REPORT

Working together

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A conference was held on 15 March 1973 at the Southern General Hospital, Glasgow. The idea came from Mr F. E. Frayn, Secretary of the Council for training of Health Visitors and Social Workers. His letter was forwarded by the Council of the Royal College of General Practitioners with a request to secretaries of education committees of various faculties to initiate discussions between the three disciplines, general practitioners, health visitors and social workers. Accordingly, several meetings of a working party culminated in this conference and 20 members, mainly from the West of Scotland Faculty Board, were invited and with the same number of health visitors and social workers.

Dr Gordon Currie

Dr Gordon Currie, a general practitioner in Glasgow called his talk *What shall we do with Granny?* He said that society was suffering from a surfeit of senior citizens. People were surviving longer because the killing diseases of youth were being conquered; but as yet no real research had been done into degenerative disease. These problems were aggravated by population movements—the young were moving out leaving the elderly in the older parts of the cities. It was also exacerbated by birth control and the employment of women. The unmarried daughter looking after her old parents was becoming extinct.

In Glasgow, 25,000 old people were living alone, of whom 20 per cent were men. There was an excess of old women, and because women marry younger, granny probably faced 20 years of widowhood. Some possible remedies were:

(1) Granny could go to a married son or daughter—but young people were abdicating their responsibility quicker than the State could make alternative arrangements.

(2) An unmarried daughter could give up her job. Dr Currie was against this—work for the 40 year-old often represented escape from the tyranny of domestic care.

(3) Another solution was to have day-centres in hospital where a daughter could leave her aged mother or father, and escape from her situation for at least some hours.

As for sheltered housing, he believed that this was often illthought out because everything was available while old people were healthy, but an illness could precipitate a social emergency and, because everyone in the block, was old they have similar problems. In other words, planners have concentrated the nuisance. It would have been a better solution to have scattered flats in the community, sympathetic wardens, and close surveillance by district nurses and health visitors.

He thought the responsibility for admitting people to frail ambulant units should be medical rather than local authority.

Mrs Reid

Mrs Reid, a mental health visitor in the community, spoke on *Mental after-care in the community*. On reflection, she thought the title of her talk should have been ' continuing ' rather than ' after-care ' as work done by mental health visitors involved pre-hospital work too. The idea of community care often produces a warm glow but little else. She emphasised the need for a team approach, and expressed a desire to increase attachments to general practitioners.

Usually a psychiatrist referred patients to mental health visitors who can often visit patients on the waiting list for hospital. This was used particularly in the case of psychogeriatric patients and she could also follow defaulters from outpatient clinics, and people referred to general practitioners. Her main problems were dealing with schizophrenic patients, depressives and psychogeriatrics.

She thought that lunch clubs were useful, as was encouragement in taking drugs. A social club was a halfway house between hospital and home, and she spoke of the great sense of security induced by membership of these clubs.

In her opinion the services needed were:

(1) One-day centres as opposed to day hospitals: these could be used mainly by younger and middle-aged people,

(2) Sheltered employment. It was distressing to see the deterioration of people discharged from hospital in good condition because of difficulty in getting a job.

She then dealt with hostel accommodation: there was none in Glasgow. She thought that where this had been tried, mentally ill people did well and their return to the community was eased. Purpose-built wards for psychogeriatric patients were also necessary because these people did not mix well with ordinary geriatric patients who did not suffer from dementia. Careful selection was needed here.

Two difficulties she experienced were:

(a) Communication with general practitioners,

(b) Difficulties in direct contact with social workers.

Miss N. Davidson

Miss Nancy Davidson, Lecturer on Social Administration at Glasgow University thought it was important to promote a dialogue between the doctor and the social worker to help increase co-operation. She said that although she was a lecturer she was also a field work teacher running a centre in East Kilbride, and mentioned how dependent she was on collaboration with general practitioners and health visitors. There had to be a readiness to share ideas about the patient. She emphasised the importance now of having a team approach and on this subject she felt that referral should not just be one way; often the doctor required to refer people to the social worker for consultation and diagnosis.

The question of confidentiality arose and she thought that a new code of conduct was required here, and that the medical profession should initiate discussion with social workers and the public to make sure there was no trouble about the usefulness of having ready access to so-called confidential medical records. She mentioned that the majority of cases referred to her were due to drug overdosage including alcohol, and these were largely precipitated by marital problems.

In general she thought that social workers were really just emerging from an adolescent period to established maturity, in contrast to the medical profession which had been functioning for upwards of 2,000 years. Because of this, perhaps new ways of thinking were required and new ways of learning; the basis of co-operation between the two disciplines was educational and she made a final plea for learning to be in practical situations as well as theoretical.

Group discussion

Next the conference divided into three smaller groups containing an equal representation from each discipline. There was a team leader and a recorder in each group, and after an hour's discussion each recorder reported back to the main meeting.

There was similarity between the feelings of each group and among the problems discussed was the question of confidentiality in co-operation with social workers, particularly in family problems. Language difficulties in communications between health visitors and social workers were raised.

The general practitioners felt they were ignorant about social workers' training and they would like closer contact at surgery level. Health visitors were critical about many social workers not wanting to help at practical level; they often referred people to the social work department and there was no follow-up. Health visitors should be used correctly in practices, and this was mainly in the education field. Space should be provided in practice premises for health visitors and social workers. Joint tasks should be carried out, for example, surveys, and these would be useful in increasing co-operation.

One important point brought up was the ignorance of each other's language: this was

probably less of a drawback between general practitioners and health visitors where there was a common medical and scientific training, but there were many more difficulties with social workers, particularly with the jargon which they seem to be acquiring.

Plenary session

After these reports, the Chairman Dr Roy, Chairman of the West of Scotland Faculty Education Committee, introduced the plenary session. General agreement was felt that there should be a much larger health team in the surgery. Where this had been used, results were satisfactory.

Social workers stressed that their work lay predominantly with lower income groups and there was some discussion about whether the social worker's sense of responsibility should lie with the local authority or with the health centre.

Some health visitors were worried that general practitioners might ' use ' the health visitor perhaps as an extra pair of hands in the surgery. Some common ground in training should be one aim for the future, although it was pointed out that only a small proportion of the social workers' time is involved with what are, strictly speaking, medical conditions.

Dr Roy thought, in summing up, that it had been very worthwhile having the conference and he hoped that delegates would return to their own areas full of enthusiasm to repeat the exercise in large or small ways, and that there was probably room for research into methods of liaison between the disciplines. There should certainly be more co-operation in planning services for the community, and this should be done at both local and national levels.

AIDS FOR THE DISABLED

A study of chemical closets by the Department of Health and Social Security reveals that there is no closet now available which is entirely suitable for disabled people. Financial backing has been given to the Royal College of Arts for the development of a closet specifically designed for use by disabled people, and trials of prototypes are now being planned.

THE SELECTION OF STUDENTS FOR MEDICAL EDUCATION

The purpose of a medical school is not to produce Nobel prize winners. It is rather to provide doctors for the health services who will meet the health needs of the country in which they are trained or of countries that lack adequate health resources, and the extent to which this purpose is fulfilled depends not only on the medical education they receive but also on the processes of selection for that education.

This was the point of view of a working Group on the Selection of Students for Medical Education, convened in Berne on 21–25 June 1971 by the WHO Regional Office for Europe, with the co-operation of the Government of Switzerland.

REFERENCE

World Health Organisation (1973). *World Health Organisation Chronicle*, **27**, 94.