The Social Worker's Role in Family Practice Education

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A questionnaire was mailed to 100 social workers involved in family practice residencies. Information pertaining to the duration and nature of the social worker's appointment, teaching responsibilities, funding sources, teaching format/tools, and assessment procedures was obtained. Problems identified which relate to the social worker's teaching role include lack of stability in funding of social work faculty in family practice programs; perceptions of the social worker's role; the influence of medical education on the interdisciplinary approach to health care; and frustration caused by heavy time commitments to service and teaching, as well as a feeling of professional isolation.

Although family medicine and social work both subscribe to the philosophy of treating the individual within the context of the family and community, family physicians have seldom worked closely with social workers. Acceptance of the formally trained social worker as a significant member of the health care team has been gradual, sometimes tentative. Differences are related in part to the differing perceptions of medical faculty throughout the country. Many physicians whose concept of patient care has been limited by their almost exclusive training in a disease-oriented hospital regard social workers solely as "financial eligibility determiners"[1] or providers of concrete social services to the medically indigent.

Methods

A survey was undertaken to learn more about the role of the social worker within family medicine and to assist in formulating a curriculum to be used within a family practice residency. From a listing of over 300 social workers who have indicated their involvement in family practice residencies throughout the United States and Canada, 100 social workers were randomly selected to receive questionnaires.

Results

There was a questionnaire return rate of 70 percent. However, only 44 of the responses will be used in tabulating the results, because the remainder of the respondents (26) indicated that they

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Table 1. Nature of Social Workers' Appointment

Appointment		No.
Teaching Faculty		23
Associate Professor	1	
Assistant Professor	20	
Instructor	2	
Clinical Faculty		6
Staff		12
Other		3
	Total	44

were no longer involved in family practice programs. Approximately 60 percent of these persons (16) indicated that their positions were terminated because funding was no longer available. The others had changed jobs or had returned to full-time graduate work.

A question regarding the nature of the social worker's appointment provided the information contained in Table 1.

The responses indicated that the mean length of time in a teaching role was 3.75 years with a range from two months to nine years. There was no breakdown specified in the question to differentiate between the teaching of residents and of medical students. It was also of interest to determine whether there was a continuing emphasis throughout the residency program on the teaching of psychosocial factors by the social work "faculty." Respondents were asked how long they had been directly involved in the training program over the three-year period.* The involvement ranged from six months to three years with a mean of two years.

The social workers in the study were also asked whether they had had training that prepared them for their teaching responsibilities. The range in responses was predictably wide, from workshops related to teaching residents and medical students, undergraduate degrees, and experience in teaching, to faculty status in Schools of Social Work (undergraduate and graduate programs).

*NB: Canadian family medicine residencies are generally two years in length.

Respondents were also asked how their time was spent. A breakdown of time distribution appears in Table 2. If one includes direct patient care as a medium for teaching, as well as co-therapy and educational (formal) teaching, it appears that a major mean percentage (72 percent) of time is devoted to educating residents and medical students. Individual responses identified a common problem, namely, not having enough time to do an "adequate" job of teaching. Respondents often stated that as the sole social worker employed in the program, the volume of case consultation alone precluded their utilizing other teaching media. Coordination with residents' schedules was an additional frustration expressed.

There was a wide range of activities included in the "other" category. A few examples are:

–Consultation to social workers in affiliated residency programs
–Staff-faculty coordination meetings
–Patient education
–Board memberships, committees
–Grant writing
–Interdisciplinary staffings/rounds
–Supportive therapy sessions for individual residents and students

Funding Sources

Social workers employed in family practice programs indicated a wide range of funding sources (Table 3). Some respondents indicated that they are funded by more than one source, hence the total percentage exceeds 100.

Respondents were also asked to indicate who the principal "grant writer" was if they were grant-funded. Their responses are indicated in Table 4.

Teaching Program

Assessment procedures

Sixteen percent of those who were ultimately included in the study use a pretraining assessment instrument with first year residents to determine their existing knowledge of the psychosocial needs of patients. The assessment process ranges from highly structured written procedures to verbal procedures such as: interviewing each new resident regarding his/her knowledge (academic and experiential) and educational needs, or videotap-

Table 2. Distribution of Social Workers' Time

Activity	Range %	Mean %
Administration	5-90	15
Co-therapy with resident/medical student	1-25	13
Direct patient care	5-80	31
Educational (formal) teaching	5-75	28
Research	2-40	10
Other	See text	

ing a resident-patient interview and giving feedback on knowledge and skills demonstrated in the interview.

Postassessments are used by 23 percent of the social workers. For the most part, they are conducted at the end of each year or before beginning a new section in the psychosocial curriculum. Assessment procedures include a verbal interchange between resident and instructor, small group peer evaluations, or assessment of videotapes of patient-resident encounters or simulated interviews.

Teaching format/tools

In response to the question regarding format/tools used, the data in Table 5 were obtained.

It is interesting to note that the more traditional lecture format and curriculum planning responsibility, which could suggest a greater acceptance of the social worker as a teacher, constitute a lesser degree of involvement, or conversely, case consultation and co-therapy, more commonly associated with a staff position and typically carrying no supervisory or evaluative components, constitute the more common pattern.

Although case consultation and co-therapy are educationally sound, there are some qualifying elements in this instance. The lecture format is more commonly associated with teaching. Medical students are socialized to that format as are the majority of students in this country. If the resident has not been exposed to a social worker in a formal teaching role during his prior medical education (which is true for the majority of medical students), that role becomes more difficult to establish in the residency program.

An interesting array of "other" tools were specified, including interpersonal process recall, video and audio tape analyses, chart reviews, personal growth groups, and interdisciplinary case presentations.

Issues and Analysis

Respondents were also asked to identify problems they have experienced relative to their teaching role.

There was a rather significant number of responses which refer to the failure of social work curricula to prepare practitioners for the teaching role. There were four major content areas which emerged from analysis of their statements:

1. Lack of stability of funding for the social work position.
2. The narrowness of the perceptions of medical personnel of social work expertise and role.
3. An exclusionary emphasis in medical education on the physical factors in the diagnosis and treatment of illness.
4. Professional isolation in combination with unrealistic time commitments to service *and* teaching.

These four issues deserve further explication as well as consideration by both medicine and social work if more comprehensive services are to be made available to the patients and families who use family physicians as their primary health care providers.

Stability of Funding Social Work in Family Practice

As noted earlier, 26 percent of the total sample of social workers surveyed were no longer employed in family practice programs because of insufficient funding. The authors find this percentage significant. Social workers are being viewed increasingly as valuable in the provision of optimal

Table 3. Funding Sources for Social Workers

Source	Approximate percentage
Federal grants	32
Private grants	5
State funding	43
Private funding	5
Patient fees	18

Table 4. Principal Grant Writer when Social Workers are Grant-Funded

Principal Writer	Percentage
Director of family medicine program	5
Hospital health planner	5
Other medical faculty	50
Departmental administrative assistant	20
Social workers	20

health care. One major problem which must be resolved if this pattern of care is to continue is financing of social work services.[2] If public and private grant monies are not available, financing through patient fees may have to be the primary source of funding.

A review of the literature shows a trend toward fee charging for social work services in medical care in general and particularly in family practice. Twerksy and Cole concluded from their study of social workers in family practice that over half charging fees offered a sliding fee scale. Fees were based on an hourly rate of $20 to $25. They used their survey to establish a range of charges for office and home visits.[3] It would be necessary to re-educate staff and patients to a fee-for-service concept rather than a hidden administrative cost. The effect of fee charging on patient outcome remains a question. It was thought by Davids[4] that fee charging seems to enhance the professional judgments and skills of the social worker in the eyes of the patient, thus increasing "compliance." Third-party payments for social workers in health care and mental health settings are also a potential funding source. The National Association of Social Workers has been instrumental in developing agreements with three major companies. Recently, four states have passed "freedom of choice" legislation which recognizes social workers as reimbursible service providers. Three of the four states require physician referral. Companion bills broadening social work services in Medicare and Medicaid have been introduced in both Congressional bodies. The Senate bill does not include physician referral or supervision and expands the settings in which clinical social workers are reimbursible.[5]

Perceptions of Social Work Role

Although valuable learning has occurred as a result of interdisciplinary care of patients, such learning needs to be based on existing knowledge of human behavior, an area in which social work has achieved competence. Theoretical content should be provided by a more traditional, cognitively oriented methodology of teaching, complemented by experiential learning which occurs in the actual care of individual patients in families. A study by Frangos and Chase[6] showed that family practice residents who were exposed to social workers in their training program valued social work services highly. Approximately three fourths of them wanted a social worker affiliated with their own practices. Residents valued the broad range of services offered by social workers and over half could see no disadvantages in such collaboration. In order for a social worker to be recognized as a team member among health care professionals, the social worker must take primary responsibility for defining the role more clearly as well as delineating the services that a social worker can make available in a health care setting.

Influence of Medical Education on Future Practice

The systems approach to working with people that is employed widely in social work practice is highly consistent with holistic health care philosophy, one which includes the family of the patient and the other social systems which comprise the patient's milieu. If there were a more widespread emphasis in the premedical and medical curriculum on the multiplicity of factors which impinge on an individual, coupled with emphasis on the significance of the variety of "helping" professionals in the provision of efficient and effective health care, the medical student and resident would be better prepared for the kind of practice that is espoused by family medicine. That is, the family practice resident would be much more likely to refer his/her patients to other profession-

als, including social workers, than are a majority of residents who are first exposed to social workers during their residency.

Simmons and Wolfe[7] have affirmed that the social worker is the physician's first ally in the social field. However, the two professions have not always been clearly aware of each other's role and have not cooperated fully in the interdisciplinary approach to patient care. Some of this may be due to a lack of awareness by physicians as to the graduate education and training of social workers which prepare them to evaluate and treat psychosocial problems of individuals and families. On the other hand, social workers have traditionally worked alone in the case work situation and have taken full responsibility for the implementation of the social work treatment plan.

Social workers have traditionally had very little input into undergraduate or graduate medical training. Tanner and Carmichael[1] in a review of the literature found a lack of descriptive material concerning the participation of the social worker in medical education. According to a study by Grinnel et al,[8] social workers comprise only 1.5 percent of the average medical school faculty. Twenty-six (22 percent) out of the 116 medical schools surveyed did not have any social worker appointed to the faculty. Therefore, many medical students and residents have little or no opportunity to learn what social workers do except, perhaps, in a very unstructured manner. There would appear to be a need for further development of the role of the social worker in medical education.

This seems particularly relevant for family practice education since social and emotional aspects of health care are as important as the medical aspects.

The team approach to health care is one way in which a better appreciation of the skills of social workers and their contributions to medical education can be achieved. In such an arrangement the social worker is recognized as a team member with diagnostic and therapeutic skills that are useful not only in assisting other professionals to do their jobs but to carry out their own jobs as well. The social worker needs to be a part of the team, to meet with the team members regularly, to visit and interview family members in the same setting as other team members, and to share social work skills with them.[9]

Table 5. Social Workers' Teaching Format/Tools

Format/Tools	Approximate percentages
Lecture	57
Workshop	25
Case consultation	93
Co-therapy	70
Curriculum planning	57
Other	See text

Isolation and Time Constraints

Insofar as many of the respondents are the sole social work practitioners/educators in the program, time constraints and professional isolation are obvious outcomes. The emphasis on direct service and/or case consultation precludes more formal teaching activities. The sense of an unrealistic teaching and service load for the amount of time available that was often expressed can be appreciated by many professionals in academic roles.

Conclusion

The preceding discussion does not represent a complete analysis of responses to the questionnaire. The data on curriculum content and structure remain as a significant area for further scrutiny.

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