*Social problems in general practice**

BY JANE E. PATERSON, M.A., A.M.I.A., EDINBURGH, SCOTLAND

Before coming to speak to you to-day I had the benefit of a discussion with some of your members whom I met in London in november when we were all attending a conference of the British College of General Practitioners.

They suggested that I should describe general practice and the general practitioner as seen through the eyes of a social worker. The last remark that was made tot me by one of your members was this "please tell the doctors just what they are like". I felt that this might be rather one-sided, in that I would have an opportunity to state my views, and you might not be able to state your views as fully as you would like to do. However as it was a serious request I have thought a lot about it and feel that the best way of meeting it would be to look at some of the reasons why we should be working together and in what ways we can work together. The answer to the first question lies in the past, the answer to the second lies in the present and future.

Many writers have suggested reasons why medicine in its development from an art to an exact science could not hold to its central purpose which is the care of the patient. One of the most interesting descriptions of this difficulty is provided by the novelist *Stefan Zweig* in the introduction to his book "Mental Healers". This is the name he gives to Mesmer, Mary Baker Eddy and Sigmond Freud, rather unorthodox practitioners whose ministrations to sick people seemed to achieve a success which the practitioners of medicine at its most scientific stage of development could not do. Treatment by the mental healers was rather puzzling to orthodox practitioners because as the writer says: "Looked at dispassionately the system of these irregular practitioners is hard to grasp and often appears ludicrously simple. The healer and the patient sit peacefully side by side and seem to be talking pleasantly to one another." This is very different from what a doctor was supposed to do at the time of which Zweig was writing, yet these practitioners were in some cases having very great success in healing. Why were patient turning to such people for help rather than to their own doctors? I would say that it was because they were giving personal care.

The concept of personal care is not new. It was present in primitive times when the doctor and the priest were one person. The Biblical story of the Good Samaritan tells of a man who cared not only for the patient's body but also for his personal circumstances. *Dr Fox*, editor of The Lancet, tells us that: "When personal medical care is abolished, it is sooner or later re-invented". The concept of personal medical care is ageless and though it may change and be refined as knowledge progresses, or be forgotten as fashion changes, it never dies.

Zweig ascribes the decline in personal medical care in the nineteenth century to lack of personal investment in the healing process on the part of the doctor. "The clinical and diagnostic methods of the contemporary physician demand a nerveless clarity of mind and complete tranquillity of soul" and again to specialisation (I quote Virchow speaking at a medical congress in Rome). "There are no general diseases. From now on we shall recognise only diseases of organs and cells". And again to a third development: "A third entity slipped itself in between patient and practitioner, an entity which was absolutely devoid of spirituality, an entity which we may call the apparatus. More and more superfluous for diagnostic purposes had now become the penetrative insight and imaginative comprehension of symptoms which are the gifts of the born healer." This idea of the apparatus coming between doctor and patient we will leave for the moment, but it is a most important one if we are to understand the place of the social worker in general practice.

I have mentioned as a recurring theme, the helper and the person helped, the doctor and the patient, this relationship between two persons engaged in the healing process. Whatever influences may have worked to separate them, these two persons have remained together from primitive times until the present time. Let us look at some of the more recent pronouncements on this subject of the doctor and his patient. *Dr Francis Peabody* says: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient". *Dr Richard Scott* tells us that the family doctor is: "A friend, and indeed in some senses a member of the family". *Prof. Lyle Saunders* of the University of Colorado suggests that: "The medical professional person must know his own field. But no amount of technical or professional training will enable him to be fully effective unless he also has a second skill, that of competence in interpersonal relations. Here his competence may be intuitive or informed; it may have been unconsciously or deliberately acquired; it may have been formally or spontaneously developed; what matters is that he has it and use it in his

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professional relationships". In 1960, bringing us right up to date, we have Dr Fox telling us that: "To be a good doctor, a man must really take care of his patients; he must make diagnoses and take decisions, not merely write little notes to specialists."

I have chosen these examples from the many that are available in medical literature, for they all indicate in their different ways what I have said, that personal care of the patient by a doctor making a personal investment in the process is indeed ageless. Now in 1961 with experiments in medical education designed to make the intending doctor aware of the need for personal care, we have come back to the stage where the relationship between doctor and patient is as important as it was in the days when medicine was an art, and the healing process one in which two persons co-operated actively.

It is important that we do not lose sight of this relationship again, now that teaching about it is formally recognised to be part of the medical curriculum. I wonder whether the introduction of a social worker into this relationship is really desirable. Let us remember now the statement that the apparatus got between the doctor and his patient. Is the social worker a piece of apparatus? This is something we should look at more closely.

The modern doctor uses many pieces of apparatus which are designed to carry out more quickly or more precisely something which he could do by himself fairly well. He uses not only apparatus but also persons to help him in his work. The nurse does dressings, tests urine, gets the patient ready for examination, imparts the principles of health education. The radiographer takes X-Ray photographs. The dietitian helps the patient to adjust food intake. The doctor could do all this, more slowly and less expertly because he bas not developed in himself the refined techniques used by these workers. Their education is essentially medical, less comprehensive than that of the doctor, but still medical. He is in charge of their work and directs what they will do for the patient.

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What about the social worker? Her education is essentially non-medical. It lies in the field of psychology and human behaviour — the study of the individual, in the field of social, cultural and group behaviour — the study of the community, and in the field of history and economics — that is the study of society. To this basic education may be added medical information, or knowledge of psychiatry, or knowledge about family problems, or knowledge about child care. There is some specialisation in social work.

In the medical social worker like myself, we have someone who knows a little about medicine, mainly how diseases affect the patient in his social functioning. In many ways, if the doctor could use such a person as a piece of apparatus, it would be very convenient for him, as she would carry out his orders and not dispute with him about the merits and demerits of certain courses of action. As it is, the social worker sees things differently from the doctor. Her view of the situation is complementry to his, rather than the same. She cannot work for him but must work with him. This is difficult to explain, and I can only do it in this way. *Walter Cannon*, the American physiologist, stressed the importance of the doctor's role in acting as a comforter to his patients. His ability to do this is "based on the ample evidence that in the body there are admirable devices for maintaining its stability against disturbing internal and external conditions".

In other words, the doctor can hope and can impart this to the patient, because he knows the body's powers for adjustment and maintenance of equilibrium. When dealing with a complex social problem on the other hand, the doctor is on less sure ground. I have seen some of my medical colleagues depressed or agitated by a social illness which seems to them as great a tragedy, and as incapable of solution, as the diagnosis of rheumatoid arthritis in a young adult seems to me.

They cannot see in the social situation the capacity of the individual for adjustment and maintenance of social functioning as I can. I cannot understand as they do the capacity of the body for satisfactory physical functioning in spite of the disease. They cannot give personal care because of their lack of knowledge and I cannot give medical care. This is why we should work together, so that what your profession has lost in the course of the years, my profession can help to replace.

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Now that we have answered the question to some extent of why we should work together, let us look as some of the ways in which this can be done. How do we work together?

In 1957, the Unit of which Dr Scott is Director, carried out a study into the functions of doctor, nurse and social worker. Some of our findings have been published, some are yet to be published. I will use material from this study to illustrate the social worker's ways of dealing with social problems in general practice, and how she works with the doctor.

The traditional method of social work is that of direct service to the patient. The social worker, rather like the mental healers we have mentioned, talks with the patient, assists him to look at his problem, to describe his feelings about both the factual and the emotional components of it. She then makes an assessment both of the problem and of the patient's strengths and weaknesses in dealing with it, and begins a regime of treatment. In doing this the social worker must remember, for example, that sick people do not function at their usual level of competence; that she may recall to the patient someone in his life whom he disliked; that different nationalities may have different attitudes to medical care; or that someone who has a very low income cannot provide an expensive diet. She has to be sure that

she does not project into the patient's situation the feelings she would have if similarly placed. Each problem is an individual one. Admittedly some problems she likes dealing with less than others. She must know why this is so.

Treatment may range from weekly discussions, which are less than psychotherapy but much more than a discussion between friends, to the giving of information about the nature and function of social insurance.

In our practice of about 5000 patients, the social worker gave this direct service on 2715 occasions in one year. This was the number of times that she discussed the patient's problems with him. The doctor, on the other hand, interviewed patients more than ten times as often as the social worker. He had 32,418 interviews with patients in the year, but in only a small proportion of these was he discussing the same problems with the patient as the social worker did. At his interviews he was taking a history of the illness, examining the patient's body, making tests, prescribing medicine, and giving explanation and advice about the illness. He discussed problems arising from the patient's social environment at 11 percent of his interviews. The social worker discussed some such problem at all of her interviews.

These interviews contained many different factors. At 72 percent of them the patient had a problem of material need. Financial difficulties, such as overspending on inessential luxuries, failure to meet current obligations such as rent, loss of income because of illness and such matters were found at 24 percent of all interviews. Poor housing accommodation was a problem at 18 percent. I should perhaps explain that housing is inadequate in most of the industrial cities of Scotland. Just over one quarter of the patients were living in households which contained more than two persons per room. Sometimes it is impossible to obtain alternative accommodation for the patient who has heart disease and lives at the top of a block of flats.

Inability to provide clothing and household goods was found at 12 percent of interviews. This sometimes happened when an elderly person, living on the Retirement Pension, had to attend hospital for examination, and wanted to have new underclothes so that the nurses and clinician would not think she was neglectful of good standards, or else when a mother with a large family could not equip her child to go to a convalescent home, because the family income would not stretch to the purchase of a new outfit.

Employment of the disabled patient; domestic help for the elderly housebound person; temporary care of the children during the mother's illness were discussed by the social worker in that order of frequency. Some patients, no matter how distressing the problem may be, do something on their own initiative to alleviate it, after it has been discussed. This is very often possible because their feelings about it have been expressed, and they are free to think more clearly. Others, because of poor mental ability, social incompetence, or the sort of paralysis which appears to overtake even the most intelligent person when he is ill and frightened by being ill, needed help to understand what social resources in the community were available to help them.

At 63 percent of interviews the social worker gave information. She told the patient what the resources of the community could do to help him in his particular difficulty, how he could obtain this help, and where to find it. Some resources were better known than others. Those dealing with the broad financial provisions for sickness, unemployment and old age were generally better known than those designed to assist sufferers from particular handicaps such as cerebral palsy, blindness, multiple sclerosis, and so forth. Full understanding about the nature and the scope of the help to be expected from institutions dealing with social problems often had to be given very carefully, so that the patient would not enter upon a course of action with false hopes. In many cases this giving of information was the main treatment, in others it formed but a part of a complicated regime.

At 42 percent of all interviews held in the course of the study, the social worker discussed a problem in human behaviour, as seen in the relationship between the patient and some other person. Difficulties between husband and wife were by far the commonest, being found to form a part of the discussion at 23 percent of all the social worker's interviews. Early marriages between immature partners, the interference of well-meaning but misguided relatives, impairment of the mother's health through too frequent child-bearing, and the intolerable nature of some over-crowded housing conditions were fruitful sources of difficulty in the marital relationship. In some instances the mental unbalance of one partner created an insoluble situation, and necessitated the social worker helping over a long period of time. Difficulties in relationship between the patient and his children occurred in 8 percent of all interviews. Sometimes this was related to the feeling on the part of the elderly patient that he was not welcome in his son or daughter's home. Sometimes mothers rejected their children who were mentally or physically handicapped. In the case of poor relationships with persons outside the family group, 9 percent of all interviews centred on these, and many patients were in conflict at work, in school, at the hospital, even with the family doctor at times.

In 12 percent of the social worker's interviews were the problems arising from attitudes towards illness, irrational fears about treatment, and superstitions connected with these. Some patients seemed to find comfort in putting their fears to a lay person, sometimes on the basis that the doctor would think them stupid. It is impossible to describe the variety of fears and attitudes that were found, and this points to a need for health education and also for better

communication between medical staff and the patient who is ignorant of the significance of words used. The taboos associated with childbirth, tuberculosis and skin disease give rise to many distressing problems.

The social worker was not the only member of the medical team to discuss these personal problems with the patient. The doctor did this at 3,2 percent of his interviews, and the nurse at 3,6 percent of hers. The social worker, as a result of her different education, was able to find and diagnose these at 42 percent of the times when she interviewed the patient.

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In some of these 2715 interviews, undoubtedly the social worker was used like a piece of apparatus in carrying out the doctor's orders and in doing what he could have done equally well by himself. There is no magic in obtaining financial aid for a patient who is anxious about a debt, or in giving information about a source of help in the community. The social worker will do this for the doctor in the same way as a nurse will do a dressing of a wound.

What is different is this: The doctor says to the social worker "Please take on this problem of my patient Mrs X. who is anxious because her child is behaving badly. She is tired and wants to place him in a nursery." What happens is that the social worker in discussing the problem finds that the real cause of the difficulty is something different. Husband and wife are unhappy together, they quarrel over money and their sexual relationship is impaired; the wife is frigid and the husband is dissatisfied and jealous. As a result the child is behaving badly, and the confused mother can see no solution but to place him in a nursery, as she feels defeated.

In this area of direct service, then, the social worker has contributed something more than a piece of apparatus could be expected to do. She has added to the diagnosis. Arguments as to the difference in diagnosis made by the social worker arise from time to time. These have to be resolved, and this is generally done by consultation — which is another method of working together.

The social worker discussed her work in relation to 21 percent of all contacts with patients, with members of the medical team. This discussion was with the doctor alone in regard to 10,4 percent of all occasions when she interviewed a patient.

What does this consultation with the doctor achieve? I think it is an educational process, a two-way activity. The social worker uses the doctor's medical knowledge to enlarge her own assessment of the situation. She must know what the course of the illness is likely to be, otherwise she cannot care for her patient's personal needs. As well as this she contributes to the doctor her understanding of the patient's social circumstances, and personal attitudes, and so enlarges his assessment of the situation.

What happens in this mutual consultation apart from enlargement of knowledge for both doctor and social worker? *Dr Balint* of the Tavistock Institute of Human Relations has spoken of the doctor's "apostolic function", his need to put the world right, and to tell people how they should behave. I have every sympathy with this apostolic function of the doctor. What has not been achieved by this drive to get results, to make people better, to force them to take care of their health? Unfortunately, however, doctors tend to project this attitude into the social problems they encounter. Because social work is not an exact science, it has no means of proving that nothing can be done, and this is anathema to a doctor who is trained by scientific methods. His expectations of social work are sometimes far too high, and he feels that all this talking indulged in by the social worker, if directed to the proper end, ought to solve the problem. He can readily accept that a malignant growth is inoperable, but cannot always agree that a personal realtionship is broken beyond repair. At times he wants to take back the social problem from the social worker and do something about it himself, as he would do in the case of physical illness.

The social worker's most important contribution is her upholding in her consultations with the doctor several principles, on which all good social work is based. These were enunciated by *Prof. Gordon Hamilton* of the New York School of Social Work, and as they are phrased in American social work terminology, I had better interpret them to you, as follows:

1 Any ability to help others effectively rests on respect for the human personality. In other words, it is no use hoping to help any patient whom you regard as a malingerer.

2 Help is most effective if the recipient participates actively and responsibly in the process. It is unwise to do things for people: they must do things for themselves with your help.

3 Respect for others includes respect for their differences. A patient of different nationality or religion or with social habits which you do not pursue, has a right to be and do these things.

4 Self-awareness is essential in understanding others. You must realise what emotional implications the patient's problem has for you.

5 The individual has responsibility not only for himself but also for the society in which he lives. You should not encourage your patient in a course of action that is harmful to others even if he rejects you because of it.

Some of these principles strike hard at the apostolic function of the doctor, by introducing a sort of equality between the patient and the helping person, and an investment of the personality of the helping person in the healing process. The social worker

can help the doctor to modify his apostolic attitude, by showing him that there are other methods of promoting the healing process than direction. The doctor may feel that she gets between him and his patient like a piece of apparatus, but at times he will admit that she adds something to his relationship with the patient, and what is more important, that she alters it.

I once heard Dr Dean Clark of the Massachusetts General Hospital define an enzyme in an unconventional way; what he said was very meaningful for social workers, I thought. "The function of the enzyme is to facilitate chemical reactions of living things; to help them to occur .... It used to be thought that enzymes did this in a kind of passive way; did not themselves take part in the reaction, were not changed or destroyed themselves. Now we know better: enzymes do take part in the reaction; actually participate, and enzymes are changed in the process, are destroyed little by little".

The aim of the social worker in general practice should be to facilitate the doctor-patient relationship by means of participation in it until such time as she has worked herself out of a job. In the unique situation which is the doctor-patient relationship, who wants a social worker anyway? Like the enzyme she should make it possible for doctor and patient to react more positively on one another by means of consultation and discussion. If she is destroyed in the process, she will have justified her existence.

Balint, M. (1957) The Doctor, his Patient and the Illness. Pittman, London.

Cannon, W. (1932) The Wisdom of the Body. Norton and Coy, New York.

Fox, T. F. (1960) Lancet I, 743.

Hamilton, G. (1948) J. soc. casework, october.

Peabody, F. W. (1927) J. Amer. med. Ass. *141*, 877.

Saunders, L. (1954) Cultural Difference and Medical Care. Russell Sage Foundation, New York.

Scott, R. (1949) The Almoner I, 209.

Zweig, S. (1933) Mental Healers, London.

VAN DE WERKGROEP: VERLOSKUNDE VAN DE HUISARTS

Kraamvrouwen naar maatschappelijke groepering

In dit overzicht wordt de vraag behandeld of de wijze, waarop de huisarts de verloskunde beoefent, wordt beïnvloed door de sociale status van de kraamvrouw. Wij waren ons er van bewust, dat dit een netelige kwestie zou kunnen zijn.

Wanneer in dit hoofdstuk, beperkt tot de enkelvoudige geboorten, wordt gesproken over de uitkomsten van het verloskundig werk en deze uitkomsten worden gekenschetst met „perinatale sterfte" en „asfyxie", dan moet vooraf worden opgemerkt, dat een al of niet gunstige afloop van een partus door zeer veel factoren kan zijn bepaald. De sociale status van de kraamvrouw zou eventueel slechts één van deze factoren kunnen zijn. Men zal dus rekening moeten houden met talrijke andere omstandigheden, die, op grond van de resultaten van het onderzoek, mede de afloop van de partus blijken te beïnvloeden. Vanzelfsprekend zal onderscheid moeten worden gemaakt naar pariteit en leeftijd van de kraamvrouw.

Het blijkt tevens noodzakelijk het materiaal te verdelen naar stad en platteland, omdat de verschillende sociale klassen in de stad en op het platteland in ongelijke mate zijn vertegenwoordigd. Daar de vroedvrouw, die in de stad steeds en op het platteland gewoonlijk niet werkzaam is, haar patiëntenmateriaal zal vinden onder de bevolkingsgroepen, wier inkomen onder de welstandsgrens der sociale verzekering valt, zal de huisarts in gemeenten waar een vroedvrouw aanwezig is, de verloskunde vooral beoefenen onder de hogere welstandsklassen, terwijl hij op het platteland als regel de hele scala der beroepsgroepen onder zijn hoede heeft. Uit het onderzoek blijkt verder, dat de huisarts in gemeenten, waar een vroedvrouw werkzaam is, relatief veel eerstgeborenen ter wereld brengt. Blijkbaar kiest een deel der vrouwen, wier eerste partus geen bijzondere moeilijkheden met zich heeft gebracht, bij latere bevallingen de vroedvrouw.

Het totale materiaal was oorspronkelijk verdeeld in de volgende beroepsgroepen: 0 = onbekend; 1 = bedrijfshoofd agrarisch; 2 = bedrijfshoofd andere bedrijfstakken; 3 = vrije beroepen, wetenschappelijk; 4 = vrije beroepen, overige; 5 = employé's; 6 = arbeiders, agrarisch; 7 = arbeiders, andere bedrijfstakken, geschoolde; 8 = overige arbeiders; 9 = zonder beroep.

Om praktische redenen leek het verstandig deze groepen terug te brengen tot drie hoofdgroepen:

A handarbeiders + onbekend beroep + zonder beroep;

B hoofdarbeiders en bedrijfshoofden met een inkomen beneden *f* 6.900,— (de in 1958 vigerende welstandsgrens der sociale verzekering);

C hoofdarbeiders en bedrijfshoofden boven deze inkomensgrens.