Working together—boundaries and bridges

A Conference *Working Together, Part II—Boundaries and Bridges*, was held in the Walton Conference Suite, Southern General Hospital, on 14 November 1973.

After the first conference, held in March 1973, the working party was reconvened. It was felt that further discussion between representatives of the health visitor, social-work and general-practice disciplines would be of advantage, and this conference—*Boundaries and Bridges* was conceived.

Dr Roy, Chairman of the Education Committee of the West of Scotland Faculty, was in the chair. He opened the conference by giving a short resumé of the previous meeting and stating that without continued activity and discussion further progress could not be made.

Dr P. Crawford, General practitioner, East Kilbride

Dr Crawford outlined the difficulties in setting up a team, the main problem being ignorance of the true function and capabilities of other team members. The best way to overcome this is to arrange regular meetings of the team, providing a basis for communication. Impromptu chats over morning coffee are inadequate.

He had found most assistance from the health visitors in the fields of paediatrics and geriatrics, their assessment and advice being of particular value in planning co-ordinated management and in assessing progress. They are also of value in maintaining elderly patients at home, who might otherwise require residential accommodation.

Integration with social workers and definition of their and the doctor's complementary roles was more difficult. The doctor's approach to a problem was too often medical, but the social worker's psychosocial approach often tempered the doctor's attitude to demanding patients.

In teamwork the problem of confidentiality arises, but in Dr Crawford's practice, agreement by the patient for referral to another member of the team is taken as tacit permission for exchange of information, unless specifically forbidden by the patient. This system has so far worked without difficulty.

Dr Crawford concluded that the combined approach was best, only as long as it was better for the patient, and provided it was not manipulated to the advantage of one member of the team, and did not stifle the potential of others. This is where it is necessary to define boundaries, although re-assessment from time to time would be necessary to ensure the greatest benefit to the community.

Miss M. Nairn, Director of Nursing Services, Dumbarton

Miss Nairn re-iterated the need for combined care and the need to be aware of other workers' roles. Health visitors and district nurses had different jobs to do except perhaps in rural areas. The Social Work (Scotland) Act had created problems by separating the administration of social workers from the Health Services, but one benefit was that nurses were doing less social work.

She declared that there was a lack of research into attachment of nurses, and such research was essential for efficient administration and progress.

The disciplines of social work, health visiting and general practice were all currently caring for the elderly, not to mention voluntary bodies, yet social tragedies persisted in geriatrics. There was insufficient co-ordination, and poor feed-back to the health visitors from social workers and general practitioners.

Other problems confronting health visitors were time and work allocation, transport for the recently qualified, and numbers far short of that considered necessary. There was already an increase in the number of training posts but this would have to be further improved.

To ensure the best care for the patients, these problems would have to be solved, and much more co-ordination in planning between the disciplines at a high level was necessary.

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Mr W. Kenny, Lecturer in Psychiatric Social Work

Mr Kenny reported that unlike the health visitors, the social workers had not yet arrived at an accepted basic rate of workers per thousand population. However, with regard to the team approach, he considered general practice to be an important primary contact area between social workers and their clients.

He then declared their objectives, including early detection and treatment, and removal of social pressures. These could only be achieved in co-ordination with general practitioners if the local authorities and the Health Services co-operated. He wondered if the Health Service reorganisation was detrimental to these objectives.

Other problems were the lack of social workers' operational programmes, and demands from other areas on their services (e.g. schools, courts).

Mr Kenny felt that without fulfilment of the objectives, attachments to general practice would fall short of requirements.

Professor F. M. Martin, Department of Social Administration, University of Glasgow

Professor Martin stated that a declaration of intent was not enough to make combined care work. The problems to be overcome were numerous, but the greatest of these was ' professionalism '. This attitude developed from the earliest training and student periods of all disciplines, and was subsequently, re-inforced, leading to confrontations and boundary disputes when co-ordination was attempted. The solution was to share early training, establishing earlier contact between the disciplines, subsequently reducing the barriers which currently exist in attempts at team work.

The scope for this was unfortunately limited, before one encountered the myriad problems of conflicting time-tables of the training courses in the different disciplines.

Group discussions

After these formal lectures the conference split up into four groups for discussion, each group having its own leader and recorder.

The reports from the groups were interesting, particularly when compared with the reports at the previous conference. The discussions seemed to have progressed from the problems of team work to consideration of the structure and management of the teams.

Nevertheless, previously discussed problems did arise . . . particularly those of confidentiality, and with particular reference to the social workers, role definition, and communications. It was generally agreed that if the team worked from the same building, much of the communications problem would be solved, and the social workers would be provided with one of their better pick-up-points . . . general practice. Such a centre would also provide the problem population with a destination . . . three groups reporting that too many people did not know where to go for help.

Team approaches could well avert many of the crises with which the social workers had to deal, thus releasing their oppressed numbers to carry out more preventive work.

Role definition also appeared with reference to disciplines other than social work. All should maintain their broad professional duties, but all also had doubts of their own efficiency. The health visitors were better able to maintain, their proper duties following the introduction of the Social Work (Scotland) Act. Social workers were reported to be more ' politically orientated ', and nurses' training was criticised for producing a much too subservient approach at inter-disciplinary contact.

It was reported that Dundee Medical School was about to start inter-disciplinary contact at undergraduate and training levels.

Finally, the most important question to arise . . . who should lead the team? Previously it had appeared to be the general practitioners, but there was considerable opinion that there was no reason for this to be maintained. Local circumstances might well make other arrangements preferable, and there was also a suggestion for rotation of leadership.

Plenary session

The plenary session then opened. Dr Barber reported that Glasgow had already started inter-disciplinary instruction between medical students, student health visitors, and student social

workers. The early session and visits to subject families had been a considerable success. Discussion then centred round the time-table problems, difficulties of finding suitable subject families, and of the ethics of having unqualified people dealing with such families. Careful selection was important, but psychosocial care from students was often the alternative to no care at all.

Fears were expressed that the team could become too health-centre orientated, and work within the community suffer. There was some difference of opinion about the value of home visiting by general practitioners, but the health visitors felt they had a real contribution to make in the home.

The social workers stated that although the bulk of their work was with social classes IV and V, these people often had an innate ability to cope with situations and circumstances which people from classes I and II might find intolerable, not to mention the fact that very difficult problems occasionally arose within classes I and II.

At Dr Roy's invitation the speakers then commented on the conference. Professor Martin stated that he felt he had been speaking to the converted and Mr Kenny felt there was a dilemma . . . what were the priorities for attachment of social workers to general practice, and what were the benefits?

Miss Nairn stated her case positively, declaring that it was time for the body of the Kirk to initiate attachments, despite the possibility of rebuffs from higher authorities.

Dr Roy then summed up the meeting by stating that the bridges, although still under construction, appeared to be in use. This conference was no end in itself, but a mere stage in a continuing process. Should the next step be the creation of widely distributed local nuclei of general practitioners, social workers, and health visitors?

Dr Roy then thanked the speakers, group leaders, and recorders and the conference adjourned for dinner.

REFERENCE

Journal of the Royal College of General Practitioners (1973). **23**, 808.

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