not afraid to criticise the medical profession while carefully constructing their case for an independent inquiry into social work.

The medical profession was never enthusiastic[4] about the pattern of social work proposed in the Seebohm Report[5] and introduced in 1970.[6] The first decade of operation has largely justified those misgivings, and few doctors would disagree with the book's condemnation of the top-heavy bureaucracy of social service departments, the lack of intellectual rigour in assessing the value of social work, and social workers' predilection for psychotherapy to the exclusion of behaviour therapy, with the inevitable clashes with doctors over the care of acutely ill mental patients. The authors suggest that social workers would be more use if they were seconded to health, housing, education, and supplementary benefit agencies rather than being isolated, as at present, in a separate department. Thus social workers should be prepared to specialise and cast off the fashionable generic cloak wrapped around them by the Seebohm Report.

The aims of social work have never been very clearly defined and the outside world might be forgiven for assuming that too many social workers see their task as putting an imperfect world to rights rather than giving practical help where it will be effective. GPs know their limitations in helping patients whose troubles have a social as well as a medical cause: a touch of the same realism could do wonders for social work. Brewer and Lait put it bluntly in a letter replying to criticism of their book: "We . . . believe in recognising a hopeless case when one sees it, and urge social workers to concentrate on areas where their skills have been shown to be effective, instead of advertising themselves as Universal Cure-Alls."[7] To be expected to cope expertly with delinquency, truancy, pregnancies in the unmarried, child abuse, compulsory hospital mental admissions, and accommodation for the elderly is an unfair demand on any individual, however well trained or experienced he or she may be, and Brewer and Lait leave their readers in no doubt that they see the training of social workers as being as diffuse and soft-centred as the social service departments they criticise.

Admittedly, doctors often find it difficult to assess objectively the value of their treatments. But in the past 50 years or so increasingly refined techniques have been developed for scientific analysis in medicine. Perhaps social workers should not be judged too harshly for not having developed such rigorous techniques in their first decade as an organised profession—though, as the book reports, trained social workers originated over a century ago. Nevertheless, Brewer and Lait make a valid point in highlighting the reluctance of social workers to submit their activities to similar evaluation. Of the several studies on social work analysed by the authors, one—the Leeds truancy study[8]—stands out: firstly, because it was a controlled trial and, secondly, because the social workers were unaware their work was being evaluated and so presumably were uninfluenced by the study. Briefly, the study showed that truants whose cases were merely adjourned by the magistrates' court subsequently had a much better attendance record and lower crime rate than those referred to a social worker for supervision. So the result suggests that intervention by social workers was harmful. Iatrogenic disease is not unknown in medicine, but doctors recognise its risks and are more willing than social workers appear to be to prevent it.

The medical profession has had—and continues to have—more than its fair share of public criticism and public inquiries since its registration and disciplinary machinery was set up over 120 years ago. With today's rapid rate of change social workers, who as yet have no GMC-type body, should not be too surprised that their public tribulations have started so early in their professional existence, though some of them did not help their cause by striking for several weeks in 1978, when anecdotal reports implied that neither clients, local authorities, nor other professional colleagues were greatly inconvenienced by their absence. Despite their book's title, Colin Brewer and June Lait clearly see social workers as having valuable skills; and the BMA, though it believes that social services should come back under the aegis of the Department of Health, has no wish to smother the infant profession. Mr Patrick Jenkin's announcement of an inquiry into social work[9] is, therefore, welcome—and Brewer and Lait can share the credit with the British Association of Social Workers,[10] which had also been pressing for this traditional British solution. In contrast to the "outside-expert" approach of the Royal Commission on the NHS, which was chaired by Sir Alec Merrison and included no hospital clinician among its members, the social work inquiry is to be headed by Mr Patrick Barclay, chairman of the National Institute of Social Work. A wide range of interests and skills will be needed in the other members if the inquiry is to be seen as independent and to find ways for investing scarce resources in social work to practical effect.

1 Anonymous. *Br Med J* 1979;ii:152.
2 Anonymous. *Br Med J* 1980;**281**:249.
3 Brewer C, Lait J. *Can social work survive?* London: Temple Smith, 1980.
4 British Medical Association. *Br Med J* 1969;ii:72-6(S).
5 Committee on Local Authority and Allied Personal Social Services. *Report*. Cmnd 3703. London: HMSO, 1968.
6 *Local Authority Social Services Act 1970*. London: HMSO, 1970.
7 Lait J, Brewer C. Getting nowhere fast. *The Sunday Times* 1980 Sep 14:36.
8 Berg I, Consterdine M, Hullin R, *et al*. The effect of two randomly allocated court procedures on truancy. *British Journal of Criminology* 1978;**18**:232-44.
9 Anonymous. *The Observer* 1980 Sep 21:2.
10 Anonymous. *Social Work Today* 1979;**10**:7.

Employment of the disabled

The recent introduction of self treatment in haemophilia has dramatically improved the management of the severe disease, reduced dependence on hospital, and increased social independence. Treatment with factor VIII concentrate given by the patient himself with minimal fuss at home or at work usually takes only 15 minutes. This change might be expected to result in an improved employment rate in haemophiliacs and an increased use of further and higher education.

These social factors were assessed by Stuart and others in the *BMJ* in May[1] in a report of the results of a questionnaire sent from four haemophilia centres in Britain to 636 patients of all grades of severity aged 16 to 65 years. Sixty per cent of the respondents to the questionnaire were under the age of 35; and 37% practised self care (half of these having done so for more than three years). The hope had been that self treatment, which costs about £2000 per patient per annum, would be cost-effective in enabling more haemophiliacs to return to or remain in employment. In fact, the overall unemployment rate had remained high at 17·5%, at a time when the overall rate in Britain was 6·9%. There were large regional differences: nearly one-third of the haemophiliacs in Glasgow had been unable to find work. These facts raise many questions.

Half the patients had registered themselves as disabled. Did

this help them? Mattingly's recent appraisal[2] made the point that, being voluntary, the register grossly underreports the incidence of disability. In practical terms, registration makes the individual eligible for sheltered work (of which there is not a great deal) and for designated employment (such as car park and lift attendants). The most useful result may be benefit under the "Fares to Work Scheme" (leaflet PL13). An arthritic, for instance, may manage to find a job but be exhausted by long painful journeys on public transport. Under the scheme, run by the Manpower Services Commission, such a patient might receive help with taxi fares to attend open employment.

A few years ago there were moves—now halted—to establish hospital resettlement officers. The idea seemed excellent, giving the resettlement officer close contact with medical and remedial therapists' thinking on the individual patient's prospects for recovery and functional ability. Close contact with medical teams would allow the resettlement officer to see patients early in their illness, preventing the loss of jobs. With mounting unemployment this function has become even more important: it may be more effective for the resettlement officer and occupational therapist to visit the patient's place of employment and suggest temporary or permanent modifications to his work than to present a newly disabled person to a new employer who knows nothing of his previous worth.

What does an employment rehabilitation centre have to offer —an important question now that doctors may refer their patients there direct? Thirty-nine per cent of the haemophiliacs in Stuart's survey[1] had attended employment rehabilitation centres but "the majority found it of no value." This comment is disconcerting. Almost 14 000 persons (including some without handicaps) attended the centres in 1977, of whom 86% completed the course. Only 44% of these were employed or in training some three months later.[3] No doubt many of those accepted at employment rehabilitation centres have been unemployed for very long periods and have severe psychiatric illnesses or severe disability, but could the figures not be improved—if for no other reason than that the consumer's view of the centres' value might be enhanced? Could courses be more flexible, more imaginative, or more responsive to the individual's preferences? Some patients' courses are "prematurely terminated" because their functional ability has not been improved to its maximum (by occupational therapy and physiotherapy) before attendance. The attendance of others is delayed, and return to work is often a tortuous and ill-managed affair with the patient receiving little helpful advice.

Future prospects for the employment of the physically handicapped may be gauged from the problems of current school leavers with such handicaps. These prospects are not good. In 1973 Tuckey[4] and her co-workers showed that of 253 such teenagers, only 65% had ever worked, and one-third of these were in sheltered work. None had started a job leading to professional qualifications, and only 4% were in apprenticeships. A survey by the National Children's Bureau showed that only one-third of such young people who could benefit from further education had received it. The National Union of Students[5] found that 43% of teachers' training colleges had admitted no disabled students between 1972 and 1975. Small wonder that the Warnock Committee[6] commented that "provision for young people over 16 with special needs has received little attention . . . is relatively uncharted and extremely complex not least because of the very disparate needs of the young people themselves." Young haemophiliacs practising self treatment have begun to obtain better educational qualifications: other groups of young handicapped people may not be so fortunate. Doctors responsible for the care of these young patients can do much to ensure that they are prepared for and have access to all necessary training.

[1] Stuart J, Forbes CD, Jones P, Lane G, Rizza CR, Wilkes S. Improving prospects for employment of the haemophiliac. *Br Med J* 1980;**280**: 1169-72.
[2] Mattingly S. The Disabled Persons Register. *Health Trends* 1978;**10**:19-20.
[3] Anonymous. Disabled people. *Department of Employment Gazette* 1980 March:283.
[4] Tuckey L, Parfit J, Tuckey B. *Handicapped school leavers.* London: National Children's Bureau, 1973.
[5] Child D. *The disabled student.* Horsham: Action Research for the Crippled Child, 1974.
[6] Great Britain. Committee of Enquiry into the Education of Handicapped Children and Young People. *Special educational needs: report of Committee of Enquiry into the Education of Handicapped Children and Young People.* Chairman M Warnock. London: HMSO, 1978.

Hazards of surgical glove powders

William Halsted first used rubber gloves in the operating theatre at the Johns Hopkins Hospital, Baltimore, at the end of the last century—an idea borrowed from his pathologist, William Welch, who used rubber gloves for necropsies. Halsted's concern was for his staff rather than his patients; his theatre sister, a Miss Caroline Hampton, had severe eczema as a result of the carbolic acid solution used as a disinfectant. Fortunately, rubber gloves cured her contact dermatitis and she and Halsted later married.[1]

Ever since surgical gloves have been worn surgeons (and manufacturers) have sought the ideal glove lubricant. Initially, talc (magnesium silicate) was thought to be the answer, but repeated reports of the formation of granulomas and adhesions in patients operated on by surgeons using talc showed that it was particularly vicious in this respect. Lee and Lehman[2] introduced starch glove powder in 1947, claiming that it was absorbed completely from the peritoneal cavity without ill effect. Experiments on animals, however, showed that granulomas can be produced by starch,[3 4] and, before long, clinical examples of wound granulomas and of starch peritonitis were being reported.[5]

The syndrome of granulomatous peritonitis due to starch is now well recognised. Ten days to four weeks after laparotomy the patient develops abdominal pain, distension, vomiting, and a low-grade fever. The abdomen is swollen and tender. The white cell count is often mildly raised and *x*-ray films of the abdomen show distended loops of bowel. Not unnaturally, in most cases a diagnosis is made of intestinal obstruction due to adhesions, intra-abdominal infection, or a combination of both. All too often these patients have a further laparotomy, when the characteristic findings are ascitic fluid, which may be yellow, greenish, or serosanguineous; a thickened nodular omentum; small miliary nodules scattered over the serosa; and dense adhesions. Examination of a specimen of one of these granulomatous nodules under polarised light will show the typical Maltese crosses of starch. If the correct diagnosis is suspected clinically examination of a sample of peritoneal aspirate obtained by fine needle puncture will show starch granules and the suspicion may be confirmed with confidence.[6]

Jagelman and Ellis[4] showed that merely washing the gloved hands in copious amounts of sterile water was insufficient to