CORRESPONDENCE

MEDICAL COMPUTING

Sir,

It is most encouraging to see the controversial subject of medical computing being raised in the July *Journal*. Drs Crombie and Pinsent are surely absolutely correct in emphasising the overriding importance of the doctor/patient relationship, which no amount of computation can displace. Not all computer technicians have appreciated the overwhelming significance of this point (Johnson, 1974).

Computer technology is expanding at a rate so prodigious, it is difficult to envisage. *The Economist* (1976) suggests that circuits have fallen in price by 40 per cent every year for the past 20 years. A magnetic disk can now store general practice records at a cost of 16 pence a week for each doctor. What will the next few years bring?

Drs Crombie and Pinsent mention the problem of dealing with items that arise *de novo* during the consultation. Technology may be of assistance here too: 'real time' systems may be used, whose response time is so rapid that the information displayed can influence the practical situation as it proceeds. The prime need for this, of course, is the distribution of drug information.

The main problem with medical computing naturally enough is professional inertia, for which there are excellent reasons and precedents. However, change is already upon us, since one can now buy for £5 in a supermarket a calculator that ten years ago would have cost £500. Today a complete computer can be bought off the shelf for £5,000: in five or ten years that will be £500 or even £50.

It is therefore very important that the medical profession, and especially general practice (Ockenden and Bodenham, 1970) become more aware of the powerful nature of these "mechanical auxilliaries". It is in this spirit that your Editorial (July *Journal*) and the article referred to, deserve such a warm welcome.

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SOCIAL WORKERS IN GENERAL PRACTICE

Sir,

I am sure Dr Paine is right (September *Journal*) when he contends that the sum of the four part-time social workers in his practice is far greater than the hypothetical whole-time equivalent that they represent. Both in terms of the four different personalities with their own individual expertise and professional networks, as well as the provision of satisfying part-time work for married social workers, the advantages are indisputable.

However, Dr Paine does not tell us where his part-time social work team is based. Are they in fact employed by the practice and thus working as freelance social workers, or are they as I suspect, employed either by a university department, a local authority Social Services Department or some other professional social work agency, and then seconded to the practice? This is a point of some importance because social workers see themselves as autonomous and independent professionals, and most certainly not as medical ancillaries. At the same time, because of the very nature of the social work profession, its practitioners usually need to be members of a larger professional organisation like a social security department from which they derive both their authority and the resources necessary for the proper fulfilment of their professional role.

If social workers are to be based in general practice and are to make a real contribution to primary care, (not primary *medical* care alone) then it is essential for them to be based squarely in the local social services area team and attached to general practice, just as the hospital social workers are currently based in the social service departments and attached to the hospitals. Social workers in general practice should be able to carry out the statutory duties of a local authority social worker and have all the powers and resources of their colleagues in the social services departments. It seems in Dr Paine's case that his social work team provide only a counselling and casework service, while what might be termed "routine" social work to the social service department.

Dr Paine is wrong in assuming that a social worker can be employed in general practice in the same way as a practice nurse or receptionist and then 70 per cent of their salary reimbursed by the Family Practitioner Committee. Other general practitioners have already explored this avenue with the Department of Health and Social Security and the suggestion has been rejected. The role of the social worker would be as partners in primary care, not employed staff, and it is obviously administratively easier for them to be employed by

social services and attached to general practice, thus removing any ambiguity about their role or remuneration.

Finally, it is all very well to describe the luxury of one whole-time equivalent social worker in a practice of three doctors with presumably a practice population of around 7,000. This is a level of provision which can only be achieved under the terms of a generous research grant and bears little relation to the country at large. Out in the real world the ratio of basic grade social workers to client population is probably in the order of 1:15,000 or even 1:20,000 in some areas (estimates only). On this basis it would be only reasonable to expect the local authority to allocate a social worker to quite large group practices, or alternatively the social worker would have to be shared by several small groups of general practitioners. Even so the concept of a part-time social work team attached to groups of general practitioners is exciting and I look forward to reading Dr Paine's detailed findings when the results of his researches are published.

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SELF-CARE

Sir,

I read with great interest the article *Symptoms Perceived and Recorded by Patients* by Morrell and Wale (June *Journal*) and would like to raise one or two points.

The statement that only one in 37 symptoms are presented to the doctor cannot be taken as a generalisation. It is surely pertinent only to the group of women studied and therefore not applicable to patients as a whole. Furthermore the type of symptom and the frequency with which patients consult vary considerably with social class, age, and environment (urban or rural), and I think it would be necessary to know these variables before drawing conclusions from the study. Another factor that might have considerable bearing on both the recorded symptoms and consultation rates is the incidence of associated disease either in the patients studied or their families. Morrell and Wale do not mention the presence of disease in their patients.

From the tables showing symptoms recorded in the patients' diaries and presented to the doctor it appears that approximately 75 per cent of the symptoms are those other than some form of pain. It would be interesting to speculate which group of symptoms over-anxious patients tend to present.

Although Morrell and Wale suggest that anxious patients are more likely to record symptoms and consult the doctor than to arrange their own medication, some of the other factors governing self-care are the availability of medical care and access to commercial over-the-counter drugs. For instance, patients having difficulty in obtaining appointments with their doctor on a regular basis in an inefficient practice might be more likely to resort to self-care.

Finally, the presentation of symptoms may be highly dependent on the discussion of those symptoms within the family. Perhaps Drs Morrell and Wale in their further analysis will be able to shed some light on the dynamics of symptom organisation by both patients and their relatives.

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COMMUNITY HOSPITALS

Sir,

To someone who has spent the last three years associated with a perhaps unusually busy and well-equipped community hospital (Kyle, 1971) the recently published report (Royal College of General Practitioners, 1976) on the special educational needs of doctors working in such hospitals proved to be not only fascinating reading, but also apparently to relate to a totally different environment from that which I have experienced here in Brecon.

The report highlights the desirable learning requirements for medical staff in a community hospital in an unusual and revealing order of priority—starting with the study of patterns of organisation of care and sadly ending with the care of the dying.

Particular emphasis is placed on late post-operative care and rehabilitation, but the impression is given that this is a field that can be quite adequately supervised medically by doctors who are totally isolated and uninvolved in the patients' earlier management.

The report appears to endorse the curiously insular British view that there is some sort of rigid distinction that can be drawn between specialist and non-specialist medicine, only the latter being suitable for the general practitioner in his office and community hospital practice. In addition, the suitably educated general practitioner is credited with a new and perhaps unique role in hospital practice, his 'specialist' skills in organisation and rehabilitation somehow distinguishing him from other hospital doctors.

In Brecon the idea that doctors fall into two separate categories — hospital doctors and