Birthday Honours

Owing to an unfortunate omission, the line signifying that the following members were honoured by being created Officers of the Order of the British Empire (Civil Division) was omitted in the notice of Birthday Honours in *Journal No.* 108.

Benjamin Holden, E.R.D., T.D., J.P., B.A., M.B., B.Chir., F.R.C.S., M.R.C.G.P.
George Swift, T.D., F.R.C.G.P., B.M., B.Ch.
P. D. Thomson, M.B., Ch.B., F.R.C.S., M.R.C.G.P.
Eric Townsend, M.C., M.B., Ch.B., M.D., D.P.H., F.R.C.G.P.
John Whewell, F.R.C.G.P., B.SC., M.B., Ch.B., D.Obst.R.C.O.G.

This error is deeply regretted and the Editor apologizes for any embarrassment which may have been caused.

REPORTS

AFTER SEEBOHM, WHAT?

Report of a meeting held at the Royal College of General Practitioners on 18 June 1971

General practitioners and members of their teams including health visitors, practice nurses and social workers met at the Royal College of General Practitioners on 18 June 1971 to discuss 'After Seebohm, What?'. The meeting, which was sponsored by the King's Fund Hospital Centre, and chaired by Dr J. G. R. Clarke and Dr E. V. Kuenssberg, examined ways in which links could be forged between general practitioners and the multi-purpose social workers of the new local authority social service departments. The meeting recognized the educational, administrative and emotional barriers which existed between the two professions and called for a greater recognition of the fact that patient and client were one and the same person and that medical and social problems were often inseparable. The majority of those present wanted to see many more experimental attachment schemes of social workers to group practices and health centres and a full evaluation of these, both to assess their value and to see to what extent administrative problems could be overcome.

A general practitioner's view

A general practitioner's view of the future was provided by Dr J. A. S. Forman from Devon, who had had a social worker attached to his group practice for an experimental three-year period. He recognized the anxiety that existed about the Seebohm re-organization but said that the generic social workers should be welcomed in the general practice situation because he or she was a generalist, with special skills in assessment and patient–client care, like the general practitioner himself. This fact provided the basis for close co-operation on the many and mixed family problems presenting in a practice, which were often medical, social, moral and ethical at one and the same time. The general practitioner and social worker supported and worked with the family over a long time while other specialists in the medical and local authority fields moved in and out as necessary.

At the present time social workers and general practitioners might be attending the same families without sharing crucial information and insights. This applied particularly to the large number of people suffering from psychiatric and emotional illness who had associated social problems and who were a heavy part of the load of both professions. An increased willingness to share these problems could lighten the burden, and attachment of social workers to general practitioners was the best way to facilitate this.

The mechanics of co-operation for any attachment scheme had to include free and frequent communication between doctor and social worker both informally and at regular meetings—this helped them to develop clear cut rôles as well as to speed up problem solving by sharing views. Dr Forman favoured an immediate increase in experimental attachments of social workers to general practitioners whether they were in health centres or not. This was the best way for doctors to share aspects of their patients' problems with social workers because it saved time and energy on both sides and because it was easier to relate to individuals rather than whole

departments. Social workers dealt with the same population whether their work was arranged on a geographical or practice basis. Their non-medical social work could also take place in a practice setting but social workers were likely to find that more of their work was medical than they might have imagined. The experimental attachment schemes should be evaulated and compared with areas where there was no attachment.

Setting up a new social service department

The meeting heard about the many problems involved in the setting up of a local authority department of social service from Mr D. J. Clifton, director of social services, Bedfordshire. He said that the real problems were those of attitudes, from the attitudes of the chairman or the mayor of the authority down to the chairman of committees and the permanent staff of the department. Some authorities had seen the need for a unified department more clearly than others and this was reflected in the support given to the new director of social services in his work of re-organization.

Social service departments were drawing together three functions, child care, welfare and mental health, with their own interests and prejudices. Where former chairman of committees or the principal officers of the old departments had been appointed to posts in the new structure they had a natural tendency to revert to their former rôles and support their staff and interests. Alternatively, they might fall over backwards not to favour their old discipline which could be equally unfair.

Mr Clifton felt that there was a place for attachment of social workers to general practitioners and said that he would be examining this. There would be difficulties. Practice areas were usually different from court areas, and magistrates, like general practitioners, did not like to have to get to know a lot of different social workers. Also many doctors did not understand what social workers could and could not do for them. They saw them as anything from administrative transport officers to psychotherapists. Both the health and social service departments were struggling towards total care situation for all of the populace who needed it and this involved adjustment and changing rôles. Social workers were moving into more multi-purpose rôles but an element of self-selection of casework based on interest and expertise was bound to continue. People's skills had to be used if they were not all to be reduced to mediocrity. Mr Clifton hoped that social workers would gradually extend their range by a process of evolution rather than revolution and he felt that it would not be as difficult as many feared. Child care officers, for example, were very anxious about taking on mental health but were likely to realize that they had been dealing for years with parents who were mentally ill.

The success of re-organization depended to a great extent on the preparation that took place beforehand. In some areas there had been considerable discussion and opportunity to express anxiety with senior staff and throughout the departments and this had made it easier for the social worker to face the implementation of Seebohm. Changes seemed to have been easier when the director was appointed from outside an authority and was able to choose the right man for each job without reference to old loyalties. Mr Clifton was planning to employ area teams with proportional representation of each of the disciplines in the teams. He thought that group work might develop but that it would be additional to work based on the traditional one to one relationship. Finally, he drew attention to the cost of the building programme for an amalgamated department and questioned whether it would be more difficult to get a large budget passed rather than the smaller budgets of the individual departments.

Rôles and leadership

In the discussion which followed these talks, several speakers raised the possible overlap of rôles between social workers and health visitors. Were health visitors being used to do things that could better be done by people with social work experience, just because they were already attached and had a relationship with a doctor, or because he could more easily understand their language and training? Doctors clearly were using health visitors and social workers in the same way on some problems, eg, social reports on mothers seeking a termination of pregnancy, and this was usually related to availability. However it was felt that health visitors had too much work in their own special field such as education, to be a threat to the position of social workers. If social workers saw them as a threat it was probably because they were not sufficiently secure in their own rôles. Where a health visitor and a social worker were part of the same practice team and worked together it soon became clear who could best do what.

The social worker's particular strength was her knowledge of the social services and human behaviour and she could give the general practitioner a view of a social situation and the dynamics involved.

The question of leadership in the practice team also came up. Some of the doctors felt very strongly that they should be in a leadership rôle because of their legal responsibility for their patients. They felt they would be reluctant to accept attached social workers who had a loyalty to the social service department as well as to the practice. Others did not accept this and pointed out that attached nurses had similarly divided loyalties which did not affect their work and that the first loyalty of the whole team was in any case to the patient or client.

It was felt that doctors and social workers should begin working together and communicating and stop thinking about themselves. Rôles and contributions to team care would then become clear and there would be no leadership problem. There was no reason why a team should have a permanent leader or an ultimate decision taken on all issues. In practices which were already working on a team basis these issues just fell into place as staff worked together. Usually, the professional worker who referred a case or raised a case for discussion among the team, was the person who took the final decision because it was his current problem.

Many speakers referred to the importance of good communications within a practice team and in particular to the value of unofficial seminars which could involve outside workers including clergy. These reviewed on-going problems, as opposed to case conferences which were usually called to solve a specific problem, and provided an opportunity to share knowledge and increasing understanding of both the patient's problems and staff rôles. It was recognized that it was difficult for medical and local authority staff to find time for face-to-face meetings of this sort but it was felt that they were invaluable, if only for putting a face to the voice on the telephone.

Many doctors were not ready to accept attachment of social workers because of the administrative problems involved. Families' members, for example, were often attending several general practitioners and practice patients were spread over wide geographical areas. Any general scheme of attachment seemed likely to involve a reduction in the doctors and the patient's freedom of choice. Mr Clifton suggested that general practitioners might be encouraged to accept a relationship with an area director of a social services team rather than an individual social worker. Seebohm had suggested areas of about 50,000 population. The general practitioner would then be protected from the rapid turnover of social-work staff which occurred in many cities and could be put in touch with the best person to handle each case. The doctors could see the point of this suggestion but were not sure how it would work in practice because of the communication difficulties that seemed to exist between general practitioners and social service departments. The whole point of an attached social worker was that she was available at the practice premises to communicate. Many doctors used health visitors rather than social workers on social problems at the present time, because communications were easier. The doctors made a plea for more use of written reports and asked social workers to make a quick assessment of any case that was referred to them, and to send a note of this to the doctor, so that he would at least know that his patient had been seen.

Finally, a doctor pointed out that as social service departments were so overloaded and under-staffed, more use should be made of community associations and volunteers. Much help could be obtained from advice centres and community service organizers who worked alongside the directors of social services and prevented a considerable amount of work from reaching their departments.

The mental health services

The first speaker at the afternoon session was PROFESSOR M. SHEPHERD of the Institute of Psychiatry. He described some of the implications of the new service for the treatment of mental illness in the community. He drew attention to a study he had published in 1966 which had revealed the large amount of mental illness among patients of general practitioners. He had estimated that the causes of this illness were only about 45 per cent medical and 55 per cent social, but had found that the doctors were offering patients drugs or no treatment at all rather than referral to social agencies. In many cases, the doctor had identified the needs accurately and still done nothing about them. In view of this, Professor Shepherd felt it was important

that there should now be some assessment of the value of therapeutic intervention on the social side. An examination, for example, of what happened if a trained social worker was partly attached to the general practitioner and health department and his value to the currently untreated population. There was a danger of floundering in a sea of goodwill on attachment schemes with no proper evaluation.

The Seebohm report recognized that there were needs which were not being expressed at the present time for help in the mental health field; but the chapter on mental health concentrated on the much smaller number, 1,500 per 100,000 population, of those whose needs were known to mental health departments. These were only the tip of the iceberg for the general practitioners but there were differences of opinion on the help needed from social workers.

Dr Forman in his account of his social worker attachment experience had said that patients suffering from major mental illness were not referred to the social worker because they were the only group already adequately covered by medical services. Other studies had shown that most patients discharged from psychiatric hospitals did not see a general practitioner and that 27 per cent received no medical follow-up. Which was the true picture?

The Seebohm report had not covered the implications of its findings for other services. There was an evident need for the new department to co-operate with doctors but there was a difference of opinion as to what social workers should be doing in hospital and general practice. However, as the general practitioner was in touch with the majority of people in difficulties he clearly needed support. Attachment, however, was not an easy answer. Facts such as the between medical and social work training and the common assumption that the doctor must doctor must be the leader of any team made for problems of attitude. Even if evaluation proved that the social worker–general practitioner relationship was of great value, it could not be translated into all the practices in an area.

Professor Shepherd's own work in an examination of 123 practitioners showed that only a small minority had regular contact with any social agency and that most did not see the need for this. They did not think of relating to social workers and did not understand Seebohm. They were opposed to teamwork and feared a loss of their scope and autonomy. About 15 per cent of those questioned had an active interest in attachment and 45 per cent were prepared to give it a try. Of those, many were in group practices, where their partners did not share their views, where there was no room or facilities that a social worker could use, where there was no existing organization for regular meetings and case conferences, and where there was no understanding of the implications of attachment for practice organization and administration.

A number of steps should be taken before any scheme such as social worker attachment was recommended generally. There should be more education of doctors to understand the concepts of the social work approach and its limitations. There should be special training for general practitioners on this, whether or not medical schools ever got to grips with the subject. Secondly, there should be research into every statement in the Seebohm report and its implications. Questions should be asked such as what are the categories and criteria for assessing social need? What is the extent of these needs? How are they related to existing services? What accounts for the under use of existing services? Finally, there was a need for an overall assessment of the psychiatric services including the rôle of general practitioners and their colleagues from non-medical disciplines.

The social worker in the team

The problems involved in the integration of the social worker into the general-practitioner team were described by MISS E. DALEY, social worker at the Caversham Centre, NW5. She said that she had been appointed part-time to two large group practices in health centres and that in one case she had followed a social worker who was attached as part of a research project. She was employed by the local authority and attached to one of the area social-service teams. She found doctors very sensitive to the social and emotional needs of their patients and was able to learn from them as well as selling social work. Both sides had a great deal to learn from each other and from the attachment relationship.

Miss Daley said that she worked with 11 doctors and found that each one used her in a slightly different way. This variation was appropriate and showed that the rôle of the social worker complemented that of the doctor depending on his individual interests. An analysis of her work showed that the social problems covered included bereavement, relationships between

parents and children, employment and accommodation difficulties, assessment for community services, marital problems, support for those who were psychiatrically disturbed or anxious over a crisis in relationships and assessment of patients presenting regularly with minor physical able to learn from them as well as selling social work to them. Both sides had a great deal to learn from each other and from the attachment relationship.

Miss Daley said that she worked closely with the health visitors and had been welcomed with open arms as a colleague to share the workload. It was easier to share cases with someone in the same premises rather than in separate local authority offices, and a health visitor often called her in when a situation, eg, of marital conflict, which she had been supporting got beyond her. It was often useful to have two people working on a case involving relationships as one could work, for example, with the husband, while the other worked with the wife. An analysis of work done by the social worker at the Caversham Centre during the research period had shown that her job was about 25 per cent initial assessment and advice, 43 per cent short-term casework in the practice and 28 per cent referral to outside agencies.

Team meetings took place once a week at the Caversham Centre and staff were able to pool knowledge and skills to examine problems. This did not reduce the need for individual team members to sit down together and discuss cases in great detail. Initially, she had found that doctors wanted her reactions too quickly and feared that there might not be enough sharing. Now she produced a short social report after two or three visits which could be filed in a separate envelope with the executive council notes.

Miss Daley was also a member of an area Seebohm team and recognized that attachment was not without its problems. It was not a parallel with the attachment of nurses to practices because health was a non-statutory department. Those social workers, like herself, who had a medical background had to help those from other disciplines who were afraid of sickness and who did not realize that their problem families were also knocking on the general practitioner's door with a string of minor complaints. General practitioners needed support but there was often no communication on the work which was taking place. The social worker who had an office in a group practice should facilitate rather than stop the dialogue between general practitioner and area social work teams.

Referral and communication

At the end of her talk, Miss Daley was asked whether she only saw patients on referral or whether they could come direct to her. She said that only a small proportion came directly and most of those had already been seen on referral. They did feel at the centre that the consumer should be allowed to choose what he considered the most appropriate agency for him. The practice nurses already held their own clinics and were seeing about 50 patients a day. Some of these were referrals but many were appointments made by the patients themselves. The nurses could refer patients on to the health visitor or social worker without going through the doctor. This was a service which the patients chose to accept.

Many of the doctors at the meeting were anxious about this and said that it suggested a supermarket approach. It was difficult enough for a doctor to make a diagnosis in many cases so how could patients be expected to do this and to choose their own therapist. Others did not share this anxiety. They pointed out that all the team were professional workers who knew their rôle and their limitations and would refer patients whenever it was appropriate to the medical practitioners. Professor Shepherd pointed out that one of his studies had shown that, given the choice and with identical problems, patients would make it quite clear that they would only see the doctor or that they were only too glad not to have to see the doctor. There was no reason why the practice team should not be available on a self-service supermarket basis where the patient chose and got the therapy that he needed; so long as all the staff discussed and were aware of the reasons why they had been chosen by the patient and so long as good communications existed between all team members.

Taking up Professor Shepherd's point about after-care for psychiatric patients, it was suggested that many general practitioners only continued the drug therapy prescribed by the hospital consultant and left the mental welfare officers to do everything else.

Other doctors present felt that they saw discharged psychiatric patients again and again and that they needed more help from the local authority services. They were also aware that

some patients went to great lengths to avoid seeing any doctor and probably received no after-care help at all.

There were reports from Scotland that doctors were worried about the disappearance of mental welfare officers who had been absorbed into the new social service departments. General practitioners were having to use health visitors more on mental health problems. The doctors at the meeting pointed to the value of community hospitals and health centres where psychiatrists could do sessions and follow up patients in the field. They all felt that mental welfare officers were now harder to contact in emergencies and many expressed anxiety that an all-purpose training would not lead to the development of the special skills needed in the mental health field. A general practitioner pointed out that this was hardly a valid criticism. Doctors had long ago pinned their faith on a common basic training followed by specialization and should not criticize social workers for following the same line. The availability of social workers was, in any case, a question of organization within the department rather than of training.

Summing up, Dr Kuenssberg, chairman of Council, the Royal College of General Practitioners, said that doctors had to accept Seebohm. They could not turn the clock back. Given sufficient teamwork in which professional staff treated each other as consultants rather than technical specialists, they could get beyond the problem of searching for a leader and work together. The leadership question was irrelevant; the needs of the patient would dictate the channels of consultation and the decision to be taken in consultation. Divided loyalties fell into place when all the loyalty was to the patient. Better communications and an ability for doctors and social workers to speak the same language followed inter-disciplinary discussion, training and on-going education.

A number of points had come out of the meeting which were worth discussing further. These included links between general practitioners and area social service departments rather than individual social workers, the need for health visitors and social workers to look at modern aids to communication, eg, dictating machines, the use of informal case seminars to share insights, skills and rôle-understanding and the need to include the community as part of the therapeutic resources of doctors and social workers. Above all the meeting had highlighted the need for education of and communication between doctors and social workers and for more experimentation geared to careful evaluation.

PROBLEMS AND PROGRESS IN VOCATIONAL TRAINING FOR GENERAL PRACTICE IN SCOTLAND

Vocational training for general practice is generally agreed to be essential if the needs of patients are to be met more appropriately and more fully, and if general practice is to develop its full potential to meet those needs in our system of medical care. There was almost complete unanimity on this point at a recent conference held in St Andrews under the auspices of Scottish Council of the Royal College of General Practitioners, in association with the universities of St Andrews and Dundee (3–7 April 1971).

However, there are many problems to be overcome before vocational training can be implemented on an appropriate scale in Scotland.

Hospital posts

No one should question the necessity for post-registration training in suitable hospital posts in schemes linked with appropriate training in one or more teaching practices. While the total number of junior hospital posts available is probably sufficient to meet training needs across the board, yet the distribution in the various specialties is such that the number available in specialties relevant to general practice is insufficient. The conflict between service and training needs is further expressed in resistance felt by some consultants to reducing the length of SHO posts from one year to six or even three month modules. An easy solution might be to create supernumerary posts, but such posts would not allow the trainee to be sufficiently and actively involved in patient care.

General medicine was seen to be particularly relevant to the training needs for general practice, yet many consultant physicians resisted the idea of making available 'their' posts to those who did not intend to make their future career in the specialty. This attitude was encoun-