

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.

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REFERENCE

Drinkwater, C. (1974). *Lancet*, 2, 210-11.

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 further 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

position as a competing generalist and concentrate on the specialised services. He would then become a consultant in relation to the general practitioner.

Having criticised the organisation of social services so fiercely the general practitioner cannot escape entirely. The saving graces of general practice are that it is not organised into a rigid hierarchical structure, and that the doctor is constantly in touch with his patients. This lack of structure does, however, mean that some doctors can isolate themselves from their colleagues. The pressures of work make it impractical for a social worker to communicate with say five or six single-handed doctors working in different premises. It is obviously easier to communicate when doctors work in the same premises. Unfortunately it must be true that social problems are most acute where general practitioners are mostly widely scattered, i.e. in the inner urban areas.

I hope that in the future general practitioners and social workers will be able to get down to the task of providing personal care for patients in the setting that matters, i.e. in general practice. I accept that there are enormous problems of adjustment that will be experienced on both sides. It is only after working together that people will be able to decide who can and cannot do what, and how this is to be achieved. Interdisciplinary discussion in a neutral setting can go some way towards ironing out problems, but it is no substitute for thorough discussion of shared problems at work.

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MEDICAL HISTORY

Sir,

I am most grateful to those members who were kind enough to reply to my questionnaire in the *Journal* about the extent and degree of interest in medical history within the College. It is hoped that anyone who did not have the opportunity to write me at the time could drop me a line using the above reference as a guideline. I am sure there are many unsung singers in our midst. We are always delighted to know what is happening in the medico-historical field.

Of the 25 letters I received two came from overseas—one from New Zealand and the other from Tanzania. Surprisingly, Ireland and Wales were silent. The length of the replies varied enormously, some correspondents being just happy to send me a postcard while others maintained a brief but fruitful exchange of letters with me. Six of the doctors concerned had retired. It was duly noted that one medical man acted as an honorary librarian and another as an honorary archivist in the faculties, while a third person had done enough work to merit the title "medical historian". Several people kindly sent us off-prints as proof of their enthusiasm. Among the many "spin-offs" from the

exercise were generous gifts to the College including a large collection of surgical instruments and an important out-of-print book on obstetrical forceps.

Over half the correspondents had published papers or articles, and three had published books. Two doctors had written books which were either unpublished or were about to go to press. Miss Margaret Hammond, the College Librarian, would be most grateful to receive manuscript or type-written copies of any unpublished medico-historical works for the reference library.

Although, for obvious reasons, no significant statistical conclusions can be drawn from this pilot study, it is encouraging to realise that there is more than a glimmer of interest in a subject which giants like Osler and Comrie rightly considered so important in medical training, both at undergraduate and postgraduate stages of medical education.

Once again, many thanks.

PETER THOMAS

Honorary Curator,

Royal College of General Practitioners

Thomas, P. (1973). *Journal of the Royal College of General Practitioners*, 23, 285.

H. K. LEWIS

Sir,

Twice during 1973 and in November 1974 I visited the metropolis, paying homage and money to the Royal Colleges to sit their examinations. On each occasion I asked at the famous H. K. Lewis's for the section of books about general practice. In 1973 I was met by blank looks and after some delay directed to the section on clinical medicine, where I found Eimerl and Laidlaw's *Research in General Practice*, but nothing else.

Last month however; no blank looks but a confident direction straight to the clinical medicine section and—*Learning to Care*, *Patient Centred Medicine*, and *A Family Doctor's Day*, adorned the shelves. The latter, by Denis Craddock was published in 1962 at 12/6d., by H. K. Lewis. No it wasn't there in 1973, and take your coat off, because I bought it—for 75p.!

London needs more than Chairs in General Practice!

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VOCATIONAL TRAINING

Sir,

I refer to Dr John Hasler's interesting article on the facts and figures about vocational training (September *Journal*). The information he has given us will be invaluable in the future planning processes.

I must however, respectfully, correct one statement. Since October 1973 there have been vocational training schemes based on all the district hospitals in East Anglia. We have been convinced that vocational training should be based on the health district. I believe there is evidence that this