coccal osteomyelitis. Any other supposed indications seem to call for careful reconsideration. Some idea of the doubtful purposes for which lincomycin or clindamycin have been prescribed may be gained from published case histories of patients with this form of colitis. Indications mentioned include acne rosacea,[11] "a superficial skin infection,"[12] "a mild upper respiratory infection,"[13] influenza,[14] dental extraction,[14] planting a pace-maker,[2] and cover for operation on a metacarpophalangeal joint.[2]

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[12] Wise, R., Tudway, A. J. C., and Pelta, D. E., *Lancet*, 1974, **1**, 878.
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Rebuilding Broken Bridges

"Reorganisation—as social service departments already know and the N.H.S. will now be discovering—is a traumatic process." Many doctors will echo that down-to-earth sentiment, which sets the tone of a recently published report *Social Work Support for the Health Service*.[1] Prepared by a departmental working party, the report is a constructive attempt to clear the air on a subject which has consistently raised the hackles of professional workers on both sides of the N.H.S./local government boundary.

One of the saddest episodes in recent Health Service history has been the sharp deterioration in relations between doctors and social workers that came in the wake of the Seebohm reforms.[2] Patients' welfare can only have suffered as a result. Furthermore the search for a satisfactory solution has been made no easier by the dual reorganization of local government and the N.H.S. and, of course, worsening inflation. So, clearly the Government could not stand back in the hope that time would repair the broken bridges.

The Working Party on Collaboration,[3] which proposed how the reorganized N.H.S. and the new local authorities could best co-operate, had looked carefully at the working relationship between social work departments and the Health Service. Its majority view was that social work support for health care should be the responsibility of local government. In accepting that advice, Sir Keith Joseph, then Secretary of State for Social Services, recognized it as controversial and so he accepted another suggestion in the collaboration report and set up a further working party (representative of all interests concerned) to study the practical aspects of the relationship.

With that background, this working party (chaired by Mr. G. J. Otton from the Department of Health) has exposed the misunderstandings between social workers and doctors, and acknowledged genuinely based criticisms. In such personal services as medicine and social work what really counts is co-operation at the level of the individual—among the patients, or clients as social workers describe them. Here doctors—especially general practitioners and psychiatrists—have often been alarmed at the succession of young, inexperienced, non-specialist social workers who seemed to have replaced, for instance, an experienced local mental welfare officer with whom they had co-operated over the years. For their part social workers found the pressing demands of a general practitioner phoning about a problem case late in the afternoon difficult to fit in with the equally urgent needs of homeless families, the difficulties of running a new department, and the permanent shortage of resources. Like the N.H.S., social work is short of skilled people—a shortage aggravated by rapid promotion of experienced workers into an enlarged management structure. Admittedly, as the report points out, social work is at a much earlier stage in its development than the N.H.S. and training programmes are still being developed. But this shortage was well known and should have made the Seebohm proponents more cautious in planning the reorganization.

Nevertheless the new system has been imposed. In it one of the most hotly debated topics is the merits of the specialist versus the generic social worker. Doctors have greeted the generic social worker with little enthusiasm, laying blame for the new arrival on Seebohm. The authors of the present report, however, see "nothing in Seebohm to imply the wholesale abandonment of specialism in social work practice." If this interpretation is accepted by social work departments doctors will breathe a sigh of relief. But this controversy, though important to the N.H.S., is only part of a more far-reaching debate raging among social workers. Some accept the present social system and regard their job as helping their clients to cope with its defects. Others want a more radical approach. They favour social workers using their unique position in the community to initiate major social change.

"Continuing personal relationship" and regular "face-to-face contact" among those responsible for patients/clients is urged in the report. In this way, it is rightly argued, "doctors learn to know that social work can contribute to patient care . . . and social workers learn to carry out their work in a manner appropriate to the particular medical situation." In the present divided situation this truism bears repeating. Thus more personal contact is a recurring theme and the working party bluntly condemns "arrangements designed merely to establish that a social worker can be called in when necessary by impersonal communication from one system to another . . ." Equally commonsense advice is proffered on communications, teamwork, management, confidentiality, and the special problems of hospitals. In the interests of the community the health authorities and social work departments must co-operate—and not just in committees or by exchanging paper. It means social workers and doctors working together day by day. This report gives them good advice on how to rebuild their broken bridges.

[1] *Report of the Working Party on Social Work Support for the Health Service*, London, H.M.S.O., 1974.
[2] *Report of the Committee on the Local Authority and Allied Personal Social Services*, Cmnd. 3703. London, H.M.S.O., 1968.
[3] *A report from the Working Party on Collaboration between the N.H.S. and Local Government on its activities to the end of 1972*. London, H.M.S.O., 1973.