RESEARCH IN SCOTLAND

The Secretary of State for Scotland, Mr William Ross, has awarded grants totalling £97,524, The money will be paid from National Health Service funds, on the recommendation of the advisory committee on medical research. None of these projects is being undertaken by a general practitioner.

GENERAL PRACTICE FINANCE CORPORATION

The General Practice Finance Corporation lent over £2½ million to 230 general practitioners in Great Britain during the financial year ended 31 March 1974. Over 3,800 doctors have received advances since the scheme started in 1967. The current lending charge is 16 per cent a year.

ABORTIONS

There were 169,362 legally notified abortions in England and Wales in 1973. Of these 110,568 were for residents, of whom slightly less than half had had no previous live-born children.

BIRTHRATE

The number of live births born legitimately fell by 14 per cent in England and Wales in the years 1970 to 1973, while illegitimate live births fell by ten per cent.

The crude birth rate of all live births per 1,000 population in the United Kingdom fell to 13·9 in 1973. This can be compared with other countries as follows:

The Republic of Ireland—22 per thousand, Canada 15·5, United States of America 14·9, Luxembourg 10·9 and West Germany 10·2.

The infant mortality rate in England and Wales was 17 in 1973. Other European countries with lower infant mortality rates included France (15) and the Netherlands (11).

CORRESPONDENCE

GENERAL PRACTITIONERS AND SOCIAL WORKERS

Sir,

The article *Social Workers and General Practitioners* which appeared in the November *Journal* is a much needed and balanced appraisal of the difficulties that an established caring profession and a young developing one experience in coming to terms both with each other and with their respective roles in society.

While continuing research and planning are essential for progress, it is in continuing dialogue and in working together that social workers and doctors have the best opportunity for understanding each other's knowledge, roles and skills.

In this Training Unit we have been working closely with general practitioners within our health district for six years.

During this time 47 social work students have been attached to general practitioners during their fieldwork placements. Learning has been a two-way process in which both disciplines have gained in understanding of each other's approach to caring.

However, during these years only *one* trainee general practitioner has chosen to spend a comparable time in this Unit (Smith, 1973). If one can do this why not many more? Is it too much to ask that others might be encouraged to do the same?

We are sure that trainee general practitioners would be welcomed by many student units. Such a shared training experience would provide an exchange of ideas, knowledge and skill in practice and would go a long way towards removing some of the myths surrounding both professions. In the long term we believe this would lead to a better service to the patient/client who, after all, is the sole reason for our professional existence.

LIZ BUDDEN, MARY POWELL (MRS.)
Student Unit Supervisors

Social Work Training Unit,
South Birmingham Health District,
Moseley Hall Hospital,
Alchester Road,
Moseley,
Birmingham 13.

REFERENCES

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Sir,

Len Ratoff, Anne Rose, and Carole Smith (November *Journal*) must be congratulated on their detailed analysis of the inter-professional problems of social workers and general practitioners. It is unfortunate that the detail tends to obscure the basic problem.

The foundation of modern medicine is objective and scientific. Doctors ideally make technical diagnoses which form the basis of action and from which outcome can be predicted. A diagnosis of pneumonia implies a prescription for antibiotics resulting in a cure. Failure to provide the antibiotic either results in spontaneous resolution or death depending on the age and resistance of the patient.

Pneumonia as a diagnosis is therefore an empirical fact which bears no relationship to the values of the doctor or of society in general. Social work problems, the isolated elderly for example, are not empirical facts of the same level. Management will depend on the value the social worker attributes to encouraging independence (providing aids and services within the home) or dependence (Part III accommodation), and this balance will obviously be influenced by the social workers knowledge of local resources (home helps as opposed to Part III beds) which may in turn reflect current social values.

The concept of diagnosis as an empirical fact free from value labels is deeply embedded in medical training. Encouraging awareness of value judgements is, similarly, an integral part of social work training. The result is that medical decisions come to be seen as wholly technical, and social work decisions, conversely, as wholly value laden.

This is obviously a parody, but my thesis is that doctors and social workers act as if they believe it, and perhaps more important it is a thesis which the public seems to accept. Housing referrals are a case in point, and I have already described (Drinkwater, 1974) how a referral by a doctor, which is seen as technical and therefore incapable of refutation, is often treated more favourably than a referral by a social worker. The doctors recommendation when made in a situation of shortage is, however, just as much of a value decision as any recommendation made by a social worker.

With economic stringency now the order of the day, doctors are increasingly going to have to make value decisions about priorities. As a fringe benefit, we may become more sympathetic to social workers who accept the uncertainties of value judgements as a part of everyday life.

C. DRINKWATER
Lecturer in General Practice

Faculty of Medicine,
Memorial University of Newfoundland,
St John's,
Newfoundland,
Canada A1C 5S7.

REFERENCE

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Sir,

The authors of the article on social workers and general practitioners raise some important points about co-operation between the two professions. Their discussion about the organisational aspects of co-operation is, however, inadequate. Recent discussions that I have had with a number of doctors in various parts of the country indicates that social work departments are having difficulties operating their organised service. A common complaint is that co-operation between social workers and general practitioners is now worse than it was before the Seebohm reorganisation. Some complain that the service provided their patients has declined in quality.

The Seebohm reorganisation created a structure which needed a large expansion in administrative posts in social work. This meant that many experienced social workers had to be promoted to administrative posts leaving a dearth of qualified field workers. It must be one of the reasons for the current difficulties, and it is to be hoped that this will correct itself when more trained social workers become available.

A more serious objection to the new hierarchical structure, however, is that it impedes communication with the other services. General practitioners were able, under the previous arrangement, to communicate directly with social workers who, themselves had direct responsibility. It is now necessary to communicate with the area team and rarely is it possible to talk directly with the person who will be dealing with the problem. By interposing one, or perhaps two, people into the chain of communication personal care is always likely to suffer. The authors rightly recognise that " Frequent face-to-face contact in the field is probably the most important single factor which would modify attitudes." Not only might it modify attitudes, which I do not deny is most important, but it also might improve the quality of care offered to our patients/clients.

A futher problem has been posed by reorganisation and this is the status of the specialist social worker. In order to fit in with the concept of " generic social work " there has been large-scale abandonment of specialist social services such as child care and services for the blind. It must be extremely doubtful whether a generically trained social worker can, or indeed wants to, provide a total range of personal services to his client. The need for experts is recognised but they are relegated to the role of consultant within the service, and do not appear to be actively concerned with fieldwork. Social Services would appear to be copying the medical model which filters its problems through a net cast by the generalist to the specialist. Are social and health services comparable in this way? I would submit that they are not and that social problems differ from health problems. It must be remembered that the vast bulk of work generated by a department of social work has nothing to do with general practice. Some general practitioners appear to have the false impression that they provide the newly formed departments with most of their work. This is not true.

The difficulty about communication with departments of social work has led many general practitioners to use their health visitors as " social workers," and this *de facto* recognition that the health visitor can perform many of the functions of a social worker may not be a bad thing. Experience has shown that the health visitor is the person to whom social workers have most difficulty in relating within the health team. Might it not be better if the social worker were to abandon his