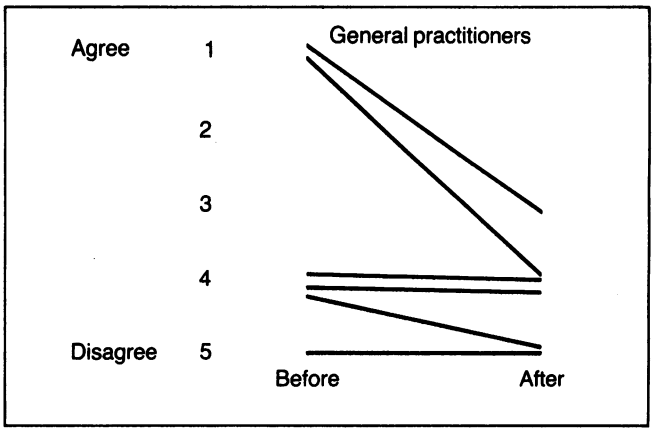

Figure 2. *Statement 18 "A social worker should concentrate on arranging resources and leave the psychological aspects of illness to the general practitioner."*

had spent a lot of time the previous week telephoning general practitioners to discuss her cases with them; this had previously been rather a rare activity for her. The doctors seemed to feel that they would like to work in practices that had attached social workers.

We achieved the four stated objectives of the course. This was largely through leaving the actual choice of topics to be examined to the participants. However, it was more difficult to assess whether there had been any positive change of attitude by the participants. Indeed, there were organizational aspects of the course that limited its impact and made assessment more difficult.

First, only six doctors and 10 social workers actually attended the whole of the course, although all of the others participated enthusiastically in those sessions that they did manage to attend. Secondly, since the course had a large element of self-direction in determining the subjects to be discussed, it was not possible to plan 'before and after' tests to measure how much learning took place. Finally, as the previous personal and professional experience of the two groups was very different, we had decided to experiment with a relatively unstructured course which we hoped would allow people to learn from their individual starting points. This seemed more suitable than a formal approach which would have assumed that we could anticipate the needs of the students as a heterogeneous group and teach them a defined body of information. Whereas many of the doctors had had essentially similar previous training, the social workers had had very dissimilar previous experience; in addition, the social workers were all working in rather similar settings, whereas the three-year trainees were working in various branches of medicine. As the participants started from these different bases of knowledge, experience and attitude, the evaluation of the course was inevitably both incomplete and inadequate.

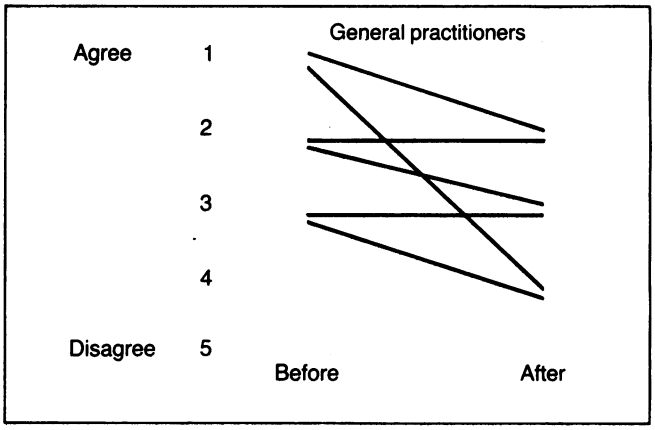

Figure 3. *Statement 15 "A social worker ought to be more professionally trained than at present."*

Despite these problems, we attempted to find out if any consistent change of attitude was taking place. Before the course began and after it was over we asked all the participants to complete an attitude scale (see Appendix), constructed on the lines described by Likert (1932). Comparison of the scales completed by those who attended the whole course showed relatively small but consistent changes. Those who had managed to attend only one session showed no change at all. Some of the social workers became more inclined to believe that general practitioners work with emotional problems and that they can be sensitive to family dynamics despite the limitations imposed on them by shortage of time (Figure 1). The doctors moved towards accepting that the social workers should work with the psychological as well as the material problems of their patients (Figure 2). They also seemed to become less certain that social workers need to be better trained than at present. This suggests that the course led them to an increased respect for social work training (Figure 3).

Discussion

Social workers and doctors are busy people and many found it difficult to attend the course regularly. Both have common areas of concern and in some fields use similar skills. Yet they have very well-known difficulties in working together with confidence and trust. The shortage of money available for developing health care and the rising demand for help from the caring professions create a powerful argument in favour of social workers and family doctors learning to work together efficiently. Their clients (or patients) need appropriate help from both professions but with a minimum of unnecessary overlap or misunderstanding.

We think that the attitudes of individual workers towards each other provided a more relevant focus for a brief training course designed to encourage mutual understanding than attempting to offer didactic instruction about the factual minutiae of each other's work. We acknowledge that many of the participants still lacked useful information about each other at the end of the course, but, nonetheless, the structure of the course involved them in intensive discussion of actual cases and allowed them to concentrate on the way the other professional group approaches its work. We hope that in this way the seeds of a change in attitude have been sown and that greater interprofessional trust and collaboration have been encouraged.

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Acknowledgements

It is a pleasure to record our thanks to Dr John Salinsky and Dr Mark Sundle who helped lead the small group discussions and to Mr Terry Bamford and Miss Marjorie Inkster for their support.

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Appendix

Name.....S/W ☐ G/P ☐

Please respond to the following statements by showing how much you agree or disagree.

If you agree strongly — encircle 1
If you agree — encircle 2
If you feel neutral — encircle 3
If you disagree — encircle 4
If you strongly disagree — encircle 5

	AGREE			DISAGREE	
1. A good general practitioner ought to conserve his time for the ill patient rather than the neurotic one	1	2	3	4	5
2. A social worker ought to understand a client's medical problems	1	2	3	4	5
3. There should be a social worker attached to every general practice	1	2	3	4	5
4. Personal problems of the patient/client ought to take precedence over legal responsibilities to society	1	2	3	4	5
5. A general practitioner referring a case to social services ought to give full confidential details to the duty officer, who may well not deal with the case personally	1	2	3	4	5
6. A general practitioner's main job ought to be sorting out the ill patients needing hospital care from those with trivial problems	1	2	3	4	5
7. Problems to do with poverty are best dealt with by social workers	1	2	3	4	5
8. Helping parents cope with an awkward acting-out adolescent ought to be part of a general practitioner's work	1	2	3	4	5
9. General practitioners are, on the whole, overworked	1	2	3	4	5
10. A case conference called about a client originally referred by a doctor should be attended by him	1	2	3	4	5
11. The more efficient the general practitioner is, the less the need to call upon social workers	1	2	3	4	5
12. A social worker ought to refer a client directly to a psychiatrist, if necessary, without depending on the general practitioner's view	1	2	3	4	5
13. Despite having only five or six minutes for each consultation, a general practitioner ought nonetheless to be able to perceive and understand a disturbed family's interaction	1	2	3	4	5
14. Every general practitioner ought to visit the local social services office to keep in personal touch	1	2	3	4	5
15. A social worker ought to be more professionally trained than at present	1	2	3	4	5
16. A general practitioner ought to be willing to help a social worker assess the need of an elderly patient to have a telephone fitted and paid for	1	2	3	4	5
17. A social worker ought to take on only as many cases as can be dealt with properly	1	2	3	4	5
18. A social worker should concentrate on arranging resources and leave the psychological aspects of illness to the general practitioner	1	2	3	4	5
19. Marital disharmony should be dealt with by either the social worker or general practitioner depending on the client's preference	1	2	3	4	5
20. If a social worker finds a client to be suffering from an illness, she ought to advise the general practitioner what she thinks is wrong	1	2	3	4	5