GENERAL PRACTITIONERS AND SOCIAL WORKERS

Sir,

It would seem obvious that Miss Tanner (May *Journal*)[1] and I have different views on the relationship to be desired between general practitioners and social workers.[2] This probably stems from our different experiences. She is a social worker practising in a family medicine programme, I am a general practitioner in service practice with access to a social worker who is not attached. I will only deal, therefore, with the points she makes rather than the points which I was reported as having made.

1. Miss Tanner says "Patients *can* relate to more than one healer at a time if they are taught and gently guided . . ." This means to me that they do not relate easily to more than one healer unless they are taught to do so. I believe that such teaching and guiding should be towards the patient learning to relate with the family and with the community rather than with the health team. This may be because my beliefs are influenced by psychoanalytical thinking, while what Miss Tanner says smacks of operant conditioning.

2. Miss Tanner has found "great utility in formulating psychosocial-physiological diagnoses and treatment plans by the use of interdisciplinary team conferences." Our College expects every general practitioner with every one of his patients to "formulate his diagnosis in physical, psychological and social terms".[3] There would not be time to use a social worker for every patient.

3. Miss Tanner states her belief about the results of having all resources "behind the same door". It is different from mine, but that is all.

4. I was neither facetious nor uninformed in excluding casework and counselling skills, or knowledge of individual and family dynamics from the resources of social workers. These skills and knowledge I would expect of a general practitioner as much as I would expect from a social worker. I was listing resources not held in common.

5. As regards "screening for emotional illness in patients and families", I would direct Miss Tanner's attention to the work of one of her compatriots, Dr Ray Greco.[4] This may be the definitive work on that subject and Dr Greco does not have a social worker.

Let me return to the matter of belief. I believe that the measure of the mature professional, social worker or general practitioner, is their ability to take independent decisions for the care of their patients or clients, referring only when necessary.

If Miss Tanner believes that the measure of maturity is only the ability of health professionals to work together, then it is no wonder that we disagree. If, however, she believes that all professionals should possess the ability to work together, but only use it when necessary for the benefit of their clients and not of themselves, then she and I are in agreement. We certainly are as regards the need for all health professionals to have a common base of training just as they have a common base of motivation.

PAUL FREELING

150 Lady Margaret Road,
Southall,
Middlesex.

REFERENCES

1. *Journal of the Royal College of General Practitioners* (1972). **22**, 351–352.
2. *Journal of the Royal College of General Practitioners* (1971). **21**, 101.
3. *Journal of the Royal College of General Practitioners* (1972). **22**, 337.
4. Greco, R. S. & Pittenger, R. A. (1966). *One Man's Practice*. London: Tavistock Publications Limited ; Philadelphia and Montreal: J. B. Lippincott Co.

VISIT TO AUSTRALIA

Sir,

You may recall the generosity and kindness extended to the Australian contingent visiting Aberdeen and points south in 1970, and we who enjoyed your hospitality, wish in some way to reciprocate.

We believe that some of your members will be visiting Australia in September–October of this year for the combined meeting of the Royal College of General Practitioners, the Canadian College of Family Physicians and the Royal Australian College of General Practitioners and subsequently the Fifth World Conference of General Practice.

There is no doubt that our colleagues in Melbourne will do all that they can, but we in Sydney would very much like to entertain and make our homes available to those of your members who will be visiting Sydney.

If any of your members would like us to help, would they please contact me at my address below, so that we can be of service?

DAVID A. BROWN

10 Railway Parade,
Penshurst,
New South Wales,
Australia 2222.

CONTROL OF DIABETES

Sir,

Loss of life from diabetic ketoacidosis continues to occur and this is particularly tragic as the life may be young and its loss preventable.

Many diabetics are admitted to hospital in severe diabetic ketoacidosis because some minor illness or infection has resulted in a rapid increase in insulin requirement, which has not been met. Often a patient will say that he omitted—or

worse, was advised to omit—his insulin, because he was not eating a normal diet, or was vomiting. Omission of insulin in the insulin dependent diabetic will inevitably lead to ketoacidosis and its prompt treatment is therefore essential if these disasters are to be avoided.

A period of thirst, polyuria and weight loss usually precedes vomiting, over-breathing and drowsiness by a matter of days or weeks in the previously undiagnosed diabetic; but for the diabetic already on insulin, omission of one dose of insulin can lead to diabetic coma within a matter of hours; vomiting under these circumstances is particularly ominous.

The diabetic must be taught how to manage his diabetes in the presence of intercurrent illness or infection. The normal carbohydrate allowance can frequently be tolerated even if solids cannot. One tablespoonful of 'Ribena', four tablespoonsful of 'Lucozade', or two teaspoonsful of sugar dissolved in water flavoured with diabetic squash, are each equivalent to ten grams of carbohydrate and can be used in place of solids.

The urine must be tested twice daily and if 1–2 per cent glycosuria develops in the presence of infection the insulin should be increased. For adult diabetics on twice daily soluble insulin an increase of about one-third of each dose until the urine shows less than one per cent glucose, is usually adequate. If this does not rapidly restore control an extra dose of about eight units of soluble insulin may be given before the midday meal, as long as the urine at that time shows 1–2 per cent glucose.

For diabetics on a single injection of soluble plus a long acting insulin, if the urine before the injection and before the evening meal shows 1–2 per cent glucose, the soluble insulin should be increased by about one third of the total dose in the morning, and an additional dose of about eight units of soluble insulin should be added before the evening meal. These doses may need further daily increases until there is less than one per cent glycosuria.

Increasing the dose of a daily injection of lente or isophane insulin is often not very effective in overcoming a rapid increase in insulin requirement, and if control is not rapidly restored by so doing it is wise to switch temporarily to twice daily soluble insulin.

Finally, if diabetes is not rapidly controlled at home in the presence of intercurrent infection and particularly if there is continued vomiting, the patient should be admitted to hospital. Hospital doctors should always be ready to admit such patients as a little trouble spent in prophylaxis can avert a major medical emergency.

D. PYKE
J. SHELDON
F. E. HIGGINS
P. E. DIPPLE
T. D. R. HOCKADAY
S. OLEESKY
J. W. FARQUHAR
K. J. GURLING
J. A. G. WATSON
C. HARDWICK
T. D. KELLOCK
Members of the medical advisory committee of the British Diabetic Association.

British Diabetic Association,
3–6 Alfred Place,
London, WC1 7EE.

MANAGEMENT OF INCONTINENCE IN THE HOME

Sir,

The King Edward Hospital Fund has made a grant to the Disabled Living Foundation for a 12 month study of the problems facing the incontinent in their own homes, looking particularly at the local authority provisions to see how adequate they are.

The study is to take account of incontinence in anyone over 18 years and whether or not it is associated with other disabilities. I am aiming to interview about 120 incontinent people in the North-west Metropolitan Hospital Board area and if any of your readers in this area knows of people who would be willing to help in the project I would be very pleased to hear from them.

P. DOBSON
S.R.N., H.V.

Disabled Living Foundation,
346 Kensington High Street,
London W14 8NS.

INFECTIOUS MONONUCLEOSIS

Sir,

I reply to Dr R. K. McElderry's comments (May *Journal*) of my article about the treatment of infectious mononucleosis (February *Journal*).

Patients were only allowed to enter the trial if they were known to be tolerant to penicillin and in fact I had no cases of sensitivity reaction.

As far as ampicillin is concerned, a number of authors have commented on the incidence of rashes when this is given to patients with infectious mononucleosis.

I would say that the percentage of rashes found in these cases was much higher than the 50 per cent suggested by Dr McElderry, being in the experience of several authors in the region of 90–100 per cent.

This does not seem to be a true and permanent ampicillin sensitivity as the drug has been given six or more months later to the same patients with no allergic response.

K. J. BOLDEN

94 Sidwell Street,
Exeter.