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Working with social services departments

Sir,

We are concerned that poorly developed inter-agency cooperation may be hampering the implementation of the children act 1989. The document *Working together under the children act 1989* states that the protection of children requires a close working relationship between social services departments, the police service, medical practitioners, community health workers, schools, voluntary agencies and others.[1] As general practitioners and health visitors in a primary health care team we do not have a balanced working relationship with our local social services child and family team. We have a considerable workload with children on the protection register, and the geographical proximity of the health centre to the social services office allows the general practitioners to attend case conferences more frequently than doctors in many other localities.

The following is a description of some of the problems we have encountered. Our concerns about individual family situations seldom influence the decisions that are made, and we have detected little willingness on the part of the social services department to integrate other professionals' opinions into their decision making. Our referrals of families for preventive work are rarely acted on convincingly, lack of resources being cited as the predominant reason. We are concerned by the many dysfunctional case conferences we have attended: there is too great a focus on whether to place a child on the protection register, so inhibiting the drawing up of a wider child protection plan. Decisions at case conferences are made on insufficient information, while at other times indiscriminate or inappropriate information is provided. An insistence on voting for decision making is often divisive and inappropriate, as 'one person one vote' leads to the view of the social services department predominating. Case conferences become confrontational if opinions other than the prevailing view of social services are expressed, with chairpersons failing to facilitate the working together of different professions. There is scanty implementation of policies or procedures for working with parents in case conferences. We are also concerned that core groups (for example, a social worker, a health visitor and a general practitioner) can fail to work, with patchy and incomplete follow up of children.

While we have made representations at a local level to try to improve working relations with social services we do not feel this has been successful. Our approaches at a county level initially led to us being able to express our concerns but this, several months on, has not yet led to anything concrete. We therefore wish to ascertain whether other primary health care teams are experiencing similar problems in their working relationships with social services. If this is so we would welcome suggestions on how to progress towards a generalizable solution.

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Aspirin and myocardial infarction

Sir,

The discussion paper by Dr Rawles presents a well argued discussion on the acute management of patients with myocardial infarction, with particular emphasis on recent advances relevant to general practice.[1]

Our only concern about this paper is the absence of reference to aspirin. The ISIS-2 trial demonstrated a 25% reduction in mortality when 160 mg aspirin was given within the first four hours of the onset of chest pain.[2] Birkhead demonstrated that for patients admitted with chest pain by their general practitioner the median time by which they received thrombolytic treatment was over four hours.[3] The ISIS-2 results demonstrate that the effect of aspirin is somewhat less when it is given more than four hours after the onset of chest pain.

It would therefore seem reasonable for all patients with suspected myocardial infarction to be given 150 mg of aspirin immediately when first seen by the general practitioner. This treatment is more likely to be acceptable to general practitioners than the administration of thrombolytics at this time. Further, the finding that patients are admitted substantially quicker if they call the ambulance themselves, suggests that the time may be right to consider whether aspirin should in fact be carried and given by ambulance crews.

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James Mackenzie

Sir,

James McCormick (letters, June *Journal*, p.262) challenges the assertion in my Mackenzie lecture (February *Journal*, p.78) that coronary thrombosis, or myocardial infarction, was rare at the beginning of the century and was not described by James Mackenzie. This challenge is a repetition of that[1] issued to a previous Mackenzie lecturer, Walter Yellowlees, 14 years ago.[2]

Yellowlees' detailed response[3] provided much of the evidence supporting our contention (and that of Mackenzie's biographer, Professor Alex Mair[4] that myocardial infarction was only just becoming recognized at the time. It may be true that, as McCormick suggests, 'angina' included some cases of 'infarction'. However, the fact that Mackenzie, writing about angina, stated that 'there are cases in which angina pectoris develops with great severity and ends speedily in death. On the whole these cases are rare'[5] and 'great as the distress is which the pain produces, pain itself is in no sense a dangerous symptom'[6] suggests that, even if 'angina' included 'infarction', the latter was not common. Review of pathology reports for autopsies carried out at the London Hospital during the period 1908–13 (when Mackenzie was cardiologist there) indicated that, al-