Social Work in the Family Medical Center

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Although family medicine and social work have much in common, each looking at the individual in his total situation, family physicians have seldom worked with social workers. This article reports the effort of one social worker to demonstrate and teach better utilization of social services by collaborating with faculty physicians, residents, and nurses in the Family Medical Center (FMC) at University Hospital, Seattle, Washington. This report discusses areas frequently dealt with by the FMC social worker and gives a number of examples.

After FMC students, residents and faculty physicians worked in cooperation with this social worker, they found her a valuable resource for comprehensive health care. There are still several problems to be resolved if social service is to maintain and expand the place it has won in the FMC, including financing for social work consultation, increased utilization of social work services by medical staff, and expansion of the social worker's teaching role in the medical setting.

Social work has always been a value-based profession, taking into consideration the total person and his or her needs. The social worker helps individuals cope with problems in their relationships with each other and their world.

The medical profession has increasingly recognized a need to take the whole person into account. In 1905, Dr. Richard Cabot of Harvard Medical School presented an innovative concept in medical care when he suggested adding "another dimension to patient care through a deeper understanding of the patient's social situation as it affected his total medical problems." In that year, he instituted the country's first medical social work department at Massachusetts General Hospital in Boston.[1]

Family medicine teaching programs clearly demonstrate the importance of looking at the individual in his total situation. Among the stated goals of the Department of Family Medicine at the University of Washington are:

> . . . to help the student understand and appreciate — the nature, structure and function of families . . . the impact of health and disease on the community and vice versa . . . to help the student to learn what are the human interactions in the patient's environment which are important in dealing with his health problems.[2]

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Clearly, there is much common ground between family medicine and social work. Unfortunately, family physicians seldom work closely with social workers, and, thus, fail to take advantage of the assistance a social worker may provide in dealing with the patient in terms of his larger environment.

This report focuses on one social worker who, from July 1972 through December 1973, collaborated with faculty physicians, residents, and nurses in the Family Medical Center (FMC) at University Hospital, Seattle, Washington, in order to demonstrate and teach better utilization of social services.

Development of Social Worker Role

The Family Medical Center serves as a Model Family Practice Unit for the family practice residency program. It occupies a wing attached to University Hospital and is staffed by three multidisciplinary teams, each consisting of six family medicine residents, two faculty physicians, a nurse, a medical assistant, and a secretary. The three teams share the time of one medical social worker whose office is located in the FMC. She is assisted by graduate student social workers, who are placed with her, one at a time, for six-month internships.

When the FMC first opened in June of 1972, the staff had few guidelines for close cooperation — the social worker had never worked directly with family physicians, and the physicians had never had a social worker readily available.

Initially, the social worker introduced herself to doctors

TABLE I: Areas Frequently Dealt with by Social Worker

1. Consultation among social worker, physicians, and nurses to develop a complete diagnosis and appropriate treatment plan.
2. Involvement of doctor or nurse as observer or participant in interview between patient or family member and social worker.
3. Crisis management.
4. Marital counselling.
5. Arrangement for economic assistance.
6. Referral to and liaison with community resources.
7. Counselling of pregnant women.
8. Counselling of isolated elderly.
9. Helping patients and families adjust to terminal illness.
10. Arranging and following up nursing home placement.
11. Helping patients establish goals and priorities.
12. Providing vocational and educational counselling.
13. Home visits for diagnostic or therapeutic reasons.
14. Teaching residents, medical students, and nurses the role of the medical social worker and how to utilize it.

and nurses by attending conferences and team meetings, and the location of her office within the FMC made her easily accessible for consultation. At this stage, physicians and nurses made conscious attempts to find problems in which the social worker might participate. By the end of the year, however, they accepted her as an essential and welcome part of the health care team. As she became increasingly involved in both direct patient care and teaching, her position in the FMC was expanded from half-time to full-time and she received an appointment as Clinical Instructor in the Department of Family Medicine, while also continuing to serve as Practicum Instructor in the School of Social Work. Her aim is to increase the well-being of patients and families, and teach residents and staff by serving as consultant, collaborator, coordinator, and liaison with community resources.

Although the FMC social worker continues to be a member of the University Hospital Social Service Department, her focus differs from that of other Social Service staff by her greater emphasis on ongoing relationships with families and their daily problems.

Areas frequently dealt with by the social worker are listed in Table I.

Some Illustrative Examples of Social Worker Intervention

1. *Consultation Among Social Worker, Physicians and Nurses.* The following case illustrates how the social worker's diagnosis broadened that of the physician and enabled a patient to carry out the physician's prescription:

> A 27-year-old laborer, with third-grade education and poor impulse control, was seen by a resident for acute back strain. Although the resident prescribed complete bed rest, the patient could not comply because he had no place to sleep but in his truck and had to earn his livelihood by his day-to-day labor. Assuming an advocate's role, the social worker made a referral to the Department of Social and Health Services for emergency assistance and explained to the intake caseworker that the man had a low tolerance level for the frustration posed by filling out forms and should be assisted with this procedure. Several follow-up phone calls by the social worker were necessary, but eventually the patient received the financial aid which made it possible for him to comply with the doctor's recommendations.

Frequently, one or more home visits are made as part of extended treatment plans. For example, once when the social worker and a resident were serving as co-therapists for twelve sessions of marital counseling, they made a home visit to the couple which not only evidenced their interest and concern but also turned out to be most helpful diagnostically.

2. *Crisis Management.* Frequently, patients are referred to the social worker in a state of crisis. The social worker's goals in crisis intervention are:

a. to cushion the impact of the stressful event by immediate or emergency emotional-environmental first aid and
b. to strengthen the person's ability to cope and aid his integrative struggles through on-the-spot therapeutic clarification and guidance during the crisis period.[3]

Crisis intervention may involve only one or two patient contacts but sometimes it requires considerable follow-up. The illustration below is of a short-term contact:

> A 59-year-old tearful patient, with a breast mass diagnosed as probable old fibrocystic disease, was referred to the social worker. She was extremely anxious because of a family history of breast carcinoma and was worried about financial problems. The social worker recognized these as real concerns, but knew that higher priority should be given to obtaining mammography as soon as possible. This was arranged at the local breast cancer detection clinic at no cost to the patient. The very day the patient was seen by that clinic, she called much relieved and expressed appreciation of FMC support and that of the cancer detection clinic social worker.

3. *Arrangement for Economic Assistance.* Poverty places a heavy burden on one quarter of our patients, taxing their coping mechanisms. Many of these patients need emotional support and/or environmental manipulation. Often patients do not know that they are entitled to food stamps or Medicaid or may be reluctant to apply:

> A 70-year-old woman, with a history of poverty, was hospitalized for congestive heart failure. She was living in an upstairs housekeeping room on an income of $81 a month and very limited savings. At first she was resistant to and fearful of applying for Medicaid. But as she began to establish a trusting relationship with the social worker, she was able to accept Medicaid and also apply for supplementary assistance and low-cost housing.

TABLE II: Patient Contacts by Social Worker

	July-Dec. 1972	Jan.-June 1973	July-Dec. 1973*
No. of Individual Patients Seen	113	141	168
Total Patient Contacts	239	274	608

**Social worker time increased from one-half to full-time.*

TABLE III: Community Resources Used by Social Worker

	July-Dec. 1972	Jan.-June 1973	July-Dec. 1973
No. of Different Resources	47	83	106
Total Resource Contacts	186	244	384

4. *Liaison with Community Resources.* The social worker has attended school staff conferences and served as intermediary between parents and the school. For example, in the case of an 11-year-old boy, a slow learner, the social worker explored special educational programs, facilitated implementation of a more appropriate school program for the boy, and improved communication between school and parents.

5. *Counseling of Pregnant Women.* The FMC social worker meets as many pregnant patients as possible, establishing communication and informing them of social services and the availability of the social worker as a regular FMC team member. The patient may have concerns about finances, medical hazards, planning for the baby, housing, child care, or family relationships.

High-risk obstetrical patients may be referred to the social worker for social assessment and appropriate follow-up. A pregnant patient who reported that she had been beaten by her husband was one such referral:

> In the first interview, it became evident that this patient was provocative and manipulative, as well as masochistic and always chose destructive male relationships. The patient herself requested a second appointment and subsequently gained considerable insight through the counseling sessions. Eventually, she was helped in obtaining legal assistance and she moved out of an increasingly untenable situation and began to plan for the future.

Single pregnant women are definitely a high-risk group and are almost always seen by the social worker. Often they need help planning for themselves as well as for the baby.

6. *Counseling of Isolated Elderly.* These individuals have suffered many losses in physical functioning, personal relationships, useful occupations and economic security. Many focus on somatic complaints, as did the following 84-year-old patient:

> A tall, frail-looking, depressed woman, living alone, felt lonely and insecure. She presented many complaints of abdominal pain and weakness. In addition to formulating the medical plan for a complete physical and appropriate tests, the resident recognized that the patient's depression certainly had a social component and introduced her to the social worker. A home visit followed. In order to help the patient consider alternate ways of living, the social worker arranged to take her to visit a senior center and apartment complex, as well as a low-cost retirement home. Appointments were made for dental and optometric care. A referral was made to the public agency for chore services. Not only did the patient become better able to maintain her independence, but when her cleaning lady became ill, she was able to seek medical help for *her.*

7. *Helping Patients and Families Adjust to Terminal Illness.*

> The social worker and resident helped a 78-year-old patient with leukemia and recurring pleural effusions by seeing her in the FMC, throughout her hospitalizations, and at the nursing home. The patient was mentally alert and could review her life's experiences. She was able to talk about the seriousness of her illness, the reality of dying, and anticipate the rest and peace that would follow. Her sister was seen by the social worker several times during the hospitalization and after the patient died, in order to help the sister cope with her conflicts and assist her with concrete arrangements, such as handling medical bills.

Utilization of Social Work Services

It has been found that social worker-patient contacts steadily increase as physicians/nurses learn to utilize social work services. The involvement of the social worker with FMC patients is shown in Table II for the 18-month period from July 1972 to December 1973.

Particularly noteworthy is the large number of community resources used as a result of the social worker's efforts (Table III). It is doubtful that many physicians in the community or in this teaching practice could name 106 community resources, much less utilize them appropriately.

Methods of Referral and Professional Interaction

Although most referrals to the social worker come from physicians, frequently it is the FMC nurse who first becomes aware of the patient's problems and discusses them with the social worker and the physician (Table IV). Sometimes the patient has difficulty expressing his problems to the physician during examination, and, just before leaving, will drop a remark to the nurse, indicating an area of stress:

> An attractive 25-year-old woman, seen by the resident for hepatitis and recurrent cystitis, was referred to the social worker by the nurse, to whom the pa-

TABLE IV: Referrals to and Consultations with Social Worker by Staff

	July-Dec. 1972	Jan.-June 1973	July-Dec. 1973
Physician Referrals/ Consults	217	277	269
Nurse Referrals/ Consults	49	115	112
Other Staff Referrals/ Consults	8	17	29

tient indicated, just as she was about to leave, that she was under some stress. During the interview with the social worker, the patient was able to look at her goals, evaluate them realistically, and set some priorities for herself. After consultation with the resident, "Destructive Mate Relationship" was added to the patient's problem list. The social worker found educational and cultural resources in which the patient indicated an interest; the resident provided counseling to the patient during subsequent visits to the FMC. Ultimately, the patient was able to separate herself from the destructive relationship and enroll at the university under the Economic Opportunity Program.

The medical record is an indispensable method of communication among members of the health care team. The social worker dictates problem-oriented notes and makes additions or changes to the problem list as indicated.[4]

Personal contact between social worker, physicians, and nurses is extremely valuable, and the social worker's physical location within the FMC encourages such communication.

Both social worker and family doctor learn that effective counseling frequently can be achieved through friendly and informal contacts. As problems arise in the course of a patient's treatment, the social worker can be easily introduced to the patient, who is often more inclined to accept such help because he can make a person-to-person contact instead of filling out forms and being given an appointment for another time and place. Although FMC patients are not required to see the social worker, they usually agree readily, perhaps because she is introduced as a regular staff member available to all patients.

Now that family medicine students, residents, and faculty physicians have worked in cooperation with a social worker, they are finding her a valuable resource for comprehensive health care. We hope that in the future, more family physicians will add social workers to their staffs.

Family physicians elsewhere have begun to utilize social workers. Ruth Goldberg at Wayne State University School of Social Work describes placement of second-year graduate social work students with private family physicians. The students provide social services for patients experiencing stress. Two overall objectives are to provide educational experience for the student and to provide comprehensive care for the patient.[5]

Social workers in Derby, England, have been assigned by the health district to work with family doctors.[6] The medical-social work team approach in the Netka Clinic, Tel Aviv, has been described by Dr. Confino of the Department of Family Medicine, Tel Aviv University.[7]

As in other medical-social work teams, the University of Washington's FMC staff constantly discovers that when the physician and the social worker consult about patient problems, there is growing respect for each other's knowledge and for the role each can play in providing optimum comprehensive health care.[8] A Family Medical Center, in particular, offers the optimum setting for such collaboration, by providing ongoing care of the total patient and assistance with his day-to-day problems.

Discussion

There are still, of course, several problems which need attention if social service is to maintain and expand the place it has won in the Family Medical Center.

1. *Financing.* At present, the FMC patient pays no fee for consultation or counseling with the social worker. Her salary is absorbed into the overall budget of the center. A professional fee for this service should be established. A real difficulty is that third-party payers as yet do not recognize this as a legitimate, illness-related service. An educational campaign may be in order.

2. *Optimum Utilization of the Social Worker.* Staff physicians utilize social worker services unevenly. One possible explanation for skewed utilization is geographical location of the social worker's office; the two teams who made most referrals to the social worker and her aide were those located nearest the social worker's office.

3. *Wider Exposure of the Social Worker's Role in Order to Maximize Teaching Effectiveness.* At present, residents learn about what a social worker can do in a very random manner. The resident who had the case of the 27-year-old laborer learned what a social worker could do to help a stubborn, impoverished, undereducated man get the help he needed in order to follow his doctor's prescription, but the other residents did not. What a resident learns in this area depends upon which patients and what problems he encounters. Although the social worker attends the weekly staff conference and has brief opportunities to discuss her work, a more thorough and systematic way of showing the entire staff how a social worker can help the patient in his total situation is needed.

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