MEDICAL PRACTICE

Conversations on the Social Services

Rural Views

Dr. A and Dr. B are two of the partners in a rural practice centred in a village near a market town in the home counties.

FROM A SPECIAL CORRESPONDENT

British Medical Journal, 1974, 2, 595-596

"We don't really think it's true that the social services are breaking down; there was a lot of confusion here last year, and the social workers didn't know what they were doing. The reason was that they were converting a bunch of specialists into general practitioners. Scattered around the area under the old scheme were blind welfare workers under some committee, home helps under the health authority, children's officers looking after child care—and all these were specialists. After all, blind welfare people took up the job because they were interested in the blind, and suddenly they found themselves looking after schizophrenics or children; they had to start learning all over again. The second problem was the influx of brand new university graduates. Most of the ones we had had were old style workers who had been in the job for years, and suddenly we had all these new people, who had generic type of training, and neither the average doctor nor the hospital had much idea of the scope of the work they undertake. Consultants still think they are lady almoners with a little money somewhere, and the general practitioners didn't know because nobody told us.

No One Told Us

"No one told us the social services had been re-organized; we just found it out. We suddenly got a circular saying your area organizer is so-and-so, and we shall be in such an office. It took everyone a year to learn addresses and numbers. Before that we knew that if we wanted a wheelchair we rang one number, for a bath-aid another, and though it was a bit of a nuisance we were used to it. In actual fact, the old arrangements were awful, a byword for inefficiency, but they were familiar.

"Well, 18 months ago we had a lot of grumbles, but now we have them ironed out, and it was done by meeting and talking. The first was the area meeting at the postgraduate centre, 200 people, too many to be very useful, but since then we have had several local meetings. The social workers arranged the first one; they have no money for this sort of thing, but they put their hands in their pockets and invited the general practitioners to lunch. The second time Dr. B was in the chair, and we had a specific topic—old people. The other day we had a grand meeting here in the surgery, 20 people for coffee. Health visitors find some difficulty in defining and maintaining their role separately from the social workers, but just think how doctors once detested health visitors because they didn't know what they had to offer. Now most practices have health visitor attachments, and we know their value. Secretaries and receptionists are very important, and, once you can ask for someone by name, your troubles start to disappear.

The One We Miss the Most

"Perhaps it is the old mental welfare officer we miss most; there were only three of them, and we knew them hand and glove, and they our patients. You only had to ring this number and say, 'Look, M is at it again,' and he coped. But now along comes a young girl who has only been here a few months and knows very little. When the new arrangements started, everybody did everything, so nobody knew anything, instead of having somebody who knew everything about a small topic. On the other hand, when all social workers were specialists you got some very good ones and were all right, but if you had a bad one, that area got completely neglected. There have, of course, been incidents. One weekend Dr. A was rather disturbed about a psychiatric patient, a big tough who abuses the neighbours. A very young man who was the duty officer came from another area, and didn't know the patient. Dr. A thought he didn't have nearly enough knowledge to say

that a patient ought to be detained, and supposing the doctor had been inexperienced too? Nevertheless, the old mental welfare officer must have been inexperienced once.

"When reorganization came many older people retired or were promoted, and there was this vast influx of new social workers, with much theoretical knowledge but no practical experience. Dr. B had a patient who had had a stroke and was to be nursed at home by our district nurse, who is 77 and four feet ten inches high, so Dr. B asked for a hoist and so on, on Friday. Monday came and nothing happened, so Dr. B rang in rage, and was told someone was coming to inspect. Next day comes a dear little girl with a notebook, who starts gathering information in a proper way. When Dr. B protested that she knew what she wanted, the girl said, 'I must do my casework the right way.' That was 18 months ago: now we know the way to ask to get things done. The social workers feel there are lots of people in social need, and only some of them are patients. Doctors think social workers are only there to look after patients, and they want them to be handmaids. A man with a stroke may be a proper subject for casework in that he may have all sorts of other needs apart from his medical ones. Doctors are sometimes a bit arrogant about this, and feel they can decide everything. They think everything social workers do is for patients, but of course it isn't.

Case Conferences Are Necessary

"District nurses can put in a request, but sometimes doctors are asked to countersign. Some general practitioners are very possessive, you mustn't go to Family Planning if they don't want you to, or have a wheelchair if they want you to walk. There are a lot more case conferences, which enrage some general practitioners, but are very necessary. The social services are very short of staff. Old-timers would work 24 hours a day; the new sort quite rightly aren't allowed to. Eighteen months ago we were prepared to say that the social services were hopeless; we didn't know what they were doing and vice versa; ring them up and they weren't there, or couldn't come. For instance, Dr. A rang up about a young family in distress, a young girl answered the phone, and said is it an urgent matter or not. Well, everything a general practitioner does is urgent, he doesn't want to stay on the phone another minute, and, of course, if you say urgent it doesn't get done because everyone says the same. It is only by getting down to discussion that you find the best procedure to use. It is surprising how often you ring up about someone and find they are already on file; they have their regulars just as doctors do.

"Meeting your team and being able to call them by name is possible in a village or small town, but it must be an enormous problem in big cities, where you have a lot of single-handed general practitioners who haven't time or staff to contact anybody, and you have a shifting population. We have our system under control, but in London, for instance, everything is short—housing, transport, police, ambulances, casualty services, not just the social services. Everything is wrong for people."

Hospital Topics

Structure and Function of a Middle-sized Accident Department

R. H. HARDY

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Summary

An account of the working of a middle-sized accident department is given, based on the study of nearly 33,000 attendance records. The work load, management, and staffing as it is actually organized is briefly described. The effectiveness of the service given is bedevilled by certain features of the N.H.S.—in particular, the deplorable conditions of employment of staff in casualty departments.

Introduction

Much has been written about accident and emergency services.[1 22] Though 109 out of 224 accident departments investigated in 1969[1] had a yearly attendance of new patients of between 9,000 and 25,000 there is little on record about how an accident department of this size may be successfully run. Most writers agree that accident services are important, not as good as they should be, understaffed or staffed by the wrong people, and could be improved by adopting the particular writer's remedy.

The department I write from handles about 16,000 new patients a year. It has its own particular function because of its size, locality, and environment. It also has its own peculiar problems.

Accident Hospital, Hereford General Hospital
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Work Load

Some 16,000 new patients per year is a lot for a staff of four to handle (fig. 1). We have one temporary medical assistant, who has held his post for nearly three years and three senior house officers, who change every six months. We can also call on the intermittent help of one experienced surgeon as clinical assistant to fill in our recurrent gaps.

We serve an extensive rural area, from parts of Gloucestershire to central Wales, from south Shropshire to parts of Monmouth. Hereford, the one major city in this area, is a bit off-