PROFESSIONAL CONTACTS BETWEEN DOCTORS AND SOCIAL WORKERS

A Comparative Survey of Awareness and
Utilization of Services,
Vancouver B.C., 1963

by

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ABSTRACT

In most modern communities, a large array of health services and welfare services are at least potentially available to all. Whether any individual or family receives a co-ordinated balanced welfare service, however, depends on many factors, including the extent to which two "helping professions", social work (as represented by social workers employed in various agencies) and medicine (as represented by general practitioners) know of each other's services and actually work together. The present study is a preliminary survey of the situation.

As background, the impact of industrialization and urbanization on the development and contemporary roles of medicine and social work is reviewed. Information for this qualitative study was obtained through questionnaires submitted to sample groups of doctors and social workers. The purpose of the questionnaires was to gain some definition of the concept of "reciprocal awareness and utilization". In each case, the attempt was made to evaluate the knowledge one profession had of the other's role and function, and the extent to which this knowledge was used for the benefit of the population they served. In addition, directors of three key agencies were interviewed to determine their views on the role of the agency in furthering reciprocal awareness and utilization.

The findings of the study indicate that a fairly typical situation is that the doctor's awareness of the social worker's role and function is limited and outdated. Social workers, in general, are more aware of the doctor's role and function, but on the other hand, their expectations are somewhat high and perhaps unrealistic. As indicated by the test of referral patterns, the utilization of each other's resources is minimal. The doctor's utilization of social work skills and resources is hampered by two facts: (a) patients have mixed feelings about being referred, and (b) doctors believe that agency policy and procedure is ineffective and frustrating. There is evidence that besides not recognizing a modern social worker's role and function, general practitioners appear to underestimate social and emotional factors in illness. Reciprocity, the main concept evaluated in this study, is minimal. Both doctors and social workers recognized that there are gains to be realized from more co-operation and some methods are recommended; but the low degree of reciprocal awareness and utilization existing between doctors and social workers must be tackled by recognizing that rather than lack of communication, faulty and hostile communication is the issue. This does not necessarily apply to medicine and social work in institutional settings, and this difference demands further exploration.

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Chapter 1

Co-operation Between Professions: Theory and Practice

Premises of the Study

Specialization, a common characteristic in all industrial societies, refers to the division of labor in the growth of skills and in some degree the allocations of authority in society. The division of labor in the sense of the rise of special skills applies in the helping professions [1] as well as industry and commerce. Wilensky and Lebeaux point out that specialization affects every sphere of life and that it prompts the growth of large formal organizations that exist to co-ordinate the activities of the specialists: [2]

> These trends in specialization are both cause and consequence of the dominance of the big organization in industry, commerce, labor, politics, the military, religion, education, recreation---in every sphere of life. Large, complex, formal organization is necessary to co-ordinate the efforts of large numbers of inter-dependent specialists, and the larger the organization the more necessity for specialization. This is true whether the specialist be clergy in a nationwide church, engineers in a corporation, scientists in a university, workers in an assembly line or caseworkers in a family agency. Large scale organization with specialized personnel are characteristic of all industrial societies.

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1 "Helping Professions" refers to the ministerial, medical, law, nursing and social work professions.

2 Wilensky, Harold L. and Lebeaux, Charles N. Industrial Society and Social Welfare, Russell Sage Foundation, New York, 1958, p. 95.

The nature of specialization raises several issues for all professions. It can be acknowledged that as services increase and become more specialized, not only is the professional person uncertain of the proper resources to call upon, but also the ordinary citizen knows less about the help which is available. In the growth of formal organization in health and welfare services, and problems of achieving effective collaberation between the many professions and between specialized agencies has become an urgent one for people in most communities.[1] This presents a considerable challenge to social workers and it prompts an increased acceptance of the necessity of teamwork among social workers and members of the other helping professions. It also prompts the need for more awareness and more joint study, as well as the recognition of limitations in the field of welfare. This idea was discussed by H. Stalwick when he stated:[2]

> To adequately study this problem in any community, all of the helping professions should be included. The focus should be upon what the representatives of one profession recognize in the other profession and to what extent they use this knowledge for the benefits of the individuals in that community.

The objective of this study is to consider how much reciprocal

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1 This fundamental point was expressed by Michael Wheeler in "A Report on Needed Research in Welfare in British Columbia." This survey was undertaken by the Community Chest and Councils of the Greater Vancouver Area and was published in March 1961.

2 Stalwick, Harvey N.S., Churches and Welfare Services in Richmond, B.C., Master of Social Work Thesis, University of British Columbia, 1962, p. 4.

awareness and utilization [1] is present in the two professions of social work and medicine in Vancouver, British Columbia. Emphasis will be placed on the interrelations between general practitioners and social workers [2] employed in primary settings. [3] In this specific community focus will be upon what social workers in the community recognize as the resources and skills of medicine and the extent to which these resources are used for the benefit of clients. Of equal importance is the objective of assessing the recognition doctors have of welfare services and the extent to which these resources are used for the benefit of the patient and his family.

Historical Background: Medicine and Social Welfare

Out of the complex developments which have and are taking place in the profession of medicine, two themes are pertinent to this study. First, is the scientific revolution in medicine which underlies all others. Second, is the technical revolution, with its far reaching influences.

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1 This concept of reciprocal awareness and utilization may be graphically explained in the following chart of the interrelationship between a Doctor and a Family Service Agency social worker.

Awareness - doctor learns of the nature of the Family Service Agency.
Utilization - he refers patients with marital problems to the agency.
Reciprocal Aspect - social worker as a result of contact with the doctor, refer clients with medical problems.

2 Social workers will be defined as the personnel associated with administering the welfare services.

3 The term "primary settings" refers to agencies designed primarily to give social services to clients either as individuals or in groups. These agencies operate under social welfare auspices and examples of such are Public Welfare Departments and family and children's societies.

Since the days of the "medicine men" of the ancient world, when the foundation for the capacities of modern medicine were laid, medical practice has undergone many changes. The great scientist of the 17th century launched modern medicine by shattering obsolete authority, by laying the foundation for an accurate knowledge of the structure of the human body, and by demonstrating how physiological functions could be studied intelligently. [1]

> From that time on, slowly and often painfully, the extension of knowledge in physics, mathematics, astronomy, chemistry and biology and the development of scientific methodology and instruments capable of precise identification and measurement, even of unseen micro-organisms and cells, inside the body lining---became part of the essential progress in medical science. Anatomy, physiology, pathology, histology, bacteriology, and anesthiology---were developed before or during the 19th century, followed by biochemistry, biophysics and even more specialized medical disciplines in the 20th century. The dependence of medicine on the basic sciences can hardly be exaggerated.

Medical science has progressed, often against much resistance. Contributing forces to the advance of medicine have been such things as higher standards of living and of mass education, the acceleration of communication and transportation, industrialization, social organizations and the spread of humanism and democracy. The best example of this can be seen in the initiation and development of the Public Health Movement.

The scientific advance of medicine has eventually resulted in new and enlarged technology. Today it is transforming a

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1 Somers, Herman S. and Somers, Anne R. Doctors, Patients and Health Insurance, Doubleday and Company, Inc., New York, 1962, pp. 16-17.

highly individualized profession into a vast and intricately interdependent network of services. Medical research and education have also become institutionalized. The physician can be scientifically accurate in his diagnosis today only because of the scientific development of a vast array of instruments and facilities.

More science and more knowledge mean increased specialization, which in turn brings subdivision of labor and interdependence of personnel.

> The division and subdivision of labor, which have characterized virtually all other aspects of life since the Industrial Revolution, when the great technological applications of science really got under way, were inevitable in the medical field. Each new discovery produced smaller and smaller fields of concentration and progressively more refined disciplines. [1]

A recent American Medical Directory [2] lists thirty-three distinct specialties. Adding the more common subspecialties, there are some fifty types of physicians. In addition, the health services industry includes about thirty-five other categories of professional, technical, managerial and assorted paramedical occupations.

The ratio of full time specialists to all physicians has expanded from eleven percent in 1923 to forty-one percent in 1957. If the count is limited to private practice, the presumed

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1 Somers, Herman, S. and Somers, Anne, R., Doctors, Patients and Health Insurance, Doubleday and Company, Inc., New York, 1963, p. 27.

2 Ibid., p. 27.

stronghold of general practice, the proportion of full time specialists increased from thirty-six percent in 1949 to forty-eight percent in 1957, while the ratio of general practitioners fell from forty-eight percent to thirty-nine percent.

Unfortunately, it is arguable today, that the fragmentation of medical practice has resulted in fragmentation of the patient. The task of reconstructing the "whole man" is an essential next step in progress of medical practice. The numerous approaches to this urgent need, advanced by various sections of the medical profession include:

1. Upgrading the general practitioner.
2. Replacing the general practitioner by a better trained type of family or personal physician.
3. Training all doctors in the philosophy and techniques of comprehensive care.
4. Promoting an institutional environment which will facilitate a co-ordinated approach.

Of the four approaches, three and four are of particular interest to this study.

The third approach, namely comprehensive care, is used with two separate but related meanings: [1]

1. Comprehensive care may mean the totality of desirable health services, promotion of health, prevention of disease, diagnosis, treatment and rehabilitation.

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1 Somers and Somers, Doctors, Patients and Health Insurance, p. 31.

2. Comprehensive care may mean a "total approach" by the individual doctor; specialist, as well as general practitioner; to the individual patient, an approach that is not confined to organic pathology and its treatment but encompasses the patient's emotional and family problems and the totality of his socio-economic environment.

In order to advance this new approach, many medical schools have tried to "humanize" their curriculum. There has been a concerted effort to change the emphasis from disease to health, from exclusive emphasis on curative treatment to the whole spectrum of services listed above, with special emphasis on prevention and rehabilitation. A more detailed discussion of comprehensive care and medical education occurs in Chapter 4.

The emphasis on comprehensive care, will not reverse the trend to specialism or change its effect. Thus the need for an institutional setting to facilitate a co-ordinated or comprehensive approach to the patient appears to be developing. Co-operative arrangements among doctors, formal or informal, are now virtually universal in the United States and Canada. Most individual practitioners have a list of specialists to whom he may refer patients and he will try to establish working relations with a hospital. There has also developed a broad range of formally organized group practices or combined practices: [1]

> Group practice is a process, rather than a form of organization. The process is one of combining the skills of physicians in order to re-create the whole patient and to maximize the resources of modern medicine that can be brought to him.

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1 Somers and Somers, Doctors, Patients and Health Insurance, p. 34.

Usually group practice consists of a formal association of three or more physicians providing services in more than one field of specialty, with income from medical practice pooled and redistributed to the members according to some pre-arranged plan.

Just as medical specialism has led doctors to form medical teams or groups, so it is leading them into even broader health teams and co-operative arrangements with a multiplicity of para-medical [1] professions. Optimum medical care has become a complicated and necessarily expensive undertaking, involving many different disciplines and institutions including in certain of its phases, the entire community.

> In essence it represents the medical side of the historical technical evolution, away from individual craftsmen, toward ever-increasing subdivision of labor and it reflects the changed nature of medical care and the growing emphasis on comprehensive care or preventive medicine which by their nature require the services of a whole gamut of paramedical as well as medical personnel. [2]

Three developments in medical care have significance for the profession of social work:

1. The trend to comprehensive medical care.
2. The growth of paramedical personnel.
3. The trend to co-operative practice.

The first two trends indicate the medical profession's increasing awareness that they can no longer be totally responsible for the

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1 The term "Para-medical" refers to those members of other health professions and occupations which supplement the services of the physician. They include the therapists, social workers, dietitians, librarians, psychologists, statisticians and medical programme administrators.

2 Somers and Somers, Doctors, Patients and Health Insurance, p. 41.

treatment of illness. Illness today means much more than physiological pathology. The involvement of other helping professions, in the treatment of illness, is almost mandatory. Social work, because of its philosophy and particular configuration of skills and resources, then becomes one of the primary helping professions that composes the paramedical team. In order to be members of a team and to be called upon by the medical profession, social workers will have to interpret their role and function to the medical profession.

The trend to co-operative practice presents two possible implications for social workers:

1. Doctors will increasingly refer patients to other medical practitioners, particularly psychiatrists. This possibility will be increased as more patients, covered by health insurance, will be able to afford psychiatric fees. Thus utilization of social work skills and some welfare resources may decrease.

2. Social workers, as private practitioners, may become partners in co-operative practice.

The trend to the former is likely to occur unless social work makes a valiant effort to "educate" medical practitioners about the distinct contributions they are making to this field and are able to make. This will afford a more precise division of labor, to the benefit of the patient as well as the members of the helping professions.

The history and heritage of social work are relatively limited in comparison to medicine. Rapid and uneven development has marked its growth, which began in Britain in the wake of the industrial revolution. Social workers began to be needed and

eventually trained as welfare services were brought into operation. Thus, "the profession" came after many decades of non-professional social work. Today there is some doubt as to whether social work, in its present state of development, is a profession in the true sense of the word.

Until the period of the industrial revolution, people had other sources of livelihood than the sale of their labor. Local churches and self help groups were able to meet most phases of human want. The advent of industrialization, accompanied by rapid social change and social disorganization, was responsible for the emergence of elementary welfare services. The social concepts and legislation [1] of England in the 17th and 18th centuries, have had a great influence in the development of modern social welfare and the profession of social work.

Early social work on the North American continent, was undifferentiated from the social survey movement. In 1879, in the United States, the Conference of Boards of Public Charities, became an independent body called the National Conference on

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1 Examples of such legislation and social concepts are as follows:

1. The Poor Law of 1601 set the pattern of public relief in England and later influenced American legislation for public welfare.

2. The Charity Organization Society established in 1869, was the first main effort to overcome the lack of co-ordination between charitable church groups and philanthropic societies.

3. Settlement Houses such as Toynbee Hall established in 1884 set a precedent for preventive social welfare.

Charities and Corrections. This was the first national association, with the specific purpose of discussing common problems in the broad field of social welfare. It became the National Conference of Social Welfare in 1917.

The Charity Organization Society, founded in 1874, in Buffalo, New York, was one of the most influential organizations in promoting the growth of social work in the United States. The Charity Organization Society, in its first years, emphasized the development and co-ordination of community services. Community Organization, as a method in social work, therefore began to emerge. Community Organization emphasizes community wide planning and the development of needed services; the elimination of duplication in services and the participation of the whole community through fund raising, board memberships, voluntary services and community councils.

The Charity Organization Society later directed more attention to formulation of principles and more constructive methods of social investigation, and diagnosis and treatment of family problems. These concepts and methods incorporated the democratic concept of the worth and freedom of the individual and eventually became the social casework [1] of today. Mary Richmond, in her book, Social Diagnosis, [2] written in 1917,

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1 Perlman, Helen, H., Social Casework, The University of Chicago Press, Chicago, 1957, p. 4.

Social casework is a process used by certain human welfare agencies to help individuals to cope more effectively with their problems in social functioning.

2 Richmond, Mary, Social Diagnosis, Russell Sage Foundation, New York, 1917.

identified the factual basis and methods of differentiated treatment of individuals and families.

Social work, like other professions, depended upon the knowledge and methods of other disciplines. Thus in the 1920's, significant influence was exerted on social work by the introduction of modern medical and psychiatric concepts and practices. These emphasized emotional and social causes and tended to divert social work from its earlier focus on environmental factors and the need for social reform to correct social injustices. At this time psychiatric and medical social work, specialties within the profession were developing. Also, in the 1920's a great interest in the discussion method as a means of creative democratic group procedure, especially for adults, produced the concept of group work [1] as a methodology useful in many settings.

Thus at the end of two decades, it was evident that a strong sense of professional self consciousness had developed. Specialization took hold early in social work in the United States as was evidenced by the development of three distinct methods [2] and by the existence of four separate practitioner groups. [3]

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1 Treker, H., Social Group Work, Association Press, New York, 1955, p. 95.

Social group work is a method through which individuals in groups in social agency settings are helped by a worker who guides their interaction in programme activities so that they may relate themselves to others and experience growth opportunities in accordance with their needs and capacities to the end of individual, group and community development.

2 The three methods are casework, group work and community organization.

3 The four practitioner groups were the medical social workers, the psychiatric social workers, family social workers and child welfare social workers.

Professional education had been initiated, as schools of social work were organized and developing. The Milford Conference report marked a high point in the development of the profession, formulating the principle reaffirmed in 1947 by the Curriculum Committee of the American Association of Social Work, that the problems of social casework and the equipment of the social caseworker are fundamentally the same for all fields. Here began the emphasis on specialization by method rather than by setting.

The decade of the 1930's was an era of crisis and improvisation. Out of it eventually came the recognition of the significance of leisure time services and recognition of group work as a method in the profession of social work. The decade of the 1930's saw too, to a large degree, the realization of the modern American concept of government in the social welfare field; a concept emphasizing services for purposes of the general welfare. The development of public welfare, affected social work practice directly and fundamentally.

From 1940 until this decade there have been other changes in the profession. Developments in casework have been ongoing particularly with the growth of the social sciences and the adaptation of social role theory into casework theory and practice. Developments have been rapid in group work, as it assumes an important role as part of therapy in hospitals and clinics. Community organization has continued to develop, although there is some doubt as to whether it is exclusively a social work

method. Acutely conscious of social work's shortcomings, after World War II, educators and practitioners, are making conscientious efforts to increase and refine its research methods. Concern for administrative process is a recent development in social work, as social work principles and processes are emerging in administrative theory.

Doctors and Social Workers: The Growth of Medical Teamwork

The present relationship between the two professions has a background of both co-operation and strife. Bruno [1] states that the medical profession has always recognized the importance of social factors which have a bearing on health and disease. Before the advent of the social worker, physicians were their own social investigators, although they may not have used modern methods. The forerunners of modern social work had an interest in health, particularly in relation to poverty. Octavia Hill and the Webbs [2] were highly articulate about the dirt, squalor, congestion and fatigue, which contributed to illness. Their descriptions of hospitals, infirmaries and the medical care given to the indigent, were used for briefs which were responsible for much of the social legislation [3] of the early 20th century.

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1 Bruno, F.J., Trends in Social Work, Columbia University Press, New York, 1948, p. 630.

2 DeSchweinitz, Karl. England's Road to Social Security, University of Philadelphia Press, Philadelphia, 1943.

3 The Poor Law Commission sat in England from 1905 to 1909. The Commission reviewed the English Poor Law and made recommendations for broad encompassing changes in social legislation.

Edwin Chadwick, the Secretary of the Poor Law Commission of England, was the initiator of the movement for Public Health. In the late 19th century, medical practitioners catered principally to those of the upper or middle classes. The untrained social workers, working amongst the poor and dependent, may have worked with the few doctors who devoted their time and energies to working with those in need, in hospitals, clinics and infirmaries. Hospital infirmaries were the only places that people of the lower classes could get medical treatment.

In the United States, as early as 1902, doctors and Charity Organization workers, co-operated to better purpose when the New York Charity Organization Society, began, through a special committee on Tuberculosis, its first campaign for prevention of disease. Other movements for improving public health, soon followed, some initiated by the medical profession and some by social workers. [1]

> Although each one of these has influenced social diagnosis, the most direct influence exerted upon this process by the medical profession comes from the medical social service movement.

The medical social service movement, initiated in the United States, by Dr. Richard Cabot, saw for almost the first time, official recognition by the medical profession of the value of the social worker to the doctor, particularly in the hospital.

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1 Richmond, Mary. Social Diagnosis, Russell Sage Foundation, New York, 1917, p. 35.

> When the doctor looks for the root cause of most of the sickness that he is called upon to help, he finds social conditions. When the social worker analyzes need he finds physical conditions staring him in the face. Therefore team work of doctor and social worker is called for. [1]

The medical social service movement had far reaching effects on the doctor, social worker, relationship in all settings.

Mary Richmond, commented in 1917, [2] on some of the difficulties encountered by the two professions when working with each other. She pointed out that the assistance which a social history could render in the medical field was such a new idea that it was being used awkwardly on both sides. Miss Richmond explained that, at that time, social workers were often handicapped in their use of medical resources, by their lack of knowledge of even the most elementary facts about disease, and by their lack of understanding of the discipline necessary in medicine. She also stated:[3]

> An uncooperative attitude on the part of the physician, where the social worker needs their help in securing social action (whether in individual cases or in other ways) can sometimes be accounted for by the inability of the non-medical social worker to make his daily contacts with Medical sources as helpful as they should be.

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1 Cabot, Richard, M.D. Social Service and the Art of Healing, Dodd, Mead, New York, 1923, p. vii.

2 Richmond, Mary, op. cit., pp. 204-219.
Miss Richmond in her chapter titled "The Medical Approach" discusses the relationship between the two professions and makes explicit suggestions to social workers on how to work with doctors.

3 Richmond, Mary, Ibid., p. 218.

Miss Richmond suggested, that at the time, the medical practitioners had a faulty understanding of the role of social workers in that they pictured them as working, solely, with the economically dependent.

In 1933, during the National Conference of Social Welfare, the following was said about the relationship between the two professions:[1]

> In attempting to cast up the gains and losses of this combination, it is apparent that at times the social worker has assumed the competency that he did not possess and has attempted to use the doctor as an aide in working out his own plan. The physician does not find it easy to work with anyone else as his peer. Even though largely intellectual, the autocratic habit of treating his patient as an inferior, too often carries over into the doctor's relations with social workers as well, leading him to identify their shortcomings rather than to welcome them as fellow workers in a common task.

In 1938, R.G. Leland argued that:[2]

> The social worker may contribute to the medical diagnosis by bringing information pertaining to the environmental maladjustments.

In the thirties, the relationship between medicine and social work became increasingly well established. Many positives emerged as well as negatives. The latter may be attributed to several factors. That the doctor has total responsibility for the care of the patient was and to some extent still is, a dictate of medical practice. The doctor-patient relationship was very

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1 Bruno, F.J., Trends in Social Work as Reflected in the Proceedings of the National Conference of Social Work, 1874-1946, Columbia University Press, New York, 1948, p. 248.

2 Ibid., p. 629.

important and the inclusion of a social worker was seen by some doctors as usurping their authority and destroying the vital relationship with the patient. Some medical practitioners often did not take social and environmental factors into consideration and there was a tendency to doubt their value in the treatment of illness. In this era of specialism doctors were preoccupied with the diseased organ, rather than with the "whole" patient. Social workers on the other hand, working in a new and suspected profession, were often unsure of the role they played in relation to the doctor and the patient or client. Over the years individual social workers and practitioners, established fine working relationships which benefitted both the professions and the clients. With the increase in specialization and the tendency toward "splitting the patient", medical practitioners began slowly to turn to social work, particularly for personality and social assessments. Social work and social workers were becoming more skilled and better trained, so that teamwork was more feasible and a greater degree of co-operation was evident. In the 1940's and 1950's, events took place in both profession which led to a firmer foundation for co-operation between the two professions.

Experience of the two world wars, emphasizing manpower as a nation's most valuable asset and the consequences of unmet health needs, gave impetus to the idea of a health programme for the whole nation. The World Health Organization, a specialized branch of the United Nations, defined health as: [1]

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1 Chisolm, Brock, "Organization for World Health", Mental Hygiene, July 1948. Vol. 32, pp. 364-371.

> A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

This statement implies that health can only be achieved in response to many favourable influences and forces, such as economic, social emotional and physical. The point of view expressed by the World Health Organization is representative of a trend voiced by leaders in all helping professions. This would tend to imply that medical care is not by any means confined to the diseased organ, but takes into consideration the total person involved, and such care requires planning on a community basis since rehabilitation requires many services. Medical care in this sense takes into consideration the economic and social, in addition to the physical aspects and implies the participation of several professions. This concept of the relatedness of social, emotional and physical factors in the cause and treatment of disease has been developed over a period of time.

New findings were brought to light which broadened the concept of disease and medical care. The studies made by Franz Alexander, [1] showed, that in addition to the physical symptology, there are psycho-social components associated with most cases of illness. The attention that each one of these factors receives, will depend on the degree to which they contribute to the dysfunctioning of the patient. The studies made by Canon [2] in the

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1 Alexander, Franz, M.D. Psychosomatic Medicine, W.W. Norton and Co., New York.

2 Canon, Walter, B. The Wisdom of the Body, Norton, New York, 1952.

area of psychological stress and by Dunbar [1] in the field of psychosomatic medicine are of particular importance, since they emphasize the concept of illness as a reaction of the whole organism to its environment. Currently the investigations of such leading physicians as Professor Hans Seyle, [2] have helped to crystalize some of the thinking on the subject of the relation of the mind and body in illness. Couched in clinical terminology, the basic ideas of the "Adaptation Syndrome" and the "Stress Concept" express the modern concept of disease and the significance of environmental conditions in the treatment plan. The doctor in medical practice today, more than ever shares the responsibility of formulating a diagnosis and effecting a treatment plan with a number of other specialists, either of his own profession or of auxiliary professions, such as nursing, dietetics, education and social work. The doctor's knowledge of community resources and other specialists to aid him should be greater than ever before.

Social workers at the same time have been adapting not only the above mentioned concepts into social work theory; but also they are attempting to incorporate them into social role theory, [3]

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1 Dunbar, Helen Flanders, Mind and Body: Psychosomatic Medicine, Random House, New York, 1947.

2 Seyle, Hans, M.D. "The Adaptation Syndrome in Clinical Medicine", The Practitioner. January 1954, Vol. 172, No. 1027, pp. 6-15.

3 For a detailed discussion of role theory refer to: Boehm, W., Curriculum Study, Volume X, Council of Social Work Education, New York, 1959.

which has been adapted from sociology. Professional educators are making efforts to provide social workers with a comprehensive conceptual framework within which individual and family functioning can be assessed.

For the purposes of this study it is not necessary to discuss social role theory in toto. Yet it is important to indicate the framework from which social workers view illness, in order to demonstrate that doctors and social workers share similar concepts. Role theory integrates the concept of man as a bio-psycho-social organism. Each of these parts is dynamically inter-related. Dysfunctioning in one area, can lead to or create breakdown in all other areas of functioning. Thus, man is viewed as a complex being and the causes of breakdown in social functioning, multiple and inter-related. In this respect, all conditions of illness have physical, as well as psycho-social components.

Doctors and social workers, incorporating similar concepts into practice, both found areas of communication and correspondence. Although the disciplines of medicine and social work, will increasingly share this common body of knowledge, the focus and method of these two professions will inevitably remain different. The physician will use his knowledge about the social components of illness as a medical practitioner, not as a social worker.

Problems of Co-operation and Co-ordination

Specialization of services and skills has created problems of co-operation and co-ordination for the representatives of the

health and welfare services. The problems are many and varied. Thus, for the purposes of this study, two primary but related problems have been selected for discussion.

At the same time that each profession was becoming more skilled and specialized, with increasing numbers joining their ranks, large bureaucratic organizations were developing through which these skills were administered. In the health field the hospital became ever increasingly the center of medical practice. Outpatient departments developed in North America as early as 1905. Public Health and Public Health agencies became prominent in large urban industrial centres. Health agencies developed to meet special needs that individual doctors could not handle. In these institutions medical and para medical teams co-operate to rehabilitate and treat specific diseases, ailments or handicaps. As industrialization became entrenched, social problems of varying kinds developed. Welfare services to meet these needs sprang up both in the private and public spheres.

In the health and welfare fields, services became specialized. Specialization among agencies not only gives rise to bureaucracy, but also creates an interdependence which ultimately requires co-ordinating mechanisms. The basic problem becomes one of how to attain effective integration of specialisms: [1]

> Among agencies however, the bases for specialization are more varied and an authoratative structure for

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1 Wilensky, Harold L. and Lebeaux, Charles N., Industrial Society and Social Welfare, Russell Sage Foundation, New York, 1958, pp. 247-248.

> exercising overall control is lacking. Further, the need for co-ordination among agencies is often obscured. It is less easy to see the community as a functional whole, with interdependence among all its parts, than it is to see the essential unity of a single agency. Nevertheless, the division of labor which binds us all together in a web of mutual dependency, though sometimes obscure, is a basic fact of community life.

This has great significance for both social work and medicine. Specialism and the creation of interdependence demands a form of reciprocal relationship between the two professions. It is the purpose of the present study to examine this relationship in detail in one city and the results are presented in Chapter two and three.

Related to the problem of inter-agency co-ordination is the problem of delineating specific skills and services and co-ordinating them into an integrated treatment plan for the patient. The concept of medical teamwork, the co-ordination of services in the interest of the patient and his family becomes even more important when the team members are not working in the same setting, guided by similar functions and purposes. Yet this very teamwork is the only valid approach to the complex problem of maintaining and restoring health. The principles of relationship, however, are intrinsically the same whether the services operate independently and call for inter agency co-operation or whether they comprise an administrative team.

> The objective of achieving a co-ordinated medical approach however, is not altered because of differences in organizational patterns, the principles of integration have equal applicability inside or outside a hospital setting. [1]

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1 Upham, Frances, A Dynamic Approach to Illness, Family Service Association of America, New York. Second Printing 1953, p. 27.

The focus of the team approach is that close working relationships made possible by a group of services working together, and result in further delineation of the special functions of each helping profession comprising the team. It should at the same time, enrich the content and skill of each service. [1]

> The various professions have come to recognize the principle of interaction in the functioning of the human being. His needs, whether medical, economic, or social, are viewed not as a series of separate entities that can be treated separately by a group of specialists, but as a unit. Each area still has its area of specialization, but each accepts that the specialized skills should be utilized within the framework of a co-ordinated interprofessional approach to the individual.

Efforts Toward Co-operation

The literature of social work, has not in explicit terms offered ways of co-operating with the medical profession. Nor have the writers of professional theory set down explicit ways of co-operating with lawyers, ministers, public health nurses and other members of the helping professions. What has been said implicitly in statements of goals and objectives of the profession offers a sound base for co-operation. Such a statement is made in "Goals of Public Social Policy", a publication by the National Association of Social Workers. In this article, under the heading "Co-operation and Co-ordination", the following comment is made: [2]

> It is recognized that many other groups and professions share these areas of social policy and social action. Social advances will be furthered through the broadest

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1 Upham, Frances, A Dynamic Approach to Illness, Family Service Association of America, New York. Second Printing 1953, p. 25.

2 Goals of Public Social Policy, National Association of Social Workers, 1959, p. 13.

> co-operation by social workers with all such groups. Moreover, it is basic to social progress that means should exist for co-operative planning among all elements in society so that each may effectively fulfill its own role and society may make the best use of all its institutional resources in advancing the welfare and meeting the needs of its members. Social workers can often make their most effective contribution to social progress by lending their support and knowledge to these broadly based democratic instruments for effecting social change.

This statement puts the concept of interprofessional relationships in the proper perspective. In this same article, the National Association of Social Workers states the professional policy concerning health and health services. In Section Six under "Co-ordination", the following statement is made: [1]

> Co-ordinating mechanisms to assure close working relationships among the various community agencies and especially between health and welfare programmes, are also vital to meeting health needs.

The National Conference on Social Welfare [2] has over the years published articles concerning the objectives and goals of

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1 Goals of Public Social Policy, National Association of Social Workers, 1959, p. 13.

2 The National Conference on Social Welfare has as its purpose the promotion and sharing in discussion of the problems and methods identified with the field of social welfare and immediately related fields. The Conference is a forum for such discussion. It does not take an official position on controversial issues and adopts no resolutions, except occasional resolutions of courtesy. The Conference conducts an annual National Forum as its principle service; also regional meetings on common service subjects in co-operation with selected state conferences.

One paper, delivered at the National Conference of Social Welfare in 1953, concerning the objectives and goals of co-operation and interprofessional relationships was:
Cockerill, Elanor, "Interdependency of the Professions in Helping People", The Social Welfare Forum. National Conference of Social Welfare, Columbia University Press, New York, 1953, pp. 137-147.

co-operation and interprofessional relationships generally, and the problems or difficulties between medicine and social work specifically. The topic of health and comprehensive medical care has been discussed in several articles published by the Conference.

The Journal of Social Casework, published by the Family Service Association of America, has contained many articles [1] on this topic. Emphasis has been placed on the growing social-medical concepts and their implications for social work practice. As was previously mentioned, these shared concepts are aids in furthering a good working relationship between the two professions.

The "Social Worker", of June-July 1962, a publication of the Canadian Association of Social Workers, states in a Brief to the Royal Commission on Health Services: [2]

> Certain community welfare services are frequently related to health care and may be needed by a patient or his family regardless of their economic status.

The professional organization, representative of professional Canadian social work, has explicitly stated the relationship between the two professions and through its Brief has made efforts to aid the medical profession in an area of mutual concern.

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1 Margolis, H.M., M.D. "The Biodynamic Point of View in Medicine", Journal of Social Casework. January 1949.

Cockerill, Elanor, "New Emphasis on an Old Concept of Medicine", Journal of Social Casework, January, 1949.

2 "Brief to the Royal Commission on Health Services", The Social Worker, June-July, 1962. Vol. 30, No. 3, p. 7.

Professional publications in the field of medicine are so numerous and varied that it is now impossible to make an adequate resume of the literature. Various journals have contained articles such as "Man, Disease and Social Environment", [1] by E.H. Vokhart. The British Columbia Medical Association, in its publication, has presented two articles on social work and medicine. One of these articles was written by a Vancouver social worker and the other by a medical practitioner. In "Medical Education and the Changing Order", R.B. Allen states: [2]

> Any well educated and experienced physician realizes that the professional services of lawyers, ministers, teachers, social workers and personnel counsellors are essential .....

This has been a rather brief description of the efforts taken by both professions to promote co-operations and understanding. The questions arise as to whether these principles are finding expression in the practice of the individual doctor and social worker. For it is actually on this level that principles and concepts, come into reality and practice. The individual social worker has the responsibility for having her facts well in hand and using her knowledge and skill in interpretation to promote co-operation. The doctor on the other hand has a similar responsibility - to be aware of welfare services and the skills of social workers, so that when necessary, he can refer a patient to an agency, and co-operate with the social worker, to further his patient's well-being.

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1 Vokhart, E.H. "Man, Disease and Social Environment", Postgraduate Medicine, Feb. 1960, Vol. 27, No. 2, pp. 257-260.

2 Allen, Raymond, B. Medical Education and the Changing Order, The Commonwealth Fund, New York, 1946, pp. 2-3.

Whether these principles are finding their way in practice is a difficult question to answer as a result of a lack of published evidence. Therefore, one assumes either one of two alternatives:

1. Nothing is being done
2. Some efforts are frequently carried out and the individual practitioner is reluctant to make these known.

The latter alternative is speculated to be more descriptive of the actual situation. Thus the reason for this study.

Methodology - Description and Definition

This study included the health and welfare services in Vancouver. The survey included questionnaires for and selected interviews with, both the representatives of health services, the doctors, and the representatives of the Welfare services, the social workers.

According to a count made of the doctors listed in the Medical Directory, 1962-63, College of Physicians and Surgeons of British Columbia, (November 1962), there are an estimated 982 doctors practicing in Vancouver, excluding North and South Burnaby. This includes doctors in private practice as well as salaried medical practitioners. Of the 982, an estimated 541 are qualified specialists and 441 general practitioners. Of the 441, 128 are salaried and 313 in private practice.

The decision to use general practitioners, as participants in this survey was based on three factors:

1. The total number of doctors practicing in the survey area was too large to include in the confines of this study.

2. General practitioners were selected as they do not specialize in the treatment of one disease or handicap and therefore see many people with a variety of illnesses.

3. The general practitioner is considered a "family doctor." Every third general practitioner in private practice was chosen to answer a questionnaire, thus realizing a control group of one hundred doctors.

Definition of doctor, to be used in this study will refer to the men and women representing the general practitioners included in the survey. A general practitioner for purposes of this survey is a doctor who is not a certified "specialist" of The Royal College of Physicians and Surgeons.

For the purposes of this study, health services, are defined as those institutions and their representatives whose function it is to treat individuals and groups suffering from disease or handicap, with the purpose of restoring them to as complete a state of physical, emotional and social well being as possible. Welfare services, as defined in this study, are those institutions and their representatives who aid individuals and groups to attain satisfying standards of life by helping them achieve personal and social relationships which permit individuals the development of their full capacities and the promotion of their well being in harmony with the needs of the community.

In Vancouver there are an estimated [1] two hundred and seven health and welfare agencies. There are one hundred and twenty-nine

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1 Count made from the:
Community Chest and Councils of Greater Vancouver, Basic Pattern of Community Agencies. Priorities Programme, Master List of Agencies. June 1963.

welfare agencies, sixty-nine health agencies and nine other [1] agencies which could not be satisfactorily classified as health or welfare agencies. An estimated [2] four hundred social workers are employed in these agencies. One hundred and fifty-three agencies are privately sponsored and fifty-four are publicly or government sponsored.

Three agencies, representing public and private welfare were included in this survey:

1. Vancouver City Social Service Department, supported by municipal and provincial funds, is an example of a public welfare agency which provides direct welfare services to those living in the Greater Vancouver area.

2. The Family Service Agency of Greater Vancouver, supported by funds from the Community Chest and Council, provides a family welfare service, encompassing counselling services to family members and individuals, as well as homemaker services and emergency financial assistance.

3. The Childrens' Aid Society of Greater Vancouver, supported by provincial and Community Chest and Council funds, provides child welfare services including adoptions, foster home finding and placement, in addition to, protective services to children.

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1 Those agencies which could not be classified according to the above definitions are:

a. The British Columbia Association for Retarded Children (4 branches)
b. The British Columbia Safety Council
c. The British Columbia Childrens' Foundation
d. The Columbia Coast Mission
e. Citizenship Branch
f. The Junior League.

2 Estimate compiled on the basis of the Membership of the British Columbia Association of Social Workers, and the estimate given by Mr. Ron Hawkes, President of the British Columbia Association of Social Workers, of social workers not belonging to the British Columbia Association of Social Workers.

The three agencies provide welfare services to the community with staff members carrying a caseload of Vancouver residents.

One of the concepts followed in this study is to consider welfare services and not specific agencies. Too frequently the term "agency" is used synonymously with "welfare services". Therefore an attempt has been made to include the main agencies and consider them as a part of welfare services.

"Social worker" is defined as the representative of the agency performing a welfare service in the survey area.

Methodology - Questionnaire

The questionnaire [1] for the doctors was intended to contribute information that would offer an overall perspective of the resources and work of the doctors in this community. The questionnaire was structured to include the following two general areas of information:

1. Understanding the doctors and the work they are doing. This was included in questionnaire A under two groupings: Counselling and General, questions 4, 5, and 6.

2. Understanding the doctor's awareness and utilization of community resources. This was included in questionnaire A under the groupings: Referrals, Welfare and Health Agencies, Social Workers and General, questions 1, 2, and 3.

The questionnaires were sent to the doctors under a covering letter [2] explaining the purpose of the survey. A slip was placed at the bottom, that the doctors were asked to fill in and return, so

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1 The questionnaire for doctors can be found in Appendix A.

2 The letter can be found in Appendix A.

that the sample could be validated. This slip offered the doctor an interview, if he so wished or the opportunity not to participate because:

a. Contacts with social workers or welfare agencies were exceptional in practice

b. The doctor, had no opinions, favourable or unfavourable about social work.

c. Other reasons that the doctor wished to state for not participating.

Excellent co-operation was realized from this method and a 53 percent return was realized; twenty-nine percent of the questionnaires were returned, completed. It was thought that only 25 questionnaires would be returned.

The questionnaire for the social workers, Questionnaire B,[1] was intended to contribute information that would offer a perspective of the resources and services offered by the welfare agencies serving the community in relation to ilness and problems with such. Questionnaire B, included the following general areas of information:

1. Understanding social workers and the work they are doing. This was included in questionnaire B under the two groupings: Counselling and Your Own Background and Experience.

2. Understanding the social workers' awareness and utilization of the resources of the doctors. This was obtained in the two groupings: Referrals and Doctors and Social Workers.

Phone calls were made to the respective agency directors, explaining the purpose of the survey and requesting their co-operation. Two agencies requested samples of the questionnaire to peruse, before

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1 The questionnaire for social workers can be found in Appendix B.

agreeing to participate. One agency agreed to full staff participation. Another agency was critical of the questionnaire but allowed six of their staff members to participate if they could be interviewed. This was done using the questionnaire as an interview schedule. City Social Service Department, although more than willing to co-operate, could only offer seven social workers as contact with doctors are made by the Public Health Nurses in the medical section. The only time that social workers talk directly with doctors, is when the casework plan deems this advisable. Twenty-six completed questionnaires were realized.

Three interviews were made as part of this survey. The first was with Miss A. Pumphrey, Director of Social Service, Vancouver General Hospital. The purpose of the interview was to discover the role of the Social Service Department in medical education. A seminar for medical students was attended as well. The latter two interviews were arranged with the Executive Director of the Family Service Agency, Mr. D. Thompson and the Welfare Director of the City Social Service Department, Miss M. Gourlay. The purpose of these interviews was to discover the role of the agency in increasing reciprocal awareness and utilization between medicine and social welfare.

Chapter 2

The General Practitioner and the Utilization of Welfare Services

The Doctors: Education and Experience

Professional education has become the guide or indicator of the competence of individuals in most of the professions. In Canada, two years of pre-medical studies, four years of medicine and a minimum of one year's internship is required before a doctor can enter private practice. Those doctors who choose to become specialists are required to continue their studies for several years after their internship.

The present survey [1] asked for the decade in which professional training was taken. Emphasis on comprehensive medical care became most pronounced following World War II and the declaration of the World Health Organization in 1948. [2] Those doctors who studied medicine in the last two decades, will have received more formalized instruction in the utilization of the skills and resources of other helping professions, of which social work is one. When this training was introduced; the amount of emphasis placed on it; and the form it took such as lectures or seminars, will vary from medical school to medical school.

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1 See questionnaire for doctors in Appendix A.

2 Chisolm, Brock, "Organization for World Health", Mental Hygiene. July 1948. Volume 32. pp. 364-371.

"Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

Of the doctors who took part in this survey, one graduated in the 1910's, seven in the 1930's, five in the 1940's and one in the 1960's. Fifteen of the twenty-nine participants graduated in the 1950's. Thus, over half of the doctors participating in this survey, graduated after World War II. It was determined [1] that twenty of the doctors were educated in Canadian Universities, five in English universities, two in Scottish universities and one in continental Europe.

In many schools of medicine, courses in community resources or social services are taught. With the philosophy of comprehensive care becoming more widespread, these courses are offered so that the doctor will be knowledgeable of the resources in the community to meet his patients' varied needs. Fifteen of the twenty-nine doctors did take courses concerning the social services. Of the fifteen, five evaluated this education as adequate and ten of the doctors evaluated it as inadequate. Fourteen doctors did not take such courses.

Often included in the social service course, is information about social work as a profession. This is included, because social workers not only administer welfare services, but also are important members of the treatment team. Knowledge about the particular configuration of skills to which social workers lay claim, can aid the doctor in knowning when to call upon the social

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1 Medical Directory, College of Physicians and Surgeons of British Columbia, November 1962.

worker and how to work with her. [1] Seven of the twenty-nine doctors took courses about social work, as a profession. Four evaluated this education as adequate and three as inadequate. Twenty-one doctors did not take this education. One doctor did not answer this question. A comment on the nature of the education concerning the social services and social work was:

> "In my opinion the doctor is not sufficiently educated to the value and services provided by the social worker. This I hope will improve in time."

Medical education is only one of the factors which contributes to the doctor's awareness of welfare services. Other contributing factors are the length of time a doctor has been in practice, as well as the geographic locale in which he practices.

The longer a doctor practices and the more patients that he treats, [2] the more acute his diagnostic and treatment skills become. Ideally, this means that a doctor will become increasingly aware of the physical, as well as the psycho-social factors associated with illness. As experience is gained, he may realize that for the treatment of some illnesses, referral to other helping professions is needed. Therefore if the doctor is to administer the best medical care, he will become increasingly aware of community resources and utilize them as the case demands.

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1 For the purposes of this study the pronoun "her" will be used in reference to social workers and the pronoun "him" in reference to doctors.

2 Somers, Herman and Somers, Anne, R., Doctors, Patients and Health Insurance, Doubleday and Co., Inc., New York, 1963, pp. 118-168. The authors point out that medical care, once a luxery has now become a civic right. More people than ever before are receiving medical treatment and a larger part of the nation's income and the average family budget is going for health than ever before. This demand is firmly based on many related scientific, demographic and social developments.

The geographic locale in which a doctor practices has a direct bearing on the doctor's awareness of community resources.[1] Geographic locale will dictate the socio-economic status of patients and to some degree the illnesses which they manifest. Also the availability of community resources will vary from locale to locale, as well as the skills of the other helping professions. Thus what a doctor comprehends as welfare services and the skills of a social worker, will depend on the nature of the welfare services in a particular locale.

For the purposes of this study it was important to determine the length of time that the doctors had been in practice and how long they had been practicing in the survey area. The doctors were asked to indicate the number of years they had been in practice in (a) Canada and (b) Vancouver. Table one, indicates that the majority of the doctors have practiced medicine both in Canada and Vancouver for a period of one to ten years. Five have practiced medicine in Canada from eleven to twenty years and six from twenty-one to thirty years. Seven of the doctors have practiced medicine in Canada from eleven to twenty years and six from twenty-one to thirty years. Seven of the doctors have practiced medicine in Vancouver for a period of eleven to twenty years and one from twenty-one to thirty years.

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1 Somers, Herman and Somers, Anne, R., Doctors, Patients and Health Insurance, Doubleday and Co., Inc., New York, 1963, pp. 118-168;

Table A. Doctors: Length of Time in Private Practice

Number of years practice: Canada.	Number of Responses	Number of years practice: Vancouver	Number of Responses
0 - 10	18	0 - 10	21
11 - 20	5	11 - 20	7
21 - 30	6	21 - 30	1
Total	29	Total	29

Understanding the Doctor's Role - Diagnosis and Treatment

Comprehensive medical care involves a "total" approach by the doctor to the individual patient. Organic pathology as well as the patient's psycho-social problems are encompassed in such. The doctor in recognizing social and emotional problems which may cause illness or which may be caused by illness, may choose to treat these problems himself or refer his patients to skilled professionals, who are specialists in these areas. Social workers, as one group of specialists, are skilled in handling social problems, particularly those related to social functioning. Thus several questions were asked to determine the extent to which social problems were recognized as associated with illness; the nature of the problems; and how the doctors treated them.

Diagnosis

In Chapter 1 reference was made to the fact that all illnesses have psycho-social components, as well as organic components. The interaction of the three is highly complex and one factor may be more prevalent than the others. Thus the assessment of social or family factors as part of the diagnostic procedure, may lead to a

greater understanding of the patient's illness. Twenty of the doctors usually include such factors in their diagnosis and eight do so occasionally. One doctor did not answer this question.

Often the medical diagnosis reveals that the physical symptoms manifested by patients have no organic basis. This, then, can lead the doctor to a closer examination of the psycho-social complex. Twenty-eight of the doctors have patients with complaints of physical illness for which there appears to be no organic basis. Twenty-five of the doctors estimated that they treated ten or more such illnesses this year. Three of the doctors estimated that they treated between six and ten patients with illnesses for which no organic basis could be found, in one year, and one doctor estimated that he treated between zero to five patients in one year. Several of the doctors added comments which indicated that the number of patients who manifest illnesses for which no organic basis can be found is large. Estimates were given that ranged from five patients in a day to a hundred or more in one year. Some of the doctors crossed out "year" and replaced it with "day" or "week."

Social problems associated with illness are often multiple and complex, as they are so closely inter-twined with the bio-psycho problems. When social problems are the strongesst apparent factors in illness they may often underlie bòth psychic and physical dysfunctioning. The doctors were asked to indicate the main social problems underlying the illnesses they encountered in practice. Their responses, as listed in the following table, indicate that the three main social problems which are causative factors in

illness are family problems, personality disturbances, such as neuroses or mild psychoses and problems of the aging. Financial problems were mentioned by twenty-one of the doctors, employment problems by nineteen of the doctors and difficulties in adjusting to disability by twelve of the doctors. Three of the doctors indicated "Other" problems.

Table B. Doctors: Social Problems Which Cause Functional Illnesses

Social Problems	Number of Times Mentioned
Problems with members of the family	27
Financial problems: debt or inadequate income	21
Personality disturbances: neuroses or mild psychoses	26
Problems of the Aging: Loneliness, boredom or feelings of being useless	24
Difficulties in adjusting to disability	12
Problems centering around employment: boredom with job or job too demanding	19
Others	3
Total	132

The social problems included under "Others" are:

1. sex and alcohol
2. unemployment
3. Immigrants unable to adjust to life in Canada

The answers returned by the doctors regarding medical diagnosis with particular reference to social problems, indicate

three important points. As the doctors are assessing psycho-social components as well as the biological ones, they are aware of the complex interactions of such and are thus practicing one facet of comprehensive medical care. The responses regarding illnesses which have no organic basis and the problems underlying such illnesses, validate to some extent the tri-interactional theory of illness. The fact that so many patients have social problems, as associated with illness, indicates the need of social workers as part of the treatment team.

Treatment

The treatment of illness, in which the psycho-social problems are strongest, is complex. More often than not it means involving members of the other helping professions. Social workers, in particular, become involved, if the illness has its roots in a network of social problems. The involvement of other helping professions presupposes an acceptance of teamwork by the doctor and ultimately the patient, who must be consulted and prepared for such. Whether the doctors are treating these special problems themselves or referring their patients to other skilled professionals, is a question of primary importance to this study.

It appears, from the following table, that all but one of the doctors either discusses the problems with the patient or counsels him about it. Twenty-two of the doctors, at the same time, refer the patient to a resource that will further meet his needs. Two of the doctors administer treatment for physical manifestations of illness and five use other treatment methods.

Three of the treatment methods listed under "Others" encompass skilled counselling which should involve a thorough knowledge of personality dynamics and a high degree of interviewing skill. The purpose is to help the patient develop insight into his illness.

Although doctors receive formalized training in interviewing, counselling and personality dynamics, the question arises as to their specialized skill in this area and to the amount of time [1] they have to give to this counselling. The proper investigation that is needed in these forms of illness involves time for interviewing the patient and members of his family. It is impossible to treat one person in isolation, if their dysfunctioning is created by difficulties in relationship. As doctors often do not treat all the members of one family, the question arises as to who takes the responsibility for interviewing family members. This is one of the primary skills of the social workers and an important contribution which she can make if called upon.

Table C. Treatment Methods Administered in Cases of Illness With No Organic Basis

Treatment	Number of Times Mentioned
Discuss problem with patient and/or counsel him about it	28
Refer patient to a resource that will further meet his need	22
Treat illness as if it had organic basis	2
Others	5
Total	57

1 Somers and Somers, op. cit., pp. 413-438. The authors discuss the doctor-patient relationship as it has changed to meet new demands and state that the brisk impersonal atmosphere of the hospital combined with the typical five to ten minute consultation are effective inhibotors of social intercourse.

The treatment methods included under "Others" are:

1. Method depends on the patient - no set routine.
2. Often I wait until the patient gets a better idea about his problem.
3. Reassurance, often mild sedation, and discussion with family if required.
4. Reassurance that the illness has no organic basis is necessary. This may involve considerable interpretation.
5. Will refer patient to another resource only if I feel I am making no headway.

Awareness and Utilization

Determining the awareness the doctors have of welfare services and the skills of the social workers, involved questioning the nature of their referrals, their contacts with welfare agencies and their knowledge of the skills of social workers and their experience in working with social workers. Attitudes and opinions about such are further indicators of the degree of awareness and utilization. The questions[1] under Referrals, Health and Welfare Agencies, Social Workers and General, questions one, two and three, will afford such information.

Referrals

The team approach to medical care, involves awareness and utilization of the skills and resources, of not only social workers, but of the many other helping professions. The referral of a patient to other professional people varies according to the patient's illness and needs, as well as the doctor's awareness of resources available and his wish to utilize such. The number of

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1 See Appendix A.

referrals [1] that the doctors made to resources in the community in a two week period, as listed in the following table, indicates that referrals to psychiatrists far outnumber those made to any other resource. Of those resources mentioned under "Others", two doctors indicated that they referred patients to associates of other medical consultants. Therefore the doctors are referring patients to members of their own profession, far more than to members of the other helping professions. The question on referrals, is only an indication of the pattern established by the doctors. All figures represent estimates of the community resources used most frequently in a two week period. Exact numbers were not called for as it was felt that the search for such would be too time consuming.

As a result of the pattern of referrals established in this study, several pertinent questions have arisen. Further research is needed to answer them.

They are as follows:

1. What psycho-social problems associated with illness do the doctors feel competent to handle themselves?
2. What degree of symptomology must a patient exhibit in order for the doctor to refer him to other skilled professionals?
3. What is the doctor's understanding of a psychiatrist's skills and the nature of the illnesses which a psychiatrist is prepared to treat?
4. Are doctors referring patients to psychiatrists who should be referred to social workers or welfare agencies?

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1 Referral was defined as giving information or telephoning directly or contacting on a patient's behalf.

5. If so, are the psychiatrists, once having examined these patients, then referring them to social workers or welfare agencies?

6. The doctors stated that the three main social problems they encounter, as associated with illness, are family problems, personality disturbances and problems of the aging. Skilled counselling and interviewing is often required in the treatment of such disturbances. A social worker is competent to treat such, yet doctors are evidently not referring as many patients to welfare agencies. Is this due to the fact that doctors do not consider social workers have an important role to play in the treatment team or is it because doctors are not as aware of the counselling skills of a social worker as they are of her skills in finding community resources and arranging financial assistance? (see Table J).

Table D. Referrals Made by Doctors to Community Resources in a Two Week Period

Resource	Number of times Mentioned
Psychiatrist	20
Welfare Agency	11
Minister	5
Lawyer	1
Others	3
Total	40

Those resources mentioned under "Others" are:

1. Family
2. Associates or Medical Consultants

Of the resources listed, welfare agencies, ranked second to those of psychiatrists. Thus, the doctors were asked which of the many welfare agencies they dealt with most often. Their answers, as listed in the following table, indicate that the resources of the City Social Service Department are utilized, for patients unable to meet their medical needs through their own resources, far more often than the other twelve agencies. Nine

of the thirteen agencies listed are health agencies and the use of such appears to be more frequent than welfare agencies. Thus, the skills and resources of medical personnel appear to be utilized far more often than those of the other helping professions.

Table E. Welfare Agencies Used Most Often by Doctors (Rank and Frequency of Use)

Welfare Agencies	Rank and Use of Resources		
	First	Second	Third
City Social Service Department	13	1	0
Childrens' Aid Society	4	5	3
Family Service Agency	2	3	1
Canadian Arthritis and Rheumatism Society	2	2	2
British Columbia Cancer Institute	0	3	3
Victorian Order of Nurses	1	1	1
G.F. Strong Rehabilitation Centre	1	2	0
Alcoholism Foundation	0	0	1
Multiple Sclerosis Society	0	0	1
Vancouver General Hospital Social Service Department	1	1	1
Old Age Assistance and Old Age Pensions Board	0	1	1
Child Guidance Clinic	0	2	0
Canadian Mental Health Association	0	0	1
Total	24	22	15

The fact that health agencies would be used more often by doctors than welfare agencies, was indicated [1] early in this study.

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1 The possibility that health agencies might be used more frequently arose after informal discussion with the doctors who advised on certain technical aspects of this study.

Therefore it was important to discover whether doctors were aware of the fact that social workers were part of the treatment team in most health agencies, and if so, whether they considered the fact that the skills of the social workers, are available when referring a patient to a health agency. The responses, in the following table, were recorded under the headings, "Yes", "No", and "Occasionally". "Yes", indicates that the doctors do consider the available skills of the social worker when making a referral to the listed agency, and "No", indicates that they do not consider the skills of the social worker when making a referral. The column marked "Occasionally", indicates that the doctors, on occasion, do consider such skills when making a referral.

It can be inferred from the doctors' responses that the skills of the social worker are more often not considered when a referral is made to a health agency. The skills of the social workers at the Alcoholism Foundation are taken into consideration most often and those available at the British Columbia Cancer Institute, least often. Why a social worker's skills are considered more often in making referrals to one agency than to another, is not known. Further research is indicated here. It may be that certain illnesses, such as alcoholism are considered to have more social and emotional components than others. It does appear, however, that the skills of the social worker, are considered by the doctor to be of lesser import than those of the other team members in treatment of certain diseases and handicaps.

As a result of the doctors' responses to this question, three further questions are raised:

1. Do doctors consider that the skills of a social worker are necessary in the treatment of certain diseases and handicaps, or do they consider them as unnecessary frills?

2. If a distinction is so made, then in the treatment of which illnesses, do the doctors consider social workers as important team members and in the treatment of which illnesses do they feel social workers have no contributions to make?

3. Why did the doctors state that adjustment to disability was one of the minor social problems encountered in practice, when utilization of health agencies by doctors, is much greater than utilization of welfare agencies?

Table F. The Doctors' Consideration of Available Social Work Skills When Referring Patients to Health Agencies.

Agency	Number of Times Mentioned		
	Yes	No	Occasionally
G.F. Strong Rehabilitation Centre	9	14	4
Alcoholism Foundation	14	11	3
Canadian Arthritis and Rheumatism Society	11	13	5
British Columbia Cancer Institute	10	15	4
Cerebral Palsy Foundation	6	14	5
Others	1	0	0
Total	51	67	21

The "Other" agency listed was the Epilepsy Society.

The answers to this question were not at all satisfactory. This may be due to the fact that the question was poorly worded. As a result two doctors did not answer concerning the G.F. Strong Rehabilitation Centre; one did not answer concerning the Alcoholism Foundation, and five did not answer concerning the Cerebral Palsy Foundation. Some doctors checked off "Others", but did not state the name of the agency.

At this point in the study the possibility arises that the doctors consider skills as related to agency function. Thus, if a patient indicated the need for marital counselling, a doctor might refer him to an agency whose function is such. The patient at the same time may be referred to a health agency for treatment of a specific disease. The doctor, although he may or may not realize social work counselling is available, and if he does, he may think the social worker's skills are directly related to counselling about health problems and not for marital counselling. This would then indicate the doctors' lack of awareness of the generic quality of the skills of a social worker.

Certain of the answers returned by the doctors indicate that this theory has some validity. The City Social Service Department was the agency most utilized by doctors for their patients. This agency has as its function the provision of public assistance to those people, who for reasons beyond their control are not able to be self supporting. Social workers determine eligibility as well as provide casework services. The doctors not only utilize this agency more frequently than others but they also indicated (See Table J) that the skills of the social workers thay they recognize more than any others are arranging financial assistance and knowledge of community resources. These are two of the primary social work skills utilized in Public Assistance agencies. This theory is further supported by the fact that doctors, in referring patients to health agencies, do not, primarily, consider the social worker's skills. If skill is seen as related to agency function, the doctors would first of all consider those of the

medical personnel when making a referral to a health agency. If the social worker is considered, she may be thought of as having skills related primarily to the treatment of illness. Further research is indicated here. If this theory does prove valid, it may be discovered that patients are being "split" [1] between various agencies, when it need not be so.

A doctor may be aware of the resources of a welfare agency that will meet a patient's need, but, for various reasons he will not utilize these resources. The reasons will vary from doctor to doctor and from patient to patient. In this study it was most important to discover the most common reasons for not using the resources of a welfare agency to meet a patient's need, so that some of the problems involved in awareness and utilization would be understood.

The answers to this question, as listed in the following table, reveal that ten of the doctors do not utilize the resources of a welfare agency as their patients have negative or mixed feelings about being referred. It could be that in the eyes of the lay public, that utilization of the resources of a welfare agency still has some stigma attached to it. Although doctors know differently, the experience of most social workers has been that many clients and the lay public, think that the stigma of

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1 For further discussion of the problem of "splitting the client" refer to:
Wilensky, Harold, L., and Lebeaux, Charles, N., Industrial Society and Social Welfare, Russell Sage Foundation, New York, 1958, p. 252.

"lesser eligibility", [1] exists for those who utilize welfare services. Six of the doctors do not utilize the resources of a welfare agency as they feel that the pressures and demands on the agency are so great that the patient would not receive enough time or attention. Four of the doctors do not utilize the resources of a welfare agency as, in their opinions, the inadequacies of the social workers are so great that the doctors can handle the problem much better. Four of the doctors have "Other" reasons for not utilizing welfare resources and five doctors did not answer this question.

Several comments which were added indicated that either none of the reasons listed were applicable or that they presented no problem. One doctor stated that his experience in this field was too limited for him to be specific and one doctor stated that he referred regardless of the reasons listed.

Table G. Reasons that the Doctors Do Not Refer a Patient to a Welfare Agency

Reasons for not Referring	Number of Times Mentioned
Patient has negative or mixed feelings about being referred	10
Pressures and demands on the agency are so great that the patient would not receive enough time or attention	6
The inadequacies of the social workers are so great that the doctor could handle the problem much better	4
Others	4
Total	24

1 The concept of "lesser eligibility" which developed as a result of the Elizabethan Poor Law, encompasses the belief that anyone who needs welfare services is of lesser character and worth than the individual who manages on his own resources.

The reasons included under "Others" are:

1. Language problems.
2. Unemployment can only be met by adequate work possibilities.
3. Not really aware of all the services a patient can draw on - not introduced to these services since being in practice.
4. The inadequacies of social workers is not a common problem but can be a real one. This seems more related to policy than individual workers.

Contacts with Welfare Agencies

When a doctor has a patient who is a client of a local welfare agency, the outcome is apt to be increased awareness on the part of the doctor, of the function and modus operandi of the agency. This may result in increased utilization. Often a social worker will contact the doctor to discuss the patient's health and social problems or the doctor may find it necessary to contact the social worker or agency administrator for a variety of reasons. As a result communication is established, teamwork initiated and a clearer understanding of the agency and the role of the social worker developed.

Twenty-eight of the doctors have patients who have had contact with a local welfare agency. Twenty-seven have talked to a social worker about a case and two have not. One added the comment that he "never saw a social worker". Seventeen of the doctors have talked with a director or administrator of an agency; twelve have not. Several of the doctors added comments which indicated that they only spoke to an administrator when the problem was acute and needed immediate action; and where the

social worker in such cases was hindered by administrative procedures. One doctor commented that he spoke to an administrator about an adoption problem and one doctor indicated that he found the administrator co-operative.

Maintenance of contact with a welfare agency, after referring a patient, indicates the doctor's desire to co-operate with the social worker and establish a team approach in treating his patient's illness. The contact will also increase awareness and utilization, as each team member defines their role according to skill and resources, and discusses treatment plans. Eleven of the doctors try to maintain contact with a welfare agency, after referring a patient and five do so occasionally. Ten doctors did not answer this question. Two specific comments were added:

> "I have rarely had occasion to refer to an agency"(this varies with locale of practice).
>
> "After referring a patient to a welfare agency, do they maintain contact with me? No!"

The second comment made in relation to maintenance of contact between the two professions, raises a most important issue. In the hospital, where team relationships are structured and roles defined, the responsibility for maintaining contact between social workers and doctors, lies with the social workers. A problem arises, when team members work in different institutions and are administering varying policies. The questions as to who has the responsibility for maintaining contact is most pertinent. The difficulty here may be due to the lack of clarification of team structure and the problem of whether comprehensive care may

need to be more structured will have to be examined most closely.

Although a doctor or any other member of the helping professions may wish to refer a patient to a resource that will further meet his need, he may not know if the resource is available. In order to solve this problem, the Community Chest and Councils of Greater Vancouver, has prepared a Directory of Health, Welfare and Recreational Services in Metropolitan Vancouver. The Directory is organized into nine categories of service for meeting the health, welfare and recreation needs of the community. Within each category are subdivisions related to specific varieties of service. A brief statement of functions and program is offered for each organization, This publication is available to all professional and lay people in the community. Eighteen of the doctors were familiar with the publication, eleven were not. Two designated that they had some other form of welfare services directory, these being their own private lists of agencies and the Canadian Medical Association Information Manual. Nine of the doctors indicated no other form of welfare services directory.

A question was asked to discover what resources the doctors utilize when wishing to know more about welfare services in the community. The following table indicates that the staff of the City Social Service Department and Medical colleagues are most often consulted, followed by the Community Chest and Council and the Vancouver General Hospital, Social Service Department. One doctor consults the Family Service Agency, one the Victorian Order

of Nurses and one doctor answered none. Three doctors did not answer this question and one added the comment, "It depends on the type of case."

Table H. Resources Utilized By Doctors to Increase Their Knowledge of Welfare Services

Resource	Number of Times Mentioned
City Social Service Department	10
Community Chest and Council	4
Social Service Department Vancouver General Hospital	4
Colleagues	6
Family Service Agency	1
Victorian Order of Nurses	1
None	1
Total	27

Doctors' View of the Social Workers

The questions concerning what the doctors knew and thought about social workers applied to the awareness and utilization they have of welfare services. Utilization of welfare services will depend on whether the doctors recognize social workers as educated individuals, adequately trained to carry out the job demands placed on them by virtue of their role and function. Reluctant use of welfare services will result if the doctors feel that social workers are not trained or skilled enough to contribute to the highly specialized medical team. The doctors were asked what they understood as the educational qualifications needed by social workers in order to practice. Seventeen of the responses, listed

in the following table, indicated that the doctors understood that social workers needed a Social Work Diploma in order to practice. Eleven of the responses indicated that post-graduate training beyond the Bachelor of Arts level was needed; eight of these stating that two years of postgraduate training is required and three of these, stating that one year of postgraduate work is necessary. Five of the responses indicated a Bachelor of Arts as the qualification for practice and one, senior matriculation. The majority of the doctors recognize that specialized training is necessary. However, the responses do not indicate whether the doctors are aware of the level on which social work training begins. Whether it is understood by the doctors that an undergraduate degree is a pre-requisite to admission into a school of social work, is not known. It is surely significant that half of the doctors interviewed specified a Social Work Diploma. This has been superseded since 1946. To be eligible for such, notably at the University of British Columbia, a student was required to have an undergraduate degree and complete fourteen months of study at the school of social work.

Table I. Opinions of the Doctors as to the Education Required for Social Work Practice

Education	Number of Times Mentioned
Senior Matriculation	1
Bachelor of Arts	5
Social Work Diploma	17
Post Graduate Training - One Year	3
Post Graduate Training - Two Years	8
Total	34

Doctors' Opinions About Social Workers

When a doctor considers the treatment team necessary to insure comprehensive medical care for his patient, he must be aware of the nature of the specialized skills which team members can contribute. Therefore, what the doctor understands to be the skills of the social worker, will affect their utilization. In order to determine what the doctors understand to be the skills of a social worker, they were asked to check off those skills they are aware of, as listed in the questionnaire. An opportunity to express their own opinions was also given (under the heading of "Others"). The responses to the question, concerning the doctors' opinions as to the particular skills of the social worker, reveal, in the following table, that the three skills of the social worker of which the doctors are most aware are knowledge of community resources; the arranging of financial assistance; and securing shelter for homeless and unattached persons. The skills of the social group worker such as guiding members of groups in various programme activities, and conducting group therapy sessions in medical settings, are the skills that the doctors are least aware of, and are in all probability, least utilized. Eighteen of the doctors indicated that the skills of a social worker included planning for the provision and maintenance of welfare services; seventeen noted specialized counselling skills; and eleven understood effecting environmental changes to be a skill possessed by social workers.

The skills of social workers, recognized most by the doctors, are those that have their roots in the early days of social work.

The skills, more recently developed, such as group work and casework, have been given less recognition. It may be that social workers are not as efficient and effective in the administration of such skills. Yet the lack of recognition given to group work, in particular, is somewhat puzzling in this era of geriatric medicine. The doctors presented problems of the aging as one of the major social problems encountered in practice and much of the geriatric literature has emphasized group activities for the aging to aid in overcoming loneliness and boredom.

Table J. The Doctors' Understanding of Social Workers' Skills

Skills	Number of Times Mentioned
Arranging of financial or material assistance	21
Securing shelter and care for homeless or unattached persons	19
Knowledge of Community Resources to meet a varied number of needs	25
Effecting environmental changes	11
Specialized counselling skills	17
Guiding members of groups in various programme activities	7
Conducting group therapy sessions in medical settings	5
Planning for the provision and maintenance of welfare services in the community	18
Others	2
Total	125

The two skills mentioned under "Others" were:

1. Explanation and guidance to the needy in making the most of the resources they have, be it physical, mental or material.
2. Maintenance of contact with the lonely and frightened.

The nature of the co-operation experienced by doctors when working with social workers, will, to some extent affect awareness and utilization. The doctors will be more willing to involve the social worker as part of the team, if past working experiences have been productive and non-irritating. The opposite is also true. Difficulties in working with social workers will tend to prejudice the nature of the doctor's awareness and hence his utilization of the skills of the social worker. The doctors were asked to indicate what difficulties they had experienced in working with social workers in (a) hospitals, (b) health agencies and (c) welfare agencies. Their complaints, as listed in the following table, have been classified under four headings: Professional Skills, Attitude, Competency, and Others. Professional Skills are those to which social workers lay claim by virtue of their training; role; and function. The manner in which a social worker approaches her clients, professional peers, and team members is referred to as attitude. Competency is defined as the accuracy and efficiency with which the social worker carries out the administrative aspects of her job.

The total number of responses indicate that the most difficulties experienced have been with social workers in welfare agencies; followed by social workers in hospitals and then in health agencies. The major difficulties met in both health and welfare agencies have been too much red tape; not enough resources; social workers over worked; and caseloads too high. The difficulties experienced here, result from agency policy as administered by social workers. Subsequently, the doctors indicated, that in all settings, the difficulties they have encountered

are due to the fact that social workers are: too theoretical; not realistic; upset the patient; try to make medical decisions and give medical advice; insufficiently trained; poorly informed about the patient; and breaching the principle of confidentiality. The social worker's lack of efficiency and competency, in hospitals and health and welfare agencies, is creating friction in the working relationships; as well as their attitude.

Table K. Difficulties Encountered by Doctors in Working With Social Workers

Problem	Number of Responses		
	Hospital	Health Agency	Welfare
Professional Skills			
Too theoretical, not realistic, upset the patient, try to make medical decisions and give medical advice, insufficient training, poor information about patient, lack of confidentiality.	4	3	4
Attitude			
Unapproachable, feel superior to patient and doctor, too interested in cutting costs, dogmatic, rigid	0	1	2
Competency			
Lack of individual continuity and follow-up, slow, delay, not report back to doctor, waste time on phone	4	1	2
Others			
Social problem is a direct reflection of an inadequate government, too much red tape and not enough resources, caseload too high and workers overworked, co-operative not too much contact or experience here	4	6	9
Total	12	11	17

This question was difficult to tabulate, due to the ways in which the doctors chose to answer. Nine doctors indicated no problems in hospitals; seven in health agencies; and five in welfare agencies. Six did not answer the total question; two did not answer the question regarding hospitals; five did not answer the question regarding health agencies; and one did not answer regarding welfare agencies. Thus the final tabulation of the difficulties encountered is not comprehensive and is somewhat unsatisfactory.

Several of the social workers' skills, criticized by the doctors, may indicate that they feel that the social worker is a threat to the doctor-patient relationship. What the doctor understands as probing may be the social worker's attempt to discover the facts about the patient in order to make an assessment and to establish a casework relationship.[1] Also, what the doctor sees as lack of confidentiality, may be the social worker's efforts to discuss the patient's illness with him and help him to make further plans. The doctor may feel that this is the essence of the doctor-patient relationship. He would then see the social worker as interfering and threatening. If this is the case, it may mean that team roles will have to be more explicitly defined for both doctors and social workers.

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1 For a discussion of the casework relationship refer to: Perlman, H.H., Social Casework, University of Chicago Press, Chicago, 1957, pp. 64-84.

Next, the doctors were asked to indicate which complaints, most often heard about social workers from doctors, they thought to have the most substance. Their answers, as listed in the following table, indicate that, mainly, social workers are using too much jargon and are upsetting the patients by too much probing. Five of the doctors have complaints about the social workers' training; four complained about social workers not taking sufficient account of medical facts; and four of the doctors complained about the fact that social workers are unable to carry out their requests. What the nature of these requests are and why the social worker cannot carry them out is not known.

The results of this question were difficult to interpret, as only a minority of the doctors answered it. Eleven doctors who stated the latter did not offer their own criticisms. Nevertheless, certain things did stand out although a definite pattern could not be established due to the minority answers.

Table L. Doctors' Complaints About Social Workers

Complaints	Number of Times Mentioned
They are insufficiently trained	5
They take insufficient account of medical facts	4
Upset patients by too much probing	7
Use too much "jargon"	7
Usually unable to carry out your requests	4
Total	27

The comments accompanying this question were varied. One doctor felt that social workers are most helpful, while others

complained about social workers upsetting the patient by being indifferent; and social workers assuming far too much responsibility in offering medical advice. One doctor stated that he had no complaints about social workers, only with the socio-economic-legal-religious system allowing these conditions to exist and another doctor made a comment to the effect that there is too much red tape about social work routine which engenders a great deal of antagonism.

Just as friction between doctors and social workers, will affect awareness and utilization, so will favourable working relationships with social workers. What the doctor considers as the social worker's best contribution to the team will be taken into consideration when making a referral and involving her as part of the medical team. The doctors were questioned about what they consider as the best contributions of social workers. Their opinions, as listed in the following table, have been classified under three headings: Professional Skills, Attitude and Others. Seven of the doctors did not answer.

Twelve of the doctors felt that the social worker's best contributions consisted in determining points at which help may be most productively given; arranging for material and environmental assistance; providing a good social history; knowledge of resources; and maintenance of welfare services in the community. Six of the doctors indicated that the social worker's supportive, reassuring, personalized attitude was the major contribution and four doctors listed "Other" contributions.

Table M. The Doctors' Opinions as to the Social Worker's Best Contributions

Contributions	Number of Responses
Professional Skills	
Determining points at which help may be most productively given, arranging for material and environmental assistance, maintenance of welfare services in the community, provide good social history, knowledge of resources and placements.	12
Attitude	
Have time to help, friend and counsellor to the needy, treating geriatric patients as human beings, understanding rapport, reassuring, maintain contact with the lonely and frightened	6
Others	
Ease the doctor's load and co-operative	4
Total	22

Chapter 3

Social Workers and the Utilization of Medical Services

The Social Workers: Education and Experience

Professional education is regarded as an indication of competence in the profession of Social Work. Emphasis is also placed on experience in social work practice. Frequently the length of experience an individual worker has, may acquire equal importance with the nature and length of professional education. It is in this context that the discussion of education should be considered.

The following table indicates that eighteen of the social workers who participated in this survey have a Bachelor of Arts; thirteen have a Bachelor of Social Work, [1] and eleven have a Masters of Social Work. [2] Four of the social workers possess the equivalent to one year of graduate social work education and four, the equivalent to two years of graduate social work education. Two of the social workers had just senior matriculation. Thus, seventeen of the social workers had attended a school of social work for one year of specialized training and fifteen for two years of specialized training. The majority of the social workers, therefore, appear to have a Bachelor of Social Work or its equivalent. Whether this is indicative of

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1 Bachelor of Social Work is granted to candidates who have a Bachelor of Arts and one year of social work education.

2 Master of Social Work is granted to candidates who have a Bachelor of Arts and two years of social work education.

the qualifications of most social workers in Vancouver is not known. The Council on Social Work Education has stated that the minimum qualification for a beginning Social Worker is a Masters of Social Work, yet a minority of the social workers have a Bachelor of Social Work or less. Four of the social workers received their education in the United States and the others attended Canadian Schools of Social Work.

Table N. Social Workers: Educational Degrees

Degrees	Number of Times Mentioned
Equivalent to one year of graduate social work education	4
Equivalent to two years of graduate social work education	4
Bachelor of Arts	18
Bachelor of Social Work	13
Masters of Social Work	11
Total	50

Social work education has changed considerably in emphasis and content over the last fifteen years. The decade in which social workers received their education will affect, to some extent, the degree of awareness and utilization they have of general practitioners. Until the 1950's social work students were given courses in medical information, in addition to explicit instruction concerning the roles of the doctor and social worker on the treatment team. Courses in medical social work were offered to those second year students who wished to specialize in this field. Since 1956, emphasis has been placed, not on specialization by setting, but rather on specialization

by method. The course on "medical information" has been redeveloped into an integrated course on "human growth and behavior." Although the importance of teamwork is stressed, instruction regarding the role of the social worker in the treatment team is less explicit.

Three of the social workers graduated in the 1940's; thirteen in the 1950's and nine in the 1960's. Two of the social workers did not graduate from a school of social work. Thus, twenty-two of the social workers graduated in the decades in which a generic approach to team work was being taught.

The "total" approach to the patient which is emphasized in medicine, is also a tenet of social work education and practice. Thus, in social work education emphasis is placed on the understanding and use of community resources and the specialized skills of other professions. In the table following, the responses to the questions determining whether courses in social work education mentioned the role of the doctor in the treatment of illness or suggested ways of working with doctors, are as follows: Twenty-four of the social workers took courses which offered an understanding of the doctor's role in the treatment of illness. The comment "limited" was added, by one of the social workers.

Fourteen of the social workers took courses which suggested ways of working with doctors who refer patients. One social worker commented that she had learned this by experience and several social workers stated that this was implied, particularly

in the casework sequence. Another social worker commented on the fact that this was taught in several courses, including, community organization, field work, medical information, medical social work and social psychiatry. The courses here mentioned were offered in the early 1950's, when specialization by setting rather than by method was emphasized.

Twenty-two of the social workers took a course which suggested ways of working with a sick client, not referred by a doctor. One commented that she learned this from practice and another stated that it was implied rather than directly taught. Another comment was that this was learned in casework seminars, in the course on medical information and in a specialized reading course. One social worker did not answe this question.

Table O. Social Workers: Education Related to the Understanding of the Doctor

Nature of the Question	Number of Responses		
	Yes	No	Total
Course material offered in increasing understanding of the doctors' role in the treatment of illness.	24	2	26
Course material suggesting ways of working with doctors who refer patients.	14	12	26
Course material suggesting ways of working with a sick client, not referred by a doctor	22	23	25

A Social workers' awareness of community resources, which leads to utilization, more often depends upon the number of years she has been in practice in the welfare field, rather than professional

education. As a social worker's caseload grows, she finds the need to be increasingly aware of community resources and to utilize them selectively, in order to aid her client in his social functioning. Thus, the longer a social worker is in practice, the more aware she usually becomes of available resources and skills in a particular community. The table following indicates that nine of the social workers have been in practice from one to five years; four from six to ten years and six, from eleven to fifteen years. Five social workers have had from sixteen to twenty years experience and one from twenty-one to twenty-five years experience. One social worker did not answer this question.

For the purpose of this study it was important to determine the number of years that the social workers had been working in the agency where they are now presently employed. Familiarity with agency policy and procedure develops over a period of time and with experience. Interpretation to the doctors of agency policy and the role of the social worker within the agency is partly dependent on such. The table following indicates that eighteen of the social workers have been employed in the agency in which they are now working, from one to five years; three, from six to ten years and three, from eleven to fifteen years. Two social workers have been employed from sixteen to twenty years, in the agency in which they are now working.

Table P. Social Workers: Number of Years in Practice in the Welfare Field and in Their Present Employing Agency.

Number of Years in Practice	Number of Responses	Number of Years Employed in Agency	Number of Responses
0 - 5	9	0 - 5	18
6 - 10	4	6 - 10	3
11 - 15	6	11 - 15	3
16 - 20	5	16 - 20	2
21 - 25	1	21 - 25	0
Total	25	Total	26

Counselling

The role of the social worker, in any agency, is to enhance, maintain or restore social functioning.[1] The nature of a client's health or any health problems being experienced by a client will affect his role performance.[2] Therefore, it is advisable to explore this area with a client in making a social assessment.[3] Twenty-six of the social workers stated that they did inquire into the nature of health problems being experienced by a client. Health problems were defined as illness, the meaning of illness to a client, difficulties in paying doctors' bills and difficulties in following the doctor's treatment programme.

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1 Social functioning refers to the sum total of an individual's interaction which individuals or groups in his environment.

2 Role performance is the enactment of the social requirements of the status held by the individual.

3 A social assessment is a combination of theory plus facts gathered by the social worker about the client's problems in social functioning. From this a hypothesis about the person-problems complex is formed.

Eleven of the social workers do this routinely, seven, occasionally and eight inquire only when the client presents this as a problem.

The role of the social worker in the treatment of illness is to help her client cope with social or emotional problems associated with illness. Twenty-six of the social workers stated that they counselled clients about the social aspects of a health problem. One added the comment "when applicable". Counselling clients about the social aspects of illness, appears to be an inherent part of every caseworker's job.

The social worker, while counselling clients about health problems, should at all times be in contact with the client's doctor in order that an integrated team approach is established. Of the twenty-six participants in this survey, twenty-five do contact the client's doctor and one does not. The latter, added the comment:

> "In this agency this is the job of the medical section, although, on a rare case I have phoned the doctor after receiving permission from the medical section."

Three of the social workers who replied in the affirmative, indicated that their contact was made through the medical section of the agency.

Comments added to this question indicate that one worker contacts the doctor only if the need is indicated. Need is determined by the nature of the problem and the role of the social worker. Another worker contacts the doctor only if she has the client's permission to do so.

Reasons for contacting the doctor may vary according to the needs of the client and the problems associated with the client's illness. Reasons for contact should stem from a competent social assessment and the social worker's desire to co-operate with the doctor. It appears, in the table following, that one of the main purposes for contacting the client's doctor is to discuss with the doctor the fact that his patient is being counselled at the agency. Twenty-two of the responses indicate that the client's doctor is contacted in order to discover the treatment recommended; twenty of the responses indicate that the purpose for contact is to ascertain the nature of the client's illness; and eighteen, to discover how well the client is following treatment. Of the twenty-two reasons listed under "Others", ten indicated that the purpose for contact was to establish an integrated team approach.

Table Q. The Social Workers' Purposes for Contacting the Client's Doctor

Purpose	Number of Times Mentioned
To ascertain the nature of the illness	20
To discover the treatment recommended	22
To discover how well the client is following treatment	18
To discuss with the doctor the fact that his patient is being counselled at the agency	23
Others	22
Total	105

Those purposes mentioned under "Others" were:

1. To discuss with the doctor how we may best work together and co-operate for the good of the client, which involves, defining professional roles, discovering how the doctor feels the social worker can help, and involving the doctor in the social work treatment plan. (10 responses)

2. To arrange for resources and referrals and in doing so co-ordinate physical and emotional help to the client. This involves arranging for appliances, payment for drugs and referrals to a psychiatrist. (4 responses)

3. To discover how the illness will affect the social functioning of the client and his family, now and in the future. (3 responses)

4. To request collateral information which will aid in a psycho-social assessment. This involves the medical diagnosis and prognosis. (2 responses)

5. To discover the nature of the counselling done by the doctor. (2 responses)

Comments, added to this question indicate that purposes for contact depended on the nature of the case. One social worker stated that this must be done with the client whenever possible, in order to insure the client's self dignity and right to self determination. This statement is indicative of the social worker's realistic application of two basic tenets of the social work philosophy.

The majority of the responses to this question indicate two important and related factors. Most of the social workers, when working with a client whose problems are those associated with illness, are taking the initiative in contacting the client's doctor. This in itself is the first step towards establishing rapport between the two helping professions. Secondly, the majority of the social workers indicated that the purpose for a contact was to establish an integrated team approach, by discussing

with the doctor the fact that his patient is being counselled at the agency and discussing with him, how the doctor and the social worker may best work together and co-operate for the good of the client. The other purposes for contacting the doctor, that were listed, also are limited facets of the team approach and indicate the emphasis and importance that the social workers place on such.

Awareness and Utilization

One of the best indicators of the degree of reciprocal awareness and utilization is the number of referrals made to doctors and received from doctors in a certain period of time.

In response to the question asking how many of their clients were referred to the agency in the last month by a doctor, the following responses were made: Three did not answer the question, and seven replied that they did not know. Ten had received no referrals from doctors in the last month. One social worker received two referrals, one received three referrals, one received six referrals and one received seven referrals. Thus of the six reporting workers, a sum total of eighteen referrals were received.

In estimating the number of referrals made to doctors in the last month the responses were as follows. Three social workers did not answer this question and four stated that they did not know. Eight reported no referrals to doctors in the last month. The remaining eleven reported a total of twenty-nine referrals to doctors in the last month. Six of the social

workers referred one client each, three referred two, one referred five and one referred ten.

Unfortunately, the number of social workers who answered the questions on referrals, represent less than half of the group. The number of referrals to doctors was weighted by one reply of ten and the number of referrals from doctors was weighted by a reply of seven.

Further research which would indicate the number of referrals to and from a doctor annually may indicate more clearly the degree of reciprocal awareness and utilization between the two professions. This is due to the fact that the referral in itself, in some cases, is indicative of a great deal of time and effort of the part of the social worker and the doctor. Although a social worker or a doctor may recognize the client's need for such, it may take time before a referral can expedited. In the interum, the client or patient may need to be helped to recognize the need himself, be prepared for the new experience and be emotionally or physically able to continue in treatment. Permission must be granted by the client or patient to release confidential information and in the case of a social work referral, agency policy and procedure must be adhered to.

Twenty-three of the social workers indicated that they made an effort to contact the doctor for collateral information when the doctor referred a client. Two did not answer the question and one replied in the negative.

Maintenance of contact with a doctor, after referring a client, indicates the social worker's desire to co-operate with the doctor as a member of the treatment team. In response to the question about maintaining contact with the doctor, after referring a client to him, twenty-three indicated they did such. Three social workers did not answer the question. Of the twenty-three who indicated they maintained contact with the doctor, ten replied that they did this on a routine basis and thirteen did this occasionally. One social worker commented that her contacts, depended on the nature of her social assessment and one maintained contact "more or less" on a routine basis with a doctor. The question as to who has the responsibility for maintaining contact appears to be of less concern to the social workers than to the doctors. It may be that the non-medical social worker feels that this is as much her responsibility as that of the medical social worker.

Problems encountered by social workers in working with doctors will affect awareness and utilization. The opposite is also true. If co-operation and good working relationships have been the social worker's experience, then she will be more clearly aware of the doctor's skills and his role in the treatment team. She herself will also be more willing to become involved in the team.

In response to the question relating to problems in trying to work with doctors on a case, seventeen indicated that they had encountered problems and six indicated they had not. Three of the social workers did not answer this question.

The two major problems apparently encountered in working with doctors are that the doctors underestimate social and emotional problems as factors in illness, and that doctors do not understand the role of the social worker and the agency policy which she administers. Three of the responses indicate that problems are encountered as a result of the doctors counselling patients without an adequate understanding of personality dynamics or the patient's complex social situation.

This reply is somewhat in contradiction to those made by the doctors. The majority of the doctors claim to assess psychosocial factors when diagnosing illnesss. Yet the social workers feel that these factors are underestimated by the doctors. What is meant by "underestimated" may have some relationship to the team role confusion, in that the social workers are not clear about the doctor's role in the treatment of illness or on the treatment team, as well as her own role on the team. Indications are that the doctors do not fully comprehend the social worker's role. Further research into this problem is necessary.

Two social workers have met problems in the working relationship as doctors have refused to share collateral information and two indicated that doctors are difficult to contact or do not respond quickly enough to requests for medical information. One social worker feels that doctors treat clients with disrespect and eight social workers did not answer this question.

Table R. Problems Encountered by Social Workers in Individual Contacts with Doctors

Difficulties Encountered	Number of Times Mentioned
Doctors underestimated social and emotional problems as factors in illness	8
Doctors do not understand the role of the social worker and the agency policy which she administers	7
Doctors counsel patients without an adequate understanding of personality dynamics or the patient's complex social situation	3
Doctors refuse to share collateral information	2
Doctors are difficult to contact or do not respond quickly enough to requests for medical information	2
Doctors treat clients with disrespect	1
Total	23

Doctors and Social Workers

The social workers' understanding of the training provided in medical schools concerning social work and the social services, is a partial indication of the social workers' awareness of the skills and knowledge that a doctor contributes to the medical team.

Fifteen of the social workers indicated (see following table) that they understand that doctors do take courses in interviewing and counselling and eight indicated that this was not their understanding. Two social workers did not answer this question and two replied that they did not know. The comment "more emphasis is needed on this", was added to this question.

This comment can be directly related to the criticisms that the doctors underestimate the psycho-social factors related to illness and that they are counselling without an adequate understanding of personality dynamics or the patient's complex social situation.

Thirteen of the social workers do not think that doctors are offered course material about the profession of Social Work and nine do. Two social workers did not answer this question and two indicated that they did not know. "A minimal smattering", was the comment added.

Fourteen of the social workers understand that doctors do receive instruction about the social services and eight replied to the negative. One social worker did not answer this question and three do not know whether doctors are educated about such. One social worker commented that the information about the social services given to doctors is limited and one social worker felt that the orientation depends on the approach of the particular medical school and the acceptance of the medical professor of social work.

Table S. The Social Workers' Understanding of Medical Education Concerning Social Work and the Social Services

Doctors' Education	Yes	No	Total
Interviewing and Counselling	15	8	23
Social Work, as a Profession	9	13	22
Social Services	14	8	22

What the social worker believes are her main contributions to the doctor, will affect the way in which she performs her duties and works with other team members. To a great degree, this will influence the doctor's awareness and utilization of social work skills. Seventeen of the social workers, who responded to the question about social work contributions rendered to doctors in (a) health agencies (b) hospitals and (c) welfare agencies, answered the three part question with one answer for all three parts. This can be seen in the following table. Fourteen of the social workers indicated that the main contribution rendered to doctors, in all settings, is to integrate the psycho-social assessment with medical findings into a co-ordinated plan for the patient. Two social workers stated the main contribution was acting as liason between team members and two, the interpretation of welfare resources and the role of the social worker.

Table T. The Social Workers' Opinions as to the Main Contributions Which Can Be Rendered to Doctors in Health Agencies, Hospitals and Welfare Agencies

Contribution	Number of Times Mentioned		
	Health Agency	Hospital	Welfare Agency
Integrated psycho-social assessment with medical findings, into a co-ordinated plan for the patient.	14	14	14
Liason among team members.	2	2	2
Interpret the role of social work and social welfare resources in the community	2	2	2
Total	18	18	18

Although difficulties in working with doctors have been met by individual social workers; it was most important to this study to ascertain whether these difficulties are being met by most social workers. If such is the case, then both doctors and social workers must take the responsibility for examining these difficulties and make some effort to overcome them. Team roles are theoretically complementary and if practice proves this to be different, then efforts must be taken to make this a reality in this era of specialization.

Thirteen of the social workers are of the opinion, as indicated in the following table, that most social workers experience difficulties in working with doctors, as the doctors do not understand the role of the social worker and the agency policy within which she works. Nine of the social workers indicated that difficulties are met due to the fact that doctors underestimate social and emotional problems as factors in illness and five feel that doctors are reluctant to share their specialized knowledge with social workers. The question raised in Chapter 2 regarding the time and specialized skills that doctors have in order to counsel patients about emotional or social problems appears to be of importance, as the social workers are finding this counselling somewhat inadequate and friction producing. Two social workers feel that difficulties in the working relationship, come as a result of doctors counselling patients without an adequate understanding of personality dynamics or the patient's social situation, and two social workers stated that difficulties arose as doctors are

reluctant to consider social work contributions. When doctors make private adoption placements and when they do not refer unmarried mothers to the proper resources, friction is created in the professional relationship. This was the opinion of two social workers. Two of the social workers feel that difficulties arise as doctors are reluctant to refer a patient to a psychiatrist, when the need is indicated and one pointed out that difficulties are due to the doctor's lack of time and interest in explaining illness to a patient. Three of the social workers did not answer the question, one claimed that no problems existed, and one did not know, as the medical section of the agency made the contacts with the doctors.

Table U. Difficulties Experienced by Most Social Workers in Working with Doctors

Difficulties Encountered	Number of Times Mentioned
Doctors do not understand the role of the social worker and the agency policy within which she works	13
Doctors underestimate social and emotional problems as factors in illness	9
Doctors are reluctant to share their specialized knowledge with social workers	5
Doctors counsel patients without an adequate understanding of personality dynamics or the patient's social situation	2
Doctors are reluctant to consider social work contributions	2
Doctors make private adoption placements and do not refer unmarried mothers to the proper resources	2
Doctors are reluctant to refer a patient to a psychiatrist, when the need is indicated	2
Doctors lack time and interest in explaining illness to a patient	1
Total	36

Certain insufficiencies exhibited in the professional role performance of social workers are creating friction between the two professions. If social workers are willing to make a realistic assessment of such and then devise ways of overcoming them; not only will the standards of professional practice improve, but also increased utilization of social work skills by doctors and members of the other helping professions, may result. Therefore, for the purposes of this study, the social workers were asked for their opinions as to the difficulties encountered by doctors in working with social workers. Eight of the social workers suggested, as indicated in the following table, that doctors have difficulties in working with social workers, because the latter are unsure of their facts. The result of such is inefficiency, indecisiveness, slowness and too much talking. An equal number of the social workers agreed to the fact that social workers do not understand their team role as well as that of the doctors. Three of the social workers indicated that the use of too much jargon is contributing to inter-professional friction. Two of the social workers claimed that doctors find agency policies to be irritating. The question arises as to whether the social workers who must administer these policies and govern their actions according to the dictates of such, are finding them equally irritating.

Table V. Opinions of the Social Workers Concerning Their Contributions to Inter-Professional Discord

Difficulties	Number of Times Mentioned
Social Workers are inefficient, lack of clarity about goals, thinking is diffuse, too verbal, unsure of facts, unable to get things done quickly and decisively	8
Social Workers do not understand their role on the team as well as that of the doctor	8
Social Workers use too much jargon	3
Social Workers do not have sufficient medical knowledge to understand the medical aspects of illness	3
Professional jealousy, Social Workers are hostile and defensive due to higher status accorded medicine	2
Agency policy is frustrating to doctors.	2
Total	26

There seems to be some agreement between the doctors and social workers as to the difficulties encountered by doctors in working with social workers. In Chapter 2, the doctors indicated that social workers were unsure of their facts, used too much jargon and have insufficient knowledge of medical facts. Irritation with agency policies was clearly stated.

Being aware of the difficulties encountered between team members is one step toward solving the complex problem. The next step, is to formulate suggestions as to how the friction might be reduced. Thus the social workers were asked to suggest

what they might do to improve working relationships in their role of caseworker and in any other role in which they might function.

Table W indicates that nine of the caseworkers felt that they must be more explicit in their interpretation of agency policy and the role of the social worker. Six of the caseworkers stated that improvement of social work skills and standards might improve working relationships and three felt that caseworkers need to extend more respect to the medical profession. Three of the social workers indicated that social agencies should establish a continuous public relations programme. They failed to state what role the caseworker might play in public relations as a staff member. One social worker felt caseworkers should take a interpretative role in medical education and four social workers did not answer the question. One stated she did not know.

Ten of the social workers seem to agree that explicit interpretation is needed both to practicing doctors and to medical students. What should be involved in this interpretation was not clearly outlined. The problem also arises, that in spite of the fact that interpretation to medical students is indicated, the medical schools have to indicate their desire for such and even if this is the case, the content of course material may be limited due to the demanding medical curriculum.

Table W. Social Workers: Suggestions as to the Role of the Caseworker in Ameliorating Inter-Professional Discord

Suggestions	Number of Times Mentioned
Explicit interpretation of the role of the social worker and agency policy	9
Improve social work skills and standards	6
Social workers need to extend more respect to the medical profession	3
Social agencies should establish a continuous public relations programme	3
Social workers should take an interpretative role in medical education	1
Total	22

Social workers, and in this particular instance, caseworkers, function in many roles that do not specifically involve clients, but which are professionally oriented. As members of agency boards or community planning groups, they are concerned with the welfare of large numbers of people. As members of the professional organization, they devote their energies to helping the profession grow and develop. Concern with social problems may lead social workers to membership in political parties and pressure groups. In their many roles, they have chances to interpret social work, by deed and action.

It appears, in the table following, that six of the social workers feel that interpretation, whenever possible, is one method of overcoming friction between social workers and doctors.

The question arises as to the nature, content and presentation of the interpretation. Three of the social workers would encourage joint discussions between the professions at meetings of both professional organizations or at conferences, and three would involve doctors as members of agency boards and community planning groups. One of the social workers thinks that some difficulties might be overcome if the British Columbia Association of Social Workers was more active in public relations and one suggested that social workers, assume the role of teachers, in medical education.

The answers to this question are not too satisfactory. Twelve social workers did not answer this question. The question, therefore arises, as to whether caseworkers are limiting their professional problem solving role to one area of their functioning and by doing so, limiting the solutions available to this problem. Further research is needed to determine what social workers understand to be the expectations and responsibilities inherent in their professional role.

Table X. Suggestions as to the Ways Social Workers, in Other Professional Roles, Can Ameliorate Inter-Professional Discord

Suggestions	Number of Times Mentioned
Interpret Social Work wherever possible	6
Encourage joint discussion between the professions at meetings of the professional organizations or at conferences	3
Involve doctors as members of agency boards and community planning groups	3
The British Columbia Association of Social Workers must be more active in public relations	1
Social Workers should participate in medical education	1

The social workers were not only asked what could be done to alleviate some of the difficulties between doctors and social workers, but also where they thought the most effective job could be done to promote better working relationships. It appears, from the following table that an equal number of the social workers feel that the responsibility lies at the administrative level as well as at the caseworker-doctor level, for promoting co-operation and co-ordination between doctors and social workers. The British Columbia Association of Social Workers was designated by eleven social workers, followed by public discussion and the university as a body generally take the responsibility. Seven of the social workers indicated that the responsibility lies at the supervisory level; six with the school of social work and five with the Community Chest and Council. Four levels of responsibility were indicated under "Other", in addition to the above mentioned thirteen. Two social workers said they did not know.

One comment added to this question, indicated, that unless there is adequate professional practice based on a firm grounding in theory, all the other efforts would be useless. One social worker commented that more co-operation is needed between the University of British Columbia School of Scoail Work and the University of British Columbia Faculty of Medicine and another would recommend more joint meetings between the British Columbia Association of Social Workers and The British Columbia Medical Association.

Table Y. The Social Workers' Opinions as to the Level at Which Most Can Be Done to Promote Co-operation and Co-ordination

Level	Number of Times Mentioned
Supervisory Level	7
Administrative Level	13
Chest and Council	5
British Columbia Association of Social Workers	11
The School of Social Work	6
The University Generally	8
Public Discussion	10
Others	17
Total	77

Included under "Others" were:

1. Demonstrated efficiency, desire to co-operate, and sensitivity to each other's needs at the caseworker-doctor level. (13 responses)
2. In the School of Social Work and Faculty of Medicine. (1 response)
3. In the hospital setting where interns can learn by many contacts with social workers. (1 response)
4. Doctors lecturing at staff meetings. (1 response)
5. Increase government rates paid to doctors for patients in recept of Public Assistance. (1 response)

An attempt was made to discover if the agencies made any attempt to promote reciprocal awareness and utilization. A question was asked about the staff development programme being devoted to increasing the professional staff's knowledge of the ways private practitioners and social workers can work together.

Seventeen of the social workers indicated that this had not occurred, eight indicated it had and one did not answer.

Thirteen of the social workers stated that their agency did not have a list of doctors from which the client may choose, if referral to a doctor is indicated, nine stated it did and four did not answer. The responses to this question are not satisfactory. Contradictory replies were returned from workers in the same agency. Some indicated they had their own lists. One raises the question as to whether agency policy and procedure has been clarified on this matter.

Chapter 4

Relations Between Doctors and Social Workers: Some Provisional Conclusions

The occurrence of specialized health and welfare services has not only given rise to large bureaucracies, but has also created interdependency between the two professions. The need then arises for inter-professional relatedness and co-ordination of services, in order to provide the means available to the population for the meeting of health and welfare needs. The objective of this study was to assess the nature of the inter-professional relatedness existing between doctors and social workers in one city and the main concept evaluated was reciprocal awareness and utilization.

Abstracting the two entities, health and welfare services, may seem to imply that they are the most important or most in need of study and change. But the two entities must not be considered out of context and viewed as only phenomena existing and functioning in a geographical area. They are much more. When combined with the other helping professions, they provide the populations' means of meeting health, educational, social personal and spiritual needs.

Reciprocal Awareness and Utilization

As a frame of reference for the evaluation of reciprocal awareness and utilization, five questions were raised that

applied to the two professions, medicine and social work. They are:

1. What contribution has been made by professional education to reciprocal awareness and utilization between the professions of medicine and social worker?

2. As doctors and social workers encounter similar problems in daily practice, how does each profession manage those problems not considered to fall within their area of specialization?

3. What does each profession consider to be the skills and resources of the other?

4. What problems have been encountered in trying to establish an integrated team approach?

5. What solutions may be offered to overcome barriers toward co-operation and understanding?

In the community sampled the profession of medicine was represented by twenty-nine general practitioners. The doctors, by their co-operation in the survey, indicated a definite interest in discussing the relationship of health to welfare services. The majority of the doctors took courses which offered information about the social services and most of them rated this education as inadequate. A small minority of the doctors were offered course material concerning social work, as a profession. It appears that the majority of those who were offered this information found it adequate. Most of the doctors have had several years of experience in the practice of medicine as well as residence in the community.

A great number of the doctors include a psycho-social assessment as part of their medical diagnosis and all of the doctors have patients whose illnesses have no organic basis. The major

social problems associated with such cases of illness are family problems, personality problems and problems of the aging. The doctors are doing a considerable amount of counselling in relation to these problems, as well as referring their patients to a resource that will further meet their need.

Of the resources utilized by doctors, welfare agencies, follow psychiatrists and health agencies, in frequency of use. The resources of the City Social Service Department are utilized more often than those of any other welfare agency. The main reasons for not utilizing the resources of a welfare agency, although the doctors are aware of its function, are that patients have negative or mixed feelings about being referred, as well as, the fact that doctors believe the pressures and demands on the agency are so great that patients will not receive enough time or attention. When referring patients to a health agency, doctors, more often do not consider the available skills of the social workers on staff.

Most of the doctors have been in touch with the personnel of welfare agencies and most of them try to maintain contact with the agency after referring a patient. A high percentage of the doctors have a Community Chest and Council Directory or other lists of agencies and most of them consult the City Social Service Department if they wish to learn more about available welfare services.

The majority of the doctors recognized the fact that specialized training was needed for social work practice, but

their understanding of the prerequisites for this and the length of contemporary training was not clear and somewhat outdated. The three skills of the social worker of which the doctors are most aware are knowledge of community resources, arranging of financial assistance, and securing shelter for homeless and unattached persons. The doctors are more aware of the pioneer skills of the social worker but less cogent of the skills and methods developed in the last fifteen years.

Of parallel consideration to the preceding information are the facts, opinions and attitudes expressed by the social workers about the doctors, as based on general knowledge and actual personal contact.

The twenty-six social workers who participated in this survey represented three welfare agencies in the community. The majority had received one year of postgraduate training or its equivalent and a minority had attained the maximum standard of a Master of Social Work degree. A high percentage of the social workers took courses which offered an understanding of the role of the doctor in the treatment of illness or suggested ways of working with doctors. However, opinions seemed to conflict as to the adequacy of such course material, and most of the comments indicated that the material was taught indirectly rather than explicitly. Most of the social workers have had a number of years of practical experience both in the welfare field generally, and in the agency in which they are now employed.

All the social workers include an inquiry about the client's state of health as part of their social assessment and all counsel clients about the social aspects of health problems. A majority of the social workers, while counselling clients about health problems, contact the client's doctor in order to establish an integrated team approach. When referrals are made by doctors, most of the social workers make an effort to contact the doctor for collateral information. Indications are that the social workers feel it to be their responsibility for maintaining contact. Most of the social workers have a good understanding of the doctors' education regarding counselling, the social services and social work as a profession. The majority of the social workers indicate that the main contributions, rendered to doctors in all settings, is to integrate the psycho-social assessment with medical findings into a co-ordinated plan for the patient.

Problems Encountered in the Team Approach

The most difficulties experienced by doctors, in working relationships have been with social workers in welfare agencies, followed by social workers in hospitals and then in health agencies. The major difficulties met in both health and welfare agencies result from agency policy as administered by social workers. These include too much red tape, not enough resources, social workers overworked and caseloads too high. Subsequently, the doctors indicated, that the difficulties they have encountered are due to the fact that social workers are too theoretical; not realistic; upset the patient; try to make medical decisions and

give medical advice; are insufficiently trained; are poorly informed about the patient and breach the principle of confidentiality. In addition, the doctors criticized the social workers' lack of efficiency and competency as well as their attitude. On the other hand the doctors felt that the social workers' best contributions consisted of determining points at which help may be most productively given; arranging for material and environmental assistance; providing a good social history; knowledge of resources; and maintenance of welfare services in the community.

Difficulties met by most social workers, in working with doctors, are due to the fact that doctors do not understand the role of the social worker and the agency policy within which she works; as well as, the fact that the doctors seem to underestimate social and emotional problems in illness. The social workers claim that the two main difficulties that doctors encounter in working with social workers are due to the fact that social workers do not understand their role on the team nor that of the doctor. Also, social workers are inefficient, lack clarity about their goals, think diffusely; are too verbal; unsure of facts and are unable to get things done quickly and decisively.

Solutions to Overcome Barriers Toward Co-operation and Understanding

The discussion of solution depends upon clarification of the difficulties that both recognize as impeding co-operation. These have been outlined in the preceding section. Both the

doctors and the social workers agree that the inefficient administration of social work skills is creating friction. The doctors feel that agency policy and procedure is contributing to inter-professional dissention; and the social workers indicated that the doctors' lack of understanding of the role of the social worker within the agency, as well as, their underestimation of the social and emotional factors associated with illness are factors which contribute to poor working relationships.

The doctors were not asked for their opinions on how the difficulties in co-operation might be overcome. However, indications of what these might be are inherent in their criticisms of welfare services and social workers. These would be an improvement of social work standards and skills as well as a revision and review of the policy and procedure of some welfare agencies.

The social workers suggested more interpretation on a case-worker-doctor level about the role of the social worker and the policy she administers, as well as improving social work skill and standards. A few mentioned the need for social agencies to establish a continuous public relations programme and the desirability of social workers taking an interpretative role in medical education. They indicated that the individual worker and the administrative staff in the agency, have an equal responsibility for carrying out such. Joint meetings between the professional organizations were suggested.

The question arises as to whether these solutions offer an all inclusive answer to the stated problems. Reflection on the

material from the survey and impressions gained during the interviews, suggest that any efforts to increase co-operation will not suddenly evolve from application of any or all these solutions. Rather the solutions will come from within each profession after a more detailed evaluation of their respective roles in the community.

The recommendations for the doctors and social workers have been arrived at after reviewing not only the findings of the survey, but also local and national efforts at promoting co-operation and the limits inherent in such programmes. The findings of the survey have been summarized in the preceding paragraphs and a summary of efforts in promoting co-operation will precede the final recommendations.

Efforts at Co-operation: Medicine

Because of the changes in our civilization and way of living, which significantly affect the nature of illness and its care, there has been an increasing awareness among medical educators of the need to give medical students an understanding of the social and environmental problems of their patients as related to the practice of medicine today.

In 1941 the Association of American Medical Colleges appointed a sub-committee to explore the subject under the chairmanship of Dr. Jean Alonzo Curran, President and Dean of the Long Island College of Medicine. Using data from questionnaires which had been answered by sixty-eight out of seventy-six medical schools, Dr. Curran compiled a progress report in the teaching of social and environmental factors by medical faculties and departments

of social work in teaching hospitals.

In 1943 at Dr. Curran's invitation the American Association of Medical Social Workers [1] appointed a committee to work with his committee. The deliberation of the committee clearly established the principle that the subject matter taught by a social worker is not "social work" but certain selected aspects for the medical curriculum: [2]

> The Study made by the American Association of Medical Social Workers in 1939 of this area of educational activity helped to clarify the fact that we should not be teaching social work but rather the social implications of illness and medical care which the physician needs to understand for the practice of his own profession.

The following recommendations were proposed by the Joint Committee on Medical Education: [3]

1. It was recommended that consideration of the three major aspects of illness - physical, psychological and social - are essential in the practice of medical diagnosis and treatment. This concept implies that the exclusion of any one of these aspects in the exploration and treatment of medical problems, means that the study of the patient has been incomplete.

2. The medical student should learn to recognize these factors in every case, to evaluate them in relation to the medical problem and to assume responsibility (himself or through others) for the relevant problems, as a part of diagnosis and treatment.

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1 The American Association of Medical Social Workers, originally a separate professional organization representing medical social workers, became a part of the National Association of Social Workers in 1955.

2 Cockerill, Elanor, "Widening Horizons in Medical Education", Journal of Social Casework. January 1948. Vol. 29, p. 4.

3 Ibid., pp. 5-6;

3. In order to assume this responsibility the medical student must be helped to acquire the skill of interviewing since this is the means through which he achieves understanding of all these facets of his patients' problems. The skills of interviewing are based upon an understanding of the nature of the doctor-patient relationship and a disciplined use of this relationship. Social casework has experience to share with the physician in this area of teaching of interviewing skills.

4. The capacity to work with other professional persons compromising the medical team in the hospital or clinic is something that has to be acquired. Medical students need to learn about the various resources within the community upon which he might draw in the care of his patient and that he should develop the capacity to make effective use of them.

The composition and purpose of the Joint Committee established a precedent in furthering the relationship between the two professions. Each profession recognized the nature of their interdependence and made recommendations to co-ordinate their activities in relation to medical education. Social work, represented by medical social work, was designated an important role in medical education. If positive relationships can be established between the two professions in the very early years of medical education, then later, when the student becomes a doctor, the effects of such will benefit patients and practitioners in both professions. The medical social workers and the medical social service departments in teaching hospitals are in a position whereby they represent social work in toto, to the medical student. How they carry out their role and function will color the physician's attitude to and use of social work and social welfare services in later years.

The Committee's recommendations affirmed the trend to the broadening and deepening of the concept of medical treatment

which inevitably means a more appropriate and meaningful use of social work skills.

This trend towards courses in comprehensive medical care has been on the increase since the 1940's. Although by no means universal, an increasing number of medical faculties are expanding their medical curriculum to include such. Various methods of teaching have developed, such as lectures, seminars, case conferences, referral and consultation. Any one or a combination of these methods may be used. Medical educators, medical students and a member or members of the medical social service departments work together, each bringing their unique professional contributions to bear on a particular case. Although the medical student may have gathered the social data as part of his medical history, it is the social worker's job to demonstrate how these particular facts may be co-ordinated and interpreted, so that they form a conscise and meaningful social assessment and a social treatment plan. In this particular way the medical student becomes aware of the skills of the social worker and the deeper meaning of the social history he has taken.

In Vancouver, the University of British Columbia, Faculty of Medicine, and the Vancouver General Hospital Social Service Department, are working together in this area. The programme,[1] initiated by the Faculty of Medicine, falls in line with the general policy that the medical students receive a modern and

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1 Information obtained from interview with Miss A. Pumphrey, Director of Social Services, Vancouver General Hospital.

comprehensive medical education. Due to the increasing emphasis on the social aspects of medical care, it was felt advisable to initiate such a teaching programme. The Director of the Social Service Department was requested by the Faculty of Medicine to work in co-operation with members of the medical teaching staff, to formulate and present the course. Course presentation has changed its form over the years. They have ranged from didactic lectures, to seminars including medical students and members of the medical and social service staffs. At this point in time the seminar, "Use of Community Resources" has taken a new form. Each fourth year medical student must attend two out of four seminars, while on Outpatient Department rotation. Cases active with the Social Service department are discussed in the seminars. A medical history is presented by a member of the medical faculty, which includes any social data that the doctor has collected. The medical students then discuss the implications of the history, why they would refer the case to the social service department and what specific request would be made. The social worker, active on the case, then presents her assessment, plan and implementation of the plan. The last minutes of the seminar are a question and answer period. Whenever possible emphasis is placed on social services outside the hospital. The medical students are made aware of the Community Chest and Council Directory of Welfare Services.

A second teaching programme has been initiated recently by the Faculty of Medicine. Every first year medical student is assigned a healthy family, which he carries in sickness or health

for at least one year. He visits the family with a Public Health Nurse from the Metropolitan Health Unit. The social work consultant, attached to the Metropolitan Health Unit is available to the nurse and if necessary to the student. This learning experience is aimed at exposing medical undergraduates to a human group so that he may be in a position to observe human interaction. Observing a family over a period of time enables a student to experience the hopes, aspirations and frustrations to which all people are exposed and which greatly affect illness.

During the past two years the University of Alberta, Medical School, has also been involved in designing and establishing such a programme. [1] Twenty family physicians are active participants. Each third year student is assigned a family belonging to the practice of one of the participating doctors. The student undertakes a detailed psycho-social medical assessment of the entire family. The significance of his observations and their interpretation are then discussed at informal seminars. Attending the seminars are the family physician, a student group and a psychiatric social worker. Specific topics are assigned to the student; topics dealing with particular aspects of family and community health. The student draws on his observations of his particular family and uses them as the basis of his presentation. Following this brief presentation, an open and non-directive discussion is held.

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1 Greenhill, Stanley, M.D. "Teaching the Undergraduate Mental Health and Family Care", Canada's Mental Health. March 1963, Vol. XI, No. 3, pp. 20-25.

The medical social worker is playing an important role in the education of medical students. She, representing her profession, indicates the skills of a social worker as well as her contribution to the medical team. The establishment of such teaching programmes, in themselves, indicate medicine's increasing awareness and utilization of the skills and resources of social workers. Whether these teaching programmes are achieving their theoretical goals is questionable. The undergraduate medical student, is rightfully more concerned about the physical aspect of illness and disease and may tend to feel that these seminars are time consuming and superfluous. As the seminars occur in the same sequence with courses in medicine, which are more demanding, and which may be more time or interest consuming, then the former is likely to suffer. The nature of the relationship between the medical and social service staffs will greatly affect the seminars. If the teaching members of the medical faculty are doubtful about the contribution made by social workers, they may have some difficulty in wholeheartedly participating in the seminars.

Interns and residents are further exposed to social work skills as they carry out their duties in the teaching hospitals. In most large hospitals social workers are assigned to a specific ward or wards. They are available for consultation at all times as well as acting on referrals made by the doctors. Conferences may be held concerning a specific patient and his family. Occasionally these conferences will include social workers from agencies outside the hospital as well as concerned members of

other helping professions. Further seminars or classes may be available, as well as the emphasis placed on the values of the social workers' skills by the teaching doctors in ward rounds.

In the Vancouver General Hospital, the framework for increasing the young doctor's awareness and utilization has been established. An orientation lecture provided at the beginning of the year is attended by a medical social worker, as well as the chiefs of the numerous medical services. Once a week social work rounds are undertaken with residents, interns, nurses, and students in attendance. These rounds are conducted by the social worker attached to the ward and in effect it is her report to the doctors and staff personnel who have made referrals to her. Staff seminars are held in the Outpatient's Department with the social worker in attendance. A yearly seminar is provided for residents and interns with the social worker attached to the service. The focus of the seminar is social work and the social services.

The problems presented in increasing the residents' and interns' awareness and utilization are manifold. The education received in this area by the interns and residents varies according to the medical school from which they graduated and the experiences that they have had. Attitudes, desire to learn and co-operate, and knowledge will vary with each individual. Too, we again find their focus on physical medicine and the degree to which they are willing to enlarge their focus will depend on many factors. The relationship of the individual worker with the intern or resident, then becomes most important. What gaps in

knowledge, any change in attitude that cannot be dealt with on a formal learning basis, can be dealt with by the individual worker. Her role then, will be partially educational and according to her knowledge, interest and skill, she will be able to increase the physician's knowledge of medical social work in particular, and social work and welfare services in general.

Recommendations for the Doctors

The following recommendations for the doctors offer a gradual approach to attaining the desired solutions:

1. There should be detailed consideration of the impact of specialization of functions and bureaucratization of the practice of medicine.

2. The doctors should review the concept of comprehensive medical care and in doing so determine their responsibility for meeting the social and personal needs of their patients.

3. Medical educators should determine the various helping professions with whom doctors must co-operate in order to give patients the best medical care and in doing so, prepare the medical student for his role in these teams. This will mean revision or expansion of some course materials, which will in particular, give the medical student an understanding of contemporary social work skills and the role of the social worker in the agency.

4. Consideration should be made of the role of the profession of medicine as an instrument of social change and in social policy formation.

It is anticipated that the preceding list of recommendations have been considered in part or in total by the various medical organizations. But it seems advantageous in this community that the doctors reconsider their role and function in order to facilitate co-operation and understanding with all the helping professions, particularly social work.

Efforts at Co-operation: Social Work and Social Welfare

Social work education has changed in length, content and emphasis over the years. As social work received more recognition by society, as a profession, the need for two years, rather than one year, of postgraduate training, became evident. Some schools of social work have initiated post-Master of Social Work programmes as well as Doctoral programmes. The adaptation of psychiatric, medical and sociological concepts into the theory of social work, gave depth and new emphasis to the course material. The emphasis on "specialized" social work practice, resulted in course material which prepared social workers for work in one particular field such as medical, psychiatric and school social work. Recent developments are leading to another approach.

The increasing interest in a comprehensive view of social work practice, and the determination to identify the common elements of practice, made it possible for social work educators to start further back; to teach theory which will provide a frame of reference relating to the basic core of social work. This is known as the generic approach and it emphasizes specialization by method rather than by setting. Thus social work students, are not explicitly taught how to work with doctors or other members of the helping professions. Rather the emphasis is on the importance of utilizing the team approach, selectively, regardless of the agency in which the social worker is employed. Whether or not the social work student needs explicit instruction concerning the skills of the doctor and the role of the social

worker on the medical team, is a question that was partially studied in Chapter 3.

The educational opportunities whereby the social work student may increase her awareness and utilization of medical skill and resources fall into two main classifications: (a) class room lectures (b) field work experience.

The social worker's role is to maintain, restore or enhance social functioning. An important part of social functionings is physical functioning. In the Human Growth and Behavior sequence, both at the University of British Columbia, School of Social Work, and at other schools of social work, the student is taught about the meaning of illness and the importance of adequate and immediate medical care for the client who is in need of it. Members of the Faculty of Medicine lecture to students on the normal pattern of physical growth and development. Student social workers are taught that physiological causes may underly many cases of social dysfunctioning and that in most cases it is wise to obtain a medical report of the state of the client's health. In cases where clients do not have a doctor, or cannot afford medical services, it is the social worker's role to direct him to the proper resources.

In the methods courses, particularly casework, the emphasis is placed on developing knowledge and skill in the use of community resources;

> The social worker must have a thorough grounding of knowledge as to the socio-economic factors in the community which have an influence upon individuals; population make-up and trends, industrial and health conditions; history of the community, political or

> government structure; educational provisions and standards; religious influences; ethical standards and so forth. [1]

Because of this knowledge, the social worker will come to understand social needs and comprehend the resources for meeting such needs.

The social work student is taught to see the agency as a part of a constellation of community resources. Knowledge of the various community resources includes understanding the personal, social and group needs which the agency or professional practitioners are set up to meet, their diverse origins and auspices, their varying structures, functions and concepts of service and the degree and quality of their interrelationship.

Co-operation with educational and religious organizations has been a long standing accepted obligation of social work. In addition, referral to medical, nursing, dental and similar resources as well as employment and legal facilities has increasingly been refined as a characteristic form of service based on established practices of inter-agency or inter-professional collaboration. Health needs are seen in their relationship to the client's requests and to other problems and treatment is geared to foster the total well being of the individual and family. The student social worker learns to appreciate and to interpret

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1 Hamilton, Gordon, Theory and Practice of Social Casework, Columbia University Press, New York, p. 84.

not only his own agency but also other agencies in the field of social welfare and health. This emphasis on co-operation is derived from the fact that the typical social case is complex and has many facets.

Every social work student at the University of British Columbia, spends two days a week in a welfare agency, under a qualified supervisor. It is here that theory is put into practice. Depending on the function of the agency and the nature of the caseload, the student comes into contact with other agencies and professional practitioners such as doctors. If all is favourable he will learn to use medical resources in such a way as to benefit his agency, client and the doctor. The students placed in medical or psychiatric settings will gain more knowledge and experience in their working relationships with medical practitioners. Nonetheless, students in welfare agencies can acquire valuable skills, increase their awareness and utilization of medical resources.

There is no doubt that the skills acquired vary greatly from student to student and from school to school, depending on the varying curriculum and field placements. Also, there are social workers who have not graduated from schools of social work. This complex situation and many variables will affect the relationship between the two professions.

The role of the agency in increasing reciprocal awareness and utilization is an important one. There is a dearth of

literature or statistics in this field and it appears that this role is underestimated or overlooked. Members of the medical profession are becoming more important in the role of policy formation, particularly in private agencies:

> The business elite coupled with high status lawyers and doctors play a prominent role in the control of these bureaucracies. Working out a satisfactory relationship with these men in the formulation of welfare policy is a major problem for welfare professionals.[1]

The nature of the presentations, and reports made by executive directors and members of the social work staff will affect the doctor's impressions of the social work profession. This will later be transmitted to working colleagues.

Many public and private agencies have doctors attached to their staff. Psychiatrists and other specialists are often hired as consultants. Staff development and in-training programmes may be dedicated to enlightening the social work staff on how to improve working relationships.

The Family Service Agency of Greater Vancouver is just one example of the role an agency can assume in heightening reciprocal awareness and utilization. In the last three years greater efforts have been made by the Family Service Agency in this direction. These efforts take the following forms: [2]

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1 Wilensky, Harold, L. and Lebeaux, Charles, N. Industrial Society and Social Welfare, Russell Sage Foundation, New York, 1958.

2 Information was obtained from an interview with Mr. D. Thomson, Executive Director, Family Service Agency of Greater Vancouver.

1. The agency credo is that the most effective way to improve relationships is on the basis of a personal, face to face consultation. Thus selected specialists, chosen on the basis of previous interest or treatment of Family Service clients, are paid to act as consultants either at staff meetings or for individual workers.

2. There has been distribution of explanatory or interpretive material to the medical profession of Vancouver. This material has included personal letters which include brief descriptions of the services offered, how to refer, and brochures for the doctor's use, when referring patients.

3. Attempts to gain access to medical publications have been made. Agency personnel have written articles for the British Columbia Medical Association publication. These articles have emphasized the Homemaker services ad administered by the Family Service Agency. Homemaker services are stressed as any application for such, in order to be accepted, must have a medical opinion attached to it.

4. The agency has made it known that staff members are available to speak at medical conferences or on panels.

5. The Board membership of the Family Service Agency represents a cross section of the community. The medical profession is always included. Efforts are made to insure that the representative of the medical profession is a staff doctor at one of the Vancouver hospitals. This doctor is then used as

liason, particularly when the agency staff are seeking information about hospitalized clients.

Recommendations for Social Workers

The following recommendations for the social workers offer a gradual approach to attaining the desired solutions:

1. Social work educators should re-evaluate the preparation that social work students receive for a role in the medical team, both inside and outside the hospital, as well as teams consisting of members of the other helping professions.

2. Standards of employment and the quality of the social work skills practiced, should be reviewed by some welfare agencies with a view to improving such.

3. The welfare agencies most utilized by doctors should examine the important role they have in promoting co-operation and co-ordination.

4. Some welfare agencies should consider the possibility of establishing a public relations programme as well as initiating a staff development programme directed at increasing reciprocal awareness and utilization between doctors and welfare agencies as well as the other helping professions.

5. The social and personal needs of the population should be studied in relation to the available welfare services and the vital role of the caseworkers in providing information about unmet needs should be considered and emphasized.

6. Priorities in welfare services should be established that will provide direction to the appropriate allocation of funds and personnel.

7. Consideration of the preventitive role, that should be inherent in social work and how other helping professions, such as medicine, may contribute to this role, should be made.

As in the case of the recommendations for the doctors, it is anticipated that the above have been considered in part or in toto by the various national welfare bodies. However, considerations of these recommendations should provide a framework for

taking initial steps toward resolving the basic problems in interprofessional relationships.

Conclusion

This project, a first study with small samples, surveyed the health and welfare services in one community on a general, pragmatic level. This approach offered a practical understanding of the circumstances that made assessment possible. The advantages and results of this approach will be amplified only as similar research projects are completed. Suggested areas for further research include.

1. Repetition of a similar study including other samples of general practitioners and social workers.
2. Repetition of a similar study, limiting it to doctors and social workers practicing in a smaller geographic locale in order to determine the relationship between geographic proximity and the nature of the existing co-operation and co-ordination of services.
3. Repetition of a similar study to determine the degree of reciprocity existing between other medical specialists and social workers such as nurses, obstetricians or internists.
4. A survey of the literature and research related to unstructured team roles, with a view to compiling a theoretical body of knowledge which would be available to members of the helping professions.

The conclusion that can be reached, as a result of this study, is that although reciprocal awareness and utilization between doctors and social workers does exist, to some extent, it is hampered by faulty and hostile communication. Thus the problems encountered are multiple and of major proportion.

Medical education intended to increase the doctors' aware-

ness, has been deemed inadequate. The doctors are unaware of recent developments in social work education, skills and methods. Indications are that doctors are not utilizing welfare services, although they are aware of their purpose and function; and that they are counselling patients about social problems without a comprehensive understanding of personality dynamics and the necessary time that this form of counselling demands. Doctors are utilizing the skills and resources of health personnel more than those of welfare personnel.

The social workers, on the other hand, appeared to be more aware of the skills and resources of medicine, although their expectations of the doctors were somewhat high and unrealistic. Social work education, in preparation for such, was somewhat nebulous and it appears that experience in the welfare field was responsible for heightened awareness. The social workers indicated their willingness to establish an integrated team approach and take the responsibility for this, although there seems to be some confusion as to the role they play on the team. An understanding of the problems encountered by both professions in working with each other was evident, but the solutions offered appeared limited and there was little agreement on which approach was most feasible.

As mutual awareness between the two professions is limited, it is important to indicate why more would be desirable. Increased awareness would insure the most efficient and adequate care for individuals and groups. However it does not stop at that but

continues as a means to the larger and more constructive end of creating a well informed professional community. If this were not attained social progress would be hindered and the many groups and professions sharing the concern of social work would not be able to fulfill their own roles.

The three general gains from more mutual awareness among the helping professions are:

1. Maximum use of community resources to meet existing needs.
2. Increased ability to detect unmet needs.
3. Potential to bring about change to meet unmet needs.

APPENDIX A

Letter to the Doctors and Questionnaire for the Doctors

THE UNIVERSITY OF BRITISH COLUMBIA

School of Social Work

Dear Dr.

RE: CONTACTS WITH SOCIAL WORK

As part of my post-graduate course in Social Work, I am conducting an exploratory survey of the use of welfare services by general practitioners in Vancouver.

I can only get information with sufficient coverage by canvassing a large number of doctors, and I realize that this means making demands on busy men. But the questionnaire has been cut down to essentials; and I am hopeful it will not take up too much of your time.

If you would sooner have me make an appointment to come for an interview with you for half-an-hour, please let me know, and I will telephone your office. Otherwise, please return the completed form, if possible, within the next two weeks.

The returns will be analyzed statistically only, i.e., there will be no mention of any individual doctor by name.

Whether or not you feel able to participate, it would be much appreciated if you would fill up and return the slip at the bottom of this letter, so that I shall be able to validate my sample.

With many thanks,

(Miss) Shirley Moscovich, B.A., B.S.W.,
(M.S.W. Student)

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1. I am willing to participate; and your questionnaire will be returned shortly....

2. I would prefer you to arrange an interview....

3. I am unable to help you because:

   a. Contacts with social workers or welfare agencies are exceptional in my practice....

   b. I have no opinions, favourable or unfavourable, about social work....

   c. Other (please state).....

   .....

Doctor's Contacts with Welfare Agencies

A. Diagnosis and Treatment

1. Do you have some patients with complaints of physical illness, for which there appears to be no organic basis? Yes.... No....

   If "Yes", how many would you estimate you treated in a representative this year? 0-5..... 6-10..... 10 or more.....

   If "Yes" would you indicate which of the factors listed below, might be causative in such cases of illness.

   a. Problems with members of the family.....
   b. Financial problems such as debt or inadequate income.....
   c. Personality disturbances, such as neuroses or mild psychoses.....
   d. Problems of the aging, such as loneliness, boredom, or feelings of being useless.....
   e. Difficulties in adjusting to disability.....
   f. Problems centering around employment, such as boredom with job or job too demanding for various reasons.....
   g. Others (explain).....

   .....

   If "Yes", how do you treat such illness?

   a. Discuss problem with patient and/or counsel him about it.....
   b. Refer patient to a resource that will further meet his need.....
   c. Treat illness as if it had organic basis.....
   d. Others (explain.....

2. Do you include any assessment of social or family factors as part of your diagnosis 1. usually.... 2. occasionally.... 3. never....

B. Referrals

1. Which of the following resources did you use most frequently in the last two weeks? (i.e. "refer" a patient, by giving information or telephoning directly or contacting on a patient's behalf)
   1. Psychiatrist.... 2. Lawyer.... 3. Minister.... 4. Welfare Agency....
   5. Others (please state).....

2. After referring a patient to a Welfare Agency, do you maintain contact (either by telephone or letter) with the Agency? Yes.... No....

3. List the three Welfare Agencies that you deal with most often, in order of frequency. 1..... 2..... 3.....

4. If you know of a Welfare Agency that might meet a patient's need and you do not use it, what are your most common reasons?
   a. Patient has negative or mixed feelings about being referred.....
   b. Pressures and demands on the agency are so great that you feel your patient would not receive enough time or attention.....
   c. The inadequacies of the social workers are such that you feel you could better handle the problem.....
   d. Other(explain).....

C. Welfare and Health Agencies

1. Have any of your patients had contact with a Welfare Agency? Yes.... No....
(Comment; if necessary.....)

2. Have you ever talked with a social worker about any cases? Yes.... No....
(Comment; if necessary .....)

3. Have you ever talked with a director or administrator of a Welfare Agency, about a case(s)? Yes.... No.... Comment.....

4. Are you acquainted with the Community Chest Directory of Major Welfare Services? Yes.... No....

If "No", do you have another directory or listing of Welfare Services?
Yes.... No.... Comment.....

5. What source do you contact if you wish to know more about Welfare Services in your community?.....

6. Does the fact that social work counselling is provided in the agencies listed below, ever enter into your decision in making a referral to them?
Yes.... No.... Occasionally.....

AGENCY	Y	N	O	AGENCY	Y	N	O
G.F. Strong Rehabilitation Centre				Cancer Institute			
Alcoholism Foundation				Cerebral Palsy Foundation			
Arthritis and Rheumatism Society				Other			

Y: Yes N: No O: Occasionally

D. Social Workers

1. What is your understanding of the qualifications needed by Social Workers in order to practice?
1. Senior matriculation.... 2. Bachelor of Arts.... 3. Social Work Diploma....
4. Post graduate training - one year.... 5. Post graduate - two years....

2. What, in your opinion, are the particular skills of the social worker?
1. Arranging of financial or material assistance.....
2. Securing shelter and care for homeless or unattached persons.....
3. Knowledge of community resources to meet a varied number of needs.....
4. Effecting environmental changes.....
5. Specialized counselling skills.....
6. Guiding members of groups in various programme activities.....
7. Conducting group therapy sessions in medical settings.....
8. Planning for the provision and maintenance of welfare services in the community.....
9. Others (explain).....

General

1. What have been the main types of difficulty you have experienced in working with social workers? (a) in hospitals, clinics.....
(b) in health agencies.....
(c) in welfare agencies.....;.....

2. What complaints about social workers do you think have most substance?

a. They are insufficiently trained .....
b. They take insufficient account of medical facts.....
c. Upset patients by too much probing.....
d Use too much "jargon".....
e Usually unable to carry out your requests.....

3. If your experiences with social workers have been favourable, what do you regard as their best contributions?.....
.....

4. Did your medical education include any courses concerning the social services? Yes.... No.... Would you describe them as: adequate.... or inadequate.... in this area?

5. Did your medical education include any courses which discussed social work as a profession? Yes.... No.... Would you describe them as: adequate.... or inadequate.... in this area?

6. For how many years have you been in private practice in Vancouver..... in Canada.....

APPENDIX B

Questionnaire for the Social Workers

Relations between Social Workers and Private Practitioners

Name of Agency.....
Type of Service.....

A. Counselling

A. Do you enquire into the nature of health problems being experienced by a client? (i.e. illness, the meaning of illness to a client, difficulties in paying doctor's bills, difficulties in following the doctor's treatment programme) Yes.... No....

If "Yes", is this done: Routinely..... Occasionally..... Only when the client presents this as a problem.....

B. Do you counsel clients about the social aspects of health problems? Yes..... No.....

If "Yes", do you contact the client's doctor? Yes..... No.....

If "Yes", to the above question, what is your purpose in contacting the doctor?

1. To ascertain the nature of the illness.....
2. To discover the treatment recommended.....
3. To discover how well the client is following treatment.....
4. To discuss with the doctor the fact that his patient is being counselled at the agency.....
5. Others (explain).....
   .....

B. Referrals

A. How many of your clients were referred to the agency, in the last month, by a private practitioner?.....

B. When a private practitioner refers to a client, do you make an effort to contact the doctor for collateral information? Yes.... No....

C. How many clients did you refer to a private practitioner in the last month?.....

D. After referring a client to a private practitioner, do you maintain contact with the doctor? Yes.... No....

If "Yes", is this done: Routinely..... Occasionally.....

E. Have you encountered any problems in trying to work with private practitioners on a case? Yes..... No.....

If "Yes", please explain.....

.....

C. Doctors and Social Workers

1. What in your opinion are the main contributions which social workers can render doctors (a) in health agencies..... (b) in hospitals, clinics etc. ..... (c) in private practice.....

2. What in your opinion, are the main difficulties social workers experience in working with private practitioners?.....
.....

3. What in your opinion, are the main difficulties private practitioners experience in working with social workers?.....
.....

4. What do you think that social workers can do to alleviate some of difficulties
(a) as caseworkers.....
(b) in other capacities.....

5. Is it your understanding that medical training includes courses in interviewing and counselling? Yes.... No....

6. Is it your understanding that medical training includes courses about Social Work, as a profession? Yes.... No....

7. Is it your understanding that medical training includes courses concerning the social services? Yes.... No....

8. Where do you think most can be done to promote better working relationships between private practitioners and social workers,
(a) supervisory level.... (b) administrative level... (c) Chest and Council... (d) British Columbia Association of Social Workers... (e) The School of Social Work... (f) The University generally... (g) Public discussion... (h) Other (explain).....

Your own Background and Experience

1. How many years have you been in practice?.....
2. How long have you been working in the agency in which you are presently employed?.....
3. Does the agency have a list of private practitioners from which the client may chose, if referral to a private practitioner is indicated? Yes... No...
4. Has any part of the staff development programme in your agency been devoted to increasing the professional staff's knowledge of the ways private practitioners and social workers can work together for the benefit of the client Yes... No...
5. Did your Social Work education include course material concerning the doctor's role in the treatment of illness? Yes... No...
6. Did your Social Work education include course material that helped you in understanding the role of the Social Worker in working with private practitioners, when they referred a patient to a Welfare Agency? Yes... No... Comment.....
7. Did your Social Work education include course material that helped you in understanding the role of the social worker when working with a client with a health problem, who was not referred by a private practitioner? Yes... No... Comment.....
8. Please list your Diplomas or Degrees and the Institution(s) from which you received them.....
9. Year of graduation from School of Social Work.....

APPENDIX C

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