Communications

The Social Work Component of a University-Based Family Practice Residency

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Social work has been given a unique and enviable status in the Family Practice Residency Program of the Medical University of South Carolina. This was reflected in the fact that a professional social worker was appointed to the first full-time, non-physician faculty position in 1972. Goals and objectives were formulated which provided the necessary foundation upon which to introduce this discipline into the family medicine curriculum. Four identifiable teaching "methods" later evolved through interaction with the family practice residents. These four methods are: (1) consultation, (2) collaboration, (3) coordination, and (4) delivery of services. In turn a checklist of critical teaching reminders has emerged which encourage self-awareness as to how a social worker uses him/herself in a university faculty position.

This paper will briefly outline the role of the social worker as a faculty member in a university-based family practice residency program. The Behavioral Science Division of the Department of Family Practice through its curriculum provides the impetus for "formal" teaching in the Family Practice Center.[1] The patient care unit affords the base for "informal" teaching which is problem-oriented and patient/family centered. The author will suggest some approaches by which the social worker can effectively contribute to teaching and patient care in such settings.

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The Social Worker as Teacher

The first responsibility of a social worker in the Family Practice Residency Program at the Medical University of South Carolina is as an educator and the second responsibility is as a practitioner. Delivery of services is to a representative number of patients/families upon referral from the residents. Indeed, each of the four teaching methods, interwoven with the common thread of "demonstration," affords a unique opportunity to teach through "the professional use of the self." This is a fundamental principle of the social work profession which complements the basic contention of our Behavioral Science Division: the person of the family physician is the primary diagnostic and therapeutic tool of family practice.[2,3]

Each of the four methods of teaching implies a different level of involvement for the social worker and the resident, either as teacher and learner or as social worker and physician. During the first year of his/her residency, the family practice resident's time in the patient care unit is limited to one half-day per week, a fact which almost dictates that the social worker's involvement with the resident in regard to patient care will be mostly through direct services to patients and families referred by the resident. At this point the social worker is primarily involved with the patient/family regarding social problems.

During his/her second year the resident has two half-days each week in the patient care unit and can elect rotations; thus, he/she can be more directly involved in his/her learning at the Family Practice Center. The social worker then has the opportunity to suggest, whenever appropriate, collaboration concerning the total problem. Together they may make a joint office or home visit to a patient/family or share in developing the plan for management. Often this becomes a three-dimensional (physical, social, psychological) consultation and diagnosis. Working closely with the resident in an ambulatory care setting also offers opportunities for coordinating or encouraging team conferences with the resident and any resource persons from the larger community and/or Family Practice Center. Through these mediums, collaboration, and coordination, the resident and social worker share primary involvement with the patient/family regarding social problems.

Entering his/her third year, the resident gradually moves more toward consultation. Here he/she is often primarily involved with the patient/family regarding social problems. He/she has considerably more time in the patient care unit. The resident is beginning to think more of moving out into private practice and being "on his own." This latter factor alone often prompts a new appreciation for, and an acute awareness of, a responsibility which the resident will soon have to discharge. In a new setting an interested and diversified faculty will no longer stand on the sidelines to encourage, educate, support, and serve. Consequently, the resident must review the learning of the past two years and his/her emerging style of practice to determine more precisely how and by whom the diverse social and psychological needs of his or her patients will be met.

Critical Teaching Reminders

While obvious, it is significant to note that no one class of residents moves through each year in unison and with the predictability of the process implied above. Likewise, no one method of teaching is allocated to a