poor (Central Council for Education and Training in Social Work *et al.*, 1980).

Although the Seebohm Committee took the view that the functions of the health visitor and social worker were distinct (DHSS, 1968), many doctors have difficulty in perceiving such distinction (Williams and Clare, 1979). This is hardly surprising if one compares the responsibilities of the health visitor as detailed by the Mayston Report (DHSS, 1969) with those of the social worker as defined by a working party of the National Institute for Social Workers (Goldberg and Fruin, 1976). Since health visitors have already established their role in dealing with social problems, social workers are at a disadvantage in developing a similar, though separate, responsibility within the primary care team.

Perhaps fortunately, several schemes for co-operation between social workers and primary health care teams have got off the ground and reports of their relative success are becoming more common (Corney and Bowen, 1980). As well as suggesting that attachment schemes will tap a wider section of the community, recent publications have also attempted to identify factors which affect the organization and success of attachment schemes in general practice. For the social worker, access to a room in the surgery for interviewing and the use of a telephone are important factors influencing the working relationships developed with members of the primary health care team. Personalities, commitment and attitudes are also of fundamental importance (Corney, 1980).

Close interprofessional co-operation between family doctors, social workers and other members of the primary health care team are encouraged by the publication of data which illustrate the advantages of collaboration to patient for client groups, and which demonstrate the importance of good working relationships. Education for co-operation in health and social work should also have a beneficial effect (Central Council for Education and Training in Social Work *et al.*, 1980). However, in both situations, such change that is induced will be very gradual and seen only in the long term.

The publication in this issue of the *Journal* (pp. 38-41) of a paper on an alternative method of employing a social worker in general practice may signal a new era in the developing relationship between family doctors and social workers. With commendable vision, Avon Family Practitioner Committee have recognized that the role of the social worker is ancillary to the family doctor's and that the practice social worker thus qualifies for 70 per cent reimbursement under Section 52.5 (a) of NHS General Medical Services, Statement of Fees and Allowances (DHSS and The Welsh Office). If implemented nationally, the implications of this decision for primary health care would be profound. It would also be a tangible demonstration of the DHSS's stated policy of shifting resources towards community-based care.

The advantages of this scheme include an exclusive commitment by social workers to the primary care team, making them more readily acceptable to both patients and doctors. Many of the difficulties associated with attachment and liaison schemes are circumvented.

In the present economic climate, social services are unlikely to expand, and attachments to general practice may well be reduced. The direct employment of social workers by family doctors represents a new dimension for the primary care team which demands comprehensive assessment and evaluation by the profession at the earliest opportunity.

CLIVE FROGGATT

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Inner cities

NO reasonable person can doubt the commitment of both the Royal College of General Practitioners and the General Medical Services Committee to the relentless and progressive raising of standards in primary medical care. The emergence of vocational training is perhaps the most obvious example, and this could not have been possible without the closest co-operation between the two bodies.

However, when the quality of primary care is under examination in a critical atmosphere, the problem of the inner cities is inevitably raised. Thereafter, discussion tends to be both anecdotal and emotive. The blame is often laid at the excessive use of deputizing services and the preponderance of elderly, single-handed general practitioners, especially in London. The fact that the share of the National Health Service budget devoted to primary care has fallen progressively over the past six years and now stands at only 5·9 per cent is rarely, if ever, given prominence. Yet anyone who has had the opportunity of visiting inner city areas does not find it difficult to identify centres of excellence.

Dr Bolden in his Occasional Paper, now available, has shown that by approaching the problem with an open and enquiring mind, it is possible to identify other factors which are prejudicing the delivery of medical care, the intransigence of some local authorities being a significant example. Dr Bolden would certainly not claim to have made even a major contribution to solving the inner city problem, but he has shown the value of an open-minded approach.

Perhaps what is now needed is a move away from prejudice and criticism towards an adequately funded study of why centres of excellence can operate with great effectiveness in areas of major social deprivation.

Inner Cities, Occasional Paper 19, is available from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £3.00, including postage. Payment should be made with order.

Whooping cough vaccination

The first 1,000 cases notified to the National Childhood Encephalopathy Study were analysed. Only 35 of the notified children (3·5 per cent) had received pertussis antigen within seven days before becoming ill. Of 1,955 control children matched for age, sex and area of residence, 34 (1·7 per cent) had been immunized with pertussis vaccine within the seven days before the date on which they became of the same age as the corresponding notified child. The relative risk of a notified child having had pertussis immunization within that time interval was 2.4 ($p<0·001$). Of the 35 notified children, 32 had no previous neurological abnormality. A year later two had died, nine had developmental retardation and 21 were normal. A significant association was shown between serious neurological illness and pertussis vaccine, though cases were few and most children recovered completely.

An accompanying editorial puts the risk of persisting neurological damage at one in 300,000 immunizations.

Source: Miller, D. L., Ross, E. M., Alderslade, R. *et al.* (1981). Pertussis immunization and serious acute neurological illness in children. *British Medical Journal,* **282**, 1595-1599.