The Medical Team

Social Workers in Hospitals: Misplaced Intruders or Essential Experts?

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The question in the title of this article is aimed at doctors, since I suspect that they have never considered the matter really seriously, and that if they have given it their attention at all, they have probably done so without a clear understanding of what social work can offer in terms of its particular orientation to the psychosocial functioning of their patients.

The essence of my argument is that the discipline of social work can make a large contribution to the successful care and understanding of hospital patients, and that this should represent, not a luxury on the sidelines of surgical or medical activities, but an essentially integrated aspect of them. Though my arguments represent entirely my own views there is evidence, presented below, to suggest that many social workers would agree with them.

Social workers today are asking for the chance to do work of a much wider scope than was expected of them in the years of the lady almoners. It was difficult for the early lady almoners to gain recognition for the value of their work, and it now seems equally difficult for doctors to appreciate that training and expertise have developed so that social workers themselves have higher expectations of their role within the hospital setting. They are not making a takeover bid, but they are asking to work on an equal footing with their colleagues in the medical profession for the greater benefit of the patient. Today's social workers frequently have a degree in sociology or psychology and have completed one or two years' professional training. You cannot expect them not to be a little perturbed at the often very limited appreciation of their role within the hospital setting. James David, in a recent article in *World Medicine*,[1] expressed his apprehension of this new breed of workers and perhaps verbalized the doubts felt by other members of his profession. He bewailed the different expectations of almoners and medical social workers and asserted that doctors would far rather work with the former than the latter: "What most doctors want of an almoner is a problem disposal expert to keep their beds clear for acute cases, skilled at wringing the appropriate amount of cash out of the State on their patients' behalf, and with intricate knowledge of the Welfare Services and how to play them. It is essentially a clerical appointment. What we do not need is a time expired sociology student fresh from the barricades of the L.S.E. creeping around the wards and forming meaningful relationships with the patients. And least of all do we want such people taking over our jobs."

Perhaps if social workers are to gain acceptance they will have to form meaningful relationships with the doctors first, and then show that they are not rampant revolutionaries or plotting to overthrow the medical profession as the first step in liberating the patients. David's article may have been written in a frivolous vein but he makes his point, and I think he really believes it. It is interesting, however, to compare the quotation above with remarks made in 1909 by Dr. Cabot, of the Massachusetts General Hospital, when he said: "Unless he [the doctor] has already acquired the 'social point of view' to the extent of seeing that his treatment of patients is slovenly without some knowledge of their homes, finances, thoughts and worries, he will think that the social worker is trying to teach him how to do his work whenever she does what he didn't or couldn't do before. Naturally he will resent this indignantly. He will not care to be advised by any woman charity worker; that she can throw light on his case implies that his vision was not previously clear. I have seen a great deal of such irritation implied or expressed in the comment of physicians on social work in hospitals, and in the long run it is sure to checkmate the effort of the social worker, no matter how tactful she is."[2]

Doctors' antipathy to any kind of intrusion into their business seems to be a geographical and historical constant; I wonder why they feel so threatened? Lady almoners, however, seemed to have managed to make their contribution appreciated to some extent. The first lady almoner at St. Thomas's Hospital, appointed to the post in 1905, went about proving her worth with due respect for the medical profession's suspicions. Bell says[2] of her that "She was essentially humble minded and saw no reason why these distinguished medical men should welcome her assistance, until she had proved its value. Her policy, therefore, was to be as inconspicuous as possible." Social workers today are again bent on proving their value, but in a way which is in no way related to the functions of a clerical assistant. They are not on the whole humble-minded either; they have a highly sophisticated training, and, perhaps with the new found confidence of female equality to sustain them, are proving their case.

Expectations of Social Workers

In 1962 the Institute of Medical Social Workers decided to sponsor a study of the work of all those who qualified as medical social workers in the year 1961-2; 74 were interviewed in the first year of their employment and 67 in their second year.[3] The new workers stressed the importance of the principal medical social worker's responsibility for promoting public relations "and saw it as especially vital, par-

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ticularly as the need for social work was not universally recognized nor its methods understood by medical and nursing staff."[3] Their anomalous position within the hospital setting caused these social workers some anxiety. The research study also looked at the new workers' experience of various medical specialties. Thirty-five general surgical units were appraised. On 28 of these, most referrals were made by ward sisters and were usually specifically concerned with convalescence or aftercare arrangements. Other common referrals were to do with financial problems or care of children while their mothers were in hospital. The workers spoke of lack of contact with consultants and lack of integration into the surgical team. The researcher concluded: "However, the actual use made of their work by consultants and sisters fell very far short of their expectations on such matters as support for patients facing major surgery, help with fears of anaesthetic, cancer and death, which were not seen as the province of the medical social worker."[3] Any attempts by the social worker to offer help within these areas "were usually not recognized and occasionally strongly disapproved of."

Twenty-nine of the new workers had experience of the same number of general medical units. Chances of referrals direct from consultants were higher on this kind of unit than on general surgical units, and the work undertaken by the social workers was more in accord with their own expectations of their role. However, "The new workers thought that the consultants on perhaps a third of the medical units would, if asked about the role of the medical social worker, describe her as being there to arrange specific services on patients' behalf and judge her usefulness on her success or failure in making such arrangements."[3]

Information was gathered about 17 orthopaedic units. On 13 of these units consultants made regular direct referrals, and workers on 10 of the units said they felt themselves to be part of the team. In this context, then, it seems to have been recognized that the social worker had at least some function to perform in relation to the patients' welfare; once again, however, this appreciation seemed to fall short of the workers' expectations: "Most of the workers said that they thought they could have helped several patients who were having long term orthopaedic treatment but who were not referred because there was 'likely to be no discharge problem.' Such patients included some who were recognized by the medical staff as 'fussy,' 'lazy,' or 'difficult'; others were those for whom age, plus the current accident, meant a complete personal upheaval."[3]

Of the four dermatological units investigated, two made little or no use of social workers, whereas the other two used them in ways which appeared to satisfy their expectations. On the six geriatric units social workers spoke of regular demand for their help, with referrals coming mainly from consultants, the latter being mainly concerned with "disposal" and "aftercare." The nine neurological units examined seemed to be most satisfactory so far as the social workers were concerned. The workers stressed not only the consultant's assessment of need but also his recognition that social workers could help patients who showed signs of personal stress. Similarly, of the eight paediatric units, referrals came regularly from consultants and involved an appreciation of the personal contact, support, and understanding which social workers could offer to children or parents or both. On four out of five of the physical medicine units referrals came mainly from consultants, and the social workers thought they were making a useful contribution. Of eight ophthalmic units, however, only four made use of the social worker in a satisfactory way.

These findings illustrate the very uneven use of social workers among different units and consultants and reflect the different evaluations of their usefulness within the hospital setting. Thirty-four social workers who experienced pressure of work said that they were involved with a large number of patients, most of whom had been referred for the arrangement of specific services at the point of discharge; "the most common referrals were for convalescence, home helps, meals on wheels, home nursing or health supervision by health visitors." Thirty of the workers who were still working in hospitals at the time of the second interview were concerned about the amount of time they were spending on work which could have been carried out by secretaries. My own experience gained from working on several surgical units certainly supports this view. When David says that the work doctors want to see done by social workers in hospitals constitutes that of a "clerical appointment" he is asserting that their dissatisfaction is therefore based on an invalid premise. Most newly trained social workers in hospitals believe that a clerk should do most of the work which it has been assumed they are there to do and that they should fulfil a quite different function altogether. Let us now investigate what form this might take.

Understanding the Patient

Cramond has said: "A sound approach to any patient is to apply the following questions: What manner of man or woman is this? Why is he or she ill, reacting or behaving in this particular way at this particular point in time?" When he has considered and answered these questions the physician, says Cramond, possesses "a three dimensional understanding of the patient. This understanding can lead him not only to correct diagnosis but also to appropriate management based on an understanding of the individual's personality resources and weaknesses, his past experiences, medical and non-medical, which influence his symptomatology in the present illness."[4]

The social worker can contribute towards this three-dimensional understanding in three ways. Firstly, there is her knowledge of the significance of certain sociological factors—class, differential social values and norms, family relationships, social attitudes to illness and death, communication patterns, and so on. Secondly, there is her appreciation of the elements at work in the human personality; this includes emotional difficulties, defence mechanisms, irrational behaviour, aggression and frustration, disguised fears, and the various weaknesses and strengths incorporated into the personality as it develops from childhood. Thirdly, the social worker is able to use the first two knowledge components of her expertise to communicate and form a relationship with the patient in a particular way. She is trained to look for and interpret various cues sent out from the patient, whether they be verbal or non-verbal, and to respond to these in an appropriate way.

A man was referred to me because he had asked for a home help. He had just got over a major operation when another serious illness was diagnosed. He had no need of a home help. His wife was an able and efficient woman who helped run the family business four days a week but who was capable of either running the household in the remaining time or of getting private help. I could see that he had a great deal on his mind which he seemed unable to formulate sufficiently well for it to be expressed. By responding to his cues, however, I was able to help him discuss his anxieties. His wife had taken over all the important functions which had once been his; her very capabilities enhanced his own weakness and inability to do anything. Their roles had been reversed and he had no way of proving his own value and worth, either in the family or in society. He was very angry with his wife for taking over so effortlessly where he had left off; he felt guilty about this anger and could not express his feelings to his wife. His hostility was therefore alienating her and he was losing the potential support which this relationship could offer. I worked through this with husband and wife, helping them to understand each other's feelings and to develop some sense of self-esteem for the patient.

A recent research project[5] undertaken by the Royal College of Nursing pointed out the lack of appropriate response by nurses to difficult patients and asserted that it was possible to identify patients who were popular and unpopular with nursing staff. Factors likely to account for unpopularity were foreign nationality, a stay in hospital over three months, patients who were difficult or demanding, and those with a psychiatric diagnosis. In summary it was asserted: "Frustration and impatience were expressed about patients who grumble, moan or demand attention, also irritation about patients considered to be wasting their time. Psychiatric patients were overtly rejected or ridiculed."

The nurses acted differently towards popular and unpopular patients; punishing behaviour towards the latter group included ignoring the patients, forgetting their requests, refusing gifts and favours, enforcing rules, using sarcasm. It was found that nurses did not approach patients unless they were going to carry out some treatment or provide a specific service. Talking or listening to patients was seen as indicating that nurses were slacking and such activity was therefore avoided. We can see that those patients who are sending out signals that they are distressed —the moaners and demanders—are the very people who do not get the help they need and whose problems are therefore intensified. It is in cases such as these that social workers could interpret to the nursing staff what is going on and thereby ease the patient's distress, making nursing care easier and enabling the staff to react more appropriately. Let me cite two cases in this context.

A referral was made by a consultant for long-term care to be arranged for a patient who was paralysed up to the neck; he insisted that this was not to be discussed with her first. The patient was very over demanding, constantly attracting nurses' attention and wanting to be moved into a more comfortable position. She was sure that staff were plotting behind her back to "send her away." This was an intelligent woman who had lost all control over her environment and future life; the consultant told her not to worry and that everything would be all right. I suggest that this patient needed someone who would recognize her doubts, fears, and emotional feelings and who would help her to express them. Once she had been helped to "work through" these feelings efforts could be made to involve her in future planning, recognizing her value as an intelligent human being and enabling her to regain some control over her situation. The consultant would not let a social worker near her because he did not want her upset. The point is that she was already very distressed, suspicious, and difficult, and her frustration lay in the fact that no one would offer her the help which she needed in order to regain any self-repect or to express the feelings that were troubling her.

The second patient was a young girl who was an inpatient on a surgical ward. She dearly wanted to go home but all she got was a flat refusal from the doctors. She became frustrated and hostile; she would not eat and refused to communicate with doctors and nurses alike. In this case the social worker talked to her about her need to return to her two young children at home and her fears that they would forget her and become closer to her mother and mother-in-law, who were looking after them. She also discussed the patient's feeling of aggression towards the medical and nursing staff and the way in which she was interpreting their attitude towards her wishes, as authoritarian and uncaring. The social worker saw all the relatives to see whether, if the patient returned home, she would be well supported, and on the basis of this recommended that she should be allowed home for the weekend. After discussing this proposal with the team the recommendation was agreed on. When the patient returned she was hopeful, cheerful, and all the signs of the former aggression had disappeared. She was discharged home at the end of the week. By allowing this patient to express her hostility, which she could control over her life, a potentially dangerous situation was resolved.

Care of the Dying

Another area in which I think social workers could more profitably work with nurses and doctors is in that of the dying patient and his bereaved relatives. The decision whether or not to tell a patient that he is dying should be made on the basis of a careful assessment of his need to know the truth, his ability to accept and cope with the news, and the benefits which he could gain from such a course. Such a decision can be made only on the basis of watching for and interpreting cues sent out by the patient. Cramond[4] and Kübler-Ross[6] have both suggested that the difficulties felt by doctors over this matter stem from their role as healers and from their own inability to face up to death, both of others and of themselves. In my own experience it appears that there is little rational consideration given to the decision of "how much to tell" on the basis of the factors which I have mentioned above. As Saunders has pointed out, "So often people are not just protected from the truth that you are protecting them from; they are left alone with it instead."[7]

Kübler-Ross concluded that one of the greatest fears of dying patients is that they will be ignored and left alone with their doubts and fears. The dying patient is faced with loss in a most profound sense, not only of his own identity but of possessions and people dear to him. Such a sense of loss provokes feelings of anger, depression, anxiety, and guilt, and, as Cramond asserts, "If these painful feelings are not recognized, not given opportunity for release, the patient may suffer more than is necessary."[4]

I suggest that the decision about what to tell such patients should be based on careful consideration by the medical team. The social worker could use her skill in noting and interpreting cues sent out by the patient to assess his need for, and ability to cope with, such news. If necessary she could then help him work through his feelings which certain knowledge would inevitably produce. I would argue that such decisions should not go by default but be based on an assessment of the patient's needs and personality strengths and weaknesses brought to the discussion by all members of the team who have had the opportunity to talk to, and gain some understanding of, the patient concerned.

Conclusion

In conclusion, then, I have tried to show some ways in which social workers can add to the knowledge and understanding of patients for the mutual benefit and heightened perceptiveness of all concerned. One of the ways in which this could be effectively achieved would be in the context of regular meetings with the medical and nursing teams. In such meetings difficulties in dealing with some patients could be discussed and a greater understanding gained of their problems through the contributions of different disciplines. Feelings of staff towards certain patients could also be worked through and personal doubts and fears about dealing with the dying could be expressed.[7] It may be that the social worker will still have to assess the needs of patients for the more mundane (but no less necessary) services. The elderly person living alone who is referred for a home help, for example, may have other problems of loneliness and anxiety with which the social worker can help. Much of the routine organization, however, such as financial inquiries and ordering of medical requisites, could be carried out by secretaries. I leave you with a quotation which though made in the context of "team" approach in general practice is equally appropriate to the views presented here:

> "The project brought out clearly what the essence of productive teamwork is. First of all it was based on a concept of partnership, equality and respect for each other's expertise and functions, and this kind of professional respect extended to all the non-medical membership of the team. . . . A social worker can probably make her fullest contribution if she

works in equal partnership with her medical and non-medical colleagues. . . . She contributes to a more comprehensive diagnosis by adding her knowledge about the psycho-social aspects of the patient's functioning, their relationships and the social system in which they move."[8]

References

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For Debate

Hypothesis: Breast Cancer Regression under Oestrogen Therapy

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Summary

Recent reports have thrown doubt on both of the major mechanisms which have been suggested for the regression of breast cancer under high-dosage oestrogen therapy—a direct effect on binding sites and an indirect inhibition of prolactin release. A searching review on the clinical response of 407 patients with advanced breast cancer treated by oestrogen therapy under my direction showed certain anomalies, including age determined tumour inhibition and stimulation, dose dependence of tumour inhibition and stimulation, differential site sensitivity, and tumour regression with oestrogen withdrawal. The hypothesis usually postulated to explain these anomalies is that the tumour may in the same individual be composed of multiple genetically distinct clones of cells. It is suggested instead that the effect of high-dosage oestrogen therapy in breast cancer may depend critically on the absolute and relative concentrations of prolactin and oestrogen actively available at the tumour. On this basis the clinical manifestation of tumour stimulation in response to oestrogen administration suggests that the oestrogen concentration at the target is inadequate. Differences in site sensitivity in the same patient may depend on tumoral factors such as the level of oestradiol and prolactin binding receptors in the tissue.

Introduction

For many years it has been assumed by analogy with experimental mammary cancer that oestrogen is necessary to maintain the growth of hormone-sensitive mammary cancer in man. In recent years the presence of high-affinity oestradiol receptor protein has been shown both in the cytoplasm and in the nucleus of about half of all human mammary cancers examined, and this has led to the suggestion that the presence of oestrogen receptor protein is a major factor in determining hormonal dependence in breast cancer.[1]

It should follow that those tumours showing high specific oestrogen binding activity in vitro (or alternatively high uptake of labelled oestradiol in vivo) would be the ones likely to show regression after ablation of the ovaries or adrenal or pituitary glands. Such a relationship has indeed been claimed in two series of patients[1 2] but was not confirmed in a more recent one.[3] It should also be mentioned that in the latter series oestrogen receptor protein was much more frequently found in the breast cancer of the older patients than in the younger ones,[4] and the significance of this observation is discussed below.

In the postmenopausal woman breast cancer may regress with high-dosage oestrogen therapy as well as after endocrine ablation. The mechanism for this apparently paradoxical response is not clear. Though it is commonly assumed that the direct effect of oestrogen on the cells of all target organs must be mediated by the specific receptor binding sites, in the case of breast cancer it has recently been reported that the likelihood of regression under high-dosage oestrogen therapy cannot be correlated either with a high or with a low level of oestradiol uptake in the tumour tissue.[3]

It is, of course, possible that high-dosage oestrogen administration can affect the growth of tumour cells by a local cell mechanism other than through the binding sites. It has been suggested that such mechanisms might include an effect on the permeability of the cell membrane or of the subcellular membranes.[5] The oestrogen therapy of breast cancer involves a dose which is at least 10 times that used generally in the treatment of gynaecological disorders, and it has been shown that the effect of oestradiol on DNA synthesis in mammary tissue in vitro is dose dependent.[6] According to its concentration it may either stimulate or inhibit DNA synthesis.

It is likely also that administration of oestrogen can exert indirect effects on breast cancer growth either by stimulating the immune mechanism[7 8] or by an effect on anterior pituitary secretion.[9 10] Thus for some years it has been suggested that the major effect of high-dosage oestrogen therapy in hormone-sensitive mammary carcinoma is to deprive the tumour of the mitosis-stimulating effect of prolactin, and the mechanism was

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